YOUR 2021
BENEFIT BOOKLET

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Thank You for Choosing Highmark

Welcome to Highmark. We appreciate your choosing us for your health coverage.

Take the time to review this booklet; it contains important information about your health insurance, including:

- How to use your member ID card
- The importance of selecting a primary care provider or provider of record
- Getting quality care and service
- Definitions of common health care insurance terms
- The Outline of Coverage and Member Agreement for your plan

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

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Your Identification Card Is Your Key to Care

You will receive your identification (ID) card in a separate mailing. Your ID card is your key to letting providers know that you have health coverage. You should carry your card with you. You can also view and fax it to a provider by logging in to **www.HighmarkBCBS.com** with your web-enabled phone.

Show your card to the health care provider when you need care. Use it at the pharmacy when you buy prescription drugs. You can even use your ID card nationwide for emergency and urgent care.

Your ID card is your source for important information. It includes:

- Your name and/or dependent's name (when applicable)
- Your identification number
- Your group number
- Effective date of your plan
- Office visit, specialist visit, and emergency room copayment amounts (if applicable)
- Toll-free Member Service phone number
- Member website address
- Blues On Call^{SM} nurse line
- Toll-free phone numbers for authorizing services
- Addresses for filing claims for emergency and urgent care that is provided out of the network or out of the coverage area.

If your ID card is lost or stolen, please contact Member Service immediately. You can order a replacement ID card on **www.HighmarkBCBS.com**. It's illegal to lend your ID card to anyone who is not eligible to use your benefits.

Select a Primary Care Provider (PCP) or Physician of Record (POR)

A Primary Care Provider/Physician of Record is the provider or practice that you visit for your primary and routine health care services. This could be an internal medicine physician, general practitioner, family practitioner, certified registered nurse practitioner, or pediatrician.

These providers are often your least costly option for getting care. Your PCP/POR can deliver routine services, such as physicals and immunizations, and can recommend and help you select appropriate specialist care when you need it. PCPs/PORs, or their covering providers, are on call 24 hours a day, seven days a week. All of our plans allow you to go directly to a specialist without a referral. This includes specialists for behavioral health.

A PCP/POR can help you to:

- Achieve health goals.
- Monitor chronic health conditions and care maintenance.
- Make sure you receive preventive services, like annual exams.
- Coordinate the care you receive from other providers, such as specialists, labs, and imaging centers. This prevents gaps or overlaps in service.
- Improve your patient experience.

How to Obtain Information Regarding Your Provider

To learn more about a provider or to find a PCP/POR:

1. Visit **www.HighmarkBCBS.com.**
    a. Select **Find a Doctor or Rx**.
    b. Select **Find a Doctor, Hospital or other Medical Provider**.
    c. Enter the name of your plan by entering the first three letters of your member ID and selecting the appropriate plan from the **Select a Plan** menu.
    d. Enter **"primary care"** into the search field.
    e. Click on the **SEARCH** button to locate providers near you who participate in your network.
    f. Select **See More** to learn more about a specific provider.
    g. Click **More Details** then select **Physician Details** to locate the physician of record's nine-digit Physician ID number.

2. Call Member Service at the number on the back of your member ID card to ask for help in locating a physician of record with an office near you.

When you search for a provider at **www.HighmarkBCBS.com**, you can view the following information:

- Physician name
- Location, office hours, and phone numbers
- Whether the provider is accepting new patients
- Professional qualifications
- Clinical specialties
- Medical school attended
- Residency completion
- Board certification status
- Hospital affiliations
- Medical group affiliations
- Patient ratings
- Performance in 13 categories of care
- Parking and public transit nearby
- Handicap accessibility
- Languages spoken
- Gender

You may also obtain more information on network providers by calling Member Service at the number on the back of your member ID card.

To select a PCP/POR:

- Log in to the member website.
- Go to **Settings.**
- Select **Physician Information** to update your physician of record.

How to Use Your Plan

Some Highmark plans provide more value by giving you two levels of in-network benefits, allowing you to choose the high-quality providers who give you the most for your health care dollars. The network includes PCPs/PORs, specialists, imaging centers, hospitals, and other facilities.

Some plans group health care professionals and hospitals into two levels of in-network benefits: an Enhanced Value Level and a Standard Value Level. What you pay for care is based on the level of participation of the provider you choose.

At both benefit levels, the network of providers offers high-quality care and easy access to every kind of service.

Here is how the Enhanced Value and Standard Value Levels of Benefits affect out-of-pocket

	Level of Benefits		Your Cost
In-Network	Enhanced Value Highest level of benefits	Access to all the covered services you need. Your out-of-pocket costs are generally lowest with this level.	$
	Standard Value Lower level of benefits	Provides additional choice, but out-of-pocket costs are generally higher than Enhanced Value.	$ $

costs.

Benefits Included with Your Plan

Free Preventive Vaccines

To help you and your family stay healthy, preventive vaccines are included with your plan when given at participating physicians' offices and pharmacies. These vaccines require no copay or coinsurance, and you do not have to have met your deductible to take advantage of these services. Visit www.HighmarkBCBS.com to find participating providers and pharmacies near you.

Preventive vaccines available at participating pharmacies are for members who meet all necessary state requirements that apply to the administration of vaccines in a retail pharmacy (such as specific vaccines that are allowed in the retail setting, age of patient, prescription requirements, etc.). These regulations vary by state. Check with your pharmacy for any such restrictions.

