TE Connectivity ChoicePlus with HSA

Group 17426-00, 70
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Independence Blue Cross and Highmark Blue Shield are independent licensees of the Blue Cross and Blue Shield Association.

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Plan:

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

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશોઃ જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នក ដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់របស់លោកអ្នក (TTY: 711)។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitiníígíí bine'dę́ę́' (TTY: 711) jį' hodíílnih.

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Table of Contents

Introduction to Your PPO Program **1**

General Information **3**
Who is Eligible for Coverage 3
Changes in Membership Status 4
Medicare 4
Leave of Absence or Layoff 5
Continuation of Coverage 5
Termination of Your Coverage Under the Employer Contract 6
Benefits After Termination of Coverage 6
Coordination of Benefits 6
Subrogation 7

How Your Benefits Are Applied **9**
Benefit Period 9
Medical and Prescription Drug Cost-Sharing Provisions 9
Maximum 11

Summary of Benefits **12**

Covered Services **16**
Ambulance Service 16
Assisted Fertilization Treatment 17
Comprehensive Eye Examination 17
Dental Services Related to Accidental Injury 17
Diabetes Treatment 17
Diagnostic Services 18
Durable Medical Equipment 18
Enteral Foods 18
Hearing Care Services 19
Home Health Care/Hospice Care Services 19
Home Infusion and Suite Infusion Therapy Services 20
Hospital Services 20
Emergency Care Services 22
Maternity Services 22
Medical Services 23
Mental Health Care Services 25
Orthotic Devices 26
Private Duty Nursing Services 26
Prosthetic Appliances 27
Skilled Nursing Facility Services 27
Smoking Cessation Program 27
Spinal Manipulations 27
Substance Abuse Services 27
Surgical Services 28
Therapy and Rehabilitation Services 30

Transplant Services 30
Preventive Care Services 31

What Is Not Covered 34

How Your PPO Program Works 40
Network Care 40
Out-of-Network Care 40
Out-of-Area Care 41
Inter-Plan Arrangements 41
Your Provider Network 45
How to Get Your Physicians' Professional Qualifications 46
Eligible Providers 46

Healthcare Management 48
Medical Management 48
Care Utilization Review Process 48
Precertification, Preauthorization and Pre-Service Claims Review Processes 50

A Recognized Identification Card 52

How to File a Claim 53
Your Plan Activity Statement 54
How to Voice a Complaint 54
Additional Information on How to File a Claim 55
Determinations on Benefit Claims 56
Appeal Procedure 57

Member Service 63
Blues On Call 63
Independence Blue Cross Website 64
Baby Blueprints 65
Member Service 65

Health Savings Account 66

Member Rights and Responsibilities 70
How We Protect Your Right to Confidentiality 70

Terms You Should Know 72

Consent Decree Addendum 79

Disclosure

Your health benefits are entirely funded by your employer. Independence Blue Cross provides administrative and claims payment services only.

Introduction to Your PPO Program

This booklet provides you with the information you need to understand your PPO program offered by your group. We encourage you to take the time to review this information so you understand how your health care program works.

This program is a ***high deductible health plan*** of inpatient and outpatient benefits, most of which are provided at both network and out-of-network benefit levels. Health care coverage is based on guidelines from the U.S. Treasury Department. These guidelines require: 1) a minimum deductible amount, 2) a maximum out-of-pocket amount, 3) all medical and drug services, with the exception of preventive care, must be applied toward the deductible, and 4) all medical and drug services must be applied toward the out-of-pocket amount. You must be enrolled in a qualified HDHP to establish and contribute to a health savings account.

For a number of reasons, we think you'll be pleased with your health care program:

- ***Your PPO program gives you freedom of choice.*** You are not required to select a primary care physician to receive covered care. You have access to a large provider network of physicians, hospitals, and other providers throughout the country. For a higher level of coverage, you need to receive care from one of these network providers. However, you can go outside the network and still receive care at the lower level of coverage. To locate a network provider near you, or to learn whether your current physician is in the network, call 1-800-810-BLUE (2583), or log onto your Independence Blue Cross member website, www.mybenefitshome.com.

- ***Your PPO program gives you "stay healthy" care.*** You are covered for a range of preventive care, including physical examinations and selected diagnostic tests. Preventive care is a proactive approach to health management that can help you stay on top of your health status and prevent more serious, costly care down the road.

You can review your Preventive Care Guidelines online at your member website. And, as a member of your PPO program, you get important extras. Along with 24-hour assistance with any health care question via Blues On Call, your member website connects you to a range of self-service tools that can help you manage your coverage. You can also access programs and services

designed to help you make and maintain healthy improvements. And you can access a wide range of care cost and care provider quality tools to assure you spend your health care dollars wisely.

If you have any questions on your PPO program, please call the Member Service toll-free telephone number on the back of your ID card. For TTY/TDD hearing impaired service, please dial 711 and the number on the back of your ID card.

Information for Non-English-Speaking Members

Non-English-speaking members have access to clear benefits information. They can call the toll-free Member Service telephone number on the back of their ID card to be connected to a language services interpreter line. Independence Blue Cross Member Service representatives are trained to make the connection.

As always, we value you as a member, look forward to providing your coverage, and wish you good health.

General Information

Who is Eligible for Coverage

You may enroll your:

- Spouse under a legally valid existing marriage
- Children under 26 years of age, unless otherwise extended pursuant to applicable state or federal law, including:
  - Newborn children
  - Stepchildren
  - Children legally placed for adoption
  - Legally adopted children and children for whom the employee or the employee's spouse is the child's legal guardian
  - Children awarded coverage pursuant to an order of court

  An eligible dependent child's coverage automatically terminates and all benefits hereunder cease at the end of the month the dependent reaches the limiting age or ceases to be an eligible dependent as indicated above, whether or not notice to terminate is received by Independence Blue Cross.

- Unmarried children over age 26 who are not able to support themselves due to mental retardation, physical disability, mental illness or developmental disability that started before age 26. Coverage automatically terminates and all benefits hereunder cease, except as otherwise indicated, on the day following the date on which the disability ceases, whether or not notice to terminate is received by Independence Blue Cross.
- A domestic partner** shall be considered for eligibility as long as a domestic partnership (a voluntary relationship between two domestic partners) exists with you. In addition, the children of the domestic partner shall be considered for eligibility as if they were your children as long as the domestic partnership exists.

**"Domestic Partner" means a member of a domestic partnership consisting of two partners, each of whom has registered with a domestic partner registry in effect in the municipality/governmental entity within which the domestic partner currently resides, or who meets the definition of a domestic partner as defined by the state or local government where the individual currently resides or meets all of the following:

- Is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time
- Is not related to the other partner by adoption or blood
- Is the sole domestic partner of the other partner and has been a member of this domestic partnership for the last six months
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner
- Meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for domestic partnerships which are currently enacted, or which may be enacted in the future

To be eligible for dependent coverage, proof that dependents meet the above criteria may be required.

NOTE: Health Savings Account funds used to pay for medical expenses of dependent, unmarried children 23 years of age and older may affect your tax status. Please consult with your tax advisor for details.

Changes in Membership Status

In order for there to be consistent coverage for you and your dependents, you must keep your plan administrator/employer informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage.

Medicare

Covered Active Employees Age 65 or Over

If you are age 65 or over and actively employed in a group with 20 or more employees, you will remain covered under the program for the same benefits available to employees under age 65. As a result:

- the program will pay all eligible expenses first.

- Medicare will then pay for Medicare eligible expenses, if any, not paid for by the program.

- or -

Non-Covered Active Employees Age 65 or Over
If you are age 65 or over and actively employed, you may elect not to be covered under your program. In such a case, Medicare will be your only coverage. If you choose this option, you will not be eligible for any benefits under the program. Contact your plan administrator for specific details.

Spouses Age 65 or Over of Active Employees
If you are actively employed in a group with 20 or more employees, your spouse has the same choices for benefit coverage as indicated above for the employee age 65 and over.

Regardless of the choice made by you or your spouse, each one of you should apply for Medicare Part A coverage about three months prior to becoming age 65. If you elect to be covered under the program, you may wait to enroll for Medicare Part B. You will be able to enroll for Part B later during special enrollment periods without penalty.

Leave of Absence or Layoff

Upon your return to work following a leave of absence or layoff that continued beyond the period of your coverage, your group's program may, in some cases, allow you to resume your coverage. You should consult with your plan administrator/employer to determine whether your group program has adopted such a policy.

Continuation of Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that covers group health plans sponsored by an employer (private sector or state/local government) that employed at least 20 employees on more than 50 percent of its typical business days in the previous calendar year. Employers that are subject to COBRA must temporarily extend their health care coverage to certain categories of employees and their covered dependents when, due to certain "qualifying events," they are no longer eligible for group coverage.

Contact your employer for more information about COBRA and the events that may allow you or your dependents to temporarily extend health care coverage.

Termination of Your Coverage Under the Employer Contract

Your coverage will be terminated when you cease to be eligible to participate under your group health plan in accordance with its terms and conditions for eligibility.

Benefits After Termination of Coverage

- If you are an inpatient on the day your coverage terminates, facility provider benefits for inpatient covered services will be continued as follows:
  - — Until the maximum amount of benefits has been paid; or
  - — Until the inpatient stay ends; or
  - — Until you become covered, without limitation as to the condition for which you are receiving inpatient care, under another group program; whichever occurs first.
- If you are pregnant on the date coverage terminates, no additional coverage will be provided.

Coordination of Benefits

Most health care programs, including your PPO program, contain a coordination of benefits provision. This provision is used when you, your spouse or your covered dependents are eligible for payment under more than one health care plan. The object of coordination of benefits is to ensure that your covered expenses will be paid, while preventing duplicate benefit payments.

Here is how the coordination of benefits provision works:

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your plan.
- When the person who received care is covered as an employee under one contract, and as a dependent under another, then the employee coverage pays first.
- When a dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the calendar year pays first. But, if both parents have the same birthday, the plan which covered the parent longer will be

the primary plan. If the dependent child's parents are separated or divorced, the following applies:

- The parent with custody of the child pays first.
- The coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody.
- Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

- When none of the above circumstances applies, the coverage you have had for the longest time pays first, provided that:

- the benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person and if
- the other plan does not have this provision regarding laid-off or retired employees, and, as a result, plans do not agree on the order of benefits, then this rule is disregarded.

If you receive more than you should have when your benefits are coordinated, you will be expected to repay any overpayment.

NOTE: In the event the other coverage is a non-high deductible health plan, certain tax advantages of this high deductible health plan, when used in connection with a Health Savings Account, may be lost. Please consult your tax advisor for information.

Prescription drug benefits are not coordinated against any other health care or drug benefit coverage.

Subrogation

As used in this booklet, “subrogation” refers to the Plan’s right to seek payment and/or reimbursement from a person or organization responsible, or potentially responsible, for the Plan’s payment of health care expenses you incurred in connection with an injury.

The Plan also has the right to seek payment and/or reimbursement from you if you receive a payment, settlement, judgment or award from a person, organization or

insurance company in connection with an injury caused or alleged to be caused by the person or organization. The Plan has this right regardless of whether:

- liability is admitted by any potentially responsible person or organization;
- the payment, settlement, judgment or award you received identifies medical benefits provided by the Plan; or
- the payment, settlement, judgment or award is otherwise designated as "pain and suffering" or "non-economic damages" only.

The Plan shall have a first priority lien on the proceeds of any payment, settlement or award you receive in connection with an injury caused by a person or organization. The lien shall be in the amount of benefits paid on your behalf regardless of whether you are made-whole for your loss or because you have incurred attorney fees or costs.

The Plan will provide eligible benefits when needed, but you may be asked to show, execute and/or deliver documents, or take other necessary actions to support the Plan in any subrogation efforts. Neither you nor any of your dependents shall do anything to prejudice the right given to the Plan by this Subrogation section without the Plan's consent.

How Your Benefits Are Applied

To help you understand your coverage and how it works, here's an explanation of some benefit terms found in your Summary of Benefits.

