Allegheny County Schools
Health Insurance Consortium
KeystoneBlue
Effective July 1, 2008
Produced November, 2008

The Allegheny County Schools Health Insurance Consortium, through an agreement with Highmark Blue Cross Blue Shield/United Concordia Companies, Inc. or Davis Vision provides medical/dental/vision benefits to you. The Consortium is operated by a Board of Trustees, appointed by the Participating School Entities (which includes School Districts, the Allegheny Intermediate Unit and other entities), and the Local Unions maintaining collective bargaining agreements with the Participating School Entities. If you are eligible for coverage under the benefit plan, your Participating School Entity will pay a monthly premium to the Consortium in order to provide the benefit plan described in this Booklet.

The Consortium is located at:

Allegheny County School Health Insurance Consortium
c/o Aon Consulting, Inc.
625 Liberty Avenue, 10th Floor
Pittsburgh, PA 15222-3110

This Booklet is your Summary Plan Description Booklet and is a summary of the most important provisions of the medical benefit plan. This summary, of course, cannot adequately present all of the details of the benefit plan. Accordingly, your rights can only be determined by the provisions of the agreement between the Consortium and the third party administrator. If any information included in this Booklet is in conflict with any provision in the agreement with the third party administrator, the provisions of the agreement with the third party administrator shall be controlling.

Only the entire Board of Trustees is authorized to render the final interpretation of the benefit plan's provisions. No Participating School Entity or Local Union, or any representative thereof, is authorized to interpret the provisions of the benefit plan, nor can such person act as an agent of the Board of Trustees.

This Booklet summarizes the provisions of the benefit plan in effect as of July 1, 2008. The benefit plan may be amended or changed in the future by the Board of Trustees, and the amendments or changes may affect your eligibility for benefits. Notice of amendments or changes to the benefit plan will be provided to you.

Board of Trustees of the
Allegheny County Schools Health Insurance Consortium

Allegheny County Schools

Health Insurance Consortium

a HMO Network Program
Administered by Keystone Health Plan West, Inc.

Utilizing the Keystone Network

Keystone Health Plan West, Inc.
Fifth Avenue Place
120 Fifth Avenue
Pittsburgh, PA 15222-3099
1-800-547-9378

Your health benefits are funded entirely by your Group. Keystone Health Plan West provides administrative and claims payment services only.

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INTRODUCTION

Your school district ("the Group") has chosen a Health Maintenance Organization Network Program, administered by Keystone Health Plan West, Inc.(KHPW), Highmark's Blue Cross Blue Shield Health Maintenance Organization (HMO).

Good health is a primary concern. The KHPW team of participating physicians, Hospitals and other health care professionals is dedicated to providing quality medical care … to keep you and your family healthy and should you get sick or injured, to restore you to good health.

The HMO Network Program offers you the comfort and security of being treated by a physician *you* choose … in a location convenient for you. Each covered family Member may choose a different physician. You and your Primary Care Physician (PCP), as your physician is known, develop a close "family doctor" relationship – firmly establishing the trust that's so important to good health care.

For added convenience, the HMO Network Program includes a 24-hour health information and support service called "Blues On Call.[sm]" By calling a toll-free phone number, you can speak with a nurse who can answer any questions or concerns you may have about your health. You can also access Blues on Call via our Web Site at www.highmarkbcbs.com.

[sm]*Blues On Call is a service mark of the Blue Cross and Blue Shield Association*

SECTION I - DEFINITIONS

AMBULANCE SERVICE - a Facility Provider licensed by the state which, for compensation from its patients, provides transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

AMBULATORY SURGICAL FACILITY - a Facility Provider, with an organized staff of Physicians, which is licensed as required by the state, and which, for compensation from its patients:

a. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;

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

c. does not provide Inpatient accommodations; and

d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

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

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, Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), Tubal Embryo Transfer (TET), Peritoneal Ovum Sperm Transfer, Zona Drilling and sperm microinjection.

AWAY FROM HOME CARE® (GUEST MEMBERSHIP) – temporary courtesy enrollment in a local Blue Cross and/or Blue Shield HMO ("Host HMO") where available, that enables Members who are living away from home to receive a comprehensive range of Benefits, including routine and preventive Covered Services. The Member remains enrolled under this HMO Network Program.

BENEFIT PERIOD – the specified period of time during which charges for Covered Services must be Incurred in order to be eligible for payment by KHPW. A charge shall be considered Incurred on the date a Member receives the service or supply for which the charge is made.

BENEFITS (COVERED SERVICES) - the services and supplies as described in this benefit booklet which are eligible for coverage under this HMO Network Program.

BIRTHING FACILITY - a Facility Provider licensed by the state which, for compensation from its patients, is primarily organized and staffed to provide maternity care and which is under the supervision of a Nurse-Midwife.

BLUECARD® PROGRAM - a program comprised of Blue Cross and/or Blue Shield Plans which allows a Member to receive Covered Services from participating Providers located outside the 29-County Service Area of KHPW. The local Blue Cross and/or Blue Shield Plan which

serves the geographic area where the Covered Service is provided is referred to as the "on-site" Blue Cross and/or Blue Shield Plan ("Host Blue").

BLUECARD WORLDWIDE - a program sponsored by the Blue Cross and Blue Shield Association that provides Members access to Covered Services from a network of health care Providers outside the United States.

BLUES ON CALL (Health Education and Support Program) - a program administered by KHPW's Designated Agent through which the Member receives health education and support services, including assistance in the self-management of certain health conditions.

BRAND DRUG - a recognized trade name drug product, usually either the innovator product for new drugs still under patent protection or a more expensive product marketed under a brand name drug for multi-source drugs, and noted as such in the pharmacy database used by KHPW.

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

CERTIFIED UTILIZATION REVIEW ENTITY (CRE) - an entity certified by the Pennsylvania Department of Health to perform utilization review.

CLAIM – a request made by or on behalf of a Member for Preauthorization or prior approval of a Covered Service or for the payment or reimbursement of the charges or costs associated with a Covered Service that has been received by a Member. Claims for Benefits includes:

Pre-Service Claim - a request for Preauthorization or prior approval of a Covered Service which, as a condition to the payment of Benefits, must be approved by KHPW before the Covered Service is received by the Member.

Post-Service Claim – a request for payment or reimbursement of the charges or costs associated with Covered Services that have been received by the Member.

Urgent Care Claim – a Pre-service Claim which if decided within the time periods established by KHPW for making non-urgent care Pre-Service Claim decisions could seriously jeopardize the life or health of the Member, the ability to regain maximum function or, in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the service requested.

For purposes of the Claim determination and complaint or grievance appeal procedure provisions of this HMO Network Program, whether a Claim or a complaint or grievance appeal of a denied Claim involves a Pre-service Claim, an Urgent Care Claim or a Post-service Claim will be determined at the time that the Claim or complaint or grievance appeal is filed with KHPW in accordance with its procedures for filing Claims and complaint or grievance appeals.

CLINICAL LABORATORY - a medical laboratory licensed where required and performing within the scope of such licensure that is not affiliated or associated with a Hospital or Physician.

SELECT FORMULARY - a select list of Prescription Drugs, which is a subset of the Formulary.

COMFORT/CONVENIENCE ITEMS - items or equipment which serve a comfort or convenience function, or are primarily for the convenience of a person caring for the Member or is used for environmental control or to enhance the environmental setting in which the Member is placed. Such items include but are not limited to: connections from medical devices to computers for monitoring purposes, air conditioners, humidifiers, dehumidifiers, diapers, electric air cleaners, physical fitness equipment, "barrier free" modifications, ramps, stair glides, elevators/lifts, posture chairs, pools and hot tubs. Comfort/Convenience Items include those items which are not Primarily Medical In Nature.

COPAYMENT - a specified dollar a Member must pay to the provider at the time services are rendered, for a specific Covered Service. Copayments, if any, are set forth in **SECTION IX - SUMMARY OF BENEFITS**.

COVERED MEDICATIONS - Prescription Drugs, which the Group is contractually obligated to pay or provide as a Benefit.

COVERED SERVICE - a Service or supply specified in **SECTION V11 – DESCRIPTION OF BENEFITS** for which coverage will be provided when rendered under the terms of this HMO Network Program.

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. Custodial Care includes but is not limited to help in walking, bathing, dressing, feeding, toileting, preparation of special diets and supervision over administration of medications not requiring Skilled Nursing Services/Skilled Rehabilitation Services provided by trained and licensed medical personnel. Multiple non-Skilled Nursing Services/non-Skilled Rehabilitation Services in the aggregate do not constitute Skilled Nursing Services/Skilled Rehabilitation Services.

DAY/NIGHT PSYCHIATRIC FACILITY - a Facility Provider licensed by the state which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the treatment of Mental Illness only during the day or only during the night.

DENTIST - a person who is a doctor of dental surgery (D.D.S.) or doctor of medical dentistry (D.M.D.), licensed where required and performing services within the scope of such licensure.

DEPENDENT - any member of a Participant's family who meets the applicable eligibility requirements as listed in **SECTION V - SCHEDULE OF ELIGIBILITY.**

DESIGNATED AGENT - an entity that has contracted with KHPW to perform a function and/or service. Such function and/or service may include, but is not limited to, medical management.

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

DIABETES EDUCATION PROGRAM - **a**n Outpatient program of self-management training and education, including medical nutrition therapy, for the treatment of diabetes. Such Program must be conducted under the supervision of a licensed health care professional with expertise in diabetes, and approved by KHPW.

DIAGNOSTIC SERVICES - procedures ordered by a Provider, because of specific symptoms, to determine a definite condition or disease or for purposes of routine screening. Diagnostic Services are set forth in **SECTION VII - DESCRIPTION OF BENEFITS**.

DIALYSIS TREATMENTS - the treatment of acute renal failure or chronic irreversible renal insufficiency by removal of waste materials from the body through hemodialysis or peritoneal dialysis.

DR. DEAN ORNISH PROGRAM (For Reversing Heart Disease) - a lifestyle modification program through which the Member receives supportive services for the management of coronary artery disease and/or to address risk factors associated with coronary artery disease.

DR. DEAN ORNISH PARTICIPATING PROVIDER - a Network Provider who has entered into an agreement with KHPW to provide Covered Services to Members through the Dr. Dean Ornish Program (For Reversing Heart Disease).

DURABLE MEDICAL EQUIPMENT - items which can withstand repeated use, are primarily and customarily used to serve a medical purpose, are generally not useful to a person in the absence of illness, injury or disease, are appropriate for use in the home, do not serve as Comfort/Convenience Items, and do not include Orthotic Devices and Prosthetic Appliances.

EFFECTIVE DATE - according to **SECTION V - SCHEDULE OF ELIGIBILTY**, the date on which coverage for a Member begins.

ELECTIVE ABORTION - Abortions which are not necessary to avert the death of the woman, or which are not performed in order to terminate a pregnancy caused by rape or incest.

EMERGENCY CARE SERVICES - the initial treatment:

a. for bodily injuries resulting from an accident; or

b. following the sudden onset of a medical condition; or

c. 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 lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one or more of the following:

a. placing the health of the Member or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; or

b. serious impairment to bodily functions; or

c. serious dysfunction of any bodily organ or part.

Treatment for an occupational injury for which benefits are provided under any Workers' Compensation Law or any similar Occupational Disease Law is not covered.

Transportation and related emergency services provided by an Ambulance Service shall constitute an Emergency Care Service if the injury or the condition satisfies the criteria above.

Use of an ambulance as transportation to an emergency room of a Facility Provider for an injury or condition that is not an emergency, will not be covered as an Emergency Care Service.

ENTERAL FORMULAE - a liquid source of nutrition administered under the direction of a Physician which may contain some or all nutrients necessary to meet minimum daily nutritional requirements and is administered into the gastrointestinal tract either orally or through a tube.

EQUIVALENT PARTIAL SESSION VISIT - a period of 20-30 minutes devoted to individual or family medical psychotherapy for the treatment of problems related to Substance Abuse, with continuing medical diagnostic evaluation, and drug management when indicated. Medical psychotherapy may include individual psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy. Two (2) Equivalent Partial Session Visits equal one (1) Full Session Visit.

EXPERIMENTAL/INVESTIGATIVE - the use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by KHPW to be medically effective for the condition being treated. KHPW will consider an intervention to be Experimental/Investigative if:

a. the intervention does not have Federal Food and Drug Administration (FDA) approval to market for the specific relevant indication(s); or

b. available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or

c. the intervention is not proven to be as safe or as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or

d. the intervention does not improve health outcomes; or

e. 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 service, it will not receive retroactive coverage even if it is found not to be Experimental/Investigative at a later date.

FACILITY PROVIDER - an entity which is licensed, where required, to render Covered Services. Facility Providers include:

Ambulance Service
Ambulatory Surgical Facility
Birthing Facility
Day/Night Psychiatric Facility
Freestanding Dialysis Facility
Home Health Care Agency
Home Infusion Therapy Provider
Hospice
Hospital
Outpatient Substance Abuse Treatment Facility
Outpatient Psychiatric Facility
Pediatric Extended Care Facility
Pharmacy Provider
Psychiatric Hospital
Rehabilitation Hospital
Skilled Nursing Facility
Substance Abuse Treatment Facility

FORMULARY - a listing of Prescription Drugs selected by KHPW based on an analysis of clinical efficacy, unique value, safety, and pharmacoeconomic impact. This listing is subject to periodic review and modification by KHPW or a designated committee of Physicians and pharmacists.

FREESTANDING DIALYSIS FACILITY - a Facility Provider licensed and approved by the appropriate governmental agency and which, for compensation from its patients, is primarily engaged in providing Dialysis Treatment, maintenance or training to patients on an Outpatient or home care basis.

FULL SESSION VISIT - a period of 45-50 minutes devoted to individual or family medical psychotherapy for the treatment of problems related to Substance Abuse, with continuing medical diagnostic evaluation, and drug management when indicated. Medical psychotherapy may include individual psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy.

GENERIC DRUG - a drug that is available from more than one manufacturing source, accepted by the Federal Food and Drug Administration ("FDA") as a substitute for those products having the same active ingredients as a Brand Drug, and listed in the FDA "Approved Drug Products with Therapeutic Equivalence Evaluations," otherwise known as the Orangebook, and noted as such in the pharmacy database used by KHPW.

HEALTH MAINTENANCE ORGANIZATION (HMO) - an organized system that combines the delivery and financing of health care and which provides basic health services to voluntarily enrolled Members.

HIGHMARK INC. (HIGHMARK) – an independent licensee of the Blue Cross Blue Shield Association. KHPW is a wholly owned subsidiary of Highmark.

HOME HEALTH CARE AGENCY - a Facility Provider program for home health care, licensed by the state and certified by Medicare which, for compensation from its patients:

a. provides skilled nursing and other services on a visiting basis in the Member's home; and

b. is responsible for supervising the delivery of such services under a plan prescribed by the attending Physician.

HOME INFUSION THERAPY - the administration of Medically Necessary and Appropriate fluid or medication via a central or peripheral vein to Members at their place of residence.

HOME INFUSION THERAPY PROVIDER - a Facility Provider, which has been licensed by the Pennsylvania Department of Health, accredited by the Joint Commission on the Accreditation of Health Care Organizations and Medicare, if appropriate, and is organized to provide Home Infusion Therapy to Members at their place of residence.

HOSPICE - a Facility Provider, licensed by the state which, for compensation from its patients, is primarily engaged in providing palliative care to terminally ill individuals.

HOSPICE CARE - a program which provides an integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients and their families. Hospice services are centrally coordinated through an interdisciplinary team directed by a Physician.

HOSPITAL - a duly licensed Provider that is a general or special Hospital which has been approved by Medicare, the Joint Commission on the Accreditation of Health Care Organizations or by the American Osteopathic Hospital Association, which, for compensation from its patients:

a. is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians; and

b. provides 24-hour nursing service by or under the supervision of Registered Nurses.

IDENTIFICATION CARD - the currently effective card issued to the Member by KHPW.

IMMEDIATE FAMILY - the Member's spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, or son-in-law, grandchild, grandparent, stepparent, stepbrother or stepsister.

INCURRED - a charge is considered Incurred on the date a Member receives the Service or supply for which the charge is made.

INFERTILITY - the medically documented inability to conceive with unprotected sexual intercourse between a male and female partner for a period of at least twelve (12) months. The condition may be present in either the male or female partner.

INPATIENT - a Member who is a registered bed patient in a Facility Provider and for whom a room and board charge is made.

INPATIENT HOSPITAL SERVICES - the Covered Services as described in this Benefit Booklet when rendered to a Member who is admitted as a registered overnight bed patient in a Facility Provider.

KEYSTONE HEALTH PLAN WEST, INC. (KHPW) - a licensed Health Maintenance Organization (HMO) operating under the supervision of the Pennsylvania Insurance Department and the Department of Health of the Commonwealth of Pennsylvania. Any reference to KHPW may also include its Designated Agent as defined herein and with whom KHPW has contracted to perform a function or service in the administration of this HMO Network Program.

MAINTENANCE PRESCRIPTION DRUGS - a Prescription Drug prescribed for the control of a chronic disease or illness or to alleviate the pain and discomfort associated with a chronic disease or illness.