Free Telemedicine Services

Speak with a network provider in just 5 – 10 minutes using your mobile phone, tablet, or laptop to get help with a variety of minor illnesses, such as colds, sore throats, pink eye, allergies, and

rashes. Visit AmWell.com to set up your account so that you can visit a doctor from the comfort of your home.

If you have a catastrophic or high-deductible health plan, subject to the terms of your benefit agreement, you must meet your deductible before your plan pays the full cost of telemedicine services.

In-Network Care

Before you see a provider, it's always important to make sure they are in-network. By keeping care in-network, **medically necessary and appropriate services** specified in the Member Agreement will be covered. There is no coverage for out-of-network care except in emergency medical situations or when urgent care is needed.

Find In-Network Providers, Hospitals, and Facilities

It's easy to find in-network providers, hospitals, and facilities, and determine the level of benefits offered by each:

- Visit **www.HighmarkBCBS.com.** Just log in, click the **Find a Doctor** tab, and follow the directions. Call My Care Navigator at 888-258-3428.
- Call Member Service at the number on the back of your member ID card.

Out-of-Network & Out-of-Area BlueCard Coverage

Care can be delivered in a variety of settings for various situations. To understand how care will be covered, it is helpful to know the types of care that are available:

Emergency Care - Emergency care is needed for the treatment of serious or life-threatening medical conditions that require immediate care. **If you think you are having a medical emergency, call 911 or go immediately to the nearest emergency room.** The hospital will provide needed care, and it will be covered at the Enhanced Level of Benefits — even if that hospital is out-of-network.

If inpatient care is required, once the patient is stabilized and able to be transported to an in-network facility, Highmark will work with the patient or the patient's family, and the treating hospital, to arrange transfer.

Urgent Care - Urgent care is care needed for an unexpected illness or injury that is not life threatening but must be treated and cannot reasonably be postponed.

Out-of-Network Care - Care received from providers who do not participate in your plan's network or at non-participating facilities.

Out-of-network care is only available for emergencies and urgent care. Except in certain situations, the plan does not pay for out-of-network health services. If you need emergency or urgent care services, the plan will cover **medically necessary and**

appropriate services specified in the Member Agreement. If your plan covers services at the Enhanced and Standard Value Levels of Benefits, emergency and urgent care services will be covered at the Enhanced Value Level of Benefits.

If inpatient care is required, once you are stabilized and able to be transported to an in-network facility, Highmark will work with you or your family, and the treating hospital, to arrange transfer. If you decline to be transferred to an in-network facility, you may be responsible for all costs associated with the care you receive.

Out-of-Area Care with BlueCard - Subject to the terms of your benefit agreement, the BlueCard® program allows you to obtain certain health care services from BlueCard participating providers while traveling outside of Highmark's service area in Pennsylvania. Depending on terms of your benefit agreement, BlueCard may only be available for emergency care and urgent care services, so please refer to your contract to determine benefits covered by BlueCard for your plan. If you are traveling and require medical care, call Highmark Member Service at the number on the back of your member ID card to determine if your plan provides coverage only for emergency and urgent care, or also covers routine care. As applicable, the BlueCard program links participating health care providers with the independent Blue Cross Blue Shield Plans across the country and allows providers to submit claims for processing and reimbursement so you don't have to. However, certain services still require you to work with your BlueCard participating provider to obtain prior authorization. To determine if your care requires prior authorization, call Member Service at the number on the back of your ID card.

You can find BlueCard participating providers by calling BlueCard Access at 1-800-810-BLUE. You can also search on the member website for a BlueCard provider by ZIP code and provider specialty, or by city and state. Or visit the BlueCard Doctor and National Hospital Finder website at **bcbs.com**.

Preventive Schedule

Preventive care helps you to stay well or find problems early, when they may be easier to treat. The preventive guidelines in the schedule on the next few pages depend upon your age, gender, health, and family history and can be an important part of your overall health and well-being. Take some time to review the preventive schedule and discuss it with your doctor.

The following preventive schedule is current as of January 1, 2021. Periodic updates may be made to the schedule. Visit the Highmark website at **www.HighmarkBCBS.com** to view the current schedule.

2021 Preventive Schedule

Effective 1/1/2021

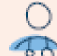
Plan your care: Know what you need and when to get it

Preventive or routine care helps us stay well or finds problems early, when they are easier to treat. The preventive guidelines on this schedule depend on your age, gender, health and family history. As a part of your health plan, you may be eligible to receive some of these preventive benefits with little to no cost sharing when using in-network providers. Make sure you know what is covered by your health plan and any requirements before you receive any of these services.

Some services and their frequency may depend on your doctor's advice. That's why it's important to talk with your doctor about the services that are right for you. CHIP Members may have additional preventive services and coverage. Please check the CHIP member booklet for further details of CHIP coverage of preventive services.

Questions?