Benefit Period

The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by your program. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Your benefit period is 12 consecutive months beginning on January 1.

Medical and Prescription Drug Cost-Sharing Provisions

Cost-sharing is a requirement that you pay part of your expenses for covered services. The terms "deductible" and "coinsurance" describe methods of such payment.

Coinsurance

The coinsurance is the specific percentage of the plan allowance for covered services that is your responsibility. For covered medications, the coinsurance is the specific percentage of the provider's allowable price that is your responsibility. You may be required to pay any applicable coinsurance at the time you receive care or medications from a provider. Refer to the Plan Payment Level in your Summary of Benefits for the percentage amounts paid by the program.

Deductible

The deductible is a specified dollar amount you must pay for covered services and covered medications each benefit period before the program begins to provide payment for benefits. See the Summary of Benefits for the deductible amount. You may be required to pay any applicable deductible at the time you receive care from a provider.

Family Deductible

For a family with several covered dependents, the deductible you pay for all covered family members, regardless of family size, is specified under family deductible. To reach this total, the entire family deductible must be satisfied in one benefit period by one or more family members. Benefits for any individual member of the family will not be payable until the family deductible has been satisfied. Once the family deductible is met, no further deductible amounts must be satisfied by any covered family member.

Out-of-Pocket Limit

The out-of-pocket limit refers to the specified dollar amount of coinsurance and deductible incurred for covered services and covered medications in a benefit period. When the specified dollar amount is attained, your program begins to pay 100% of all covered expenses. See your Summary of Benefits for the out-of-pocket limit. The out of pocket limit does not include amounts in excess of the plan allowance.

Family Out-of-Pocket Limit

The family out-of-pocket limit refers to the amount of coinsurance and deductible incurred by you or your covered family members for covered services and covered medications received in a benefit period.

Once all covered family members have incurred an amount equal to the family out-of-pocket limit, claims received for all covered family members during the remainder of the benefit period will be payable at 100% of the plan allowance for covered services or 100% of the provider's allowable price for covered medications.

The dollar amount specified shall not include any amounts in excess of the plan allowance.

However, if any covered family member has incurred an amount equal to the individual out-of-pocket limit, the benefits payable by your program for covered services for that particular individual family member will be payable at 100% of the plan allowance during the remainder of the benefit period.

Total Maximum Out-of-Pocket

The total maximum out-of-pocket, as mandated by the federal government, refers to the specified dollar amount of deductible, coinsurance incurred for network covered services and covered medications and any qualified medical expenses in a benefit period. When the specified individual dollar amount is attained by you, or the specified family dollar amount is attained by you or your covered family members, your program begins to pay 100% of all covered expenses and no additional coinsurance and deductible will be incurred for network covered services and covered medications in that benefit period. See your Summary of Benefits for the total maximum out-of-pocket. The total maximum out-of-pocket does not include out-of-network cost-sharing, amounts in excess of the plan allowance or amounts paid for penalties assessed under the Health Care Management Services program.

The dollar amount specified shall not include any amounts in excess of the plan allowance.

However, if any covered family member has incurred an amount equal to the individual total maximum out-of-pocket, the benefits payable by your program for covered services for that particular individual family member will be payable at 100% of the plan allowance during the remainder of the benefit period.The entire family deductible must be satisfied before claim reimbursement begins, and the entire family out-of-pocket must be satisfied before additional claims reimbursement. However, once any eligible family member satisfies his/her individual total maximum out-of-pocket, benefits for covered expenses will be reimbursed at 100% of the allowance for that individual family member, regardless of whether the family total maximum out-of-pocket has been satisfied.

Maximum

The greatest amount of benefits that the program will provide for covered services within a prescribed period of time. This could be expressed in dollars, number of days or number of services.

If you purchase a brand-name drug when a generic is available – and your doctor has not written "Dispense As Written (DAW)" on the prescription – you will pay the brand copayment plus the difference in cost between the brand and the generic. This additional cost will not be applied to your deductible or out-of-pocket maximum. The difference in cost between the brand and the generic will still be your responsibility even after you have met your out-of-pocket maximum.

Summary of Benefits

This Summary of Benefits outlines your covered services. More details can be found in the Covered Services section. Independence Blue Cross may utilize the services of Highmark Inc. to administer certain portions of this benefit program

Benefits	Network	Out-of-Network
General Provisions		
The following are your PPO program cost-sharing provisions which include your medical and prescription drug benefits		
Benefit Period[1]	Contract Year	
Deductible (per benefit period)[2]		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Plan Payment Level - Based on the plan allowance	70% after deductible until out-of-pocket limit is met; then 100%	60% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limits [3]		
Individual	$4,000	$8,000
Family	$8,000	$16,000
Total Maximum Out-of-Pocket See the section "How Your Benefits Are Applied" for exclusions/details		
Individual	$4,000	None
Family	$8,000	None
Lifetime Maximum (per member)	Unlimited	
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits (including virtual visits)	70% after deductible	60% after deductible
Primary Care Physician Office Visits (including virtual visits)[4 5]	70% after deductible	60% after deductible
Specialist Office Visits (including virtual visits)[4]	70% after deductible	60% after deductible
Virtual Visit Originating Site Fee[4]	70% after deductible	60% after deductible
Urgent Care Center Visits	70% after deductible	
Telemedicine Services[6]	70% after deductible	Not Covered
Preventive Care Services[7]		
Adult		
Routine physical exams	100%; deductible does not apply	60% after deductible
Adult Immunizations	100%; deductible does not apply	60% after deductible
Diagnostic services and procedures	100%; deductible does not apply	60% after deductible
Routine gynecological exams, including a PAP Test	100%; deductible does not apply	60% after deductible
Mammograms		
Routine	100%; deductible does not apply	60% after deductible
Medically Necessary	70% after deductible	60% after deductible
Pediatric		
Routine physical exams	100%; deductible does not apply	60% after deductible
Pediatric immunizations	100%; deductible does not apply	60% after deductible
Diagnostic services and procedures	100%; deductible does not apply	60% after deductible
Prescription Drugs - Preventive Covered Medications (Outpatient)	100%; deductible does not apply	60% after deductible

Benefits	Network	Out-of-Network
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Services - Inpatient	70% after deductible	60% after deductible
Hospital Services - Outpatient[8]	70% after deductible	60% after deductible
Maternity (non-preventive facility and professional services)	70% after deductible	60% after deductible
Medical/Surgical Expenses (except office visits)	70% after deductible	60% after deductible
Gender Reassignment Surgery	70% after deductible	60% after deductible
Emergency Services		
Emergency Room Services	70% after deductible	Same as network services
Emergency Ambulance Service	70% after deductible	Same as network services
Non-Emergency Ambulance Service	70% after deductible	60% after deductible
Therapy and Rehabilitation Services		
Infusion Therapy	70% after deductible	60% after deductible
Occupational Therapy, Physical Medicine and Speech Therapy	70% after deductible	60% after deductible
	Limit: 90 visits per benefit period for Occupational Therapy, Physical Medicine and Speech Therapy combined	
Radiation Therapy	70% after deductible	60% after deductible
Respiratory Therapy	70% after deductible	60% after deductible
Spinal Manipulations	70% after deductible	60% after deductible
	Limit: 25 visits per benefit period	
Other Therapy Services (Cardiac Rehabilitation, Chemotherapy, and Dialysis Treatment)	70% after deductible	60% after deductible
Mental Health/Substance Abuse Services		
Mental Health Care Services - Inpatient	70% after deductible	60% after deductible
Mental Health Care Services - Outpatient (including virtual visits) [6]	70% after deductible	60% after deductible
Substance Abuse Services - Inpatient Detoxification	70% after deductible	60% after deductible
Substance Abuse Services - Inpatient Residential Treatment and Rehabilitation Services	70% after deductible	60% after deductible
Substance Abuse Services - Outpatient	70% after deductible	60% after deductible
Other Services		
Allergy Extracts and Injections	70% after deductible	60% after deductible
Assisted Fertilization Treatment	70% after deductible	60% after deductible
	Limit: $10,000 maximum per lifetime	
Bariatric Surgery	70% after deductible	Not Covered
	Service Limit: One surgery per lifetime	
Dental Services Related to Accidental Injury	70% after deductible	60% after deductible
Diabetes Treatment	70% after deductible	60% after deductible
Diagnostic Services (Lab, x-ray, allergy testing and other diagnostic medical tests)	70% after deductible	60% after deductible
Durable Medical Equipment	70% after deductible	60% after deductible
Enteral Foods	70% after deductible	60% after deductible

Benefits	Network	Out-of-Network
Hearing Care Services Routine Hearing Screening	100%; deductible does not apply	Not Covered
Hearing Aids	70% after deductible	60% after deductible
	Limit: $2,000 maximum every 36 months	
Hearing Aid Exam	70% after deductible	60% after deductible
Home Infusion and Suite Infusion Therapy Services	70% after deductible	60% after deductible
Home Health Care	70% after deductible	60% after deductible
	Limit: 100 visits per benefit period	
Hospice	70% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment[9]	70% after deductible	60% after deductible
Orthotics	70% after deductible	60% after deductible
Private Duty Nursing	70% after deductible	60% after deductible Limit: $10,000 maximum per benefit period
Prosthetics	70% after deductible	60% after deductible
Routine Eye Examination Routine Vision Screening	100%; deductible does not apply	60% after deductible
	Limit: One routine eye exam per benefit period	
Comprehensive Eye Exam	70% after deductible	60% after deductible
Skilled Nursing Facility Care	70% after deductible	60% after deductible
Smoking Cessation	70% after deductible	Not Covered
Sterilization Tubal Ligation	100%; deductible does not apply	60% after deductible
Vasectomy	70% after deductible	60% after deductible
Skilled Nursing Facility Care	70% after deductible	60% after deductible
Transplant Services Blue Distinction Specialty Care @ *Blue Distinction Center* Transplant [10]	100% after deductible	60% after deductible
@ *Non-Blue Distinction Center* Transplant	70% after deductible	
Travel and Lodging Hotel	$50 per day up to 21 days	
Meals	$25 per day up to $500 maximum	
Precertification Requirements	Yes[11]	
		Failure to precertify will result in benefits payable being reduced by **$500.**

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during a benefit period will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

[1] Your group's benefit period is based on a contract year. The contract year is a consecutive 12-month period beginning on January 1.

[2] The individual deductible only applies for a member with individual coverage. For a member with family coverage, the family deductible must be met by one or more members of the family before benefits will be paid.

[4] You ***may*** be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a hospital, facility provider, ancillary provider, retail clinic or urgent care center. The specialist virtual visit is subject to availability within your service area.

[5] A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics.

[6] Telemedicine services are provided for acute care for minor illnesses when provided by an approved telemedicine provider. Virtual behavioral health visits provided by an approved telemedicine provider are eligible under the outpatient mental health benefits.

[7] Services are limited to those on a predefined schedule. Gender, age and frequency limits may apply.

[8] Other cost sharing provisions and/or limits may apply to specific benefits, i.e., physical medicine, therapies, diagnostic services, mental health/substance abuse visits.

[9] If testing is required, cost sharing may apply as outlined under Diagnostic Services. Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.To locate one of the Blue Distinction Centers and Blue Distinction Center Plus, call the Member Service number on the back of your identification card or use the Provider Directory found on www.mybenefitshome.com.

[10] To locate one of the Blue Distinction Centers and Blue Distinction Center Plus, call the Member Service number on the back of your identification card or use the Provider Directory found on www.mybenefitshome.com.

[11] Independence Blue Cross must be contacted prior to a planned inpatient admission or within 48 hours of an emergency inpatient admission. Some facility providers will contact Independence Blue Cross and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Independence Blue Cross for precertification. If not, you are responsible for contacting Independence Blue Cross. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

Covered Services

Your PPO program provides benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate. All benefit limits and deductible amounts are described in the Summary of Benefits. Network care is covered at a higher level of benefits than out-of-network care.