MASTER LEVEL THERAPIST - a person licensed in an accepted human service specialty including, but not limited to a master level psychologist, professional counselor or marriage and family therapist and performing services within the scope of such licensure. Where there is no licensure law, the Master Level Therapist must be certified by the appropriate professional body.

MAXIMUM - the greatest amount payable by KHPW for Covered Services within a prescribed period of time. This could be expressed in dollars, number of days, or number of Services.

MEDICAL DIRECTOR - a Physician designated by KHPW to design and implement quality assurance programs and continuing education requirements, and to monitor appropriate utilization of Covered Services by Members.

MEDICAL SUPPLY/SUPPLIES - non-reusable items or items with limited reusability which are:

a. primarily medical in nature;

b. used in the treatment of illness or injury;

c. used for a therapeutic purpose; and

d. not a Comfort/Convenience Item.

MEDICALLY NECESSARY AND APPROPRIATE (MEDICAL NECESSITY AND APPROPRIATENESS) - services or supplies 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:

a. in accordance with generally accepted standards of medical practice;

b. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

c. not primarily for the convenience of the patient, physician, or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

No benefits hereunder will be provided unless it is determined that the service or supply is Medically Necessary and Appropriate. .

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

MEMBER - a Participant or Dependent who meets the applicable eligibility requirements and is enrolled in the HMO Network Program.

MENTAL ILLNESS - an emotional or mental disorder characterized by a neurosis, psychoneurosis, psychopathy, or psychosis without demonstrable organic origin.

METHADONE MAINTENANCE - the treatment of heroin or other morphine-like drug dependence where the patient is taking methadone hydrochloride daily in prescribed doses to replace the previous heroin or other morphine-like drug abuse.

NETWORK - all Keystone Health Plan West Providers, approved as a Network by the Pennsylvania Department of Health, that have entered into a contractual agreement either directly or indirectly with KHPW.

NETWORK PROVIDER - Facility Providers and Professional Providers that have an agreement with KHPW, pertaining to payment as Network participants for Covered Services rendered to a Member.

NETWORK SPECIALIST - a Specialist Provider that has an agreement with KHPW, pertaining to payment as a Network participant for Covered Services rendered to a Member.

NON-HOSPITAL RESIDENTIAL TREATMENT - the provision of medical, nursing, counseling or therapeutic services to patients suffering from Substance Abuse or dependency in a residential environment, according to individualized Treatment Plans.

NURSE-MIDWIFE - a person who is legally licensed, and performing services within the scope of such licensure, to practice the profession of midwifery. Where there is no licensure law, the Nurse-Midwife must be certified by the appropriate professional body.

OPEN ENROLLMENT PERIOD - the period of time established by the Group, during which eligible persons who have not previously enrolled in this Benefit program may do so.

ORTHOTIC DEVICES - a rigid or semi-rigid supportive device which restricts, modifies or eliminates motion of a weak or diseased body part. Such a device must be Primarily Medical in Nature and not be a Comfort/Convenience Item.

OUT-OF-AREA SERVICES - those services provided outside the Keystone Network Service Area.

OUTPATIENT - a Member who receives services or supplies and is not admitted as a registered bed patient in a Facility Provider.

OUTPATIENT PSYCHIATRIC FACILITY - a Facility Provider which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the treatment of Mental Illness on an Outpatient basis.

OUTPATIENT SERVICES - the Covered Services described in **SECTION VII – DESCRIPTION OF BENEFITS** when rendered to a Member who is not admitted as a registered bed patient in a Facility Provider.

OUTPATIENT SUBSTANCE ABUSE TREATMENT FACILITY - a Facility Provider which, for compensation from its patients, is primarily engaged in providing rehabilitative counseling services, diagnostic and therapeutic services for the treatment of Substance Abuse. This Facility must also meet the minimum standards set by the Pennsylvania Department of Health, the Pennsylvania Office of Drug and Alcohol Programs, or other appropriate governmental agency.

PARTIAL HOSPITALIZATION - the provision of medical, nursing, counseling or therapeutic Mental Health 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 who does not require Inpatient care.

PARTICIPANT - a person whose employment or other status, except for family dependency, is the basis for eligibility for enrollment in this HMO Network Program.

PARTICIPATING PHARMACY PROVIDER - a Pharmacy Provider performing within the scope of its license that has an agreement with KHPW pertaining to the payment of Covered Medications provided to a Member.

PEDIATRIC EXTENDED CARE FACILITY - a Facility Provider licensed by the state which, for compensation from its patients, is primarily engaged in providing basic non-residential services to infants and/or young children who have complex medical needs requiring skilled nursing and therapeutic care and who may be technologically dependent.

PHARMACY PROVIDER - an entity licensed by the state which is engaged in dispensing Prescription Drugs through a licensed pharmacist.

PHYSICAL THERAPIST - a person who is legally licensed, and performing services within the scope of such licensure, the profession of physical medicine. Where there is no licensure law, the Physical Therapist must be certified by the appropriate professional body.

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

PREAUTHORIZATION - the process whereby the PCP, or the Network Specialist, must contact KHPW to determine the coverage eligibility for and/or the Medical Necessity or Appropriateness of certain Covered Services, as specified in this benefit booklet. Unless otherwise stated in this benefit booklet, a PCP or the Network Specialist must first obtain Preauthorization prior to providing Covered Services to a Member. A Member will not be responsible for payment other than any applicable Copayment if the PCP or the Network Specialist provides Covered Services without first obtaining the required Preauthorization.

PRESCRIPTION DRUGS - any drugs or medications ordered by means of a valid Prescription Order, bearing the federal legend: "Caution: Federal law prohibits dispensing without a prescription," or legend drugs under applicable state law and dispensed by a licensed Pharmacist. Also included are: prescribed injectable insulin and disposable insulin syringes, and compounded medications, consisting of the mixture of at least two ingredients other than water, one of which must be a legend drug.

PRESCRIPTION ORDER - the request for medication issued by a Professional Provider.

PRIMARILY MEDICAL IN NATURE - an item which is used in connection with the treatment of an illness or injury or other medical purpose, and which is not generally useful in the absence of illness or injury.

PRIMARY CARE PHYSICIAN (PCP) - a Physician selected by a Member in accordance with provisions established by KHPW who has specifically contracted with KHPW to supervise, coordinate and provide basic medical services and maintain continuity of patient care.

PROFESSIONAL PROVIDER - a person, practitioner or entity licensed where required and performing services within the scope of such licensure. Professional Providers include:

- Audiologist
- Certified Registered Nurse
- Chiropractor
- Clinical Laboratory
- Dentist
- Physical Therapist
- Physician
- Podiatrist
- Psychologist
- Respiratory Therapist

Master Level Therapist
Nurse-Midwife
Occupational Therapist
Optometrist
Social Worker
Speech-Language Pathologist

PROSTHETIC APPLIANCES - devices and related Medical Supplies which replace all or part of:

a. an absent body limb or body organ (including adjoining tissue); and/or

b. the basic function of a permanently inoperative or malfunctioning body organ.

Such appliance must be Primarily Medical in Nature and not a Comfort/Convenience Item.

PROVIDER - a Facility Provider or Professional Provider licensed where required, and performing within the scope of such licensure.

PROVIDER'S ALLOWABLE PRICE(PAP) - the amount at which a Participating Pharmacy Provider has agreed with KHPW to provide Covered Medications to Members as outlined in this benefit booklet.

RESPITE CARE - short-term care for a terminally ill patient provided by a Facility Provider when necessary to relieve a person (caregiver) who is caring for the patient at home free of charge.

SERIOUS MENTAL ILLNESS - any of the following Mental Illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual: Schizophrenia, Bipolar Disorder, Obsessive-Compulsive Disorder, Major Depressive Disorder, Panic Disorder, Anorexia Nervosa, Bulimia Nervosa, Schizo-Affective Disorder and Delusional Disorder.

SERVICE AREA - the geographic area designated by KHPW which may be modified from time to time, served by the Network and approved by the Pennsylvania Department of Health.

SKILLED NURSING FACILITY - a Facility Provider licensed by the state and certified by Medicare as a Skilled Nursing Facility which for compensation from its patients is primarily engaged in providing Skilled Nursing Services on an Inpatient basis to patients requiring 24-hour Skilled Nursing Services but not requiring confinement in an acute care general Hospital. Such care is rendered by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

a. minimal care, Custodial Care, ambulatory care, or part-time care services; or

b. care or treatment of Mental Illness, Substance Abuse, or pulmonary tuberculosis.

SKILLED NURSING SERVICES/SKILLED REHABILITATION SERVICES - services which have been ordered by and under the direction of a Physician, and are provided either directly by or under the supervision of a medical professional: e.g., Registered Nurse, Physical Therapist, Licensed Practical Nurse, Occupational Therapist, Speech-Language Pathologist or

Audiologist with the treatment described and documented in the patient's medical record. Unless otherwise determined, in the sole discretion of KHPW, Skilled Nursing Services/Skilled Rehabilitation Services shall be subject to the following:

a. the Skilled Nursing Services/Skilled Rehabilitation Services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified licensed medical professional and must be such that the care could not be performed by a non-medical individual instructed to deliver such Services.

b. Skilled Rehabilitation Services consist of the combined use of medical, social, educational and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Skilled Rehabilitation Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse. The Skilled Rehabilitation Services must be provided with the expectation that the patient has restorative potential and the condition will improve materially in a reasonable and generally predictable period of time. Once a maintenance level has been established or no further progress is attained, the services are no longer classified as Skilled Rehabilitation, and will be considered to be Custodial Care.

The mere fact that a Physician has ordered or prescribed a therapeutic regimen does not, in itself, determine whether a service is Skilled Nursing Services or Skilled Rehabilitation Services.

SOCIAL WORKER - a person holding a master's degree or doctoral degree in social worker, licensed where required and performing services within the scope of such licensure.

SPECIALIST - a Professional Provider who limits his or her practice to a particular branch of medicine or Surgery.

SUBSTANCE ABUSE - any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

SUBSTANCE ABUSE TREATMENT FACILITY - a Facility Provider licensed by the state, approved by the Joint Commission on Accreditation of Health Care Organizations which, for compensation from its patients, is primarily engaged in providing Detoxification and/or rehabilitation treatment for alcohol abuse and/or drug abuse. This facility must also meet the minimum standards set by the Pennsylvania Department of Health, the Pennsylvania Office of Drug and Alcohol Programs, or other appropriate governmental agency.

SURGERY - **t**he performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures and the correction of fractures and dislocations. Payment for Surgery includes an allowance for usual and related Inpatient pre-operative and post-operative care.

THERAPY AND REHABILITATION SERVICES - the following services or supplies ordered by a Professional Provider to promote the recovery of the Member. Therapy and Rehabilitation Services are covered as listed in **SECTION VII - DESCRIPTION OF BENEFITS** and **SECTION IX - SUMMARY OF BENEFITS**.

a. **Cardiac Rehabilitation Therapy**

The physiological and psychological rehabilitation of patients with cardiac conditions through regulated exercise programs.

b. **Chemotherapy**

The treatment of malignant disease by chemical or biological anti-neoplastic agents.

c. **Infusion Therapy**

Treatment by the administration of Medically Necessary and Appropriate fluid or medication via a central or peripheral vein when performed by, furnished by and billed by a Facility Provider in accordance with accepted medical practice.

d. **Occupational Therapy**

Treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

e. **Physical Medicine**

The treatment by physical means or modalities such as, but not limited to, mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities, and rehabilitative procedures, performed to relieve pain, restore level of function following disease, illness or injury.

f. **Radiation Therapy**

The treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

g. **Respiratory Therapy**

Introduction of dry or moist gases into the lungs for treatment purposes.

h. **Speech Therapy**

Treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

i. **Spinal Manipulation Therapy**

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.

TREATMENT PLAN - a plan of care which is prescribed in writing by a Professional Provider for the treatment of an injury or illness. The Treatment Plan should be limited in scope and extent to that care which is Medically Necessary and Appropriate.

VISIT - the physical presence of a Member at a location designated by the Facility Provider or Professional Provider for the purpose of providing Covered Services.

SECTION II - YOUR HMO IDENTIFICATION CARD

The key to receiving full benefits and the best possible service under your HMO Network Program is seeking services from a Network Provider. In addition, it is very important that you present your Identification Card to your PCP – or any other Provider – when you or a covered family Member seeks medical services.

Your HMO Identification Card includes important information that must be given to Providers whenever you receive medical care. Carry your Identification Card with you. When you call KHPW Member Service at the number printed on the back of your card, please have your card handy so you can provide information that will help the representative answer your questions promptly.

You must show your card to the participating Premier network pharmacy where you have your prescription filled. You must include your group and identification numbers on any mail order for Prescription Drugs.

Your Identification Card shows the specific copayment amounts that you are required to pay at the time you visit your PCP, a specialist or an emergency room. For a complete list of copayments applicable to your HMO Network Program, please see **SECTION IX - SUMMARY OF BENEFITS** in this benefit booklet. If your program includes a deductible, you may be required to pay this amount at the time you receive care from your network provider.

The back of your Identification Card provides additional important information, including the toll-free phone numbers for Member Service, Blues On Call and Mental Health and Substance Abuse Services.

If your card is lost or stolen, please call Member Service immediately. It is illegal to lend your Identification Card to any person who is not covered under this HMO Network Program.

SECTION III - HOW TO OBTAIN SERVICES

A. *Selection of Providers*

Under this HMO Network Program, you must receive Covered Services from Network Providers, except in the following circumstances: 1) for Emergency Care Services; 2) when you receive Preauthorization to receive services from a Provider outside the Network; 3) as provided in the TRANSITION/CONTINUITY OF CARE or 4) as otherwise provided herein. The Provider Directory lists health care Providers who participate in the Network, includes their addresses and telephone numbers and indicates whether a PCP is accepting new patients. However, you should always contact a Provider to verify whether that Provider is still participating in the Network and accepting new patients.

B. *The Role of Your Primary Care Physician*

1. ***Selecting Your PCP***
   When you enrolled in the HMO Network Program, you and each of your covered Dependents selected a Primary Care Physician (PCP) in Family Practice, General Practice, Internal Medicine or Pediatrics. Your PCP is your personal physician and must provide certain services, such as routine adult physicals, routine pediatric physicals and routine pediatric immunizations. When you need medical attention, talk to your PCP and schedule appointments at his or her office. For all other services, you have the flexibility you want to go directly to any Network Provider without a referral from your PCP.

   Though you don't need to contact your PCP to receive specialty care, we encourage you to develop a relationship with your PCP. He or she can become familiar with your medical history and you can enjoy personal attention and trust that develops through a strong "family physician" relationship. PCPs or their covering physicians are on call 24 hours a day, seven (7) days a week for your convenience and security.

   If you have not selected a PCP, you should do so as soon as possible by calling Member Service. Otherwise, you may be responsible for paying for most of the services yourself. If you fail to select a PCP within thirty (30) days of your enrollment in this HMO Network Program, KHPW reserves the right to select a physician for you.

2. ***Changing Your PCP***
   You are free to change PCPs whenever you feel it is necessary. Visit our Web Site at www.highmarkbcbs.com or call the KHPW Member Service Department at the number printed on the back of your Identification Card. A Member Service representative will take your PCP change over the phone if you have the information needed.

   If you need help choosing a new PCP, the representative can send you a copy of the latest Provider Directory. The directory, which is also available on our Web site, lists health care Providers who participate in the network, includes their addresses and telephone numbers and indicates whether PCPs are accepting new patients. However, you should always call a PCP or specialist to verify whether he or she is still participating and accepting new patients.

If you prefer to make the change in writing, ask a Member Service representative to send a "PCP Change Form" which you complete and mail to KHPW. Whatever option you choose to change your PCP,

(a) if the change is made between the 1st and 15th day of the month, your PCP change will become effective the 1st day of the following month; or

(b) if the change is made between the 16th and the last day of the month, your change will become effective the 1st day of the second month after it is received.

When you transfer to a new PCP, you will receive a new Identification Card with the new physician's name and telephone number.

C. *Specialist Care*

With your HMO Network Program you have the flexibility to go directly to any Network Provider, including specialists. Though you don't need to contact your PCP to receive specialty care, you may want to talk to your PCP about which type of care you may need. He or she may also be able to recommend a network specialist.

If needed, your PCP can obtain authorization for you to see a specialist who is not in your plan Network and your eligible specialty care will be covered.

D. Transition of Care

If you are receiving medical care from an out-of-network Provider at the time of your effective date of coverage, which is not otherwise covered by your prior coverage, you may, at your option, continue an ongoing course of treatment with that Provider for a period of up to sixty (60) days from the effective date of your coverage. KHPW must be notified of your request to continue ongoing course of treatment for the Transition of Care period.

This transition of care period may be extended if determined to be Medically Necessary and Appropriate by KHPW following consultation with you and your Provider. In the case of a Member who is in the second or third trimester of pregnancy on the effective date of coverage, care may continue with the Provider through postpartum care related to delivery. Any services authorized under this section will be covered in accordance with the same terms and conditions as applicable to Network Providers. Nothing in this section shall require the payment of benefits for health care services that are not otherwise provided under the terms and conditions of this HMO Network Program. To receive transition of care benefits, call the Member Services phone number listed on the back of your Identification Card and request a transition of care form.