Call Member Service


Ask your doctor

Log in to your account

Adults: Ages 19+

Female Male

GENERAL HEALTH CARE		
Female, Male	Routine Checkup* (This exam is not the work- or school-related physical)	• Ages 19 to 49: Every 1 to 2 years • Ages 50 and older: Once a year
Female, Male	Depression Screening	Once a year
Female	Pelvic, Breast Exam	Once a year
SCREENINGS/PROCEDURES		
Male	Abdominal Aortic Aneurysm Screening	Ages 65 to 75 who have ever smoked: One-time screening
Female, Male	Ambulatory Blood Pressure Monitoring	To confirm new diagnosis of high blood pressure before starting treatment
Female	Breast Cancer Genetic (BRCA) Screening (Requires prior authorization)	Those meeting specific high-risk criteria: One-time genetic assessment for breast and ovarian cancer risk
Female, Male	Cholesterol (Lipid) Screening	• Ages 20 and older: Once every 5 years • High-risk: More often
Female, Male	Colon Cancer Screening (Including Colonoscopy)	• Ages 50 and older: Every 1 to 10 years, depending on screening test • High-risk: Earlier or more frequently
Female, Male	Certain Colonoscopy Preps With Prescription	• Ages 50 and older: Once every 10 years • High-risk: Earlier or more frequently
Female, Male	Diabetes Screening	High-risk: Ages 40 and older, once every 3 years
Female, Male	Hepatitis B Screening	High-risk
Female, Male	Hepatitis C Screening	Ages 18-79
Female, Male	Latent Tuberculosis Screening	High-risk
Female, Male	Lung Cancer Screening (Requires prior authorization and use of authorized facility)	Ages 55 to 80 with 30-pack per year history: Once a year for current smokers, or once a year if currently smoking or quit within past 15 years

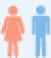
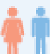
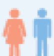
* Routine checkup could include health history; physical; height, weight and blood pressure measures; body mass index (BMI) assessment; counseling for obesity, fall prevention, skin cancer and safety; depression screening; alcohol and drug abuse, and tobacco use assessment; age-appropriate guidance, and intimate partner violence screening and counseling for reproductive age women.

PREV/SCH/NG-W-9

Adults: Ages 19+

SCREENINGS/PROCEDURES	
Mammogram	Ages 40 and older: Once a year including 3-D
Osteoporosis (Bone Mineral Density) Screening	Age 65 and older: once every 2 years. Younger if at risk as recommended by physician
Cervical Cancer Screening	• Ages 21 to 65 PAP: Every 3 years, or annually, per doctor's advice • Ages 30 to 65: Every 5 years if HPV only or combined PAP and HPV are negative • Ages 65 and older: Per doctor's advice
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV and Syphilis)	Sexually active males and females
IMMUNIZATIONS**	
Chicken Pox (Varicella)	Adults with no history of chicken pox: One 2-dose series
Diphtheria, Tetanus (Td/Tdap)	One dose Tdap, then Td or Tdap booster every 10 years
Flu (Influenza)	Every year (Must get at your PCP's office or designated pharmacy vaccination provider; call Member Service to verify that your vaccination provider is in the Highmark network)
Haemophilus Influenzae Type B (Hib)	For adults with certain medical conditions to prevent meningitis, pneumonia and other serious infections; this vaccine does not provide protection against the flu and does not replace the annual flu vaccine
Hepatitis A	At-risk or per doctor's advice: One 2 or 3 dose series
Hepatitis B	At-risk or per doctor's advice: One 2 or 3 dose series
Human Papillomavirus (HPV)	• To age 26: One 3-dose series • Beginning on 9/1/2020: Ages 27–45 at-risk per doctor's advice
Measles, Mumps, Rubella (MMR)	One or two doses
Meningitis*	At-risk or per doctor's advice
Pneumonia	High-risk or ages 65 and older: One or two doses, per lifetime
Shingles	• Zostavax - Ages 60 and older: One dose • Shingrix - Ages 50 and older: Two doses
PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Aspirin	• Ages 50 to 59 to reduce the risk of stroke and heart attack • Pregnant women at risk for preeclampsia
Folic Acid	Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid
Chemoprevention drugs such as raloxifene, tamoxifen or aromatase*** inhibitor beginning on 10/1/2020	At-risk for breast cancer, without a cancer diagnosis, ages 35 and older
Tobacco Cessation (Counseling and medication)	Adults who use tobacco products

* Meningococcal B vaccine per doctor's advice.
** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.
*** Aromatase inhibitors effective 10.1.2020 when the other drugs can't be used such as when there is a contraindication or they are not tolerated.

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION			
	Low to Moderate Dose Select Generic Statin Drugs For Prevention of Cardiovascular Disease (CVD)	Ages 40 to 75 years with 1 or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and have calculated 10-year risk of a cardiovascular event of 10% or greater.	
	Select PrEP Drugs for Prevention of HIV Infection	Adults at-risk for HIV infection, without an HIV diagnosis	
PREVENTIVE CARE FOR PREGNANT WOMEN			
	Screenings and Procedures	• Gestational diabetes screening • Hepatitis B screening and immunization, if needed • HIV screening • Syphilis screening • Smoking cessation counseling • Depression screening during pregnancy and postpartum • Depression prevention counseling during pregnancy and postpartum	• Rh typing at first visit • Rh antibody testing for Rh-negative women • Tdap with every pregnancy • Urine culture and sensitivity at first visit • Alcohol misuse screening and counseling
PREVENTION OF OBESITY, HEART DISEASE AND DIABETES			
	Adults With BMI 25 to 29.9 (Overweight) and 30 to 39.9 (Obese) Are Eligible For:	• Additional annual preventive office visits specifically for obesity and blood pressure measurement • Additional nutritional counseling visits specifically for obesity	• Recommended lab tests: – ALT – AST – Hemoglobin A1c or fasting glucose – Cholesterol screening
ADULT DIABETES PREVENTION PROGRAM (DPP)			
	Applies to Adults • Without a diagnosis of Diabetes (does not include a history of Gestational Diabetes) and • Overweight or obese (determined by BMI) and • Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7 to 6.4 percent or Impaired Glucose Tolerance Test of 140-199mg/dl.	Enrollment in certain select CDC recognized lifestyle change DPP programs for weight loss.	