Ambulance Service

Ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

- from your home, the scene of an accident or medical emergency to a hospital or skilled nursing facility;
- between hospitals; or
- between a hospital and a skilled nursing facility;

when such facility is the closest institution that can provide covered services appropriate for your condition. If there is no facility in the local area that can provide covered services appropriate for your condition, then ambulance service means transportation to the closest facility outside the local area that can provide the necessary service.

Transportation and related emergency services provided by an ambulance service will be considered emergency ambulance service if the injury or condition is considered emergency care. Use of an ambulance as transportation to an emergency room for an injury or condition that is not considered emergency care will not be covered as emergency ambulance services. Refer to the Terms You Should Know section for a definition of emergency care services.

Local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

- from a hospital to your home, or
- from a skilled nursing facility to your home.

Assisted Fertilization Treatment

Benefits will be provided for covered services in connection with the treatment of infertility when such services are ordered by a physician and are determined to be medically necessary and appropriate.

Comprehensive Eye Examination

Benefits will be provided for one comprehensive eye examination, including but not limited to eye refraction and glaucoma testing.

Dental Services Related to Accidental Injury

Dental services initially rendered by a physician which are required as a result of accidental injury to the jaws, sound natural teeth, mouth or face. Injury as a result of chewing or biting shall not be considered an accidental injury.

Diabetes Treatment

Coverage is provided for the following when required in connection with the treatment of diabetes and when prescribed by a physician legally authorized to prescribe such items under the law:

- Equipment and supplies: Blood glucose monitors, monitor supplies, injection aides, syringes and insulin infusion devices
- Diabetes Education Program*: When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through a diabetes education program:
  - Visits medically necessary and appropriate upon the diagnosis of diabetes
  - Subsequent visits under circumstances whereby your physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in your self-management, or b) identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to your treatment and/or management of diabetes

*__Diabetes Education Program –__ an outpatient program of self-management, training and education, including medical nutrition therapy, for the treatment of diabetes. Such outpatient program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education services will be covered subject to Independence Blue Cross's criteria. These criteria are based on the certification programs for outpatient diabetes education developed by the American Diabetes Association (ADA).

Diagnostic Services

Benefits will be provided for the following covered services when ordered by a professional provider:

- Diagnostic x-ray consisting of radiology (including diagnostic mammography), magnetic resonance imaging (MRI), ultrasound and nuclear medicine
- Diagnostic pathology consisting of laboratory and pathology tests
- Diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by Independence Blue Cross
- Allergy testing consisting of percutaneous, intracutaneous, and patch tests

Durable Medical Equipment

The rental or, at the option of Independence Blue Cross, the purchase, adjustment, repairs and replacement of durable medical equipment for therapeutic use when prescribed by a professional provider within the scope of his/her license. Rental costs cannot exceed the total cost of purchase.

Enteral Foods

Enteral foods is a liquid source of nutrition equivalent to a prescription drug that is administered orally or enterally and which may contain some or all nutrients necessary to meet minimum daily nutritional requirements. Enteral foods are intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are identified through medical evaluation.

Coverage is provided for enteral foods when administered on an outpatient basis for:

- amino acid-based elemental medical formulae ordered by a physician for infants and children for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short bowel syndrome; and
- nutritional supplements administered under the direction of a physician for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria; and
- enteral foods prescribed by a physician, when administered on an outpatient basis, considered to be your sole source of nutrition and provided:

- through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulas; or
- orally and identified as one of the following types of defined formulae with: hydrolyzed (pre-digested) protein or amino acids, specialized content for special metabolic needs, modular components, or standardized nutrients.

Once it is determined that you meet the above criteria, coverage for enteral foods will continue as long as it represents at least 50% of your daily caloric requirement.

Coverage for enteral foods <u>excludes</u> the following:

- Blenderized food, baby food, or regular shelf food
- Milk or soy-based infant formulae with intact proteins
- Any formulae, when used for the convenience of you or your family members
- Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance
- Semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally

This coverage does not include normal food products used in the dietary management of the disorders included above.

Hearing Care Services

Benefits include coverage for diagnostic testing, an audiometric examination and purchase of hearing aid devices, when prescribed by a professional provider.

Home Health Care/Hospice Care Services

This program covers the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care:

- Skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN), excluding private duty nursing services
- Physical medicine, speech therapy and occupational therapy
- Medical and surgical supplies provided by the home health care agency or hospital program for home health care or hospice care

- Oxygen and its administration
- Medical social service consultations
- Health aide services when you are also receiving covered nursing services or therapy and rehabilitation services
- Family counseling related to the member's terminal condition

No home health care/hospice benefits will be provided for:

- dietitian services;
- homemaker services;
- maintenance therapy;
- dialysis treatment;
- custodial care; and
- food or home-delivered meals.

Home Infusion and Suite Infusion Therapy Services

Benefits will be provided when performed by a home infusion and/or suite infusion therapy provider at an infusion suite or in a home setting. This includes pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with infusion therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with infusion therapy.

Hospital Services

This program covers the following services received in a facility provider. Benefits will be covered only when, and so long as, they are determined to be medically necessary and appropriate for the treatment of the patient's condition.

Inpatient Services

Bed and Board

Bed, board and general nursing services are covered when you occupy:

- a room with two or more beds;
- a private room. Private room allowance is the average semi-private room charge;

- a bed in a special care unit which is a designated unit which has concentrated all facilities, equipment and supportive services for the provision of an intensive level of care for critically ill patients.

Ancillary Services

Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms and equipment;
- drugs and medicines provided to you while you are an inpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives;
- anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;
- medical and surgical dressings, supplies, casts and splints;
- diagnostic services; or
- therapy and rehabilitation services.

Outpatient Services

Ancillary Services

Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms and equipment;
- drugs and medicines provided to you while you are an outpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives;
- anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;
- medical and surgical dressings, supplies, casts and splints.

Pre-Admission Testing
Tests and studies required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.

Surgery
Hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies and services rendered by an employee of the facility provider, other than the surgeon or assistant at surgery.

Emergency Care Services

As a PPO member, you're covered at the higher, network level of benefits for emergency care received in *or outside* the provider network. This flexibility helps accommodate your needs when you need care *immediately*.

In emergency situations, where you must be treated immediately, go directly to your nearest hospital emergency provider; or call "911" or your area's emergency number.

Once the crisis has passed, call your physician to receive appropriate follow-up care.

Emergency care services are services and supplies, including drugs and medicines, for the outpatient emergency treatment of bodily injuries resulting from an accident or a medical condition. Also included is a medical screening examination and ancillary services necessary to evaluate such injury or emergency medical condition and further medical examination and treatment as required to stabilize the patient.

Refer to the Terms You Should Know section for a definition of emergency care services. Treatment for any occupational injury for which benefits are provided under any worker's compensation law or any similar occupational disease law is not covered.

Maternity Services

If you think you are pregnant, you may contact your physician or go to a network obstetrician or nurse midwife. When your pregnancy is confirmed, you may continue to receive follow-up care which includes prenatal visits, medically necessary and appropriate sonograms, delivery, postpartum and newborn care in the hospital.

Hospital, medical and surgical services rendered by a facility provider or professional provider for:

Complications of Pregnancy
Physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.

Normal Pregnancy
Normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy.

Nursery Care
Covered services provided to the newborn child from the moment of birth, including care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Routine nursery care includes inpatient medical visits by a professional provider.

Under Federal law, your self-insured group health program generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, under Federal law, your self-insured program can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

If you are pregnant, now is the time to enroll in the Baby Blueprints® Maternity Education and Support Program offered by Independence Blue Cross. Please refer to the Member Services section of this booklet for more information.

Medical Services

Inpatient Medical Services
Medical care by a professional provider when you are an inpatient for a condition not related to surgery, pregnancy or mental illness, except as specifically provided herein:

Concurrent Care

Medical care rendered concurrently with surgery during one inpatient stay by a professional provider other than the operating surgeon for treatment of a medical condition separate from the condition for which surgery was performed. Medical

care by two or more professional providers rendered concurrently during one inpatient stay when the nature or severity of your condition requires the skills of separate physicians.

Consultation

Consultation services rendered to an inpatient by another professional provider at the request of the attending professional provider. Consultation does not include staff consultations which are required by facility provider rules and regulations. Benefits are limited to one consultation per consultant per admission.

Inpatient Medical Care Visits

Benefits are provided for inpatient medical care visits.

Intensive Medical Care

Medical care rendered to you when your condition requires a professional provider's constant attendance and treatment for a prolonged period of time.

Routine Newborn Care

Professional provider visits to examine the newborn infant while the mother is an inpatient.

Outpatient Medical Care Services (Office Visits)

Medical care rendered by a professional provider when you are an outpatient for a condition not related to surgery, pregnancy or mental illness, except as specifically provided. Benefits include medical care visits, telemedicine services and consultations for the examination, diagnosis and treatment of an injury or illness.

Please note that as a Independence Blue Cross member, you enjoy many convenient options for where you can receive outpatient care. You can physically go to one of the following providers:

- Primary care physician's (PCP) or specialist's office
- Physician's office located in an outpatient hospital/hospital satellite setting
- Urgent Care Center
- Retail site, such as in a pharmacy or other retail store

Or you can interact with a professional provider as follows:

- A virtual visit between you and a PCP or retail clinic via an audio and video telecommunications system
- A virtual visit between you and a specialist via the internet or similar electronic communications for the treatment of skin conditions or diseases

- A specialist virtual visit between you and a specialist at a remote location via interactive audio and video telecommunications. Benefits are provided for a specialist virtual visit which is subsequent to your initial visit with your treating specialist for the same condition. The provider-based location from which you communicate with the specialist is referred to as the "originating site". Benefits will not be provided for a specialist virtual visit if the visit is related to the treatment of mental illness or substance abuse. (The specialist virtual visit is subject to availability within your service area.)

Different types of providers and their locations may require different payment amounts. The specific amounts you are responsible for paying depend on your particular Independence Blue Cross benefits.

Allergy Extract/Injections

Benefits are provided for allergy extract and allergy injections.

Therapeutic Injections

Therapeutic injections required in the diagnosis, prevention and treatment of an injury or illness.

Mental Health Care Services

Your mental health is just as important as your physical health. That’s why your PPO program provides professional, confidential mental health care that addresses your individual needs. You have access to a wide range of mental health and substance abuse professional providers, so you can get the appropriate level of responsive, confidential care.

You are covered for a full range of counseling and treatment services. The PPO program covers the following services you receive from a provider to treat mental illness:

Inpatient Facility Services

Inpatient hospital services provided by a facility provider for the treatment of mental illness.

Inpatient Medical Services

Covered inpatient medical services provided by a professional provider:

- Individual psychotherapy
- Group psychotherapy

- Psychological testing
- Counseling with family members to assist in your diagnosis and treatment
- Electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same professional provider

Partial Hospitalization Mental Health Care Services
Benefits are only available for mental health care services provided on a partial hospitalization basis when received through a partial hospitalization program. A mental health care service provided on a partial hospitalization basis will be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.

Outpatient Mental Health Care Services
Inpatient facility service and inpatient medical benefits (except room and board) provided by a facility provider or professional provider as previously described, are also available when you are an outpatient, including a virtual visit between you and a specialist or approved telemedicine provider via an audio and video telecommunications system.

Orthotic Devices

Purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.

Private Duty Nursing Services

Services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) when ordered by a physician, providing such nurse does not ordinarily reside in your home or is not a member of your immediate family.

- If you are an inpatient in a facility provider only when Independence Blue Cross determines that the nursing services required are of a nature or degree of complexity or quantity that could not be provided by the regular nursing staff.
- If you are at home only when Independence Blue Cross determines that the nursing services require the skills of an RN or an LPN.

Prosthetic Appliances

Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues, or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered.

Skilled Nursing Facility Services

Services rendered in a skilled nursing facility to the same extent benefits are available to an inpatient of a hospital.

No benefits are payable:

- after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care;
- when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or
- for treatment of substance abuse or mental illness.