E. Continuity of Care

If at the time you are receiving medical care from a Network Provider, notice is received from KHPW that it intends to terminate or has terminated the contract of that Network Provider for reasons other than cause, you may, at your option, continue an ongoing course of treatment with that Provider for a period of up to ninety (90) days from the date of the notification of the termination or pending termination.

This continuity of care period may be extended if determined to be Medically Necessary and Appropriate by KHPW following consultation with you and your Provider. In the case of a Member who is in the second or third trimester of pregnancy on the effective date of coverage or at the time notice of the termination or pending termination is received, care may continue with the Provider through postpartum care related to delivery. Any services authorized under this section will be covered in accordance with the same terms and conditions as applicable to Network Providers. Nothing in this section shall require the payment of benefits for health care services that are not otherwise provided under the terms and conditions of this HMO Network Program.

If the Network Provider is terminated for cause and you continue to seek treatment from that Provider, payment will not be made for health care services provided to you following the date of termination.

F. Designation of a Network Specialist as a PCP

A Member with a life-threatening, degenerative or disabling disease or condition can continue to receive care from any Network Specialist with clinical expertise in treating the disease or condition, or shall, upon request, receive an evaluation by KHPW and, if the established requirements of KHPW are met, be permitted to designate a Network Specialist to assume responsibility to provide and coordinate the Member's primary and specialty care. The Network Specialist once designated, will be able to provide those Covered Services which are indicated as being covered only when rendered by the PCP as set forth in **SECTION VII - DESCRIPTION OF BENEFITS**. The designation of a Network Specialist shall be in accordance with a Treatment Plan approved by KHPW, in consultation with the PCP and/or Network Specialist and the Member.

G. Prescription Drug Services

When a Network physician gives you a prescription, take it to one of the participating Premier Network pharmacies and show the pharmacist your HMO Identification Card. For maintenance type Prescription Drugs needed to treat a chronic or long-term condition, you may use the mail order program.

If you forget your HMO Identification Card when you go to a Participating Pharmacy Provider to have a prescription filled, the pharmacy may ask you to pay in full for the prescription. If this happens call Member Service at the number printed on the back of your

Identification Card to request a drug reimbursement claim form or to obtain information on the mail order program.

H. When You Need Non-Emergency Care Outside the Network Service Area

1. Urgent and Follow up Care

Your HMO Network Program covers your urgent or follow-up care while you are traveling on business or vacation. Through the Blue Cross Blue Shield Association's BlueCard® program, you can get access to the country's largest network of providers.

Urgent care is an unexpected illness or injury that cannot wait to be treated until you return home. You do not need to contact your PCP for the initial urgent care visit. However, if the out-of-area physician you receive care from recommends you return for an additional visit or recommends that you go to another physician or facility for non-emergency care, you must coordinate this care through your PCP before receiving services.

Follow-up care is ongoing services started before you left home that you require while traveling. Follow-up care must be coordinated with your PCP prior to traveling.

To receive out-of-area urgent or follow-up care, Members call the BlueCard Provider Access number at **1-800-810-BLUE**. You can call 24 hours a day, 7 days a week. When you call, you will be given the names of Blue Cross Blue Shield participating physicians in the area where you are traveling. You just call one of these physicians to schedule an appointment. You can also find a provider online at www.bcbs.com at the BlueCard Doctor and Hospital Finder Web site.

Along with the BlueCard Program for urgent and follow-up care, you can use the service of BlueCard Worldwide to locate providers outside the U.S. by calling the same number, **1-800-810-BLUE**. Should you receive care out of the country, call your PCP when you return home to inform him or her about your care. To file for reimbursement, save your medical receipts and call a Member Service representative who will assist you with your Claims filing.

2. Away from Home Care (Guest Membership)

This HMO Network Program also allows members to receive benefits through the Away From Home Care® Guest Membership Program. Through this program, Members temporarily residing in another plan area for at least 90 days or eligible Dependents who permanently reside in another plan area, are able to become guest members in the area's local Blue Cross Blue Shield HMO if one is available. This service can be especially valuable for Members who have ongoing health needs that require regular or follow-up care while they are away. More information on this Guest Membership program is available from Member Service.

I. If You Receive A Bill

If you receive a bill for a medical service provided by a Hospital, specialist, radiologist, anesthesiologist or other Provider, check it over carefully. Often these bills do not include correct insurance information or they were filed incorrectly by the Provider.

Make sure your Member Identification Number, which is found on your Identification Card, is correct. Correct the spelling of the patient's name, if necessary. Then call Member Service at the number shown on the back of your Identification Card and ask if a Claim for the service in question has been received. Your Member Service Representative will investigate the Claim for you, answer any questions you may have about it, and keep you informed of its status.

SECTION IV – VALUE ADDED SERVICES

A. Blues On Call (Health Information and Support Program)

Your coverage includes Blues On Call, a service that you can access by phone or on our Web site. You can receive objective information 24 hours a day which can help you make the right decisions about your health care. Blues On Call supports your relationship with your PCP and other treating physicians—it is not a substitute for your PCP or other physician's care.

When you use this service, you may communicate with a specially trained registered nurse who can answer questions you have about your health. For example, if you need to begin taking a new medication, you can learn more about it and any possible side effects. Or perhaps you must decide between outpatient therapy or surgery for recurring back pain. Blues On Call can help you understand the risks, benefits and alternatives, so you can work with your physician to make the best choice for you.

You can also receive:

- Comprehensive care support for any medical condition, including chronic conditions.
- An immediate health care assessment for an illness or injury.
- Educational audiotapes and videotapes on a wide range of care topics.

Blues On Call is a free service provided as part of the total health care management services of your HMO Network Program. You can call Blues On Call anytime, day or night, seven days a week, simply by calling toll-free, 1-888-BLUE-428. You can also reach Blues On Call through our Web site at www.highmarkbcbs.com.

B. Visit www.highmarkbcbs.com For A World Of Information, Interactive Tools And Services

As a Member, you have access to health and wellness information, user-friendly services related to your health care coverage, and valuable tools for managing your own health and well-being. Visit our Web site at www.highmarkbcbs.com, and follow the steps to log on to "My BlueLink" where you can accomplish the following tasks and more:

- Check the status of a Claim
- Request claim forms and/or Identification Cards
- Send a secure message to a Member Service representative. Send a secure message to a Blues on Call nurse
- Look up a medical topic on Healthwise Knowledgebase®, a comprehensive health information resource
- Access health and wellness tools, such as the Personal Wellness Profile or lifestyle improvement programs, which can help you manage your weight, decrease stress, quit smoking and improve your eating habits.

Plus, My BlueLink lets you connect to information tailored to your needs and interests. Topics include exercise and fitness, food and nutrition…just to name a few.

SECTION V - SCHEDULE OF ELIGIBILITY

A. Effective Date of Coverage

When a person makes written application for membership on or prior to the date he/she satisfies the eligibility requirements listed in this Eligibility section, coverage shall be effective as of the date the eligibility requirements are satisfied.

When a person makes written application for membership, after the date he/she satisfies the eligibility requirements listed in this Eligibility section, coverage will be effective as of the first day of the calendar month following the month in which the application is received by the Group.

For newborn children, coverage shall become effective at birth for thirty-one (31) days, and continue in effect thereafter if the newborn is enrolled by the Participant within thirty-one (31) days of the newborn's birth.

When a person makes written application for membership during the Group's Open Enrollment Period, coverage will be effective on the first day of the calendar month as defined by the Group.

B. Eligibility

The Participant
To be eligible as a Participant, an individual must reside or work in the Keystone Service Area, and be entitled to participate in the Group's health benefits program, by reason of employment - including compliance with any probationary or waiting period established by the Group. In addition, such individuals may be entitled to participate in the Group's health benefits program pursuant to special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Eligible Dependents
To be eligible to enroll as a Dependent, an individual must meet all eligibility requirements established by the Group, and be:

a. the Participant's spouse under a legally valid existing marriage between persons of the opposite sex; or

b. an unmarried Dependent child, including a newborn child, stepchild, a child placed for adoption, a legally adopted child, a child awarded coverage pursuant to an order of court, or natural child of either the Participant or the Participant's spouse, who is under the limiting age for Dependents as specified in **SECTION IX - SUMMARY OF BENEFITS**. Additionally, a Dependent child shall include a child for whom the Participant or Participant's spouse is a court appointed legal guardian; or

c. an unmarried Dependent child who is over the limiting age for Dependents as specified in **SECTION IX - SUMMARY OF BENEFITS**, who, as medically certified by a physician, is incapable of self-support due to mental retardation, physical disability,

mental illness or developmental disability that started before the limiting age. KHPW may require proof of such Dependent's disability from time to time; or

d. an unmarried Dependent child, who is under the limiting age for full-time students as specified in **SECTION IX - SUMMARY OF BENEFITS**, and is a full-time student in an accredited educational institution; or

e. a Dependent entitled to enroll for coverage under this HMO Network Program pursuant to special enrollment rights granted under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

– **Newly Eligible Dependents.** Members who want to enroll newly eligible dependents should contact the Group for policies related to this process.

C. Notice of Ineligibility.

It shall be the Participant's responsibility to notify the Group of any changes, which will affect the Participant's or Dependent's eligibility for Services or Benefits.

D. Keeping Your Membership Up to Date

Changes in your Membership Status
Please notify the Benefits Administrator at the Group, as soon as you experience a change in the following:

- Name or address
- Marital status (marriage or divorce)
- Addition of a Dependent (birth, placement for adoption or adoption)
- Termination or death of a Dependent
- Eligibility for Medicare or other group health insurance
- Employment

It is important that you enroll any newly acquired Dependents as soon as possible. Contact the Benefits Administrator at the Group for policies related to this process. If the Group is not notified in time, your new Dependent may experience a lapse in coverage or may not be eligible until the next open enrollment. You will need to select a PCP for each new Dependent. Please call Member Service at the number shown on the back of your Identification Card for assistance. Each new Dependent will be mailed an Identification Card once enrolled for coverage.

Verifying Dependent Student Status
Under the HMO Network Program, coverage is provided for your unmarried Dependent children who are full-time students enrolled in an accredited college, university, trade or secondary school. You will be asked annually to verify the status of each student you wish to include under your HMO Network Program enrollment.

Assignment
Any rights of a Member to receive Covered Services or payments under this HMO Network Program are personal to the Member and may not be assigned to any person, Provider or entity, without the written consent of KHPW, unless otherwise required by law.

E. Certificates of Creditable Coverage

A “certificate of creditable coverage” provides evidence of an individual’s length of coverage in a group health plan or other health insurance program defined under the Health Insurance Portability and Accountability Act of 1996.

Upon termination from this HMO Network Program, you and your covered Dependents will automatically receive a certificate of creditable coverage. The certificate of creditable coverage may be used to reduce the applicable pre-existing condition exclusion that a successor plan or program may impose. In addition, you and your Dependents have the right to request a certificate of creditable from your Plan Administrator for up to 24 months after coverage under this HMO Network Program has terminated.

SECTION VI – MANAGED HEALTH CARE

A. *Healthcare Management Services (HMS)*

1. ***Determining Care Coverage***
   For benefits to be paid under your HMO Network Program, services and supplies must be considered "Medically Necessary and Appropriate."

   HMS will review your care to assure it is "medically necessary and appropriate" in the following ways:
   - Appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury; and
   - Provided for your diagnosis or the direct care and treatment of your condition, illness, disease or injury; and
   - Not primarily for the convenience of you, your hospital or health care provider; and
   - In accordance with standards of good medical practice; and
   - The most appropriate supply or level of service that can safely be provided. When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered or your condition, and you cannot receive safe or adequate care in some other setting without adversely affecting your condition or quality of medical care.

2. ***A Summary Of KHPW Care/Utilization Process***
   To assure that you get appropriate care, HMS administers a care/utilization review process comprised of prospective, concurrent and retrospective reviews. In addition HMS conducts discharge planning. These activities are conducted via phone by a HMS nurse working closely with a Physician Advisor who is in direct contact with your physician.

   a. **Prospective Review**
      Prospective review, also known as pre-certification or pre-admission review, begins once a request for medical services is received. Requests can be for services such as inpatient or outpatient Hospital care, specific therapies, durable medical equipment or home health services.

      After receiving the request for medical services, the HMS nurse:
      - Gathers information needed to make a decision, including patient demographics, diagnosis, and plan of treatment;
      - Confirms care is "Medically Necessary and Appropriate";
      - Authorizes care or refers to a Physician Advisor for a determination;
      - When required, assigns an appropriate length of Hospital stay

b. **Concurrent Review**
Concurrent review occurs during the course of inpatient hospitalization and is used to ensure appropriateness of admission, length of stay and level of care at an inpatient facility.

The HMS Nurse:
- Contacts the facility's utilization reviewer;
- Checks the Member's progress and ongoing treatment plan;
- Decides, when necessary, to either extend the Member's care, offer an alternative level of care, or refer to the Physician Advisor for further determination of care.

c. **Discharge Planning**
Discharge planning is a review of the case to identify the Member's discharge needs. The process begins prior to admission and extends throughout the Member's stay in a facility. Discharge planning ensures continuous, quality care and is coordinated with input from the Member's physician.

To plan effectively, the HMS Nurse assesses the Member's:
- Level of function pre- and post-admission;
- Ability to perform self-care;
- Primary caregiver and support system;
- Living arrangements pre- and post-admission;
- Special equipment, medication and dietary needs;
- Obstacles to care;
- Need for referral to case management or disease management
- Availability of benefits or need for benefit adjustment.

d. ***Retrospective Review***
Retrospective review occurs when a service or procedure has been rendered prior to HMS notification.

e. **Case Management Services**
When a Member is injured, seriously ill or considering certain types of surgery, Case Management may begin a collaborative process that involves HMS and case managers, the member, their family or significant others, physicians and institutional providers. Using communication, education and available resources, Case Management assesses, plans, implements, coordinates, monitors and evaluates all of the options and services required to meet the member's health needs…always with the goal of enabling the member to reach optimum recovery in a timely manner.

f. **Preauthorization**
Certain Covered Services require Preauthorization by KHPW. The Member's PCP, or any other Network Specialist is responsible for obtaining the Preauthorization.

B. Prescription Drug Care Management

Your prescription drug plan also includes clinical programs designed to ensure best practices in medication prescribing, dispensing, and use to maximize the positive impact of the prescription drug benefit on your health.

1. **Prior Authorization**

   Certain Prescription Drugs, as designated by KHPW, may require prior authorization to ensure the Medical Necessity and Appropriateness of the Prescription Order. The Member's PCP or Network Specialist must obtain authorization from KHPW, prior to the dispensing of the drug if applicable at a Participating Pharmacy Provider or through mail order. If it is determined by KHPW that the Prescription Drug is Medically Necessary and Appropriate, the Prescription Drug will then be dispensed by the Participating Pharmacy Provider or through mail order.

2. **Managed Prescription Drug Coverage**

   A Prescription Order or refill, which exceeds the manufacturer's recommended dosage over a specified period of time will be denied by KHPW when presented to the Participating Pharmacy Provider. KHPW will contact the prescribing Physician to discuss the Member's drug therapy. If it is determined by KHPW, that the Prescription Drug is Medically Necessary and Appropriate, the Prescription Drug will then be dispensed by the Participating Pharmacy Provider or through mail order.

3. **Quantity Level Limits**

   Quantity level limits may be imposed on certain Prescription Drugs by KHPW, based on the manufacturer's recommended daily dosage, and are applied to promote adherence to an appropriate course of therapy. These quantity level limits control the number of tablets, patches, inhalers, injections or nasal spray bottles that will be covered each time a new Prescription Order or refill is dispensed at a Participating Pharmacy Provider or through mail order, if applicable. Quantity level limits do not restrict the number of refills a Member may obtain.

C. Determination if Technology or Drug is Experimental

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

KHPW believes medical technology decisions should be made by medical professionals. That's why a panel of more than 400 medical professionals work with our nationally recognized Medical Affairs Committee to review new technologies. 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 doesn't merit this status is usually considered "Experimental/Investigative" and is not generally covered. However, it may be re-evaluated in the future.

D. Additional Care Utilization Process Information

1. **Authorized Representatives**
   A Member has the right to designate an authorized representative to file or pursue a Preauthorization or other Pre-service Claim on the Member's behalf. KHPW reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on a Member's behalf. Such procedures as adopted by KHPW shall, in the case of an Urgent Care Claim, permit a Physician or other professional health care Provider with knowledge of the Member's medical condition to act as your authorized representative.

2. **Decisions Involving Non-Urgent Care**
   A Member will receive written notice of any decision on a request for Preauthorization 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 fifteen (15) days from the date KHPW receives the Claim. This fifteen (15) day period of time however may be extended one time by KHPW for an additional fifteen (15) days provided KHPW determines that the additional time is necessary due to matters outside its control and notifies the Member of the extension prior to the expiration of the initial fifteen (15) day Pre-service Claim determination period. If an extension of time is necessary because the Member failed to submit information necessary for KHPW to make a decision on the Member's Pre-service Claim, the notice of extension that is sent to the Member will specifically describe the information that the Member must submit and will afford the Member at least forty-five (45) days from the receipt of the notice in which to submit that information.