2021 Preventive Schedule

Plan your child's care: Know what your child needs and when to get it

Preventive or routine care helps your child stay well or finds problems early, when they are easier to treat. Most of these services may not have cost sharing if you use the plan's in-network providers. Make sure you know what is covered by your health plan and any requirements before you schedule any services for your child.

It's important to talk with your child's doctor. The frequency of services, and schedule of screenings and immunizations depends on what the doctor thinks is right for your child.

Questions?

- Call Member Service
- Ask your doctor
- Log in to your account

Children: Birth to 30 Months[1]

GENERAL HEALTH CARE	BIRTH	1M	2M	4M	6M	9M	12M	15M	18M	24M	30M
Routine Checkup* (This exam is not the preschool- or day care-related physical.)	●	●	●	●	●	●	●	●	●	●	●
Hearing Screening	●										
SCREENINGS											
Autism Screening									●	●	
Critical Congenital Heart Disease (CCHD) Screening WithPulse Oximetry	●										
Developmental Screening						●			●		●
Hematocrit or Hemoglobin Screening							●				
Lead Screening						●	●			●	
Newborn Blood Screening and Bilirubin	●										
IMMUNIZATIONS											
Chicken Pox							Dose 1				
Diphtheria, Tetanus, Pertussis (DTaP)			Dose 1	Dose 2	Dose 3			Dose 4			
Flu (Influenza)**					Ages 6 months to 30 months: 1 or 2 doses annually						
Haemophilus Influenzae Type B (Hib)			Dose 1	Dose 2	Dose 3		Dose 4				
Hepatitis A							Dose 1		Dose 2		
Hepatitis B	Dose 1	Dose 2			Dose 3						
Measles, Mumps, Rubella (MMR)							Dose 1				
Pneumonia			Dose 1	Dose 2	Dose 3		Dose 4				
Polio (IPV)			Dose 1	Dose 2	Ages 6 months to 18 months: Dose 3						
Rotavirus			Dose 1	Dose 2	Dose 3						

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance. Additional: Instrument vision screening to assess risk for ages 1 and 2 years.

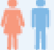
** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.

Children: 3 Years to 18 Years[1]

GENERAL HEALTH CARE	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	15Y	18Y
Routine Checkup* (This exam is not the preschool- or day care-related physical)	●	●	●	●	●	●	●	●	Once a year from ages 11 to 18			
Ambulatory Blood Pressure Monitoring**												●
Depression Screening									Once a year from ages 11 to 18			
Hearing Screening***		●	●	●		●		●		●	●	●
Visual Screening***	●	●	●	●		●		●		●	●	●
SCREENINGS												
Hematocrit or Hemoglobin Screening			Annually for females during adolescence and when indicated									
Lead Screening	When indicated (Please also refer to your state-specific recommendations)											
Cholesterol (Lipid) Screening							Once between ages 9-11 and ages 17-21					
IMMUNIZATIONS												
Chicken Pox		Dose 2								If not previously vaccinated: Dose 1 and 2 (4 weeks apart)		
Diphtheria, Tetanus, Pertussis (DTaP)		Dose 5							One dose Tdap			
Flu (Influenza)****	Ages 3 to 18: 1 or 2 doses annually											
Human Papillomavirus (HPV)							Provides long-term protection against cervical and other cancers. 2 doses when started ages 9-14. 3 doses all other ages.					
Measles, Mumps, Rubella (MMR)		Dose 2										
Meningitis*****									Dose 1		Age 16: One-time booster	
Pneumonia	Per doctor's advice											
Polio (IPV)		Dose 4										
CARE FOR PATIENTS WITH RISK FACTORS												
BRCA Mutation Screening (Requires prior authorization)					Per doctor's advice							
Cholesterol Screening	Screening will be done based on the child's family history and risk factors											
Fluoride Varnish (Must use primary care doctor)	Ages 5 and younger											
Hepatitis B Screening									Per doctor's advice			
Hepatitis C Screening											High-risk	
Latent Tuberculosis Screening												High-risk
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV and Syphilis)									For all sexually active individuals HIV routine check once between ages 15-18			
Tuberculin Test	Per doctor's advice											

*Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance; alcohol and drug abuse, and tobacco use assessment. ** To confirm new diagnosis of high blood pressure before starting treatment. *** Hearing screening once between ages 11-14, 15-17 and 18-21. Vision screening covered when performed in doctor's office by having the child read letters of various sizes on a Snellen chart. Includes instrument vision screening for ages 3, 4 and 5 years. A comprehensive vision exam is performed by an ophthalmologist or optometrist and requires a vision benefit. **** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network. ***** Meningococcal B vaccine per doctor's advice.