Smoking Cessation Program

Covered services will be provided for the participation in any accredited smoking cessation program upon receipt of satisfactory proof of enrollment and completion of the smoking cessation program.

Spinal Manipulations

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.

Substance Abuse Services

Benefits are provided for individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance abuse and include the following:

- Inpatient hospital or substance abuse treatment facility services for detoxification

- Substance abuse treatment facility services for non-hospital inpatient residential treatment and rehabilitation services
- Outpatient hospital or substance abuse treatment facility or outpatient substance abuse treatment facility services for rehabilitation therapy

For purposes of this benefit, a substance abuse service provided on a partial hospitalization basis shall be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.

Surgical Services

This program covers the following services you receive from a professional provider. See the Healthcare Management section for additional information which may affect your benefits.

Anesthesia

Administration of anesthesia for covered surgery when ordered by the attending professional provider and rendered by a professional provider other than the surgeon or the assistant at surgery.

Assistant at Surgery

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

Second Surgical Opinion

A consulting physician's opinion and directly related diagnostic services to confirm the need for recommended elective surgery.

Keep in mind that:

- the second opinion consultant must not be the physician who first recommended elective surgery;
- elective surgery is covered surgery that may be deferred and is not an emergency;
- use of a second surgical opinion is at your option;
- if the first opinion for elective surgery and the second opinion conflict, then a third opinion and directly related diagnostic services are covered services; and
- if the consulting opinion is against elective surgery and you decide to have the elective surgery, the surgery is a covered service. In such instance, you will be

eligible for a maximum of two such consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

Special Surgery

- Sterilization

    - Sterilization regardless of medical necessity and appropriateness.

- Bariatric surgery

    Benefits are provided for bariatric surgery for the treatment of obesity including the treatment of sickness or injury resulting from such surgery.

- Mastectomy and Breast Cancer Reconstruction

    Benefits are provided for a mastectomy performed on an inpatient or outpatient basis and for the following:
    - All stages of reconstruction of the breast on which the mastectomy has been performed
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance
    - Prostheses; and
    - Treatment of physical complications of mastectomy, including lymphedema

- Gender Reassignment Surgery

    - Benefits are provided for genital and breast surgeries and associated covered services such as, but not limited to, hormonal therapy performed in connection with a planned or completed gender reassignment surgery if you are diagnosed with gender dysphoria and subject to you meeting specific benefit eligibility criteria.

Surgery

- Surgery performed by a professional provider. Separate payment will not be made for pre- and post-operative services.

- If more than one surgical procedure is performed by the same professional provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure and no allowance shall be

made for additional procedures except where Independence Blue Cross deems that an additional allowance is warranted.

Therapy and Rehabilitation Services

This program covers the following services when such services are ordered by a physician:

- Cardiac rehabilitation
- Chemotherapy
- Dialysis treatment
- Infusion therapy when performed by an eligible provider and for self-administration if the components are furnished and billed by an eligible provider
- Occupational therapy
- Physical medicine
- Radiation therapy
- Respiratory therapy
- Speech therapy

Transplant Services

Benefits will be provided for covered services furnished by a hospital which are directly and specifically related to the transplantation of organs, bones, tissue or blood stem cells.

If a human organ, bone, tissue or blood stem cell transplant is provided from a living donor to a human transplant recipient:

- when both the recipient and the donor are members, each is entitled to the benefits of their program;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this program subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other health care coverage, other Blue Cross or Blue Shield coverage or any government program; and 2) benefits provided to the donor will be charged against the recipient's coverage under this program to the extent that benefits

remain and are available under this program after benefits for the recipient's own expenses have been paid;

– when only the donor is a member, the donor is entitled to the benefits of this program, subject to the following additional limitations: 1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this program; and 2) no benefits will be provided to the non-member transplant recipient; and

– if any organ, tissue or blood stem cell is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the member recipient's program limit.

Travel and Lodging Expenses

Reimbursement of travel and lodging expenses are available in connection with covered transplant services when medical care is not available locally and the treatment facility is located more than 100 miles from the member's home. Covered services include:

- Reimbursement of travel expenses. Benefits are provided for the adult transplant recipient and one other adult companion. If the transplant recipient is a child, transportation is allowed for the recipient and two parents or guardians. No reimbursement is available for automobile maintenance or repair.
- Lodging expenses for one companion or one parent/guardian per night.

Benefits are subject to the maximums and limits shown in the Summary of Benefits section. For additional information, please contract the Member Service Department using the telephone number on the back of your ID card.

Preventive Care Services

Preventive benefits are offered in accordance with a predefined schedule based on age, sex and certain risk factors. The schedule of covered services is periodically reviewed based on the requirements of the Patient Protection Affordable Care Act of 2010, and advice from organizations such as the American Academy of Pediatrics, the U.S. Preventive Services Task Force, the Blue Cross Blue Shield Association and medical consultants. Therefore, the frequency and eligibility of services is subject to change. Benefits include periodic physical examinations, well child visits, immunizations and selected diagnostic tests. For a current schedule of covered services, log onto your Independence Blue Cross member website, www.mybenefitshome.com, or call Member Service at the toll-free telephone number listed on the back of your ID card.

Adult and Pediatric Care

Routine physical examinations, regardless of medical necessity and appropriateness, including a complete medical history for adults, and other items and services.

Well-woman benefits are provided for items and services including, but not limited to, an initial physical examination to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods and counseling for all members capable of pregnancy and breastfeeding support and counseling.

Adult Immunizations

Benefits are provided for adult immunizations, including the immunizing agent, when required for the prevention of disease.

Diagnostic Services and Procedures

Benefits are provided for routine screening tests and procedures, regardless of medical necessity and appropriateness.

Routine Gynecological Examination and Pap Test

Benefits are provided for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine Papanicolaou smear (pap test) per calendar year.

Mammographic Screening

Benefits are provided for the following:

- An annual routine mammographic screening starting at 40 years of age or older pursuant to the 2002 recommendations by the United States Preventive Services Task Force.
- Mammographic screenings for all members regardless of age when such services are prescribed by a physician.

Benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified.

Pediatric Immunizations

Benefits are provided to members through 18 years of age and dependent children for those pediatric immunizations, including the immunizing agents, which conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services.

Tobacco Use, Counseling and Interventions

Benefits are provided for screenings for tobacco use and, for those who use tobacco products, two tobacco cessation attempts per year. A tobacco cessation attempt includes four tobacco cessation counseling sessions and covered medications.

Prescription Drugs (Outpatient)

Coverage will be provided for prescription and over-the-counter drugs that are prescribed for preventive purposes.

Routine Eye Examination

Benefits will be provided for one routine eye examination per calendar year.

What Is Not Covered

Except as specifically provided in this program or as Independence Blue Cross is mandated or required to provide based on state or federal law, no benefits will be provided for services, supplies, prescription drugs or charges:

Key Word	Exclusion
Acupuncture	• For acupuncture services.
Allergy Testing	• For allergy testing, except as provided herein.
Ambulance	• For ambulance services, except as provided herein.
Comfort/Convenience Items	• For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider.
Cosmetic Surgery	• For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, including surgery or procedures to improve gender specific appearance, except as otherwise provided herein. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; b) surgery to correct a congenital birth defect; and c) surgery to correct a functional impairment which results from a covered disease or injury.
Court Ordered Services	• For otherwise covered services ordered by a court or other tribunal as part of your or your dependent's sentence.
Custodial Care	• For custodial care, domiciliary care, protective and supportive care including educational services, rest cures and convalescent care.
Dental Care	• Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses otherwise

covered because of accidental bodily injury to sound natural teeth and for orthodontic treatment for congenital cleft palates as provided herein.

Effective Date

- Rendered prior to your effective date of coverage.

Enteral Foods

- For the following services associated with the additional enteral foods benefits provided under your program: blenderized food, baby food, or regular shelf food; milk or soy-based infant formulae with intact proteins; any formulae, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance; semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally; normal food products used in the dietary management of the disorders provided herein.

Experimental/ Investigative

- Which are experimental/investigative in nature.

Eyeglasses/Contact Lenses

- For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury).

Felonies

- For any illness or injury you suffer during your commission of a felony, as long as such illness or injuries are not the result of a medical condition or an act of domestic violence.

Foot Care

- For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.

Healthcare Management program	• For any care, treatment, prescription drug or service which has been disallowed under the provisions of Healthcare Management program.
Home Health Care	• For the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: dietitian services; homemaker services; maintenance therapy; dialysis treatment; custodial care; food or home-delivered meals.
Immunizations	• For immunizations required for foreign travel or employment.
Inpatient Admissions	• For inpatient admissions which are primarily for diagnostic studies. • For inpatient admissions which are primarily for physical medicine services.
Learning Disabilities	• For any care that is related to conditions such as autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change. Care which extends beyond traditional medical management or for inpatient confinement for environmental change includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services provided for purposes of behavioral modification and/or training; d) services related to the treatment of learning disorders or learning disabilities; e) services provided primarily for social or environmental change or for respite care; f) developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the member has not yet attained; and g) services provided for which, based on medical standards, there is no established expectation of achieving measurable, sustainable improvement in a

reasonable and predictable period of time.

Legal Obligation	• For which you would have no legal obligation to pay.
Medically Necessary and Appropriate	• Which are not medically necessary and appropriate as determined by Independence Blue Cross.
Medicare	• To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program.
Methadone Hydrochloride	• For methadone hydrochloride treatment for which no additional functional progress is expected to occur.
Military Service	• To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.
Miscellaneous	• For telephone consultations which do not involve telemedicine services, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
	• For any other medical or dental service or treatment or prescription drug except as provided herein.
Naturopathic Services	• For naturopathic providers and naturopathic services.
Nutritional Counseling	• For nutritional counseling, except as provided herein.
Obesity	• For treatment of obesity, except for medical and surgical treatment of morbid obesity or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
Oral Surgery	• For oral surgery procedures, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, except as provided herein.
Physical Examinations	• For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided

herein.

Prescription Drugs (Medical Program)	• For any drug or medication which is otherwise excluded herein.
Preventive Care Services	• For preventive care services, wellness services or programs, except as provided herein.
Provider of Service	• Which are not prescribed by or performed by or upon the direction of a professional provider. • Rendered by other than ancillary providers, facility providers or professional providers. • Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group. • Which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same member. • Rendered by a provider who is a member of your 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.
Respite Care	• For respite care.
Sexual Dysfunction	• For treatment of sexual dysfunction that is not related to organic disease or injury.
Skilled Nursing	• For skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness.
Sterilization	• For reversal of sterilization.

Termination Date	• Incurred after the date of termination of your coverage except as provided herein.
Therapy	• For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate.
TMJ	• For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
Vision Correction Surgery	• For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.
War	• For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.
Weight Reduction	• For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
Well-Baby Care	• For well-baby care visits, except as provided herein.
Workers' Compensation	• 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 any federal, state, or local government’s workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.

How Your PPO Program Works

Your PPO program lets you get the care you want from the provider you select. When you or a covered family member needs medical care, you can choose between two levels of health care services: **network** or **out-of-network.**

Network Care

For further information, please refer to the Consent Decree Addendum provided at the end of this benefit booklet.

Network care is care you receive from providers in the PPO program's network.

When you receive health care within the PPO network, you enjoy maximum coverage and maximum convenience. You present your ID card to the provider who submits your claim.

Out-of-Network Care

For further information, please refer to the Consent Decree Addendum provided at the end of this benefit booklet.

Out-of-network care is care you receive from providers who are not in the PPO network.

Even when you go outside the network, you will still be covered for eligible services. However, your benefits generally will be paid at the lower, out-of-network level. Additionally, precertification may be required from Independence Blue Cross before services are received. For specific details, see your Summary of Benefits.

You may be responsible for paying any difference between the provider's actual charge and the PPO program's payment.