3. **Decisions Involving Urgent Care Claims**.
   If a Member's request involves an Urgent Care Claim, KHPW will make a decision on the request as soon as possible taking into account the medical exigencies involved. The Member will receive notice of the decision that has been made on the Urgent Care Claim no later than seventy-two (72) hours following receipt of the Claim. If KHPW determines that the Member has not provided sufficient information to determine whether or to what extent benefits are to be paid under the HMO Network Program, KHPW will notify the Member within twenty-four (24) hours of its receipt of the Claim of the specific information needed to complete the Claim. The Member will then be given not less than forty-eight (48) hours to provide the specific information to KHPW. KHPW

will notify the Member of its determination within forty-eight (48) hours after the earlier of (i) its receipt of the specific information, or (ii) the date KHPW informed the Member that it must receive the specific information. In addition, the seventy-two (72) hour time frame may be shortened in those cases where a Member's Urgent Care Claim request seeks to extend a previously approved course of treatment and was made at least twenty-four (24) hours prior to the expiration of that previously approved course of treatment. In those situations, KHPW will notify the Member of its decision on his/her Urgent Care Claim request to extend that course of treatment not later than twenty-fours (24) hours following receipt of the request.

4. **Notices of Determination Regarding Preauthorization and Other Pre-Service Claims**.
   Any time a Member's request for Preauthorization or other Pre-service Claim is approved, the Member will be notified in writing that the Claim has been approved. Any time a Member's request for Preauthorization is denied, the Member will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse determination and a statement describing the Member's right to file a complaint or grievance.

   For a description of a Member's right to file a complaint or grievance concerning an adverse benefit determination of a request for Preauthorization or any other Pre-service Claim, see the SECTION X, Subsection B-COMPLAINT AND GRIEVANCE PROCESSES **of this benefit booklet.**

SECTION VII - DESCRIPTION OF BENEFITS

REFER TO SECTION IX - SUMMARY OF BENEFITS, TO DETERMINE IF ANY COPAYMENT, DEDUCTIBLE AMOUNT OR LIMITATION APPLIES TO ANY OF THE BENEFITS DESCRIBED IN THIS SECTION. ALSO, SEE SECTION VIII – EXCLUSIONS, FOR CONDITIONS WHICH MAY AFFECT COVERAGE.

The following are Covered Services:

A. OUTPATIENT BENEFITS

Ambulance Services

Benefits are provided for transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured: from a home, scene of an accident, or a medical emergency to a Hospital; between Hospitals; between a Hospital and a Skilled Nursing Facility; from a Hospital or Skilled Nursing Facility to a home; or from a home to a Professional Provider's office. In an emergency, Preauthorization is not required.

Anesthesia

Benefits are provided for Anesthesia Services when performed in connection with Covered Services, except as provided in connection with the **Oral Surgery** Benefits set forth in this Section.

Blood

Benefits are provided for whole blood, blood derivatives, blood plasma and blood components; the administration and processing of blood; the storage of blood when done in preparation for a scheduled surgical procedure; and, transfusion supplies and equipment when administered in connection with Covered Services.

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:

a. **Equipment and Supplies.** Coverage is provided for blood glucose monitors, monitor supplies, syringes, injection aids and insulin infusion devices.

b. **Diabetes Education.** When the Member's Physician certifies that a Member requires diabetes education as an Outpatient, coverage is provided for the following when rendered through a Diabetes Education Program:

   (1) Visits Medically Necessary and Appropriate upon the diagnosis of diabetes; and

(2) Subsequent Visits under circumstances whereby a Physician: a) identifies or diagnoses a significant change in the Member's symptoms or conditions that necessitates changes in a patient's self-management; or b) identifies as Medically Necessary and Appropriate, a new medication or therapeutic process relating to the Member's treatment and/or management of diabetes.

Diagnostic Services

Benefits are provided for the following Diagnostic Services:

a. diagnostic X-ray consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine;

b. diagnostic pathology consisting of laboratory and pathology tests;

c. diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing; and

d. allergy testing consisting of percutaneous, intracutaneous, and patch tests.

Dialysis

Benefits are provided for Dialysis Treatments when Preauthorized by KHPW and when provided in the Outpatient facilities of a Hospital, a free-standing renal dialysis facility which has been approved by KHPW, or in the home with the Preauthorization of KHPW. In the case of home dialysis, Covered Services will include equipment, training, and Medical Supplies. The decision to provide Benefits for the purchase or rental of necessary equipment for home dialysis will be made by KHPW. When the Member becomes eligible for Medicare coverage for dialysis, dialysis Benefits provided under this HMO Network Program will be coordinated with such Medicare coverage.

Dr. Dean Ornish Program (For Reversing Heart Disease)

a. The Dr. Dean Ornish Program (For Reversing Heart Disease) is a comprehensive lifestyle modification program which emphasizes nutritional counseling, therapeutic exercise, stress management techniques, and regular participation in a professionally supervised support group, on an Outpatient basis. It is designed to assist the Member in the management of coronary artery disease and to address key risk factors associated with the onset and progression of coronary artery disease.

b. The Program requires a minimum one (1) year participation commitment and must be provided by a Dr. Dean Ornish Participating Provider.

c. Coverage will be provided subject to the Member meeting specific benefit eligibility criteria and KHPW's receipt of a recommendation from the Member's attending Physician.

d. Coverage is limited to a one (1) time enrollment in the Program per lifetime, regardless of whether the Member completes the Program.

e. The Program may be subject to class size limits and is offered at selected sites. Therefore, the availability of a Dr. Dean Ornish Participating Provider within a particular geographic area may be limited.

Durable Medical Equipment

Benefits will be provided for the rental or, at the option of KHPW the purchase, adjustment, repairs and replacement, if necessitated because of normal wear and not neglect, of Durable Medical Equipment determined to be the standard to restore basic function, when prescribed by a Professional Provider within the scope of their license and required for therapeutic use. If more than one type of Durable Medical Equipment exists, KHPW will Preauthorize coverage for only the Durable Medical Equipment Medically Necessary and Appropriate to restore basic function. Medical Supplies which are necessary for the essential function of the Durable Medical Equipment and are Primarily Medical In Nature, not a Comfort/Convenience item, and used for therapeutic purposes are also eligible under this Benefit. Durable Medical Equipment does not include Prosthetic Appliances and Orthotic Devices.

Enteral Formulae

a. Benefits are provided for Enteral Formulae, as defined in this benefit booklet, when administered on an Outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders. Benefits for such Enteral Formulae are exempt from any applicable Deductible requirements.

b. Additional coverage for Enteral Formulae is provided when administered on an Outpatient basis, when Medically Necessary and Appropriate for the Member's medical condition, when considered to be the Member's sole source of nutrition, and:

   (1) when provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulas; or,

   (2) when provided orally, and identified as one of the following types of defined formula with:

      (a) Hydrolyzed (pre-digested) protein or amino acids; or

      (b) Specialized content for special metabolic needs; or

      (c) Modular components; or

      (d) Standardized nutrients.

   Once it is determined that the Member meets the above criteria, coverage for Enteral Formulae will continue as long as the Formulae represents at least 50% of the Member's daily caloric requirement.

   Additional coverage for Enteral Formulae excludes the following:

   (1) Blenderized food, baby food, or regular shelf food when used with an enteral system;

(2) Milk or soy based infant formulae with intact proteins;

(3) Any formulae, when used for the convenience of the Member or their family members;

(4) Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance;

(5) The following formulae when provided orally: semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; and

(6) Normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

Family Planning and Infertility Services

Benefits are provided for voluntary family planning services and Infertility services when provided by the PCP or a Network Specialist. Coverage will be provided for the correction of a physical or medical problem, Diagnostic services, counseling and Assisted Fertilization procedures as defined in this benefit booklet.

Also covered is the performance of sterilization procedures such as tubal ligation or vasectomy.

Gynecological Services

Members may receive treatment for any gynecological medical condition at any time from the PCP, a Network gynecologist or Network Nurse-Midwife. The Network gynecologist or Network Nurse-Midwife may coordinate any Preauthorization required for Covered Services with KHPW.

Hearing Screening

Benefits are provided for routine hearing screening when performed by the PCP.

Home Health Care

a. Benefits are provided for the following when Covered Services are rendered by a Home Health Care Agency or a Hospital program for Home Health Care and may require Preauthorization from KHPW:

(1) Skilled Nursing Services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN), including private duty nursing Services;

(2) Therapy and Rehabilitation Services;

(3) medical and surgical supplies provided by the Home Health Care Agency or Hospital program for Home Health Care;

(4) oxygen and its administration;

(5) medical social service consultations;

(6) health aide services to a Member who is receiving covered nursing or Therapy and Rehabilitation Services.

b. Exception - No Home Health Care Benefits will be provided for:

(1) dietitian services;

(2) homemaker services;

(3) maintenance therapy;

(4) Custodial Care; and

(5) food or home delivered meals.

Home Visits

Benefits are provided for PCP or Specialist Visits to a Member's home.

Hospice Care

Benefits provided for Home Health Care are also available when the services are rendered by a Hospice program. Respite care and family counseling related to the Member's terminal condition are Covered Services.

Injections

Benefits are provided for injectable medication for the treatment of an injury or illness when provided by the PCP or other Network Specialist and administered in the Physician's office.

Mastectomy and Breast Cancer Reconstruction

Benefits are provided for a mastectomy performed on an Outpatient basis and for the following:

a. Surgery to reestablish symmetry or alleviate functional impairment including, but not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy;

b. initial and subsequent prosthetic devices to replace the removed breast or portions thereof; and

c. physical complications of all stages of mastectomy, including lymphedemas.

Coverage is also provided for one (1) home health care Visit, as determined by the Member's Physician, received within forty-eight (48) hours after discharge, if such discharge occurs within forty-eight (48) hours after an admission for a mastectomy.

Maternity Care

Benefits are provided for obstetrical care, including prenatal and postnatal care, sonograms, complications of pregnancy, childbirth and newborn care in the Facility Provider. Maternity Care can be provided by a Network obstetrician, Network Nurse-Midwife, or a PCP who has been credentialed to provide routine obstetrical care.

Coverage is also provided for one (1) maternity home health care Visit within forty-eight (48) hours of discharge when the discharge occurs prior to: (a) forty-eight (48) hours of inpatient care following a normal vaginal delivery; or (b) ninety-six (96) hours of inpatient care following a caesarean delivery. Such Visit shall be made by a Network Provider whose scope of practice includes post-partum care. Visits include parent education, assistance and training in breast and bottle-feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments. Such Visit may, at the mother's sole discretion, occur at the facility of the Network Provider. Such maternity home health care Visit must be authorized by the Member's PCP, Network obstetrician/gynecologist, Network Nurse-Midwife or a PCP who has been credentialed to provide routine obstetrical care, and is subject to all terms of this HMO Network Program, and is exempt from any Copayment amount.

Medical Supplies

Benefits are provided for Medical Supplies which are necessary for the essential function of Durable Medical Equipment, Prosthetic Appliances, or Orthotic Devices and for the follow-up care and treatment required as a result of Emergency Accident Care, Emergency Medical Care, Home Health Care or following Inpatient care.

Mental Health Care

a. Benefits are provided for the treatment of mental illness. Benefits include but are not limited to individual psychotherapy, group psychotherapy, psychological testing, family counseling and convulsive therapy treatment. Members may seek these Covered Services directly by calling the telephone number for Mental Health Care which is listed on their Member Identification Card. Covered Services must be Preauthorized by KHPW.

b. **Serious Mental Illness Care Services**

   Coverage is provided for inpatient care for the treatment of serious mental illness for up to 30 days per benefit period.

   Coverage is provided for outpatient care for the treatment of serious mental illness for up to 60 outpatient care visits per benefit period.

In any event, no matter how many inpatient care days or outpatient care visits for the treatment of mental illness are utilized, coverage for 30 inpatient care days and 60 outpatient care visits for the treatment and care of serious mental illness as required under Act 150 of 1998 are always available per benefit period. Once you have exhausted your benefit period outpatient care visits, additional outpatient care visits may be obtained in exchange for each unused inpatient care day on a two-for-one basis.

When the inpatient care days and outpatient care visits specified in this mental health care services benefit have been exhausted, but additional inpatient care days and outpatient care visits for the treatment of serious mental illness are required in accordance with Act 150 of 1998, these additional benefits will only be available at the network level. No benefits will be available at the out-of-network level of benefits.

c. **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 to be an outpatient care visit, will accumulate against any outpatient mental health visit limit and is subject to any outpatient care cost-sharing amounts.

d. **Outpatient Mental Health Care Services**
Inpatient facility service and inpatient medical benefits (except room and board) provided by a facility provider or professional provider when you are an outpatient.

Newborn Care

Benefits are provided for the care of a newborn child of a Member for a period of thirty-one (31) days following birth. Such care shall include routine nursery care, prematurity services, preventive health care services, as well as coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Newborns' and Mothers' Health Protection Act Notice

Under Federal law, the HMO Network 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 forty-eight (48) hours following a vaginal delivery; or less than ninety-six (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 forty-eight (48) hours (or ninety-six (96) as applicable). In any case, under Federal law plans may not require that a Provider obtain authorization from KHPW for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

Office Visits

Benefits are provided for Covered Services received in a Professional Provider's office.

Oral Surgery

Benefits are provided for limited oral surgical procedures in an Outpatient setting. Services may require Preauthorization by KHPW:

a. extraction of teeth in preparation for radiation therapy;

b. Facility Provider, and Anesthesia services rendered in conjunction with non-covered dental procedures when determined by KHPW, to be Medically Necessary and Appropriate due to the age and/or medical condition of the Member;

c. accidental injury to the jaw or structures contiguous to the jaw;

d. the correction of a non-dental physiological condition which has resulted in a severe functional impairment;

e. treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of mouth;

f. orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus;

g. mandibular staple implant, provided the procedure is not done in preparation of the mouth for dentures;

h. mandibular frenectomy; and

i. extraction of impacted third molars when partially or totally covered by bone.

Orthotic Devices

Benefits will be provided for the purchase, fitting, necessary adjustment, repairs, and replacements, if necessitated because of normal wear and not neglect, of Orthotic Devices determined to be the standard to restore basic function, when prescribed by a Professional Provider. If more than one (1) type of Orthotic Device exists KHPW will provide coverage for only the Orthotic Device Medically Necessary and Appropriate to restore basic function. This includes shoes permanently attached to a brace or when prescribed in connection with the treatment of diabetes. Medical Supplies which are necessary for the essential function of the Orthotic Device and are Primarily Medical In Nature, not a Comfort/Convenience item, and used for therapeutic purposes are also eligible under this Benefit.

Pediatric Extended Care Services

Note: *The Pediatric Extended Care Services Benefit is subject to availability within the Member's Service Area. A Pediatric Extended Care Facility may have limited enrollment. If such a Provider reaches maximum enrollment, the child may be placed on a waiting list until an opening becomes available.*

a. Covered Services rendered by a Pediatric Extended Care Facility pursuant to a Treatment Plan for which Benefits may include one or more of the following:

   (1) Skilled Nursing Services of an Registered (RN) or Licensed Practical Nurse(LPN);

   (2) Physical Medicine, Speech Therapy and Occupational Therapy Services;

   (3) Respiratory Therapy;

   (4) Medical and surgical supplies provided by the Pediatric Extended Care Facility;

   (5) Acute health care support; and

   (6) Ongoing assessments of health status, growth and development.

b. Pediatric Extended Care Services will be covered for children eight (8) years of age or under, pursuant to the attending Physician's Treatment Plan only when provided in a Pediatric Extended Care Facility, and when approved by KHPW.

c. A prescription from the child's attending Physician is necessary for admission to a Pediatric Extended Care Facility.

d. No Benefits are payable after the Member has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care.

Prescription Drugs and Other Medications

a. Benefits are provided for the following drugs when prescribed by a licensed practitioner in connection with a Covered Service and when purchased at a Participating Pharmacy Provider upon presentation of a valid Member Identification Card.

   Benefits provided under this Paragraph are not subject to Subsection C. **COORDINATION OF BENEFITS** or Subsection O. **SUBROGATION** of **SECTION X - GENERAL PROVISIONS** in this benefit booklet.

   Prescription Drugs

Maintenance Prescription Drugs

The Copayment for each Prescription Order or refill for the drugs listed above is described in **SECTION IX - SUMMARY OF BENEFITS**.

b. **Limitations**

- Except in Emergency situations, no coverage is provided for Prescription Drugs purchased at a non-Participating Pharmacy Provider.

- Each Prescription Drug from a Participating Pharmacy Provider is limited to a Maximum of up to a thirty-four (34) day supply. Maintenance Prescription Drugs available through a mail service program are limited to a Maximum of up to a ninety (90) day supply. Commercially available packaging of some drug products may further limit the Maximum days supply.

- Insulin syringes, needles, and/or disposable diabetic testing materials will be covered by the same Copayment as the insulin, if dispensed in days supply corresponding to the amount of insulin dispensed. Insulin syringes, needles, and/or disposable diabetic testing material dispensed without insulin will require a separate Copayment when dispensed.

- Coverage for impotency treatment Prescription Drugs obtained from a Participating Pharmacy Provider is limited to 6 units per thirty (30) days. This coverage is only available to male Members age eighteen (18) years or older. Commercially available packaging of some drug products may further limit the Maximum days supply.