Children: 6 Months to 18 Years[1]

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Oral Fluoride	For ages 6 months to 16 years whose primary water source is deficient in fluoride
PREVENTION OF OBESITY AND HEART DISEASE	
Children With a BMI in the 85th to 94th Percentile (Overweight) and the 95th to 98th Percentile (Obese) Are Eligible For:	• Additional annual preventive office visits specifically for obesity • Additional nutritional counseling visits specifically for obesity • Recommended lab tests: – Alanine aminotransferase (ALT) – Aspartate aminotransferase (AST) – Hemoglobin A1c or fasting glucose (FBS) – Cholesterol screening
ADULT DIABETES PREVENTION PROGRAM (DPP) AGE 18	
 Applies to Adults • Without a diagnosis of Diabetes (does not include a history of Gestational Diabetes) and • Overweight or obese (determined by BMI) and • Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7 to 6.4 percent or Impaired Glucose Tolerance Test of 140-199mg/dl.	Enrollment in certain select CDC recognized lifestyle change DPP programs for weight loss.

Women's Health Preventive Schedule

SERVICES	
Well-Woman Visits (Includes: preconception and first prenatal visit, urinary incontinence screening)	Up to 4 visits each year for age and developmentally appropriate preventive services
Contraception (Birth Control) Methods and Discussion*	All women planning or capable of pregnancy
SCREENINGS/PROCEDURES	
Diabetes Screening	• High-risk: At the first prenatal visit • All women between 24 and 28 weeks pregnant • Postpartum women without Diabetes but with a history of gestational diabetes
HIV Screening and Discussion	All sexually active women: Once a year
Human Papillomavirus (HPV) Screening Testing	Beginning at age 30: Every 3 years
Domestic and Intimate Partner Violence Screening and Counseling	Once a year
Breast-feeding (Lactation) Support and Counseling, and Costs for Equipment	During pregnancy and/or after delivery (postpartum)
Sexually Transmitted Infections (STI) Discussion	All sexually active women: Once a year
Screening for Anxiety	The Women's Preventive Services Initiative recommends screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum.

* FDA-approved contraceptive methods may include sterilization and procedures as prescribed. One form of contraception in each of the 18 FDA-approved methods is covered without cost sharing. If the doctor recommends a clinical service or FDA-approved item based on medical necessity, there will be no cost sharing.

Information About the Affordable Care Act (ACA) [1]

This schedule is a reference tool for planning your family's preventive care, and lists items and services required under the Affordable Care Act (ACA), as amended. It is reviewed and updated periodically based on the advice of the U.S. Preventive Services Task Force, laws and regulations, and updates to clinical guidelines established by national medical organizations. Accordingly, the content of this schedule is subject to change. Your specific needs for preventive services may vary according to your personal risk factors. Your doctor is always your best resource for determining if you're at increased risk for a condition. Some services may require prior authorization. If you have questions about this schedule, prior authorizations or your benefit coverage, please call the Member Service number on the back of your member ID card.

Information About Children's Health Insurance Program (CHIP)

Because the Children's Health Insurance Program (CHIP) is a government-sponsored program and not subject to ACA, certain preventive benefits may not apply to CHIP members and/or may be subject to copayments.

The ACA authorizes coverage for certain additional preventive care services. These services do not apply to "grand-fathered" plans. These plans were established before March 23, 2010, and have not changed their benefit structure. If your health coverage is a grandfathered plan, you would have received notice of this in your benefit materials.

Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association.

Discrimination is Against the Law

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

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

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

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

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

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

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

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

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

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

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

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

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

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

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

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

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

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

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

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

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

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

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highmarkbcbs.com

Using Your Prescription Drug Coverage

Your benefits include prescription drug coverage. You can fill prescriptions at pharmacies in your plan's pharmacy network. To locate a network pharmacy, go to your member website, **www.HighmarkBCBS.com**, log in, and click the **Prescriptions** tab. Scroll down to **Find a Pharmacy** and click on **Search Pharmacies**. Or call Member Service at the number on the back of your ID card.

For maintenance prescription drugs, you have two choices:

- Your prescriptions can be delivered to your home.
- You can pick up your prescriptions at a retail pharmacy.

You may save money on medications that you take on an ongoing basis by choosing the convenient home delivery option. You can arrange for home delivery from the Express Scripts Pharmacy by calling 1-800-903-6228. You can change your preference for retail or mail order delivery at any time by contacting Express Scripts.

Prescription Drug Management for Your Formulary

Your formulary is a list of Food and Drug Administration (FDA)-approved prescription drugs. It covers products in every major treatment category. Your drug formulary may limit coverage of certain drugs to the generic formulation(s) or it may prefer generic formulations by assigning a lower cost share to those products as compared to the brand name formulations. Generic drugs have been determined by the FDA to be equivalent to the brand name drug. A list of drugs included on your formulary is on the Highmark member website. You can also call Member Service at the number on the back of your Member ID card for more information. Please note that formulary changes may occur throughout a plan year, so be sure to check the Highmark website often.

Highmark may impose quantity level limits on certain prescription drugs. Limits are based on the manufacturer's recommended dosage and Highmark's determination. The limits control the quantity the pharmacy provider gives you for each new prescription or refill. Additional quantity restrictions may be imposed on your first prescription for certain covered drugs. This means that the quantity you get will be reduced as necessary while it is established that you can tolerate the drug.

Additional quantity restrictions may be imposed which limit the duration of therapy for a medication to ensure it's used for an appropriate length of time. A prescribing provider may contact Highmark if an additional quantity of the drug is medically necessary and appropriate. If Highmark determines that it is medically necessary and appropriate, additional quantities of the drug will be covered.