When you receive care from an out-of-network provider, coverage is almost always paid at the lower level - *unless it is an emergency or you are referred by Independence Blue Cross to an out-of-network provider because the non-emergency service is not available from a network provider*. **That's why it is critical - in all cases - that you check to see that your provider is in the network before you receive care.**

Out-of-Area Care

Your program also provides coverage for you and your eligible dependents who are temporarily away from home, or those dependents who permanently reside away from home.

Services received from providers across the country who are part of the local Blue Cross and Blue Shield PPO network will be covered at the higher level of benefits. If you receive covered services from a provider who is not part of the local Blue Cross and Blue Shield PPO network, these services will be covered at the lower, out-of-network level of benefits.

If you are traveling and an urgent injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic:

- If the illness or injury is an emergency, it will be covered at the higher benefit level, regardless of whether the provider is in the local Blue Cross and Blue Shield PPO network. If the treatment results in an admission, you need to obtain precertification. If precertification is not obtained and the admission is not considered to be medically necessary and appropriate, you will be responsible for all costs associated with the stay. For specific details, see the Healthcare Management section of this booklet.
- If the illness or injury is not an emergency, you are required to use providers in the local Blue Cross and Blue Shield PPO network in order to be covered at the higher benefit level. If you receive care from an out-of-network provider, benefits for eligible services will be provided at the lower, out-of-network level of benefits.

Inter-Plan Arrangements

Out-of-Area Services

Independence Blue Cross has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "inter-plan arrangements." These inter-plan arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association. Whenever members access health care services outside the geographic area Independence Blue Cross serves, the claim for those services may be processed through one of these inter-plan arrangements, as described generally below.

Typically, when accessing care outside the geographic area Independence Blue Cross serves, members obtain care from health care providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, members may

obtain care from health care providers in the Host Blue geographic area that do not have a contractual agreement ("non-participating providers") with the Host Blue. Independence Blue Cross remains responsible for fulfilling our contractual obligations to you. Independence Blue Cross's payment practices in both instances are described below.

BlueCard® Program

The BlueCard® Program is an inter-plan arrangement. Under this arrangement, when members access covered services outside the geographic area Independence Blue Cross serves, the Host Blue will be responsible for contracting and handling all interactions with its participating health care providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method per Claim

Unless subject to a fixed dollar copayment, the calculation of the member liability on claims for covered services will be based on the lower of the participating provider's billed charges for covered services or the negotiated price made available to Independence Blue Cross by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's health care provider contracts. The negotiated price made available to Independence Blue Cross by the Host Blue may be represented by one of the following:

- an actual price - An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases, or
- an estimated price - An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives, or
- an average price - An average price is a percentage of billed charges for covered services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices,

(ie, prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Independence Blue Cross in determining your premiums.

Special Cases: Value-Based Programs
Independence Blue Cross has included a factor for bulk distributions from Host Blues in your premium for Value-Based Programs when applicable under your program. Additional information is available upon request.

Return of Overpayments
Recoveries of overpayments from a Host Blue or its participating and non-participating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/health care provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to Independence Blue Cross, they will be credited to your account. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to you as a percentage of the recovery.

Non-Participating Providers Outside of the Plan Service Area

Member Liability Calculation
When covered services are provided outside of the plan service area by non-participating providers, the amount(s) a member pays for such services will generally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable law. In these situations, the member may be responsible for the difference between the amount that the non-participating provider bills and the payment Independence Blue Cross will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services are governed by applicable federal and state law.

Exceptions
In some exception cases, Independence Blue Cross may pay claims from non-participating health care providers outside of the plan service area based on the provider's billed charge. This may occur in situations where a member did not have reasonable access to the participating provider, as determined by Independence Blue

Cross in Independence Blue Cross's sole and absolute discretion or by applicable law. In other exception cases, Independence Blue Cross may pay such claims based on the payment Independence Blue Cross would make if Independence Blue Cross were paying a non-participating provider inside the plan service area. This may occur where the Host Blue's corresponding payment would be more than the plan in-service area non-participating provider payment. Independence Blue Cross may choose to negotiate a payment with such provider on an exception basis.

Unless otherwise state, in any of these exception situations, the member may be responsible for the difference between the amount that the non-participating health care provider bills and payment Independence Blue Cross will make for the covered services as set forth in this paragraph.

Blue Cross Blue Shield Global Core Program

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

Inpatient Services

In most cases, if members contact the service center for assistance, hospitals will not require members to pay for inpatient covered services, except for their cost-sharing amounts. In such cases, the hospital will submit member claims to the service center to initiate claims processing. However, if the member paid in full at the time of service, the member must submit a claim to obtain reimbursement for covered services. **Members must contact Independence Blue Cross to obtain precertification for non-emergency inpatient services**.

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for covered services.

Submitting a Blue Cross Blue Shield Global Core Claim

When members pay for covered services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims,

members should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center address on the form to initiate claims processing. The claim form is available from Independence Blue Cross, the service center or online at www.bcbsglobalcore.com. If members need assistance with their claim submissions, they should call the service center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

Blue Distinction®

The Blue Distinction designation is awarded by Blue Cross and Blue Shield companies to hospitals based on thorough, objective evaluation of their performances in the areas that matter to you – quality care, treatment expertise and overall patient outcomes. The criteria we measure are established with the help of expert physicians and medical organizations.

Note: Designation as Blue Distinction Centers® means these facilities' overall experience and aggregate data met objective criteria established with expert clinicians' and leading professional organizations' recommendations. Individual outcomes may vary. To find out which services are covered under your policy at any facilities, please call your local Blue Cross and/or Blue Shield Plan.

Your Provider Network

Your PPO provider network is your key to receiving the higher level of benefits. The network includes: primary care physicians; a wide range of specialists; mental health and substance abuse providers; community and specialty hospitals; and laboratories.

To determine if your current provider is in the network or to locate the provider nearest you, call 1-800-810-BLUE (2583), or log onto www.mybenefitshome.com.

Please note that while you or a family member can use the services, including behavioral health and well-woman care, of any network physician or specialist without a referral and receive the maximum coverage under your benefit program, you are encouraged to select a personal or primary care physician. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal physician can help you select an appropriate specialist and work closely with that specialist when the need arises. In addition, primary care providers or their covering physicians are on call 24/7.

Remember:
If you want to enjoy the higher level of coverage, it is *your* responsibility to ensure that you receive network care. You may want to double-check any provider recommendations to make sure the doctor or facility is in the network.

How to Get Your Physicians' Professional Qualifications

To view a doctor's board certification, hospital affiliation or practice information, such as office hours and locations, visit your member website at www.mybenefitshome.com. and click on "Find a Doctor or Rx" and "Find a Doctor, Hospital or Other Medical Provider". Or call Member Service at the number on the back of your member ID card.

Eligible Providers

Eligible network providers include facilities, general practitioners, internists, obstetricians/gynecologists and a wide range of specialists.

Facility Providers

- Hospital
- Psychiatric hospital
- Rehabilitation hospital
- Ambulatory surgical facility
- Birthing facility
- Day/night psychiatric facility
- Freestanding dialysis facility
- Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility
- Home health care agency
- Hospice
- Outpatient substance abuse treatment facility
- Outpatient physical rehabilitation facility
- Outpatient psychiatric facility
- Pharmacy provider
- Residential treatment facility
- Skilled nursing facility
- State-owned psychiatric hospital
- Substance abuse treatment facility

Professional Providers

- Audiologist
- Certified registered nurse*
- Chiropractor
- Dentist
- Dietician-nutritionist
- Licensed practical nurse
- Nurse-midwife
- Occupational therapist
- Optometrist
- Physical therapist
- Physician
- Podiatrist
- Psychologist
- Registered nurse
- Respiratory therapist
- Speech-language pathologist
- Teacher of hearing impaired

Ancillary Providers:

- Ambulance service
- Clinical laboratory
- Home infusion and suite infusion therapy provider
- Suppliers

Contracting Suppliers (for the sale or lease of):

- Durable medical equipment
- Supplies
- Hearing aids
- Orthotics
- Prosthetics

**Excluded from eligibility are registered nurses employed by a health care facility or by an anesthesiology group.*

Healthcare Management

Medical Management

For your benefits to be paid under your program, at either the network or out-of-network level, services and supplies must be considered medically necessary and appropriate.

Independence Blue Cross, or its designated agent, is responsible for determining whether care is medically necessary and provided in the appropriate setting.

A Independence Blue Cross nurse will review your request for an inpatient admission to ensure it is appropriate for the treatment of your condition, illness, disease or injury, in accordance with standards of good medical practice, and the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered for your condition and you cannot receive safe or adequate care as an outpatient.

You are responsible for notifying Independence Blue Cross of your admission. However, some facility providers will contact Independence Blue Cross and obtain preauthorization of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Independence Blue Cross for preauthorization. If not, you are responsible for contacting Independence Blue Cross.

You should call 7 to 10 days prior to your planned admission. For emergency admissions, call Independence Blue Cross within 48 hours of the admission, or as soon as reasonably possible. You can contact Independence Blue Cross via the toll-free Member Service telephone number located on the back of your ID card.

If you do not notify Independence Blue Cross of your admission to a facility provider, Independence Blue Cross may review your care after services are received to determine if it was medically necessary and appropriate. **If your admission is determined not to be medically necessary and appropriate, you will be solely responsible for all costs not covered by your program.**

Care Utilization Review Process

In order to assess whether care is provided in the appropriate setting, Independence Blue Cross administers a care utilization review program comprised of prospective, concurrent and/or retrospective reviews. In addition, Independence Blue Cross assists hospitals with discharge planning. These activities are conducted by a Independence

Blue Cross nurse working with a medical director. Here is a brief description of these review procedures:

Prospective Review

Prospective review, also known as precertification or pre-service review, begins upon receipt of treatment information.

After receiving the request for care, Independence Blue Cross:

- verifies your eligibility for coverage and availability of benefits;
- reviews diagnosis and plan of treatment;
- assesses whether care is medically necessary and appropriate;
- authorizes care and assigns an appropriate length of stay for inpatient admissions

Concurrent Review

Concurrent review may occur during the course of ongoing treatment and is used to assess the medical necessity and appropriateness of the length of stay and level of care.

Discharge Planning

Discharge planning is a process that begins prior to your scheduled hospital admission. Working with you, your family, your attending physician(s) and hospital staff, Independence Blue Cross will help plan for and coordinate your discharge to assure that you receive safe and uninterrupted care when needed at the time of discharge.

Retrospective Review

Retrospective review may occur when a service or procedure has been rendered without the required precertification.

Case Management Services

Case Management is a voluntary program in which a case manager, with input from you and your health care providers, assists when you are facing and/or recovering from a hospital admission, dealing with multiple medical problems or facing catastrophic needs. Independence Blue Cross case managers can provide educational support, assist in coordinating needed health care services, put you in touch with community resources, assist in addressing obstacles to your recovery such as benefit and caregiver issues and answer your questions.

Independence Blue Cross case managers are a free resource to all Independence Blue Cross members. If you have an inpatient hospital admission, you may be contacted as part of our Outreach program. If your claims history indicates that your needs appear to be more complex, you may be contacted by a case manager from our Complex program. In either case, you are always free to call and request case management services if you feel you need it by contacting Member Services at the telephone number listed on the back of your ID card.

Precertification, Preauthorization and Pre-Service Claims Review Processes

Authorized Representatives

You have a right to designate an authorized representative to file or pursue a request for precertification or other pre-service claim on your behalf. Independence Blue Cross reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Procedures adopted by Independence Blue Cross will, in the case of an urgent care claim, permit a physician or other professional health care provider with knowledge of your medical condition to act as your authorized representative.

Decisions Involving Requests for Precertification and Other Non-Urgent Care Pre-Service Claims

You will receive written notice of any decision on a request for precertification or other pre-service claim, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed 15 days from the date Independence Blue Cross receives the claim.

Decisions Involving Urgent Care Claims

If your request involves an urgent care claim, Independence Blue Cross will make a decision on your request as soon as possible taking into account the medical exigencies involved. You will receive notice of the decision that has been made on your urgent care claim no later than 72 hours following receipt of the claim.