- The Participating Pharmacy Provider will dispense generic drugs in accordance with State and Federal laws unless the prescribing Professional Provider specifically prohibits dispensing a Generic Drug and a Brand Drug must be dispensed; or, a generic equivalent is not available. If the Member will not or cannot accept a generic substitution, when the prescription permits and the generic equivalent is available, the Member will be required to pay the difference between the price for a Brand Drug and any available generic equivalent, for each separate Prescription Order or refill. This amount is in addition to the applicable Brand Drug Copayment stipulated in **SECTION IX - SUMMARY OF BENEFITS**.

c. **Excluded from coverage under this Benefit**

- weight control drugs

- drugs and supplies which can be purchased without a prescription unless specifically described in this Subsection

- drugs whose labeled indications are for cosmetic purposes only

- injectable drugs that require administration and/or monitoring by a health care professional

Preventive Health Services

Benefits are provided for prevention, early detection and minimization of the ill effects and causes of disease or disability based on the Member's health assessment by the PCP or Network Specialist. The PCP or Network Specialist determines the frequency of these exams and procedures based on KHPW's guidelines in conjunction with the Member's age, sex, and medical history. Unless otherwise indicated, Preventive Health Services are covered when provided by the PCP or Network Specialist. Covered Services include, but are not limited to, the following:

a. **Allergy Testing and Treatment**

Benefits are provided for allergy tests, testing materials, and treatment, including serums.

b. **Immunizations**

Benefits are provided for adult immunizations, including the immunizing agent, when required for the prevention of disease (except those required for foreign travel or employment).

Coverage will be provided to Members under age twenty-one (21) for those pediatric immunizations, including the immunizing agents, which, as determined by the Pennsylvania Department of Health, conform to the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and the U.S. Department of Health and Human Services, when provided by the PCP. Benefits for pediatric immunizations are exempt from any applicable Deductibles or dollar limits.

c. **Mammographic Screening**

Benefits are provided for the following Covered Services:

(1) an annual routine mammographic screening for all female Members forty (40) years of age or older; and

(2) a mammographic examination for all female Members regardless of age when such Service is prescribed by the PCP or by a Network Specialist.

Benefits for mammographic examinations are payable only if performed by a mammography service Provider who is properly certified by the Pennsylvania Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

d. **Pediatric Care**

Benefits are provided for routine physical examinations, regardless of Medical Necessity and Appropriateness when performed by the PCP and in accordance with a predefined schedule* based on age and sex.

e. **Routine Gynecological Examination and Papanicolaou Smear**

Benefits are provided for one (1) routine gynecological examination, including a pelvic examination and clinical breast examination and one (1) routine Papanicolaou Smear per calendar year for all female Members when provided by the PCP or Network gynecologist or Network Nurse-Midwife of the Member's choice.

f. **Routine Physical Examinations (Adult)**

Benefits are provided for physical examinations, regardless of their Medical Necessity and Appropriateness, including a complete medical history when performed by the PCP and in accordance with a predefined schedule* based on age and sex.

Prosthetic Appliances

Benefits are provided for the purchase, fitting, necessary adjustment, repairs, and replacements, if necessitated because of normal wear and not neglect, of Prosthetic Appliances determined to be the standard to restore basic function and related Medical Supplies when prescribed by a Professional Provider. Replacements are also covered when required due to normal growth of a child. If more than one type of Prosthetic Appliance exists, KHPW will provide coverage for only the Prosthetic Appliance Medically Necessary and Appropriate to replace the basic function of the missing or malfunctioning body limb or organ. This includes prosthetic shoes for a person with a partial amputation of the foot or feet, and the initial and subsequent prosthetic devices to replace the removed breast or portions thereof as provided under the **Mastectomy and Breast Cancer Reconstruction** Benefit in this Section. Medical Supplies which are necessary for the essential function of

* This schedule is reviewed and updated periodically by the Plan based on the advise of the American Academy of Pediatrics, U.S. Preventive Service Task Force, the Blue Cross and Blue Shield Association, and medical consultants. Accordingly, the frequency and eligibility of services is subject to change.

the Prosthetic Appliance and are Primarily Medical In Nature, not a Comfort/Convenience item, and used for therapeutic purposes are also eligible under this Benefit.

Substance Abuse Services

Benefits are provided for Outpatient Visits and Partial Hospitalization Services for the treatment of Substance Abuse. Members may seek these Covered Services directly by calling the telephone number listed on their Member Identification Card for Substance Abuse Services. Covered Services must be Preauthorized by KHPW.

The following Services are covered:

a. Physician, Psychologist, nurse, Master Level Therapist and Social Worker services;

b. rehabilitation, therapy and counseling;

c. family counseling and intervention;

d. psychiatric, psychological and medical laboratory tests; and

e. drugs, medicines, equipment use and supplies.

For purposes of this benefit, a substance abuse service provided on a partial hospitalization basis shall be deemed an outpatient care visit and will accumulate against the outpatient substance abuse visit limit and is subject to any outpatient care cost-sharing amounts. Once you have exhausted your benefit period inpatient residential treatment and rehabilitation days, any unused full session, equivalent partial-session or partial hospitalization outpatient care visits may be exchanged on a two-for-one basis to secure additional residential treatment and rehabilitation service days beyond the residential treatment and rehabilitation service day maximum per benefit period as set forth herein. These additional residential treatment and rehabilitation service days may be deducted from the lifetime residential treatment and rehabilitation service day limit.

Surgery

Benefits are provided for covered surgical services required for treatment of disease, illness or injury.

Therapy and Rehabilitation Services

Benefits are provided for specific Therapy Services as follows when performed by a Professional Provider:

a. Radiation Therapy

b. Chemotherapy

c. Physical Medicine

d. Respiratory Therapy

e. Occupational Therapy

f. Speech Therapy

g. Infusion Therapy

h. Cardiac Rehabilitation Therapy

i. Spinal Manipulation Therapy

Vision Screening

Benefits are provided for vision screening when provided by the PCP.

B. INPATIENT BENEFITS

Anesthesia

Benefits are provided for Anesthesia services when performed in connection with Covered Services, except as provided in connection with the **Oral Surgery** Benefit set forth in this Section.

Diagnostic Services

Benefits are provided in a Hospital for the following Diagnostic Services:

a. diagnostic X-ray consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine;

b. diagnostic pathology consisting of laboratory and pathology tests;

c. diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by KHPW; and

d. allergy testing consisting of percutaneous, intracutaneous, and patch tests.

Family Planning and Infertility Services

Benefits are provided on an Inpatient basis for voluntary family planning services and Infertility Services when provided by the PCP or a Network Specialist. Coverage will be provided for the correction of a physical or medical problem, Diagnostic Services, counseling and Assisted Fertilization procedures as defined in this benefit booklet.

Also covered is the performance of sterilization procedures such as tubal ligation or vasectomy.

Hospice Care

Benefits are provided for Hospital Services for a Member who is enrolled in a program for Hospice Care.

Hospital Services

Benefits are provided for the following Covered Services when provided in a Facility Provider:

a. semi-private room and board (or private or specialty accommodations when certified as Medically Necessary and Appropriate by the attending Physician or the PCP, and KHPW);

b. general nursing care;

c. drugs, medications, and biologicals;

d. meals (including special diets or Enteral Formulae when Medically Necessary and Appropriate);

e. use of the operating room and related facilities;

f. use of intensive care or cardiac units or related services;

g. oxygen services;

h. whole blood, blood derivatives, blood plasma and blood components; the administration and processing of blood; the storage of blood when done in preparation for a scheduled surgical procedure, and transfusion supplies and equipment when administered in connection with Covered Services;

i. Medical Supplies, Durable Medical Equipment, Prosthetic Appliances, Orthotic Devices; and

j. Dialysis Treatments.

Inpatient Professional Services

Benefits are provided for generally accepted, Medically Necessary and Appropriate Covered Services performed, prescribed, or supervised by a Professional Provider for an Inpatient, within a Facility Provider.

Mastectomy and Breast Cancer Reconstruction

Benefits are provided for a mastectomy, and for the following when performed on an inpatient basis:

a. Surgery to reestablish symmetry or alleviate functional impairment including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy;

b. initial and subsequent prosthetic devices to replace the removed breast or portions thereof; and

c. physical complications of all stages of mastectomy, including lymphedemas.

Coverage is also provided for one (1) home health care Visit, as determined by the Member's Physician, received within forty-eight (48) hours after discharge, if such discharge occurs within forty-eight (48) hours after an admission for a mastectomy.

Maternity Care

Benefits are provided in a Facility Provider for obstetrical care, including prenatal and postnatal care, complications of pregnancy and childbirth. Maternity Care can be provided by a Network obstetrician, Network Nurse-Midwife or a PCP who has been credentialed to provide routine obstetrical care, and is subject to all the terms of this HMO Network Program.

Mental Health Care

a. Benefits are provided for the treatment of mental illness in a Facility Provider. Benefits include but are not limited to individual psychotherapy, group psychotherapy, psychological testing, family counseling and convulsive therapy treatment. Members may seek these services directly by calling the telephone number listed on their Member Identification Card for Mental Health Care. Covered Services must be Preauthorized by KHPW.

b. **Serious Mental Illness Care Services**

   Covered Inpatient Services are provided for treatment of Serious Mental Illness for up to thirty (30) days per Benefit Period. A Maximum of thirty (30) of these Inpatient days may be exchanged on a one-for-two basis to secure up to sixty (60) additional Outpatient or Partial Hospitalization days per Benefit Period.

   Each day of Inpatient Services for the treatment of Serious Mental Illness or any other Mental Illness reduces the total number of Inpatient days available under the Mental Health Care benefit by one (1) day.

   In any event, no matter how many days of Inpatient Services for the treatment of Mental Illness are utilized, thirty (30) days of coverage per Benefit Period for the treatment of Serious Mental Illness are always available.

Newborn Care

Benefits are provided for the care of a newborn child of a Member for a period of thirty-one (31) days following birth. Covered Services shall include routine nursery care, prematurity services, preventive health care services, as well as coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Oral Surgery

When Medically Necessary and Appropriate to be performed in an Inpatient setting, and Preauthorized by KHPW, Benefits are provided for limited oral surgical procedures:

a. extraction of teeth in preparation for radiation therapy;

b. Facility Provider and Anesthesia services rendered in conjunction with non-covered dental procedures when determined by KHPW to be Medically Necessary and Appropriate due to the age and/or medical condition of the Member;

c. accidental injury to the jaw or structures contiguous to the jaw;

d. the correction of a non-dental physiological condition which has resulted in a severe functional impairment;

e. treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of mouth;

f. orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus;

g. mandibular staple implant, provided the procedure is not done in preparation of the mouth for dentures;

h. mandibular frenectomy; and

i. extraction of impacted third molars when partially or totally covered by bone.

Skilled Nursing Facility Services

Benefits are provided for Skilled Nursing Facility Services when Preauthorized by KHPW. No Benefits are payable: (a) after the Member has reached the maximum level of recovery possible for a particular condition and no longer requires definitive treatment other than routine supportive care; (b) when confinement in a Skilled Nursing Facility is intended solely to provide Custodial Care to the Member; and (c) for the treatment of Substance Abuse.

Substance Abuse Services

Benefits are provided for the treatment of Substance Abuse, including Detoxification and rehabilitation therapy services in a Hospital or Substance Abuse Treatment Facility. Members may seek these services directly by calling the telephone number listed on their Member Identification Card for Substance Abuse Services. Covered Services must be Preauthorized by KHPW. The following are Covered Services:

a. lodging and dietary services;

b. Physician, Psychologist, nurse, Master Level Therapist and Social Worker services;

c. rehabilitation, therapy and counseling;

d. family counseling and intervention;

e. psychiatric, psychological and medical laboratory tests; and

f. drugs, medicines, equipment use and supplies.

Surgery

Benefits are provided for covered surgical Services required for the treatment of disease, illness or injury.

Therapy and Rehabilitation Services

Benefits are provided for Therapy and Rehabilitation Services when Preauthorized by KHPW, and performed by a Professional Provider. Admissions primarily for certain Therapy and Rehabilitation Services such as Physical Medicine, Speech Therapy, Occupational Therapy and Cardiac Rehabilitation must be expected to make measurable or sustainable improvement in the level of functioning within a reasonable period of time as determined by KHPW. The following Therapy and Rehabilitation Services are Covered Services:

a. Radiation Therapy

b. Chemotherapy

c. Physical Medicine

d. Respiratory Therapy

e. Occupational Therapy

f. Speech Therapy

g. Infusion Therapy

h. Cardiac Rehabilitation Therapy

Inpatient rehabilitation admissions primarily for Physical Medicine, Speech Therapy and/or Occupational Therapy Services may be subject to limitations.

Transplant Services

Subject to the provisions of this HMO Network Program, Benefits are provided for Covered Services furnished by a Hospital which are directly and specifically related to transplantation of organs, bones or tissue. Eligibility for Covered Services related to human organ, bone, tissue or blood stem cell transplant are as follows.

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

a. When both the recipient and the donor are Members, each is entitled to the Benefits as outlined in this benefit booklet.

b. When only the recipient is a Member, both the donor and the recipient are entitled to the Benefits as outlined in this benefit booklet. However, donor Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program.

c. When only the donor is a Member, the donor is entitled to the Benefits outlined in this benefit booklet, subject to 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 HMO Network Program; and

   (2) No Benefits will be provided to the non-Member transplant recipient.

d. 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.

C. EMERGENCY CARE SERVICES

Emergency Care Services are available seven (7) days a week, twenty-four (24) hours a day. In the event that the Member requires Emergency Care Services, the Member should immediately proceed to the nearest emergency services Provider. All reasonably necessary costs for Emergency Care Services, including evaluation, testing, and if necessary, stabilization of the Member's condition, will be paid whether provided within or outside the Network Service Area. No prior authorization is required for Emergency Care. The Member should notify the PCP or Network Specialist of the receipt of Emergency Care Services to coordinate any follow-up care.

Treatment for an occupational injury for which benefits are provided under any Workers' Compensation Law or any similar Occupational Disease Law is not covered.

Transportation and related emergency services provided by an Ambulance Service shall constitute an Emergency Care Service if the injury or the condition satisfies the criteria set forth in the definition of Emergency Care Services in **SECTION I - DEFINITIONS**.

Use of an ambulance as transportation to an emergency Facility Provider for an injury or condition that is not an emergency, will not be covered as an Emergency Care Service.

SECTION VIII - EXCLUSIONS

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

- **Ambulance**

  For Ambulance Services, except as outlined in this benefit booklet.

- **Blood storage**

  For the storage of blood, except when done in preparation for a scheduled surgical procedure.

- **Comfort/Convenience Items**

  For personal or Comfort/Convenience Items as defined in this benefit booklet.

- **Complementary alternative medicine**

  For complementary alternative care services such as, but not limited to, acupuncture, massage therapy, hypnotherapy, holistic medicine, herbal treatments and naturopathic services, except as outlined in this benefit booklet.

- **Contraceptive devices**

  For contraceptive devices and contraceptive implants, including services related to the provision of such devices or implants.

- **Cosmetic procedures**

  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, except as otherwise provided in **SECTION VII – DESCRIPTION OF BENEFITS.** 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 functional impairment which results from a covered disease or injury.

- **Court ordered services**

  For court ordered services when not Medically Necessary and Appropriate, as determined by the PCP or Network Specialist and KHPW.

- **Custodial care**

  For Custodial Care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care.

- **Dental care**

  a) **Teeth**
  For treatment 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, except as outlined in this benefit booklet. 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 covered because of an accidental bodily injury to sound natural teeth and for the orthodontic treatment for congenital cleft palates as outlined in this benefit booklet.

  b) **Temporomandibular joint syndrome (TMJ)**
  For the treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimension and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.

- **Effective Date**

  Rendered prior to the Member's Effective Date of coverage.

- **Experimental/Investigative**

  Which are Experimental/Investigative in nature.

- **Eye examinations (routine)**

  For all routine eye examinations and services except as outlined in this benefit booklet.

- **Eyeglasses/contact lenses**

  For 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).

- **Foot care (routine)**

  For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone Surgery), calluses, toe nails (except Surgery for ingrown 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.

- **Hair**

  For hair growth stimulants, hair replacement Surgery or wigs.

- **Hearing devices**

  For fitting, purchase, repair and replacement of hearing aids.

- **Hearing examinations (routine)**

  For all routine hearing examinations, including examinations for the prescribing of hearing aids, except as outlined in this benefit booklet.

- **Immunizations**

  For immunizations required for foreign travel or employment.

- **Legal obligation**

  For which a Member would have no legal obligation to pay.

- **Maintenance 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.

- **Maternity**

  For normal deliveries outside the Service Area which could have been foreseen, and non-medical fees associated with maternity services.

- **Medically Necessary and Appropriate**

  Which are not Medically Necessary and Appropriate.

- **Medicare**

  Unless the group is otherwise obligated by federal law to offer you all of the benefits of this program, to the extent payment has or would have been made by Medicare (both Parts A and B) regardless of whether you applied for such Medicare benefits. Accordingly, unless otherwise required by federal law, this program will provide you with supplemental benefits only (i.e. Medicare benefits will be taken into account when calculating the payment of your benefits).

- **Mental Health**

  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 the 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.