Certain drugs that your physician may prescribe require a prior authorization from Highmark. You can find out what specific drugs or drug classifications require prior authorization by simply calling the Member Service number on your ID card. Once the prescription is written, the provider or the member must request prior authorization from Highmark.

To obtain a prescription medication that is not included in the formulary, or to request prior authorization, your physician must complete the "Prescription Drug Medication Request Form" and return it to Highmark using either the fax number or the address as shown on the form for clinical review.

To print a copy of the **Prescription Drug Medication Request Form** for your provider to complete, log in to **www.HighmarkBCBS.com,** click on the **Coverage** tab, and then click on **Prescriptions Summary & Drug List**. Scroll down to the **Drugs Coverages** section and then click on the **Prescription Drug Medication Request Form** link.

You may also initiate this process yourself by following these steps: Log in to **www.HighmarkBCBS.com,** click on the **Coverage** tab, and then click on **Prescriptions Summary & Drug List**. Scroll down to the **Drugs Coverages** section and then click on **Submit an online request**. Complete the form and click **Submit**.

Once a clinical decision has been made, a decision letter will be mailed to you and your provider. If your request for an exception is not granted, you can ask for a review of Highmark's decision by making an appeal.

See your Member Agreement for more details about your prescription drug benefits.

Women's Health and Cancer Rights Act of 1998

A diagnosis of breast cancer can be devastating. And while we hope you never face such a situation, we want you to know that Highmark will be there if you need us.

Our health plans are in compliance with the Women's Health and Cancer Rights Act of 1998. The federal act requires group health plans that cover mastectomies to also cover all stages of reconstruction and surgery of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. The act also requires such plans to offer coverage for prostheses and treatment of physical complications of a mastectomy, including lymphedema. Coverage may be subject to deductibles and coinsurance. If you have any questions, please call Member Service at the number on the back of your ID card.

Info Is a Call Away

If you are facing decisions about breast cancer, you can discuss your options or concerns with a Blues On Call health coach anytime, day or night, by calling 1-888-BLUE-428.

Definitions of Health Care Terms

Definitions of health care terms to help understand your benefits and rights:

Balance billing — When an out-of-network provider bills you for the difference between the provider's charge and the plan allowance. For example, if the provider's charge is $100 and the plan allowance is $70, the provider may bill you for the remaining $30. Providers who are in network may not balance bill you for covered services. If you have an EPO or HMO plan, you are not covered for out-of-network services except in the case of emergency and urgent situations.

Coinsurance — Your part of a medical bill that you pay after reaching your deductible. For example, if your medical bill for covered, in-network services is $100 and your coinsurance is 20%, you pay $20. The insurance company pays $80. (See balance billing for details on out-of-network care.)

Copayment (copay) — The fixed amount you pay for a health service, such as a PCP/POR visit, specialist visit or urgent care. The copay may vary by plan. The copay for each service may be different. For example, a PCP/POR visit may require a $30 copay. But a visit to a specialist may require a $50 copay. You usually have to pay the copay when you get a health care service, such as at your doctor's office or at the drugstore.

Deductible — The dollar amount you must pay each benefit period (usually a year) for most of your health care expenses before your plan begins to pay for covered services. For example, if you have a $500 in-network deductible, that's the amount you will pay before your insurance plan will pay for covered in-network services. Copayments are not included for many plans. Refer to your member agreement for additional information specific to your plan.

Network provider — A doctor, hospital, or other provider in the plan's network. Network providers have agreed to accept the plan allowance as payment in full for covered services. You pay less when you use a network provider instead of an out-of-network provider. With the exception of care for emergent and urgent conditions, if the plan does not offer out-of-network coverage, you must see an in-network provider for all covered services.

Out-of-pocket maximum — The most you pay during a coverage period (usually a year) before your health insurer begins to pay 100 percent of the plan allowance. The maximum never includes your premium, balance-billed charges or payments for services your health plan doesn't cover. All of your copayments, deductibles, and/or coinsurance payments count toward this maximum.

Out-of-network provider — A provider who does not have a contract with your health insurer to provide services to you at a discount. You will generally pay more to see an out-of-network

provider. If you have an EPO or HMO plan, you are not covered for out-of-network services (except for emergency and urgent care services).

Plan allowance — The most a health plan will pay for a health service. A health service could be a test or a procedure. Your plan's network providers have signed a contract to provide services at a discount. They agree not to charge more than this plan allowance to members of the health plan. Out-of-network providers may charge more than the plan allowance. If you see an out-of-network provider who charges more, you may have to pay the extra cost. If you have an HMO or EPO plan, you only have out-of-network coverage for emergency and urgent care. (See balance billing.)

Premium — The dollar amount you pay each month for your health insurance or plan.

Paying Your Monthly Premium

It's important to pay your monthly premiums to ensure that your coverage is active when you seek medical care. There are several ways to pay your premium, just pick the one that's right for you!

e-Bill

When you sign up online for e-Bill, your monthly premium is automatically deducted from your checking or savings account on the first day of each month – saving you time and eliminating the need to write checks. Set up recurring payments or pay month-by-month.

Set up your safe, secure and convenient e-Bill account today!

1. Visit **HighmarkBCBS.com**
2. Select **Pay Premium**
3. Select **Log In** if you have already set up your online account and follow the prompts.
4. Select **Pay as a Guest** to make a payment without logging in and follow the prompts.
5. Select **Register Here** to set up your online account.*
6. Once registered, select **Pay Premium** and follow the prompts.