If Independence Blue Cross determines in connection with an urgent care claim that you have not provided sufficient information to determine whether or to what extent benefits are provided under your coverage, your physician will be notified within 24 hours following Independence Blue Cross's receipt of the claim of the specific information needed to complete your claim. Your physician will then be given not less than 48 hours to provide the specific information to Independence Blue Cross. Independence Blue Cross will thereafter notify you of its determination on your claim as soon as possible but not later than 48 hours after the earlier of (i) its receipt of the

additional specific information, or (ii) the date Independence Blue Cross informed your physician that it must receive the additional specific information.

Similarly, when your urgent care claim seeks to extend a previously approved course of treatment and that request is made at least 24 hours prior to the expiration of the previously approved course of treatment, Independence Blue Cross will notify you of its decision as soon as possible, but no later than 24 hours following receipt of the request.

Notices of Determination Involving Precertification Requests and Other Pre-Service Claims

Any time your request for precertification or other pre-service claim is approved, you will be notified in writing that the request has been approved. If your request for precertification or approval of any other pre-service claim has been denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an internal appeal or request an external review.

For a description of your right to file an appeal concerning an adverse benefit determination involving a request for precertification or any other pre-service claim, see the Appeal Procedure subsection in the How to File a Claim section of this benefit booklet.

A Recognized Identification Card

The Blue Cross and Blue Shield symbols on your identification (ID) card are recognized throughout the country and around the world. Carry your ID card with you at all times, destroy any previously issued cards, and show this card to the hospital, doctor, pharmacy, or other health care professional whenever you need medical care.

If your card is lost or stolen, please contact Independence Blue Cross Member Service immediately. You can also request additional or replacement cards online by logging onto www.mybenefitshome.com.

Below is a sample of the type of information that will be displayed on your ID card:

- Your name and your dependent's name, if applicable
- Identification number
- Group number
- Premier Pharmacy network logo (when applicable)
- Member Service toll-free number (on back of card)
- Precertification toll-free number (on back of card)
- "PPO in Suitcase" symbol

There is a logo of a suitcase with "PPO" inside it on your ID card. This PPO suitcase logo lets hospitals and doctors know that you are a member of a Blue Cross and Blue Shield PPO, and that you have access to PPO providers nationwide.

How to File a Claim

If you receive services from a network provider, you will not have to file a claim. If you receive services from an out-of-network provider, you may be required to file the claim yourself.

The procedure is simple. Just take the following steps:

- ***Know Your Benefits.*** Review this information to see if the services you received are eligible under your medical program.
- ***Get an Itemized Bill.*** Itemized bills must include:
  - The name and address of the service provider;
  - The patient's full name;
  - The date of service or supply;
  - A description of the service or supply;
  - The amount charged;
  - The diagnosis or nature of illness;
  - For durable medical equipment, the doctor's certification;
  - For private duty nursing, the nurse's license number, charge per day and shift worked, and signature of provider prescribing the service;
  - For ambulance services, the total mileage.

  Please note: If you've already made payment for the services you received, you must also submit proof of payment (receipt from the provider) with your claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

- ***Copy Itemized Bills.*** You must submit originals, so you may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.
- ***Complete a Claim Form.*** Make sure all information is completed properly, and then sign and date the form. *Claim forms can be obtained by contacting Member Service using the telephone number on your ID card.*
- ***Attach Itemized Bills to the Claim Form and Mail.*** After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the back of your ID card.

Remember: Multiple services for the same family member can be filed with one claim form. However, a separate claim form must be completed for each member.

Your claims must be submitted within one year from the date of service.

Your Plan Activity Statement

When you submit a claim, you will receive a plan activity statement when you have both medical coverage and an active, eligible spending account.

The plan activity statement includes the following features:

- plan contact information;
- claims for each person in your family are grouped together by name;
- summary of the total amount you spent out of your spending account(s) during the statement period;
- summary of all the medical claims submitted, how much was paid, and the amount you may owe;
- shows which health spending account paid the medical claim and the date the payment was made;
- shows your medical approved amount you are responsible for, how much was paid and what you still may owe; and
- tells you exactly how much was paid out of your spending account or why payment was not made.

In those instances where you are not required to submit a claim because, for example, the network provider will submit the bill as a claim for payment under its contract with Independence Blue Cross, you will receive a plan activity statement only when you are required to pay any deductible or coinsurance amounts.

If you do not have access to a computer or prefer to continue receiving printed plan activity statements, please notify Member Service by calling the number on the back of your ID card.

How to Voice a Complaint

In the event that you are dissatisfied with any aspect of your health care benefits or you have an objection regarding participating health care providers, coverage, operations or management policies, please contact Independence Blue Cross via the toll-free Member Service telephone number located on the back of your ID card.

A representative will review, research and respond to your inquiry as quickly as possible.

If the informal dissatisfaction process is not successful and does not meet your needs, you have the right to have your objection reviewed by our Member Grievance and Appeals Department. For details about how this process works, please refer to the Appeal Procedure section of this booklet or call Member Service at the number on your member ID card.

Fraud or Provider Abuse
If you think that a provider is committing fraud, please let us know. Examples of fraud include: Submitting claims for services that you did not get; Adding extra charges for services that you did not get; Giving you treatment for services you did not need. Please call the local state toll-free Fraud Hotline.

Additional Information on How to File a Claim

Member Inquiries

General inquiries regarding your eligibility for coverage and benefits do not involve the filing of a claim, and should be made by directly contacting Member Service using the telephone number on your ID card.

Filing Benefit Claims

– ***Authorized Representatives***

  You have the right to designate an authorized representative to file or pursue a request for reimbursement or other post-service claim on your behalf. Independence Blue Cross reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

– ***Requests for Precertification and Other Pre-Service Claims***

  For a description of how to file a request for precertification or other pre-service claim, see the Precertification and Pre-Service Claims Review Processes subsection in the Healthcare Management section of this benefit booklet.

– ***Requests for Reimbursement and Other Post-Service Claims***

  When a hospital, physician or other provider submits its own reimbursement claim, the amount paid to that provider will be determined in accordance with the provider's agreement with Independence Blue Cross or the local licensee of the Blue Cross Blue Shield Association serving your area. Independence Blue Cross will notify you of the amount that was paid to the provider. Any remaining amounts

that you are required to pay in the form of a coinsurance or program deductible will also be identified in that plan activity statement or notice. If you believe that the coinsurance or deductible amount identified in that plan activity statement or notice is not correct or that any portion of those amounts are covered under your benefit program, you may file a claim with Independence Blue Cross. For instructions on how to file such claims, you should contact Member Service using the telephone number on your ID card.

Determinations on Benefit Claims

– ***Notice of Benefit Determinations Involving Requests for Precertification and Other Pre-Service Claims***
  For a description of the time frames in which requests for precertification or other pre-service claims will be determined by Independence Blue Cross and the notice you will receive concerning its decision, whether adverse or not, see the Precertification and Pre-Service Claims Review Processes subsection in the Healthcare Management section of this benefit booklet.

– ***Notice of Adverse Benefit Determinations Involving Requests for Reimbursement and Other Post-Service Claims***
  Independence Blue Cross will notify you in writing of its determination on your request for reimbursement or other post-service claim within a reasonable period of time following receipt of your claim. That period of time will not exceed 30 days from the date your claim was received. However, this 30-day period of time may be extended one time by Independence Blue Cross for an additional 15 days, provided that Independence Blue Cross determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day post-service claim determination period. If an extension of time is necessary because you failed to submit information necessary for Independence Blue Cross to make a decision on your post-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your post-service claim.

If your request for reimbursement or other post-service claim is denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

For a description of your right to file an appeal concerning an adverse benefit determination of a request for reimbursement or any other post-service claim, see the Appeal Procedure subsection below.

Appeal Procedure

Your benefit program maintains an appeal process involving two levels of review with the exception of urgent care claims (which involve a single level of review). At any time during the appeal process, you may choose to designate a representative to participate in the appeal process on your behalf. You or your representative shall notify Independence Blue Cross in writing of the designation.

For purposes of the appeal process, "you" includes designees, legal representatives and, in the case of a minor, parent(s) entitled or authorized to act on your behalf.

Independence Blue Cross reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by Independence Blue Cross shall, in the case of an urgent care claim, permit your physician or other provider of health care with knowledge of your medical condition to act as your representative.

At any time during the appeal process, you may contact Member Service at the toll-free telephone number listed on your ID card to inquire about the filing or status of your appeal.

Initial Review

If you receive notification that a claim has been denied by Independence Blue Cross, in whole or in part, you may appeal the decision. Your appeal must be submitted not later than 180 days from the date you received notice from Independence Blue Cross of the adverse benefit determination.

Upon request to Independence Blue Cross, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit or present additional evidence or testimony, which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of your appeal.

A representative from Appeal Review will review the initial appeal. The representative will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on your appeal, Appeal Review will take into account all evidence, comments, testimony, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Independence Blue Cross. Appeal Review will also afford no deference to any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, Appeal Review will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal.

Your appeal will be promptly investigated and Independence Blue Cross will provide you with written notification of its decision within the following time frames:

- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of the appeal;

- When the appeal involves an urgent care claim, as soon as possible taking into account the medical exigencies involved but not later than 72 hours following receipt of the appeal; or

- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 30 days following receipt of the appeal.

In the event Independence Blue Cross renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, the procedure for appealing the decision and, in the case of an adverse benefit determination involving a pre-service claim, a statement regarding your right to request an external review or pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Your decision to proceed with a second level review of a pre-service claim (other than an urgent care claim, which involves one level of review) is voluntary. In other words, you are not required to pursue the second level review of a pre-service claim before

pursuing a claim for benefits in court under § 502 of ERISA. Should you elect to pursue the second level review before filing a claim for benefits in court, your benefit program:

- Will not later assert in a court action under § 502 of ERISA that you failed to exhaust administrative remedies (i.e. that you failed to proceed with a second level review) prior to the filing of the lawsuit;

- Agrees that any statute of limitations applicable to the claim for benefits under § 502 of ERISA will not commence (i.e. run) during the second level review; and

- Will not impose any additional fee or cost in connection with the second level review.

If you have further questions regarding second level reviews of pre-service claims, you should contact Member Service using the telephone number on your ID card.

Second Level Review

If you are dissatisfied with the decision following the initial review of your appeal (other than the review of an urgent care claim), you may request to have the decision reviewed by Independence Blue Cross. The request to have the decision reviewed must be submitted in writing (or communicated orally under special circumstances) within 45 days from the date of an adverse benefit determination.

Upon request to Independence Blue Cross, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit or present additional evidence or testimony, which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of your appeal.

A representative from Appeal Review will review your second level appeal. The representative will be an individual who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the matter under review.

In rendering a decision on the second level appeal, Appeal Review will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Independence Blue Cross. Appeal Review will also afford no deference to any previous adverse benefit determination regarding the matter under review.

In rendering a decision on a second level appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, Appeal Review will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the matter under review.

Your second level appeal will be promptly investigated and Independence Blue Cross will provide you with written notification of its decision within the following time frames:

- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 business days following receipt of the appeal; or

- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 30 days following receipt of the appeal.

In the event Independence Blue Cross renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination and, in the case of an adverse benefit determination involving a post-service claim, a statement regarding your right to request an external review or pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

External Review

You must contact Health Advocate within four (4) months of your receipt of this letter to formally request an external appeal of this final internal adverse benefit determination. If you would like to request an external review, please complete and return the attached External Review Request Form to:

Health Advocate
PO Box 977
Blue Bell, PA 19422

Your written request should include:

- ✓ A copy of this letter;
- ✓ A specific request for an external review;
- ✓ The participant's name, address, and insurance ID Number;

- ✓ Your designated representative's name and address, when applicable;
- ✓ Description of the service(s) that was denied; and
- ✓ Any new, relevant information that was not provided during the internal review.

You will be provided with more information about your eligibility for the external review process at the time your request is received.