- **Methadone Maintenance**

  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 or to patients in Veteran's Administration facilities for service-connected illness or injury, unless the Member has a legal obligation to pay.

- **Miscellaneous**

  For any medical or dental service or treatment, except as outlined in this benefit booklet.

- **Motor vehicle accident**

  For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such medical treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.

- **Nutritional counseling**

  For nutritional counseling, except as outlined in this benefit booklet.

- **Organ donation**

  Required by a Member related to organ donation where the Member serves as the organ donor. Expenses for donors donating organs to Members are covered only as outlined in this benefit booklet. No payment will be made for human organs/tissue/blood which are sold rather than donated.

- **Physical examinations**

  For routine or periodic physical examinations, the completion of forms, and 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 outlined in this benefit booklet or as mandated by law.

- **Private duty nursing**

  For private duty nursing when provided in an Inpatient setting.

- **Provider of service**

  Rendered by a Provider who is a Member of the patient's Immediate Family.

- **Public Facility**

  Care for conditions that federal, state or local law requires to be treated in a public facility.

- **Respite care**

  For short-term care for a terminally ill Member provided by a Facility Provider to relieve a person (caregiver) who is caring for the Member at home free of charge.

- **Sex transformations**

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

- **Smoking (nicotine)**

  For nicotine cessation support programs and/or classes.

- **Termination date**

  Incurred after the date of termination of the Member's coverage, except as outlined in this benefit booklet.

- **Vision correction (radial keratotomy)**

  For the correction of myopia, hyperopia or presbyopia, including, but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants and Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.

- **War**

  For loss sustained or expenses incurred while on active duty as a member of the armed forces or any nation, or 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.

- **Workers' Compensation**

  For any illness or injury eligible for or covered by any federal, state or local government Workers' Compensation Act, Occupational Disease Law or similar type legislation.

SECTION IX - SUMMARY OF BENEFITS

Benefits	Coverage
Benefit Period	Calendar Year
Primary Care Physician (PCP) Office / Home Visit	100%
Specialist Office / Home Visit	100% after $15 copayment
Preventive Care **Adult** Routine physical exams (must be performed by PCP)	100%
Routine gynecological exams, including a PAP Test	100%
Pediatric Routine physical exams (must be performed by PCP)	100%
Pediatric Immunizations	100%
Emergency Room Services	100% after $35 copayment (waived if admitted)
Ambulance	100%
Hospital Expenses Inpatient	100%
Outpatient	100%
Inpatient Physical Rehabilitation	100% Admissions primarily for Physical, Occupational and/or Speech Therapy are limited to a combined total of 60 calendar days, per course of treatment, for the same condition, beginning on the date of the rehabilitation admission.
Pediatric Extended Care Services	Limit: 100 days/Benefit Period
Maternity	100%
Infertility counseling, testing and treatment	100%
Assisted Fertilization Procedures	100% Limit: $15,000 maximum/lifetime
Medical/Surgical Expenses	100%
Outpatient Physical Medicine	100%
Outpatient Speech Therapy	100%
Outpatient Occupational Therapy	100%
Spinal Manipulations	100% after $15 copayment
Diagnostic Services (Lab, Xray, other tests)	100%
Dr. Dean Ornish Program(For Reversing Heart Disease)	Limit: (1) enrollment per lifetime.
Durable Medical Equipment	100%
Skilled Nursing Facility Care	100%
Home Health Care	100%

Benefits	Coverage
Private Duty Nursing (excludes inpatient)	100%
Hospice	100%
Mental Health *Inpatient*	100%
Outpatient	100%
Serious Mental Illness	Each day of Inpatient Services for the treatment of Serious Mental Illness or any other Mental Illness reduces the total number of Inpatient Service days available under the Mental Health Care benefit by one (1) day. Each day of Outpatient Services for the treatment of Serious Mental Illness or any other Mental Illness reduces the total number of Outpatient Service Visits available under the Mental Health Care benefit by one (1) Visit. In any event, no matter how many days of Inpatient Services or Outpatient Services for the treatment of Mental Illness are utilized, 30 Inpatient days per Benefit Period and 60 Outpatient days per Benefit Period of coverage for the treatment and care of Serious Mental Illness, are always available.
Substance Abuse *Inpatient* Detoxification	100% 7 days / admission; 4 admissions / lifetime
Rehabilitation	100% 30 days /Benefit Period; 90 days / lifetime
Outpatient	100% 60 Visits /Benefit Period; 120 Visits / lifetime

Prescription Drug Program	Copayment for each Prescription Drug or Refill
Retail Prescription Drugs (Defined by Premier Pharmacy Network – not physicians network)	
Generic Drugs	$5 copayment or the Provider's Allowable Price, whichever is less
Brand Drugs appearing on the Select Formulary	$25 copayment or the Provider's Allowable Price, whichever is less
Brand Drugs not appearing on the Select Formulary	$40 copayment or the Provider's Allowable Price, whichever is less
Mail Order Maintenance Prescription Drugs	
Generic Drugs	$5 copayment or the Provider's Allowable Price, whichever is less
Brand Drugs appearing on the Select Formulary	$25 copayment or the Provider's Allowable Price, whichever is less
Brand Drugs not appearing on the Select Formulary	$40 copayment or the Provider's Allowable Price, whichever is less
Important: See SECTION VII – DESCRIPTION OF BENEFITS in this benefit booklet for additional conditions and limitations which affect your Prescription Drug Coverage	

Dependent Coverage	Limitation
Limiting Age for Dependent Children	The Participant's eligible child is covered under this HMO Network Program until the end of the calendar month in which the child turns age 19. A Participant's eligible child who is a full-time student in an accredited institution is covered until the end of the calendar month in which the child turns age 25, or is no longer a full time student in an accredited institution, whichever occurs earlier.

SECTION X - GENERAL PROVISIONS

A. BLUECARD PROGRAM

When a Member obtains health care Services through BlueCard outside the geographic area KHPW serves, the amount a Member pays for Covered Services is calculated on the lower of:

- The billed charges for a Member's Covered Services; or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to KHPW.

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

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

B. COMPLAINT AND GRIEVANCE PROCESSES

The HMO Network Program maintains complaint and grievance processes.

At any time during the complaint or grievance process, a Member may choose to designate a representative to participate in the complaint or grievance process on his/her behalf. The Member or the Member's representative shall notify KHPW of the designation in writing. KHPW reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on a Member’s behalf. Such procedures, as adopted by KHPW shall, in the case of an Urgent Care Claim, permit a physician or other professional health care provider with knowledge of the Member’s medical condition to act as the Member’s authorized representative.

For purposes of the complaint and grievance processes, "Member" includes designees, legal representatives and, in the case of a minor, parents of a Member entitled or authorized to act on the Member's behalf.

At any time during the complaint or grievance process, at the request of the Member, KHPW will appoint a person from its Member Service Department to assist the Member, at no charge, in preparing the complaint or grievance. The KHPW employee made available will not have participated in any previous adverse benefit determination regarding the Member's complaint or grievance.

At any time during the complaint and grievance process, a Member may contact the Member Service Department at the toll-free telephone number listed on his/her Identification Card to inquire about the filing or status of a complaint or grievance.

Complaint Process

a. **Internal Complaint Process**

The HMO Network Program maintains a complaint process for the resolution of disputes or objections by a Member regarding a Network Provider or coverage (including contract exclusions and non-covered benefits), KHPW operations or management policies, the delivery of services or a breach or termination of the HMO Network Program. A complaint does not include a grievance. With the exception of Urgent Care Claims, for which a single level internal review process applies, as outlined in the "Expedited Review" paragraph below, Members have the right to have complaints internally reviewed through the two (2) level process described below.

With the exception of Pre-Service claims, the second level review of a complaint is mandatory and must be exhausted before you can: (i) seek a third level review of the complaint; or (ii) institute an action in court.

(1) Initial Complaint Review

The Member's initial complaint shall be directed to the Member Service Department. The complaint, which may be oral or in written form, must be submitted within one hundred and eighty (180) days from the date of the Member's receipt of the notification of an adverse benefit determination or the occurrence of the issue which is the subject of the complaint. Upon receipt of the complaint, KHPW will provide written confirmation to the Member that the request has been received, and that KHPW has classified it as a complaint for purposes of internal review.

A Member may, upon request to KHPW, review all documents, records and other information relevant to his/her complaint. Upon request, copies of all such materials will be made available to the Member free of charge. A Member shall also have the right to submit any written data, comments, documents, records and other material in support of the complaint.

The initial level complaint review will be performed by an Initial Review Committee, which will include one (1) or more employees of KHPW. The Members of the Committee will not have been involved in a previous adverse benefit determination regarding the complaint and will not be the subordinate of any individual involved in a previous adverse benefit determination regarding the complaint. In rendering a decision on the complaint, the Initial Review Committee will take into account all comments, records and other information submitted by the Member without regard to whether such information was previously submitted to or considered by KHPW and will afford no deference to any previous adverse benefit determination regarding the complaint.

Each complaint will be promptly investigated and KHPW will provide written notification of its decision within the following time frames:

- When the complaint involves a non-Urgent Care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances, not to exceed thirty (30) days following receipt of the complaint;

- When the complaint involves an Urgent Care Claim, within the period of time provided in the description of the "Expedited Review" process set forth below; or

- When the complaint involves a Post-service Claim, within a reasonable period of time appropriate to the medical circumstance, not to exceed thirty (30) days following receipt of the complaint.

In the event KHPW renders an adverse benefit determination on the complaint, the written notification will include, among other items, the specific reason or reasons for the decision, the procedure to file a request for a second level review and, in the case of an adverse benefit determination involving a Pre-service Claim (which includes an Urgent Care Claim), a statement regarding the Member's right to pursue legal action.

A Member's 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, the Member is not required to pursue the second level review of a Pre-service Claim before pursing a court action. Should the Member elect to pursue the second level review before instituting a court action, the Member's benefit program:

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

- Agrees that any statute of limitations applicable to the court action 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.

A Member who has further questions regarding second level reviews of Pre-service Claims, should contact Member Service using the telephone number on his/her ID card**.**

(2) Second Level Complaint Review

A Member who is dissatisfied with the decision following the initial review of the complaint (other than an Urgent Care Claim), may request to have the decision reviewed by a Second Level Review Committee. The request to have the decision reviewed must be submitted in writing (or communicated orally under certain circumstances) within forty-five (45) days from the date an adverse benefit determination is received and may include any written information from the Member or a party in interest. The Second Level Review Committee will be comprised of three (3) individuals who did not participate in a previous adverse benefit determination regarding the complaint or be the subordinate of any individual involved in a previous adverse benefit determination regarding the complaint. In rendering a decision on the complaint, the Second Level Review Committee will take into account all comments, records and other information submitted by the Member without regard to whether such information was previously submitted to or considered by KHPW and will afford no deference to any previous adverse benefit determination on the claim. At least one (1) individual of the Committee will not be an employee of KHPW or of any KHPW related subsidiary or affiliate.

A Member may, upon request to KHPW, review all documents, records and other information relevant to his/her complaint. Upon request, copies of all such materials will be made available to the Member free of charge. A Member shall also have the right to submit any written data, comments, documents, records and other material in support of the complaint.

The Committee will hold an informal hearing to consider the Member's complaint. When arranging the hearing, KHPW will notify the Member in writing of the hearing procedures and rights at such hearing, including the right of the Member to be present at the review. If a Member cannot appear in person at the second level review, KHPW shall provide the Member the opportunity to communicate with the Committee by telephone or other appropriate means.

When the complaint involves a non-Urgent Care Pre-service Claim, the hearing will be held and a decision will be rendered within thirty (30) days following receipt of the request for review; or

When the complaint involves a Post-service Claim, the hearing will be held and a decision rendered within thirty (30) days of KHPW's receipt of the Member's request for review.

In the event KHPW renders an adverse benefit determination, the written 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 Post-Service Claim, a statement regarding the Member's right to pursue legal action.

b. **Appeal of Complaint**

The Member may appeal the Second Level Review Committee's adverse benefit determination regarding coverage (including contract exclusions and non-covered benefits) to the Group or its designee. Members should contact the Group's Plan Administrator for this appeal procedure.

Grievance Process

a. **Internal Grievance Process**

The HMO Network Program maintains an internal grievance process by which a Member or a health care Provider, with the written consent of the Member, may file a written grievance regarding the denial of payment for a health care service on the basis of Medical Necessity and Appropriateness. Any Member who consents to the filing of a grievance by a health care Provider may not file a separate grievance. This consent may be rescinded by the Member at any time during the grievance process and, in the event the health care Provider fails to file or pursue a grievance, shall be deemed as having been automatically rescinded without further action on the part of the Member.

A grievance may be filed regarding a decision that: (a) disapproves full or partial payment for a requested health care service; (b) approves the provision of a requested health care service for a lesser scope or duration than requested; or (c) disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service. **A grievance does not include a complaint.** With the exception of Urgent Care Claims, for which a single-level internal

review process applies, as outlined in the "Expedited Review" paragraph below, Members have the right to have grievances reviewed through a two (2) level internal process described below.

With the exception of Pre-Service claims, the second level review of a grievance is mandatory and must be exhausted before you can: (i) seek a third level review of the grievance; or (ii) institute an action in court.

(1) Initial Grievance Review

The Member's initial grievance must be submitted in writing (or communicated orally under special circumstances) within one hundred and eighty (180) days from the Member's receipt of the notification of an adverse benefit determination or occurrence of the issue that is the subject of the grievance and shall be directed to the Member Service Department. Upon receipt of the grievance, KHPW will provide written confirmation to the Member and the health care Provider that the request has been received, and that KHPW has classified it as a grievance for purposes of internal review.

A Member may, upon request to KHPW, review documents, records and other information that relevant to his/her grievance. Upon request, copies of all such materials will be made available to the Member free of charge. A Member shall also have the right to submit any written data, comments, documents, records and other information in support of the grievance.

The initial level grievance review will be performed by an Initial Review Committee, which shall include one (1) or more individuals selected by KHPW. The members of the Committee will not include any individual who was previously involved in an adverse benefit determination regarding the Member's grievance and will not be the subordinate of any individual who was previously involved in an adverse benefit determination regarding the Member's grievance. The Member or his/her health care Provider may specify the remedy or the corrective action to be sought. The initial review will include a licensed Physician or, where appropriate, an approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service at issue. The licensed Physician or licensed psychologist will be an individual who is different from, and not subordinate to, any individual who was consulted in connection with a prior adverse benefit determination regarding the Member's grievance. In rendering a decision on the grievance, the Committee will take into account all comments, records and other information submitted by the Member without regard to whether such information was previously submitted to or considered by KHPW and will afford no deference to any previous adverse benefit determination regarding the claim.

Each grievance will be promptly evaluated and KHPW will provide written notification of its decision to the Member and the Member's health care Provider with the following time frames:

- When the grievance involves a non-Urgent Care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances, not to exceed thirty (30) days following receipt of the grievance;

- When the grievance involves an Urgent Care Claim, within the period of time provided in the description of the "Expedited Review" process set forth below; or

- When the grievance involves a Post-service Claim, within a reasonable period of time appropriate to the medical circumstance, not to exceed thirty (30) days following receipt of the grievance.

In the event KHPW renders an adverse benefit determination on the grievance, the written notification shall include, among other items, the specific reason or reasons for the adverse benefit determination including clinical rationale, the procedure for appealing the decision and, in the case of a grievance involving the denial of a Pre-service Claim (which includes an Urgent Care Claim), a statement regarding the Member's right to pursue legal action.

A Member's 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, the Member is not required to pursue the second level review of a Pre-service Claim before pursing a court action. Should the Member elect to pursue the second level review before instituting a court action, the Member's benefit program:

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

- Agrees that any statute of limitations applicable to the court action 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.

A Member who has further questions regarding second level reviews of Pre-service claims, should contact Member Service using the telephone number on his/her ID card.

(2) Second Level Grievance Review

A Member who is dissatisfied with the decision following the initial review of a grievance (other than an Urgent Care Claim), may request to have the decision reviewed by a Second Level Review Committee. The request to have the decision reviewed by

the Second Level Review Committee must be submitted in writing (or communicated orally under special circumstances) within forty-five (45) days from the date an adverse benefit determination is received and may include any written information from the Member or health care Provider.

The Second Level Review Committee will be comprised of three (3) KHPW employees who did not previously participate in an adverse benefit determination regarding the Member's grievance or be the subordinate of any individual involved in a previous adverse benefit determination regarding the Member's grievance. In rendering a decision on the grievance, the Second Level Review Committee will take into account all comments, records and other information submitted by the Member without regard to whether such information was previously submitted to or considered by KHPW and will afford no deference to any previous adverse benefit determination regarding the claim. The Committee will include a licensed Physician or, where appropriate, an approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service at issue. The licensed Physician or licensed psychologist will be an individual who is different from, and not subordinate to, any individual who was consulted in connection with a prior adverse benefit determination regarding the Member's grievance.

A Member may, upon request to KHPW, review documents, records and other information that relevant to his/her grievance. Upon request, copies of all such materials will be made available to the Member free of charge. A Member shall also have the right to submit any written data, comments, documents, records and other information in support of the grievance.