*By registering, you'll gain full access to your member website in addition to e-Bill. Your member website allows you to view claims, keep track of your prescriptions and request refills, learn more about your coverage and benefits, locate doctors, hospitals, and other providers, and find a variety of wellness tools.

Electronic Funds Transfer (EFT)

EFT is a convenient way to pay your premiums by having them automatically withdrawn from your bank account each month. To set up EFT payments:

1. Go to **HighmarkBCBS.com**
2. Scroll down to **Helpful Links**
3. Select **Forms Library**
4. Select **Automatic Premium Payment**
5. Download the PDF file
6. Complete the form and mail it with a voided check and your bill to the address indicated

Please note that it takes 6 – 8 weeks for EFT set up and you must continue to pay your premium payments by another method during this time.

Mail

To pay your premium by mail, just include a check with your invoice and mail both to the address on the invoice.

Pay by Phone
To make your payment by phone, just call the Member Service number on the back of your member ID card. Be sure to have your account number and the bank's routing number available when you call.

In Person
To pay in person using a debit card, credit card, money order, or check, visit your local Highmark Direct Store. To find a Highmark Direct Store near you:

1. Visit **www.HighmarkDirect.com**.
2. Select **Store Locations.**
3. Enter your ZIP code.
4. Click **Submit** to find a list of stores near you.

Changes That Affect Your Premium

Here are three things that can change your premium amount that you need to report to us:

1. **Changes in Membership Status**
   You must report when you or any of your dependents have a change that can affect your enrollment, such as:

   - Marriage or divorce.
   - Adding or removing a domestic partner or dependent.
   - Termination or death of a dependent or policyholder.
   - Eligibility for employer group health insurance coverage.*
   - Eligibility for Medicare.*

   To report a change for coverage you bought directly from Highmark, call the Member Service number on the back of your ID card. For coverage purchased on the Pennsylvania Insurance Exchange, call 1-844-844-8040 or visit the Pennsylvania Insurance Exchange website, **www.pennie.com**.

   *These situations won't affect your premium, but they should be reported.

2. **Changes in Household Income**
   If you bought your health coverage from the Pennsylvania Insurance Exchange, you must report changes in your household income. Increases or decreases in your income can affect your eligibility for the federal Advance Premium Tax Credit and/or cost-sharing reductions. To report changes, you must call 1-844-844-8040 or visit the Pennsylvania Insurance Exchange website, **www.pennie.com.**

   You can also check for increased or reduced premium credits or cost-sharing reductions on the Pennsylvania Insurance Exchange website, **www.pennie.com.**

3. **Changes in Tobacco Use**
   Tobacco use means that you used tobacco products on average four or more times per week within the past six months. If you indicated that you are a tobacco user when you enrolled for health coverage, your premium includes a tobacco surcharge. This means you pay a higher rate.

If you are tobacco-free for six months, the new health care law no longer considers you to be a tobacco user. You are then eligible for an adjustment in your health insurance premium rate. After you have stopped using tobacco for six months, let us know so that we can adjust your rate. Simply call the Member Service number on the back of your ID card.

If You Need to Cancel or Terminate This Plan or Your EFT/eBill Payments

This section applies only to plans purchased directly from Highmark and does not affect those purchased through the Pennsylvania Insurance Exchange, www.pennie.com.

If you purchased your plan directly from Highmark and you would like to cancel or terminate coverage under this plan, the subscriber must contact the plan to request cancellation/termination of your individual policy. The subscriber must provide notice by calling the Member Service number on the ID Card prior to the requested termination date. Member requested cancellation/termination effective dates can only occur on the first of the month. Coverage will be canceled/terminated as of the first of the month following receipt of notification or as of your account paid to date (whichever is earlier). Cancellations will void the coverage and must be requested prior to the coverage effective date or no later than ten (10) days after receipt of the Member Agreement. Member Service can instruct you on cancellation/termination procedures. Please do **not** send policy change requests back with your monthly premium payment/invoice coupon. Contact Member Service instead.

In the event you plan to enroll in other coverage, the subscriber must contact the plan to request cancellation/termination of the individual policy. If applicable, it is the subscriber's responsibility to notify any third party that is paying the premium on the subscriber's behalf (the plan will not refund premium payments because the subscriber's request to the plan or the third party payer was not provided in a timely fashion).

You are solely responsible for payment setup and cancellation for any EFT/eBill recurring payments, even when a third party payer is paying your premium on your behalf. Requesting cancellation/termination of your policy will cancel the recurring payment/EFT payments; however, you must first contact Member Service to request cancellation/ termination of your policy. Member Service can explain how recurring payments are done and can provide the date the next payment is scheduled to be withdrawn.

Highmark will communicate renewal, enrollment discontinuation and premium information to you using the billing/correspondence addresses you have provided. Communications sent to a third party address provided by you or your agent/broker acting on your behalf do not relieve you of the responsibility for providing payment and timely requests for cancellation/termination to the plan.

Additional information can be found in the Member Agreement located in this booklet.

Paying for Your Care

Paying in the Provider's Office

A copayment, or copay, is a fixed amount you pay for a health service, such as a doctor's visit. If you owe a copayment, you need to pay it when you check in for your visit. Coinsurance is a percentage of the total cost of care that you also may need to pay. Network providers may have online tools to estimate your coinsurance costs. They can do this at the time of your visit. This lets you talk about costs with your provider before getting services. It also allows you to pay your share of the cost for services before leaving the office. Please note that copayments and coinsurance may not be required for some covered services.