Important Information If Your Situation is Urgent: If your situation meets the definition of urgent under the law, an external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your heath may be in serious jeopardy or, in the opinion of your physician; you may experience pain that cannot be adequately controlled, while you wait for a decision on the external review of your claim. If you believe your situation is urgent, you may request an expedited external review by completing the "Expedited Review" section of the External Review Request Form or by calling 866-695-8622.

Important Information Regarding Authorized Representatives: You or someone you name to act for you (your authorized representative) may file a request for external review. If you wish to designate an authorized representative to act on your behalf in pursuing a benefit claim or appeal, the designation must be explicitly stated in writing and it must authorize disclosure of protected health information with respect to the claim by this Plan. If a document is not sufficient to constitute a designation of an authorized representative, as determined by ABC Company, then this Plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

The External Review Request Form includes an Appointment of Authorized Representative section. If you would like to designate an authorized representative now, you should complete the Appointment of Authorized Representative section. Additionally, the authorized representative should provide notice of commencement of the action on your behalf to you, which we may verify with you prior to recognizing the authorized representative status.

In any event, a health care provider with knowledge of your medical condition acting in connection with an urgent care claim will be recognized by this Plan as your authorized representative.

You should carefully consider whether to designate an authorized representative. An authorized representative may make decisions independent of you, such as whether and how to appeal a claim denial.

Other Resources to Help You: After you've exhausted your opportunities to appeal, you have the right to bring a civil action under section 502(a) of ERISA. You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state regulatory agency.

If you have questions about your rights, this letter, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3772). Additionally, a consumer assistance program or ombudsman in your state or territory may be able to assist you.

Member Service

As a Independence Blue Cross member, you have access to a wide range of readily available health education tools and support services, all geared to help you "Have A Greater Hand in Your Health."

Blues On Call[sm] - 24/7 Health Decision Support

Just call **1-888-BLUE-428 (1-888-258-3428)** to be connected to a specially-trained wellness professional. You can talk to a Health Coach whenever you like, any time of the day, any day of the week.

Health Coaches are specially-trained registered nurses, dietitians and respiratory therapists who can help you make more informed health care and self-care (when appropriate) decisions. They can assist with a health symptom assessment, provide health-related information, and discuss your treatment options. Please be assured that your discussions with your Health Coach are kept strictly confidential.

Help with common illnesses, injuries and questions

Health Coaches can address any health topic that concerns you:

- Everyday conditions, such as a rash, an earache or a sprain
- A recent diagnosis you've received
- A scheduled medical test
- Planned surgery or other medical procedure
- Questions to ask your doctor at your next appointment
- How to care for a child or elder

You don't have to be ill to talk to a Health Coach. Call to learn about programs and other resources available to help you manage:

- Stress
- Personal nutrition
- Weight management
- Physical activities
- Insomnia
- Depression

Help with chronic conditions

If you have diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease or coronary artery disease, you need to manage your condition every day in order to stay healthy and avoid hospital stays. That means keeping track of medications, tests, doctor appointments and your diet. Your Blues On Call Health

Coach can help you work more closely with your doctor and get more involved in taking good care of yourself.

You can even establish a relationship with a specific Health Coach and schedule time to talk about your concerns and conditions.

Independence Blue Cross Website

As a Independence Blue Cross member, you have a wealth of health information at your fingertips. It's easy to access all your online offerings. Whether you are looking for a health care provider or managing your claims…want to make informed health care decisions on treatment options…or lead a healthier lifestyle, Independence Blue Cross can help with online tools and resources.

Go to www.mybenefitshome.com. Then click on the "Members" tab and log in to your homepage to take advantage of all kinds of programs and resources to help you understand your health status, through the online Wellness Profile, then take steps toward real health improvement.

You have access to a wide selection of Lifestyle Improvement and Condition Management Programs. Here are examples of the types of free programs available to you as a Independence Blue Cross member:

Eat Healthy - You know that a healthy diet is key to a healthy body. You have a range of programs to help you learn more about food and nutrition, change your eating habits, and enjoy it all in the process!

Get Active - Exercise enhances both the body and the mind. It's a critical component of a healthy lifestyle for everyone, but not everyone needs the same kind of workout. That's why you've got a variety of "get fit" programs to help you feel better and get in shape.

Manage Your Stress - Stress has more impact on your health than you might think. It can damage your immune system and make you more susceptible to illnesses. It can also have a detrimental impact on your job and personal life. You can learn proven techniques to better cope and reduce stress.

Manage Your Weight - You *can* get control over your weight! Healthy eating habits and a healthy attitude toward food can help. You have a choice of programs to take the approach best suited for you.

Quit Smoking - There's no doubt about the dangers of smoking. And there's no time like the present to quit. As a Independence Blue Cross member, you can choose the program that suits your style and quit for good!

Baby Blueprints®

If You Are Pregnant, Now Is the Time to Enroll in Baby Blueprints

If you are expecting a baby, this is an exciting time for you. It's also a time when you have many questions and concerns about your health and your developing baby's health.

To help you understand and manage every stage of pregnancy and childbirth, Independence Blue Cross offers the Baby Blueprints Maternity Education and Support Program.

By enrolling in this free program you will have access to online information on all aspects of pregnancy and childbirth. Baby Blueprints will also provide you with personal support from a nurse Health Coach available to you throughout your pregnancy.

Easy Enrollment

Just call toll-free at 1-866-918-5267. You can enroll at any time during your pregnancy.

Member Service

When you have questions about a claim, benefits or coverage, our Member Service Representatives are here to help you. Just call Member Service at the toll-free number on your member ID card or log in to your Independence Blue Cross member website at www.mybenefitshome.com. For TTY/TDD hearing impaired service, please dial 711 and the number on the back of your ID card.

Health Savings Account

The Perfect Companion to your ChoicePlus Plan

Your *PPO* qualified High-Deductible Health Plan comes with a critical component—a Health Savings Account, or HSA.

Your Independence Blue Cross HSA is an employee-managed, tax-sheltered account similar to an IRA (Individual Retirement Account), but can be used for care expenses before you reach your *PPO* plan deductible.

Your HSA not only lets you use account funds for plan-covered expenses, it lets you use funds for a wide range of "qualified medical expenses." So you can use your HSA to pay for a broad range of care services and products that include everything from acupuncture to chiropractic care… dental care to eyeglasses. You can even use account funds to improve your health by joining a weight loss or stop smoking program. Not all qualified expenses contribute to your deductible and out-of-pocket maximum and that only medical and Rx expenses count to your deductible and out-of-pocket maximum.

To access a complete list of eligible care services and products you can purchase through your HSA, log onto your Independence Blue Cross member website at www.mybenefitshome.com and click on "Spending" and "Covered Expenses."

Now and in The Future

Since your plan deductible amount you must pay before the plan covers benefits— is higher, establishing an HSA lets you:

- pay for your out-of-pocket care expenses before your deductible is met to address your immediate care needs; or
- save money in your account for future care expenses. You can even use your HSA as a "medical nest egg" to help cover care costs in your retirement years.

How to Enroll in the Account:

Your HSA is integrated with your *PPO* High-Deductible Health Plan. So managing your account is as quick and easy as managing your coverage.

If your employer has not chosen to automatically enroll you in the HSA, you can activate your account by logging onto your Independence Blue Cross website at www.mybenefitshome.com. Select "Your Spending" and "Start a Health Savings Account and save!" From this HSA link, you will be able to check your account balance, view deposits and transactions.

How to Fund your Account:
Your employer may contribute to the account. And you contribute either through payroll deduction or through direct payment to the account.
In 2016, the maximum amount that can be contributed to your HSA each calendar year is $3,350 for an individual plan or $6,750 for a family plan. In 2017, these amounts increase to $3,400 for an individual and remain the same at $6,750 for a family. If you are 55 or older, you may also be able to make an annual "catch-up" contribution of $1,000. (These amounts are adjusted yearly by the IRS for inflation and are displayed at your Independence Blue Cross member website.)

How to Manage your Account:
Everything you need to manage your care spending is at your Independence Blue Cross member website. So in one convenient, central location you can:

- Contribute to your account
- Pay a care provider directly from the account
- Enter claims for reimbursement for out-of-pocket costs
- View deposits, transactions and claims
- Track your care costs
- Look up typical care costs through health education tools.

With your Independence Blue Cross HSA, you enjoy triple-tax savings!

1. Contributions are tax-deductible.
2. Earnings accumulate tax-free.
3. Withdrawals for qualified medical expenses are free from Federal income tax.

Those are savings that *add* up!

How to Invest in Your Account:
If you're like many people with a Health Savings Account, you want to maximize your savings year after year.

Independence Blue Cross HSA is offered through a respected industry leader who serves as custodian: Bank of America. Once your HSA balance reaches $500 you may invest any portion of your HSA balance above this level. You have a wide selection of mutual funds*— from conservative options such as a U.S. Treasury fund, to more aggressive stock funds. Your choice or choices depend on your risk tolerance and time frame.

*Shares of mutual funds are not deposits or obligations or guaranteed or endorsed by any bank; nor are they federally insured or otherwise supported by the FDIC or any governmental agency, and may lose value.

An Added Convenience – Your Own Personal Health Care Visa® Debit Card!

Using your Independence Blue Cross Health Savings Account to pay for health care services is now easier than ever.

When you enroll in your Independence Blue Cross HSA, you will receive a Visa debit card that you can use exclusively for purchases at:

- Doctors' and dentists' offices
- Pharmacies
- Discount chains and club stores
- Other merchants who sell health care products and services and accept Visa

Take control of your health care spending— take advantage of this valued health coverage option!

And learn why more than 10 million people trust Health Savings Accounts to help them manage their care costs!

"Studies have shown that people with Health Savings Accounts take better care of themselves than people with traditional health coverage."
***U.S News & World Report,* May, 2010**

Why Independence Blue Cross Health Savings Account May be Perfect for You

- It's *your* money. *You* choose how to pay for care services.
- It's portable. It goes where you go, even if you change jobs.
- Account funds roll over from year to year.
- You can pay for an exceptional range of health care services and products. That includes services—such as dental and vision care—that may not be covered by your *PPO Blue* plan.
- You get "triple-tax savings." HSA contributions and earnings are tax exempt. Withdrawals from your HSA are also tax exempt as long as they are used for qualified medical services.
- Once you reach a $500 account balance, you can invest in a wide range of mutual funds for short- or long-term growth potential.
- It's *convenient*. You access and track all of your health care spending online at your Independence Blue Cross member website.

- Your account is offered through a trusted industry leader, Bank of America, who serves as the custodian.

Visa is a registered mark of Visa, Inc.

Member Rights and Responsibilities

Your participation in the PPO program is vital to maintaining quality in your program and services. Your importance to this process is reflected in the following statement of principles.

You have the right to:

1. Receive information about your group health plan, its practitioners and providers, and your rights and responsibilities.
2. Be treated with respect and recognition of your dignity and right to privacy.
3. Participate with practitioners in decision-making regarding your health care. This includes the right to be informed of your diagnosis and treatment plan in terms that you understand and participate in decisions about your care.
4. Have a candid discussion of appropriate and/or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Your group health plan does not restrict the information shared between practitioners and patients and has policies in place, directing practitioners to openly communicate information with their patients regarding all treatment options regardless of benefit coverage.
5. Voice a complaint or file an appeal about your group health plan or the care provided and receive a reply within a reasonable period of time.
6. Make recommendations regarding the Members' Rights and Responsibilities policies.

You have a responsibility to:

1. Supply to the extent possible, information that the organization needs in order to make care available to you, and that its practitioners and providers need in order to care for you.
2. Follow the plans and instructions for care that you have agreed on with your practitioners.
3. Communicate openly with the physician you choose. Ask questions and make sure you understand the explanations and instructions you are given, and participate in developing mutually agreed upon treatment goals. Develop a relationship with your doctor based on trust and cooperation.