The Committee will hold an informal hearing to consider the Member's grievance. When arranging the hearing, KHPW will notify the Member or the health care Provider, in writing, of the hearing procedures and rights at such hearing, including the right of the Member or the health care Provider to be present at the review and to present a case. If a Member or health care Provider cannot appear in person at the second level review, KHPW shall provide the Member or health care Provider the opportunity to communicate with the Committee by telephone or other appropriate means.

When the grievance involves a non-Urgent Care Pre-service Claim, the hearing will be held and a decision will be rendered within thirty (30) days following receipt of the request for review; or

When the grievance involves a Post-service Claim, the hearing will be held and a decision rendered within thirty (30) days of KHPW's receipt of the Member's request for review.

In the event KHPW renders an adverse benefit determination, the written notification shall include, among other items, the specific reason or reasons for the adverse benefit determination including clinical rationale, the procedure for appealing the decision and,

in the case of an adverse benefit determination involving a Post-Service Claim, a statement regarding the Member's right to pursue legal action.

A Member's decision to proceed with a third level review of a Claim is voluntary. In other words, the Member is not required to pursue the third level review of a Claim before pursing a court action. Should the Member elect to pursue the third level review before instituting a court action, the Member's benefit program:

- Will not later assert in a court action that the Member failed to exhaust administrative remedies (i.e. that the Member failed to proceed with a third level review) prior to the filing of the lawsuit;

- Agrees that any statute of limitations applicable to court action will not commence (i.e. run) during the third level review; and

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

A Member who has further questions regarding third level reviews of Claims, should contact Member Service using the telephone number on his/her ID card.

b. **Appeal to Group**

The Member or a health care Provider, with the designation of the Member, may appeal the decision of the Second Level Review Committee to the Group or its designee. Members should contact the Group's Plan Administrator by writing to:
ACSHIC / AON, 625 Liberty Avenue, Tenth Floor, Pittsburgh, PA 15222.

Expedited Review

In those cases involving an Urgent Care Claim, there is a procedure for expedited review, if due to delay occasioned by the complaint or grievance process, the Member's life, health or ability to regain maximum function would be placed in jeopardy by delay occasioned by the complaint and grievance processes. In order to obtain an expedited review, the Member should identify the particular need for an expedited review to the Member Service Department. If, based on information available at the time your request is made, the Claim cannot be determined to be an Urgent Care Claim, you shall provide KHPW with a written certification from the Member's Physician that the Member's life, health or ability to regain maximum function would be placed in jeopardy or in the opinion of a Physician with knowledge of the Member's medical condition would subject the Member to severe pain that cannot be adequately managed without the service request as a result of the delay occasioned by the review process. KHPW will accept the Physician's certification, and provide an expedited review.

In general the expedited internal review process shall be bound by the same rules and procedures as the second level grievance review process. Any exceptions to those rules

and procedures will be provided, in writing, upon receipt by KHPW of the Member's request for an expedited review.

KHPW shall conduct an expedited internal review and issue its decision as soon as possible, taking into account the medical urgency, but not later than forty-eight (48) hours of receipt of the Member's request for an expedited review accompanied by a Physician's statement, if applicable. In the event KHPW renders an adverse benefit determination, the notification to the Member and health care Provider will include, among other items, the specific reason or reasons for the adverse benefit determination, including any clinical rationale.

C. COORDINATION OF BENEFITS

1. With Other Health Care Plans

Except as otherwise stated, all Benefits are subject to the following provisions of this Paragraph. KHPW will provide access to Covered Services first and determine liability later.

a. Definitions

In addition to the Definitions in this benefit booklet, the following definitions apply to this Subsection:

(1) "Other Contract" means any individual coverage or group arrangement providing health care Benefits or services through:

(a) group blanket or franchise insurance coverage, except that it shall not mean any blanket school/student accident coverage or a Hospital indemnity plan of one hundred dollars ($100) per day or less;

(b) Blue Cross, Blue Shield, group or individual practice plan, health maintenance organization or other prepayment coverage;

(c) coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; and

(d) coverage under any tax supported or government program to the extent permitted by law.

"Other Contract" shall be applied separately with respect to each arrangement for Benefits or services and separately with respect to that portion of any arrangement which reserves the right to take the Benefits or services of Other Contracts into consideration in determining its Benefits and that portion which does not.

(2) "Allowable Benefit" as used in this Subsection, means the total charge for a Service or supply for which Benefits will be provided, to the extent that such service or supply is covered by this HMO Network Program and/or the Other Contract.

When Benefits are provided in the form of services, the reasonable cash value of each Service shall be deemed the Benefit.

When Benefits are reduced under the Primary Contract because a Member does not comply with its provisions, the amount of such reduction will not be considered an Allowable Benefit. Examples of such provisions are those related to Preauthorization of admissions or services.

(3) "Dependent" means, for any Other Contract, any person who qualifies as a Dependent under that Other Contract.

(4) "Primary/Secondary Contract" refers to the application of Benefit determination rules to state whether this HMO Network Program is a Primary Contract or Secondary Contract.

(a) When this HMO Network Program is a Primary Contract, its Benefits are determined before those of the Other Contract and without considering the Other Contract's Benefits.

(b) When this HMO Network Program is a Secondary Contract, its Benefits are determined after those of the Other Contract and may be reduced because of the Benefits of the Other Contract.

(c) When there are more than two Other Contracts covering the person, this HMO Network Program may be a Primary Contract as to one or more Other Contracts, and may be a Secondary Contract as to a different contract or contracts.

b. **Effect on Benefits**

(1) This Subsection shall apply in determining the Benefits of this HMO Network Program if, for the Covered Services received, the sum of the Benefits payable under this HMO Network Program and the Benefits payable under Other Contracts would exceed the total Allowable Benefits.

(2) Except as provided in item (3) of this Subparagraph, the Benefits payable under this HMO Network Program for Covered Services received will be reduced so that the sum of the reduced Benefits and the Benefits payable for Covered Services under Other Contracts would not exceed the total Allowable Benefits. Benefits payable under Other Contracts include the Benefits that would have been payable had Claim been made.

(3) If,

(a) an Other Contract contains a provision coordinating its Benefits with those of this HMO Network Program and its rules require the Benefits of this HMO Network Program to be determined first; and

(b) the rules set forth in Subparagraph (4) below require the Benefits of this HMO Network Program to be determined first, then the Benefits of the Other Contract will be disregarded in determining the Benefits under this HMO Network Program.

(4) This HMO Network Program determines its order of Benefits using the first of the following rules which applies:

(a) The Benefits of a contract which covers the person as other than a Dependent shall be determined first (Primary Contract).

(b) In the case of a Dependent child, the following rules apply:

(i) Dependent Child-Parents Not Separated or Divorced. Except as stated in Items (ii) and (iii), when this HMO Network Program and an Other Contract cover the same child as a Dependent of different persons, called parents:

(aa) the Benefits of the contract of the parent whose birthday (excluding year of birth) falls earlier in a year shall be determined before those of the contract of the parent whose birthday falls later in that year; but,

(bb) if both parents have the same birthday, the Benefits of the contract which covered the parent longer are determined before those of the contract which covered the other parent for a shorter period of time.

However, if the Other Contract does not have the rule described in item (i) above, but instead has a rule based upon the gender of the parent, and if, as a result, the contracts do not agree on the order of Benefits, the rule in the Other Contract will determine the order of Benefits.

(ii) Dependent Child-Separated or Divorced Parents. If two (2) or more contracts cover a person as a Dependent child of divorced or separated parents, Benefits for the child are determined in this order:

(aa) first, the contract of the parent with custody of the child;

(bb) then, the contract of the spouse of the parent with custody of the child;

(cc) finally, the contract of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the Benefits of the contract of that parent has actual knowledge of those terms, the Benefits of that contract are determined first (Primary Contract). This paragraph does not apply to any Claim determination period during which any Benefits are actually paid or provided before the entity has that actual knowledge.

(iii) Court Decree. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the contracts covering the child shall follow the order of Benefit determination rules outlined in subparagraph (4)(b)(i), Dependent Child-Parents Not Separated or Divorced.

(c) When rules in items (a) and (b) above do not establish an order of Benefit determination, the Benefits of the contract which has covered the person the longest period of time shall be determined first (Primary Contract) provided that:

(i) the Benefits of the contract covering the person as an employee who is neither laid-off nor retired, or as a Dependent of such person, are determined before the Benefits of the contract covering the person as a laid-off or retired employee or as a Dependent of such person.

(ii) if the Other Contract does not have this rule, and if, as a result, the contracts do not agree on the order of Benefits, then this rule is disregarded.

(5) If an Other Contract does not contain provisions establishing the same order of Benefit determination rules, the Benefits under that contract/agreement will be determined before the Benefits under this HMO Network Program. This HMO Network Program will be the Secondary Contract.

c. **Facility of Payment**

Whenever payments should have been made under this HMO Network Program in accordance with this Subsection, but the payments have been made under any Other Contract, KHPW has the right to pay to any organization that has made such payments any amounts it determines to be warranted to satisfy the intent of this Subsection.

Amounts so paid shall be deemed to be Benefits paid under this HMO Network Program and, to the extent of the payments for Covered Services, KHPW shall be fully discharged from liability under this HMO Network Program.

d. **Right of Recovery**

(1) Whenever payments have been made by KHPW for Covered Services in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Subsection, irrespective of to whom paid, KHPW shall have the right to recover the excess from among the following as KHPW shall determine: any person to or for whom such payments were made; insurance company; or other organization.

(2) Upon reasonable request, the Member, shall execute and deliver any documents that may be required and do whatever else is reasonably necessary to secure KHPW's rights to recover the excess payments.

e. **Determination of Other Contracts**

KHPW shall not be required to determine the existence of any Other Contract or amount of Benefits payable under any Other Contract except this HMO Network Program, and the payment of Benefits under this HMO Network Program shall be affected by the Benefits payable under any and all Other Contracts only to the extent that KHPW is furnished with information relative to such Other Contract by the Group or Member, or any other insurance company or organization or person.

2. **<u>Medicare</u>**

a. Except as otherwise provided by applicable federal law, the Benefits under this HMO Network Program for Members age sixty-five (65) and older, or Members otherwise eligible for Medicare payments by reason of end stage renal disease or disability (under age sixty-five (65)), do not duplicate any Benefit to which such Members are eligible under the Medicare Act, including Part B of such Act. Where Medicare is the responsible payor, all sums payable pursuant to the Medicare program for Covered Services provided hereunder to Members are payable to and retained by KHPW.

b. Under the Medicare as Secondary Payer Statute, employers are required to identify their group health plan Members who are also eligible for Medicare. Therefore, Participants should notify their employer of their or their eligible Dependents' Medicare status including their Health Insurance Claim (HIC) number, reason for Medicare eligibility (age, disability, or end stage renal disease), effective date of Medicare eligibility and any other information required by the employer for the correct coordination of Claims payment.

3. **Workers' Compensation**

The Benefits described herein for Members eligible for Workers' Compensation are not designed to duplicate any Benefit for which such Members are eligible under the Workers' Compensation Law. All sums payable pursuant to Workers' Compensation for Covered Services provided hereunder to Members are payable to and retained by KHPW. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation.

4. **Members' Cooperation**

Each Member shall complete and submit such consents, releases, assignments and other documents as may be required by KHPW or Group in order to obtain or assure reimbursement under any other group health plan, Medicare, motor vehicle insurance or Workers' Compensation. Any Member who fails to so cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for charges incurred for Covered Services rendered, subject to this Subsection.

D. ERRONEOUS PAYMENTS

If KHPW pays for any excluded Services or supplies through inadvertence or error, the Member shall reimburse KHPW on behalf of the Group for such payments.

E. GOVERNING LAW

To the extent that federal law is not applicable, the rights and obligations under this HMO Network Program are subject to the laws of the Commonwealth of Pennsylvania. The invalidity or unenforceability of any terms or conditions hereof shall in no way affect the validity or enforceability of any other terms or provisions. The waiver by either party of a breach or violation of any provision of this HMO Network Program shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

F. LIMITATIONS

In the event that, due to circumstances not within the control of KHPW, including but not limited to a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, or similar causes, the rendition of Covered Services is delayed or rendered impractical, KHPW shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, KHPW shall arrange for the provision of Covered Services in so far as practical, and according to its best judgment; but neither Group or KHPW nor Providers shall incur liability or obligation for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such event(s).

G. MEMBER INFORMATION

1. **Member Service**
   When a Member has questions concerning their HMO Network Program benefits, the Member can contact Member Service, by calling the toll free number on the back of their HMO Identification Card. A Member Service representative who is familiar with their HMO Network Program can assist the Member.

2. **Information for non-English speaking members**
   Non-English Speaking Members have access to clear benefit information by calling the toll-free Member Service number on the back of their Identification Card to be connected to the language line. Our Member Service people are trained to make this connection

3. **Requesting Additional Information**
   A Member may, upon written request, receive information on any of the following:
   - A list of the names, business addresses and official positions of the membership of the KHPW Board of Directors and Plan Officers;
   - The procedures adopted to protect the confidentiality of medical records and other member information;
   - A description of the credentialing process for health care Providers;
   - A list of the participating health care Providers affiliated with a specific Hospital—please note the Hospital you want this information on;
   - Whether a specific drug is included or excluded from their coverage. The Member's ID number and group number should be included with this request;
   - A description of the process by which a health care Provider can prescribe a medication that is not included in the plan's prescription drug formulary;
   - A description of how KHPW determines if a medical technology or drug is experimental;
   - A summary of the methods used to reimburse plan Providers;
   - A description of KHPW's quality assurance program.

   To obtain any of the above information the Member should include their name, address and phone number, and mail the request to Member Information, P.O. Box 226, 120 Fifth Avenue, Pittsburgh, PA 15230. Please note that this P.O. Box is for these requests only—other requests will not be handled through this address.

H. MEMBERS' RIGHTS AND RESPONSIBILITIES

HMO Network Program Members have certain rights and responsibilities that are a vital part of their HMO membership. Listed below are some of the rights and responsibilities Members should know to maximize their benefits in a managed care environment.

Members have the Right to:

- Receive information about their HMO Network Program, including the products and services it provides, practitioners and the Providers who provide care and members' rights and responsibilities;
- Be treated with respect and recognition of their dignity and right to privacy;
- Participate with practitioners in decision making regarding the Members' health care. This includes the right to be informed of their diagnosis and treatment plan in terms Members understand and participate in decisions about their care;
- Have a candid discussion of appropriate and medically necessary treatment options for the Member's condition(s), regardless of cost or benefit coverage. KHPW 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;
- Voice a complaint or appeal about KHPW or the care provided and receive a reply within a reasonable period of time;
- Select their own Personal practitioner or practitioner group from the Keystone Primary Care Physician (PCP) network;
- Expect the PCP's team of health care workers to provide or help the Member arrange for appropriate care;
- Have reasonable access to appropriate medical services;
- Have the right to review medical records with your PCP;
- Make recommendations regarding the HMO Network Program Members' Rights and Responsibilities;
- Both the Member and the PCP have the right to request an end to this relationship if one feels the other is not fulfilling his/her responsibilities.

Members have the Responsibility to:

- To the extent possible, provide information that managed care organizations need in order to make care available to Members, and that practitioners need in order to care for Members;
- Follow the plans and instructions for care that they have agreed to with their practitioners;
- Carefully read all Member literature and make sure that they understand their benefits and HMO Network Program requirements;
- Communicate openly with physicians Members choose. Ask questions and make sure Members understand the explanations and instructions they are given and participate in developing mutually agreed upon treatment goals. Develop a relationship with physicians based on trust and cooperation;
- Help maintain Members' health, prevent illness and consider the potential consequences if they decide not to follow physicians treatment plans or recommendations;
- Treat all network physicians and personnel respectfully and courteously, as the Members' partners in good health care;
- Keep scheduled appointments or give adequate notice of delay or cancellation;

- Express their opinions, concerns or complaints in a constructive manner to the appropriate people;
- Pay any applicable copayments at the time of service.

I. HOW WE PROTECT YOUR RIGHT TO CONFIDENTIALITY

Keystone Health Plan West has established policies and procedures to protect the privacy of Members' protected health information from unauthorized or improper use.

As permitted by law, Keystone Health Plan West may use or disclose protected health information for treatment, payment and health care operations, such as: claims management, certain types of routine audits by Highmark's group customers, 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, KHPW is able to manage members' health care needs, even targeting certain individuals for quality improvement programs, such as health, wellness and disease management programs.

If KHPW ever uses Member's protected health information for non-routine uses, KHPW will ask the Member to give KHPW their permission by signing a special authorization form, except with regard to court orders and subpoenas.

The Member has the right to access the information the Member's physician has been keeping in their medical records. Any such request should be directed first to the Member's network physician.

The Member benefits from the many safeguards KHPW has in place to protect the use of data KHPW maintains. This includes requiring Keystone Health Plan West employees to sign statements in which they agree to protect the Member's confidentiality, using computer passwords to limit access to the Member's protected health information, and including confidentiality language in KHPW contracts with physicians, Hospitals, vendors and other health care Providers.

KHPW provides aggregate information to employer groups whenever possible. In those instances where protected health information is required, the employer group will be required to sign an agreement before the information is released.

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

Recognizing that the Member has the right to privacy in all settings, KHPW inspects the privacy of examination rooms when KHPW conducts on-site visits to physicians' offices. It's all part of assuring that the Member's protected health information is kept confidential.