How We Protect Your Right to Confidentiality

We have established policies and procedures to protect the privacy of our members' protected health information ("PHI") in all forms, including PHI given verbally, from unauthorized or improper use. Some of the ways we protect your privacy include not discussing PHI outside of our offices, e.g., in hallways, elevators, as well as verifying your identity before we discuss PHI with you over the phone. As permitted by law, we

may use or disclose protected health information for treatment, payment and health care operations, such as: claims management, routine audits, coordination of care, quality assessment and measurement, case management, utilization review, performance measurement, customer service, credentialing, medical review and underwriting. With the use of measurement data, we are able to manage members' health care needs, even targeting certain individuals for quality improvement programs, such as health, wellness and disease management programs.

If we ever use your protected health information for non-routine uses, we will ask you to give us your permission by signing a special authorization form, except with regard to court orders and subpoenas.

You have the right to access the information your doctor has been keeping in your medical records, and any such request should be directed first to your network physician.

You benefit from the many safeguards we have in place to protect the use of data we maintain. This includes requiring our employees to sign statements in which they agree to protect your confidentiality, using computer passwords to limit access to your protected health information, and including confidentiality language in our contracts with physicians, hospitals, vendors and other health care providers.

Our Privacy Department reviews and approves policies regarding the handling of confidential information.

Recognizing that you have a right to privacy in all settings, we even inspect the privacy of examination rooms when we conduct on-site visits to physicians' offices. It's all part of safeguarding the confidentiality of your protected health information.

Terms You Should Know

Assisted Fertilization - Any method used to enhance the possibility of conception through retrieval or manipulation of the sperm or ovum. This includes, but is not limited to, artificial insemination, In Vitro Fertilization (IVF), Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), Tubal Embryo Transfer (TET), Peritoneal Ovum Sperm Transfer, Zona Drilling, and sperm microinjection.

Blues On Call - A 24-hour health decision support program that gives you ready access to a specially-trained health coach.

Board-Certified - A designation given to those physicians who, after meeting strict standards of knowledge and practices, are certified by the professional board representing their specialty.

Claim – A request for precertification or prior approval of a covered service or for the payment or reimbursement of the charges or costs associated with a covered service. Claims include:

- **Pre-Service Claim** – A request for precertification or prior approval of a covered service which under the terms of your coverage must be approved before you receive the covered service.

- **Urgent Care Claim** – A pre-service claim which, if decided within the time periods established for making non-urgent care pre-service claim decisions, could seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service. Whether a request involves an urgent care claim will be determined by your attending physician or provider.

- **Post-Service Claim** – A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

Custodial Care - Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting the 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.

Designated Agent - An entity that has contracted, either directly or indirectly, with the health plan to perform a function and/or service in the administration of this program. Such function and/or service may include, but is not limited to, medical management and provider referral.

Emergency Care Services - The treatment of bodily injuries resulting from an accident, or following the sudden onset of a medical condition, or following, in the case of a chronic condition, a sudden and unexpected medical event that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- placing your health or, with respect to a pregnant member, the health of the member or the unborn child in serious jeopardy;
- causing serious impairment to bodily functions; and/or
- causing serious dysfunction of any bodily organ or part

and for which care is sought as soon as possible after the medical condition becomes evident to you.

Experimental/Investigative - The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined to be medically effective for the condition being treated. An intervention is considered to be experimental/investigative if: the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or, available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or, the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or, the intervention does not improve health outcomes; or, the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date.

Medical researchers constantly experiment with new medical equipment, drugs and other technologies. In turn, health care plans must evaluate these technologies.

Decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and

devices should be made by medical professionals. That is why a panel of more than 400 medical professionals works with a nationally recognized Medical Affairs Committee to review new technologies and new applications for existing technologies for medical and behavioral health procedures and devices. To stay current and patient-responsive, these reviews are ongoing and all-encompassing, considering factors such as product efficiency, safety and effectiveness. If the technology passes the test, the Medical Affairs Committee recommends it be considered as acceptable medical practice and a covered benefit. Technology that does not merit this status is usually considered "experimental/investigative" and is not generally covered. However, it may be re-evaluated in the future.

A similar process is followed for evaluating new pharmaceuticals. The Pharmacy and Therapeutics (P & T) Committee assesses new pharmaceuticals based on national and international data, research that is currently underway and expert opinion from leading clinicians. The P & T Committee consists of at least one pharmacist and/or medical director, five board-certified, actively practicing network physicians and two Doctors of Pharmacy currently providing clinical pharmacy services. At the committee's discretion, advice, support and consultation may also be sought from physician subcommittees in the following specialties: cardiology, dermatology, endocrinology, hematology/oncology, obstetrics/gynecology, ophthalmology, psychiatry, infectious disease, neurology, gastroenterology and urology. Issues that are addressed during the review process include clinical efficacy, unique value, safety, patient compliance, local physician and specialist input and pharmacoeconomic impact. After the review is complete, the P & T Committee makes recommendations.

Situations may occur when you elect to pursue experimental/investigative treatment. If you have a concern that a service you will receive may be experimental/investigational, you or the hospital and/or professional provider may contact Independence Blue Cross's Member Service to determine coverage.

Immediate Family - Your spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, daughter-in-law, son-in-law, grandchild, grandparent, stepparent, stepbrother or stepsister.

Infertility - The medically documented inability to conceive with unprotected sexual intercourse between a male and female partner for a period of at least 12 months. The inability to conceive may be due to either the male or female partner.

Medically Necessary and Appropriate (Medical Necessity and Appropriateness) - Services, supplies or covered medications that a provider, 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: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (iii) 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. Independence Blue Cross reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply or covered medication is medically necessary and appropriate. No benefits will be provided unless Independence Blue Cross determines that the service, supply or covered medication is medically necessary and appropriate.

Methadone Maintenance - The treatment of heroin or other morphine-like drug dependence where you are taking methadone hydrochloride daily in prescribed doses to replace the previous heroin or other morphine-like drug abuse.

Partial Hospitalization - The provision of medical, nursing, counseling or therapeutic mental health care services or substance abuse services on a planned and regularly scheduled basis in a facility provider designed for a patient or client who would benefit from more intensive services than are generally offered through outpatient treatment but who does not require inpatient care.

Plan - Refers to Independence Blue Cross; which is an independent licensee of the Blue Cross Blue Shield Association. Any reference to the plan may also include its designated agent as defined herein and with whom the plan has contracted, either directly or indirectly, to perform a function or service in the administration of this program.

Plan Allowance - The amount used to determine payment by your program for covered services provided to you and to determine your liability. Plan allowance is based on the type of provider who renders such services or as required by law. The plan allowance for an in-area out-of-network provider is based on an adjusted contractual allowance for like services rendered by a network provider in the same geographic region. You will be responsible for any difference between the provider's

billed charges and your program's payment. The plan allowance for an out-of-area provider is determined based on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your program's participation in the BlueCard program described in the How Your PPO Program Works section of this booklet.

The plan allowance for an out-of-network state-owned psychiatric hospital is what is required by law.

In some cases, an allowance may be negotiated with an out-of-area non-participating provider. The negotiated reimbursement amount will be based on prevailing market reimbursement amounts. In the event the negotiations with a non-participating out-of-area provider are unsuccessful, the plan allowance will be based on pricing determined by a national database. For facility claims, the pricing will be determined on the basis of detailed data reflecting actual reported billings and payments over the preceding 24 months and includes an inflation factor. For professional claims, pricing will be determined on median-based cost of care that is adjusted for geography.

Precertification (Preauthorization) - The process through which medical necessity and appropriateness of inpatient admissions, services or place of services is determined prior to or after an admission or the performance of a procedure or service.

Preferred Provider Organization (PPO) Program - A program that does not require the selection of a primary care physician, but is based on a provider network made up of physicians, hospitals and other health care facilities. Using this provider network helps assure that you receive maximum coverage for eligible services.

Primary Care Physician (PCP) - A physician who limits his or her practice to family practice, general practice, internal medicine or pediatrics and who may supervise, coordinate and provide specific basic medical services and maintain continuity of patient care.

Specialist - A physician, other than a primary care physician, who limits his or her practice to a particular branch of medicine or surgery.

Telemedicine Service - A real time interaction between you and a designated telemedicine provider conducted by means of telephonic or audio and video

telecommunications, for the purpose of providing specific outpatient covered services.

You or Your - Refers to individuals who are covered under the program.

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Consent Decree Addendum to Your Benefit Booklet

On June 27, 2014, Highmark and UPMC entered into a Consent Decree that was designed to protect your access to UPMC providers.

Please be aware that certain UPMC providers may still continue to participate in the network for your plan. You can always receive benefits at the network level from these UPMC network providers. Be sure to check the provider directory for the most up-to-date listing of network providers.

Under the Consent Decree, covered services may be available at the network level of benefits from out-of-network UPMC providers under your plan but only in the circumstances described below:

Continued Care

If you are in the midst of a course of treatment from an out-of-network UPMC provider, you may choose to request to continue treatment with that UPMC provider. Covered services will be available at the network level of benefits.

The need for a continuing course of treatment with a UPMC provider shall be determined, in the first instance, by your treating physician acting in consultation with you and in accordance with your wishes or your authorized representative. If you are pregnant, and your pregnancy was confirmed before December 31, 2015, or if you started a continuing course of treatment for a chronic or persistent medical condition with a UPMC provider in calendar years 2013, 2014 or 2015 (or on or before June 30, 2016 for UPMC Mercy), you may continue treatment with that UPMC provider through the period of delivery and post-partum care for that pregnancy or completed treatment of the chronic or persistent medical condition. Notwithstanding the above, if you were treated at UPMC Mercy and by a UPMC Mercy physician for a confirmed pregnancy on or before June 30, 2016, you may continue to receive treatment at UPMC Mercy through the period of delivery and post-partum care for that pregnancy or completed treatment of the chronic or persistent medical condition.

Services such as routine wellness care and routine preventive care are not considered to be continued care for purposes of this addendum. Furthermore, benefits will not be provided for purposes of this addendum when the course of treatment for a chronic or persistent medical condition started before January 1, 2013, but for which no treatment was subsequently received from a UPMC provider, unless the UPMC provider can demonstrate that the member was receiving ongoing care in accordance with recognized medical protocols and/or standards.

While undergoing a continuing course of treatment with such UPMC provider, benefits will include all covered services reasonably related to the treatment including, but not limited to, testing and follow-up care. In the event that Independence Blue Cross disputes the opinion of the treating physician that a continuation of care is medically necessary and appropriate, or disputes the scope of that care, the Pennsylvania Department of Health or its designated representative will review that matter and make a final non-appealable determination.

Oncology Services (Cancer Care)

If you have been diagnosed with cancer and your treating physician determines that you should be treated by an out-of-network UPMC provider that renders oncology services, you may choose to request treatment from that UPMC provider. Covered services will be available at the network level of benefits. Treatment includes care for illnesses resulting from the cancer treatment such as, but not limited to, mental health, endocrinology, orthopedics and cardiology. The need for a treatment of a resulting illness shall be determined, in the first instance, by your treating physician acting in consultation with and in accordance with your wishes or your authorized representative.

Local Community Needs

If your treating physician believes that you require certain medical services and the Pennsylvania Department of Health has determined that such services are not available from another source locally other than from an out-of-network UPMC provider, you may receive covered services from that UPMC provider. Covered services will be available at the network level of benefits.

Emergency Care Services

When emergency care services are received from an out-of-network UPMC provider, hospital and medical benefits are provided as described in the Covered Services section. This also includes other services and supplies necessary to continue your treatment, including any resulting inpatient admission through the period of discharge. Covered services will be available at the network level of benefits.

Other Out-of-Network Services

In other situations not specifically described above, if you receive covered services from an out-of-network UPMC provider, these services will be covered at the lower, out-of-network level of benefits. However, out-of-network UPMC providers, if paid promptly, cannot require you to pay any amount greater than the difference between Independence Blue Cross's payment and 60 percent of the UPMC provider's billed charge. The UPMC provider must advise you of these charges before rendering any services. If you receive services that are not covered under this program, you will be responsible for all charges associated with those services.