J. MEMBER LIABILITY

Except when certain Copayments or other limitations or exclusions are specified under this HMO Network Program, the Member is not liable for any charges for Covered Services when such services are received from a Network Provider or preauthorized, when appropriate, by KHPW. In the event a Member receives Covered Services from a Provider outside the Network without the required Preauthorization, except for Emergency Care Services, or as otherwise provided herein, the Member will be responsible for all charges associated with those services regardless of whether the services received were Medically Necessary and Appropriate. If a Member receives services not covered under this HMO Network Program, the Member is responsible for all charges associated with those services.

If KHPW terminates the contract of a Network Provider for cause, KHPW will not be responsible for health care services or supplies provided to the Member by that terminated Provider following the date of termination.

Refer to **SECTION IX - SUMMARY OF BENEFITS** in this benefit booklet to determine if a Benefit described in **SECTION VII - DESCRIPTION OF BENEFITS** includes a Copayment, a Deductible amount or any other limitation. Please keep in mind that you could be financially responsible for total payment to the provider for any services you receive which are not covered by this HMO Network Program.

K. MODIFICATION

The terms of the HMO Network Program, administered by KHPW, shall be subject to amendment, modification and termination in accordance with applicable laws and by notice to KHPW by the Group without the consent or concurrence of the Participant unless required by law. By accepting Benefits under the HMO Network Program, the Participant agrees to all terms, conditions and provisions hereof.

L. NOTICE OF CLAIM AND PROOF OF LOSS

1. Notice of Claim

KHPW will not be liable for any Claims unless proper notice is furnished to KHPW that Covered Services have been rendered to a Member. Written notice of a Claim must be given to KHPW within twenty (20) days, or as soon as reasonably possible after Covered Services have been rendered to the Member. Notice given by or on behalf of the Member to KHPW that includes information sufficient to identify the Member that received the Covered Services, shall constitute sufficient notice of a Claim to KHPW. The Member can give notice to KHPW by calling or writing to the Member Service Department. The telephone number and address of the Member Service Department can be found on the Member's Identification Card. A charge shall be considered incurred on the date a Member receives the Covered Service for which the charge is made.

2. **Proof of Loss**

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

3. **Claim Forms**

If a Member (or if deceased, his/her personal representative) is required to submit a proof of loss for Benefits, it must be submitted to KHPW on the appropriate claim form. KHPW will, within fifteen (15) days following the date notice of Claim is received, furnish to the Member claim forms for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of such notice, the Member shall be deemed to have complied with the requirements of this Subsection as to filing a proof of loss upon submitting, within the time fixed in this Subsection for filing proofs of loss, itemized bills for Covered Services as described below. Itemized bills may be submitted to KHPW at the address appearing on the Member's Identification Card. Itemized bills cannot be returned.

4. **Submission of Claim Forms**

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

To avoid delay in handling Member-submitted claims, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing all of the following information:

- Person or organization providing the service or supply
- Type of service or supply
- Date of service or supply
- Amount charged
- Name of patient

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

5. **Time of Payment of Claims**

Claims payment for Benefits payable will be processed immediately upon receipt of proper proof of loss. Notice of KHPW's claim determination will be issued within a reasonable period of time not to exceed thirty (30) days following the receipt of a proper proof of loss. This period of time may be extended one (1) time by KHPW for an additional period of time not to exceed fifteen (15) days provided the extension is due to matters outside the control of KHPW and the Member is notified of the extension.

In the event that KHPW renders an adverse decision on the claim, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement describing the right of the Member to file a complaint or grievance appeal.

M. POLICIES AND PROCEDURES

KHPW may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this HMO Network Program, with which Members shall comply.

N. RELATIONSHIP OF PARTIES

Network Professional Providers maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services. The relationship between KHPW and any Network Provider is an independent contract or relationship. Network Providers are not agents or employees of KHPW, nor is any employee of KHPW an employee or agent of a Network Provider. KHPW shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any Network Professional Provider, or from any Provider to whom the Member has been referred.

O. RELEASE OF INFORMATION

Each Member agrees that any person or entity having information relating to an illness or injury for which Benefits are claimed may furnish to KHPW upon its request any information (including copies of records) relating to the illness or injury. In addition KHPW may furnish similar information regarding claims and charges submitted to KHPW by Hospitals, Physicians or other Providers.

KHPW may, as permitted by applicable privacy laws and regulations (including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")) and KHPW policies, provide to the Group at the Group's request any and all information regarding claims and charges submitted to KHPW by Providers and furnish other plans or plan sponsored entities with membership and/or coverage information for the purpose of claims processing or facilitating patient care.

KHPW may implement quality of care and medical management initiatives and may review Members' medical records to evaluate care and determine if it meets professional and industry standards.

KHPW, as permitted by applicable laws and regulations (including HIPAA) and KHPW policies, may share information about Members with Designated Agents, including medical professionals and other health care experts, each of whom must sign confidentiality agreements. Members agree to permit KHPW to review and share such information.

P. REPORTS AND RECORDS

The Member agrees that any person or organization, which furnishes Services, is authorized to furnish KHPW with medical or other information necessary for KHPW to administer this HMO Network Program. The Member further agrees that KHPW may furnish such information to persons engaged in peer review or utilization review procedures, and such information to parties as is required by law. The Member agrees that approval by KHPW of payment for any Services, facilities or supplies is contingent upon receipt by KHPW of such information or records or copies of such records.

The Member understands that the processing of claims and access to contracting provider arrangements under this HMO Network Program is governed by an agreement for Administrative Services between the Group and KHPW. Under this agreement, the Group funds the cost of Covered Services and benefits administered by KHPW. Accordingly claims data (including, but not limited to Member specific diagnosis, treatment information and other related information) utilized by KHPW to review and process claims for Members may, to the extent permitted by applicable privacy laws and regulations (including HIPAA) and KHPW policies, be provided to the Group so it may effectively implement its commitment to monitor expenses and carefully manage costs. In addition, subject to the requirements of applicable privacy laws and regulations (including HIPAA) and KHPW policies, the claims data requested by and provided to the Group may include information pertaining to HIV/AIDS, mental health, mental retardation, drug and alcohol treatment.

Q. SUBROGATION

1. To the extent that Benefits for Covered Services are provided or paid under this HMO Network Program, KHPW on behalf of the Group shall be subrogated and succeed to any rights of recovery of a Member as permitted by law for expenses Incurred against any person, firm or organization except insurers on policies or health insurance issued to and in the name of the Member.

2. The Member shall execute and deliver such instruments and take such other reasonable action as KHPW may require to secure such rights, as permitted by law. The Member shall do nothing to prejudice the rights given KHPW by this Paragraph without its consent.

3. This Subsection does not apply where subrogation is specifically prohibited by law.

R. WAIVER OF LIABILITY

KHPW shall not be liable for injuries resulting from negligence, misfeasance, nonfeasance or malpractice on the part of any of its officers or employees, agents or independent contractors.

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 and your developing baby's health.

To help you understand and manage every stage of pregnancy and childbirth, Highmark offers the Baby BluePrints Maternity Education and Support Program.

By enrolling in this free program* you will have access to printed and online educational information on all aspects of pregnancy and childbirth. Baby BluePrints will also provide you with personal support from a nurse Health Coach who will be available to you throughout your pregnancy for any kind of assistance or information. *And* you'll be sent valuable gifts for participating!

Easy Enrollment
Enrolling in Baby BluePrints is convenient. Simply call toll free, **1-866-918-5267**. You can enroll at any time during your pregnancy.

Once you enroll, you will receive a Welcome Package that includes:

- a comprehensive Maternity Guide with important health information and guidelines
- a Guide to educational resources and programs found on your Highmark member Web site
- flyers describing available discount programs/services
- a Childbirth Education Class Reimbursement form
- a Child Immunization and Preventive Care pamphlet
- vouchers for the three free gifts:
    - gift at initial enrollment -- choice of book on pregnancy/childcare
    - gift at the end of the second trimester -- baby photo album
    - gift after delivery -- child's dish set and book on child emergency and first aid care

For More Information
If you have any questions about Baby BluePrints, please call Member Service at the number on your ID card. We encourage you to enroll early in your pregnancy to take full advantage of this exciting new program.

** [Please note not all employers offer Baby BluePrints. You will be notified at the time of enrollment if this program is not included in your plan.]*

NOTICE

THIS IS IMPORTANT TO YOU

Please keep this attached to your benefits booklet.

Effective March 1, 2006, Your HMO Network Program will be utilizing an exclusive pharmacy provider for selected specialty medications covered under the prescription drug portion of your benefit program. As part of this change, these particular prescription drugs will be limited to your benefit program's retail cost sharing provisions and retail days supply.

Benefits will be provided for selected prescription drugs within, but not limited to, the following drug classifications only when such drugs are covered medications and are dispensed through an exclusive pharmacy provider.

- Oncology related therapies
- Interferons
- Agents for multiple sclerosis and neurological related therapies
- Antiarthritic therapies
- Anticoagulants
- Hematinic agents
- Immunomodulators
- Growth hormones
- Fertility drugs

These selected prescription drugs may be ordered by a physician or other health care provider on your behalf or you may submit the prescription order directly to the exclusive pharmacy provider. In either situation, the exclusive pharmacy provider will deliver the prescription drug to you.

For a complete listing of those prescription drugs that must be obtained through an exclusive pharmacy provider, log onto Highmark's Web Site, www.highmarkbcbs.com or contact Member Service at the toll-free telephone number appearing on the back of your identification card.

HIGHMARK INC.
NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE ALSO DESCRIBES HOW WE COLLECT, USE AND DISCLOSE NON-PUBLIC PERSONAL FINANCIAL INFORMATION.

Our Legal Duties

At Highmark, we are committed to protecting the privacy of your protected health information. "Protected health information" is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members' protected health information. We are required by applicable federal and state laws to maintain the privacy of your protected health information. We also are required by the HIPAA Privacy Rule (45 C.F.R. parts 160 and 164, as amended) to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information.

We will inform you of these practices the first time you become a Highmark Inc. customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice became effective April 1, 2003, and will remain in effect unless we replace it.

On an ongoing basis, we will review and monitor our privacy practices to ensure the privacy of our members' protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this Notice. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will become effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. Before we make a material change in our privacy practices, we will change this Notice and notify all affected members in writing in advance of the change.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. Uses and Disclosures of Protected Health Information

In order to administer our health benefit programs effectively, we will collect, use and disclose protected health information for certain of our activities, including payment and health care operations.

A. Uses and Disclosures of Protected Health Information for Payment and Health Care Operations

The following is a description of how we may use and/or disclose protected health information about you for payment and health care operations:

Payment

We may use and disclose your protected health information for all activities that are included within the definition of "payment" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "payment," so please refer to 45 C.F.R. § 164.501 for a complete list.

For example:
We may use and disclose your protected health information to pay claims from doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and/or to issue explanations of benefits to the person who subscribes to the health plan in which you participate.

Health Care Operations
We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "health care operations," so please refer to 45 C.F.R. § 164.501 for a complete list.

For example:
We may use and disclose your protected health information to rate our risk and determine the premium for your health plan, to conduct quality assessment and improvement activities, to credential health care providers, to engage in care coordination or case management, and/or to manage our business and the like.

B. Uses and Disclosures of Protected Health Information to Other Entities

We also may use and disclose protected health information to other covered entities, business associates, or other individuals (as permitted by the HIPAA Privacy Rule) who assist us in administering our programs and delivering health services to our members.

(i) Business Associates.
In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation, or pharmacy benefit management). To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

(ii) Other Covered Entities.
In addition, we may use or disclose your protected health information to assist health care providers in connection with *their* treatment or payment activities, or to assist other covered entities in connection with certain of *their* health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

II. Other Possible Uses and Disclosures of Protected Health Information

In addition to uses and disclosures for payment, and health care operations, we may use and/or disclose your protected health information for the following purposes:

A. To Plan Sponsors

We may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us regarding a member's question, concern, issue regarding claim, benefits, service, coverage, etc. We may also disclose summary health information (this type of information is defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

B. Required by Law

We may use or disclose your protected health information to the extent that federal or state law requires the use or disclosure. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.

C. Public Health Activities

We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability.

D. Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

E. Abuse or Neglect

We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence.

F. Legal Proceedings

We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information.

G. Law Enforcement

Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; or (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person.

H. Coroners, Medical Examiners, Funeral Directors, and Organ Donation

We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

I. Research

We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

J. To Prevent a Serious Threat to Health or Safety

Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

K. Military Activity and National Security, Protective Services

Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

L. Inmates

If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

M. Workers' Compensation

We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

N. Others Involved in Your Health Care

Unless you object, we may disclose your protected health information to a friend or family member that you have identified as being involved in your health care. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

III. Required Disclosures of Your Protected Health Information

The following is a description of disclosures that we are required by law to make:

A. Disclosures to the Secretary of the U.S. Department of Health and Human Services

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

B. Disclosures to You

We are required to disclose to you most of your protected health information that is in a "designated record set" (defined below) when you request access to this information. We also are required to provide, upon your request, an accounting of many disclosures of your protected health information that are for reasons other than payment and health care operations.

IV. Other Uses and Disclosures of Your Protected Health Information

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

V. Your Individual Rights

The following is a description of your rights with respect to your protected health information:

A. Right to Access

You have the right to look at or get copies of your protected health information in a designated record set. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your protected health information.

To inspect and/or copy your protected health information, you may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. The first request within a 12-month period will be free. If you request access to your designated record set more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. If you request an alternative format, we will charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

B. Right to an Accounting

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment or health care operations. You should know that most disclosures of protected health information will be for purposes of payment or health care operations.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or submitting your request in writing to the Highmark Privacy Department, 1800 Center Street, Camp Hill, PA 17089. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

The first list you request within a 12-month period will be free. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

C. Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

You may request a restriction by contacting us at the Customer Service phone number on the back of your identification card, or writing to the Highmark Privacy Department, 1800 Center Street, Camp Hill, PA 17089. In your request tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

D. Right to Request Confidential Communications

If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. For example, you may ask that we contact you only at your work address or via your work e-mail.

You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence by the alternative means or to the alternative location you want. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the subscriber of the health plan in which you participate.

E. Right to Request Amendment

If you believe that your protected health information is incorrect or incomplete, you have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended.

We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

F. Right to a Paper Copy of this Notice

If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. Please contact us using the information listed at the end of this Notice to obtain this Notice in written form.

VI. Questions and Complaints

If you want more information about our privacy policies or practices or have questions or concerns, please contact us using the information listed below.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made to amend or restrict the use or disclosure of your protected health information or to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed below.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Highmark Privacy Department

Telephone: 1-866-228-9424 (toll free)

Fax: 1-717-302-3601

Address: 1800 Center Street

Camp Hill, PA 17089

PART II – NOTICE OF PRIVACY PRACTICES (GRAMM-LEACH –BLILEY)

Highmark is committed to protecting its members' privacy. This notice describes our policies and practices for collecting, handling and protecting personal information about our members. We will inform each group of these policies the first time the group becomes a Highmark customer and will annually reaffirm our privacy policy for as long as the group remains a Highmark customer. We will continually review our privacy policy and monitor our business practices to help ensure the security of our members' personal information. Due to changing circumstances, it may become necessary to revise our privacy policy in the future. Should such a change be required, we will notify all affected customers in writing in advance of the change.

In order to administer our health benefit programs effectively, we must collect, use and disclose non-public personal financial information. Non-public personal financial information is information that identifies an individual member of a Highmark health plan. It may include the member's name, address, telephone number and Social Security number or it may relate to the member‘s participation in the plan, the provision of health care services or the payment for health care services. Non-public personal financial information does not include publicly available information or statistical information that does not identify individual persons.

Information we collect and maintain: We collect non-public personal financial information about our members from the following sources:

- We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.

- We collect and create information about our members' transactions with Highmark, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

Information we may disclose and the purpose: We do not sell any personal information about our members or former members for marketing purposes. We use and disclose the personal information we collect (as described above) only as necessary to deliver health care products and services to our members or to comply with legal requirements. Some examples are:

- We use personal information internally to manage enrollment, process claims, monitor the quality of the health services provided to our members, prevent fraud, audit our own performance or to respond to members' requests for information, products or services.

- We share personal information with our affiliated companies, health care providers, agents, other insurers, peer review organizations, auditors, attorneys or consultants who assist us in administering our programs and delivering health services to our members. Our contracts with all such service providers require them to protect the confidentiality of our members' personal information.

- We may share personal information with other insurers that cooperate with us to jointly market or administer health insurance products or services. All contracts with other insurers for this purpose require them to protect the confidentiality of our members' personal information.

- We may disclose information under order of a court of law in connection with a legal proceeding.

- We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.

- We may disclose information under a subpoena or summons to government agencies that investigate fraud or other violations of law.

How we protect information: We restrict access to our members' non-public personal information to those employees, agents, consultants and health care providers who need to know that information to provide health products or services. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to guard non-public personal financial information from unauthorized access, use and disclosure.

For questions about this Privacy Notice, please contact:

Contact Office: Highmark Privacy Department

Telephone: 1-866-228-9424 (toll free)

Fax: 1-717-302-3601

Address: 1800 Center Street

Camp Hill, PA 17089

08/11/2008