The Explanation of Benefits

Once your claim is processed, you may receive an Explanation of Benefits (EOB) from us. The EOB is not a bill. It's a statement that gives you information about services you received. Services can be from physicians, facilities or other professional providers. The EOB also includes costs you may owe for these services.

The EOB includes:

- The provider's charge.
- The allowable amount.
- The copayment, deductible, and coinsurance amounts, if applicable, that you're required to pay.
- The total benefits payable.
- The total amount you owe.

You can get your EOB online by simply registering on the member website. Your EOB can also be mailed to you if that is your preference. If you do not owe a payment to the provider, you may not receive an EOB.

Filing Claims

A claim is a request you make for payment of the charges or costs for a covered service you received. If you receive services from a network provider, you do not have to file a claim. Your network provider takes care of that for you. If you go to an out-of-network provider, you may have to file the claim yourself. It is important to note that if you have an EPO or HMO plan, you only have coverage for emergency and urgent care when out-of-network. If you have to file the claim yourself, simply follow these easy steps:

1. Know your benefits. Review your Member Agreement to see if the services you received are eligible under your plan.

2. Get a detailed bill that includes:
   - The name and address of the service provider
   - The patient's full name
   - Date of service
   - Description of the service/supply
   - Amount charged
   - Diagnosis or nature of illness
   - Doctor's certification for durable medical equipment
   - Nurse's license number and shift worked for private duty nursing
   - Total mileage for ambulance services

Canceled checks, cash register receipts, or personal lists are not acceptable as bills.

3. Copy bills for your records. You must submit original bills. Once your claim is received, we cannot return bills.

4. Complete a claim form. Make sure all information is completed properly. Date the form. To download claim forms, go to **www.HighmarkBCBS.com,** click **Spending**, then **Forms Library**. You can also get a claim form by calling Member Service.

After you complete steps 1 through 4, attach all detailed bills to the claim form. Mail the form to the address on the form.

You can file multiple services for the same family member with one claim form. However, you must complete a separate claim form for each covered member. You must submit your claim no later than 15 months after the date you received services.

How to Submit a Complaint

You can submit a complaint if you are not satisfied with:

- Any part of your health care benefits
- A participating health care provider
- Coverage
- Operations
- Management policies

Please contact Member Service at the number on the back of your member ID card or by mail at the address listed below. Please include your identification and group numbers as displayed on your ID card.

For plans purchased on the Pennsylvania Insurance Exchange:
Highmark Blue Cross Blue Shield
Member Grievance
Attn: Review Committee
P.O. Box 1988
Parkersburg, WV 26102-1988

For all other plans:
Highmark Blue Cross Blue Shield
Member Grievance
Attn: Review Committee
P.O. Box 535095
Pittsburgh, PA 15253-5059

If this process does not meet your needs, your objection can be reviewed through an appeal process. Please refer to your Member Agreement in the back of this booklet for more details regarding your appeal rights. You may also call Member Service at the number on your member ID card.

Appeal Procedure

If you receive notification that your coverage has been rescinded or that a claim has been denied by Highmark, in whole or in part, you may appeal the decision. You can file an appeal in writing or on the phone by calling the Member Service number on the back of your member ID card. If you file in writing please include your identification and group numbers as displayed on your ID card. Mail your appeal to:

For plans purchased on the Pennsylvania Insurance Exchange:
Highmark Blue Cross Blue Shield
Member Grievance and Appeals
Attn: Review Committee
P.O. Box 1988
Parkersburg, WV 26102-1988

For all other plans:
Highmark Blue Cross Blue Shield
Member Grievance and Appeals
Attn: Review Committee
P.O. Box 535095
Pittsburgh, PA 15253-5059

If you decide to appeal by phone, you can call Member Service at the number on the back of your ID card. You must submit this appeal no later than 180 days from the date we notified you in order for your appeal to be reviewed. You should submit information to support your appeal.

We will review your appeal. You will be notified in writing of the appeal decision. Please refer to your Member Agreement in the back of this booklet for more details regarding your appeal rights.

Get Quality Care

Your plan pays for covered services, supplies, or medications that are medically necessary and appropriate. These might be to prevent, evaluate, diagnose, or treat an illness, injury, disease, or its symptoms. They must:

- Be generally accepted standards of medical practice.
- Be clinically appropriate in type, frequency, extent, site, and duration.
- Be considered effective for your illness, injury, or disease.
- Not be for your or your provider's convenience.
- Not be more costly than another service that may give you similar results.

If your care requires prior authorization, and you are receiving care from a BlueCard or out-of-network provider, you or your family will be responsible for contacting our Utilization Management (UM) team in Clinical Services to review the medical necessity of the service being requested. This includes inpatient and outpatient non-emergency care. This review helps to determine if a service, supplies, or medication are medically necessary and appropriate. For requests related to planned or non-emergency care, this review is done before the care is given. This must be done before your plan pays benefits. Your plan will not pay benefits if our team of doctors and nurses determine that the service, supplies, or medication are not medically necessary and appropriate.

Out-of-Network Services

Your plan does not include coverage for out-of-network services except in the case of emergencies or urgently needed care. If you choose to receive care from an out-of-network provider for a non-emergent or non-urgent situation, you will be responsible for all costs associated with that care. This includes if you are admitted as an inpatient to an out-of-network facility (provider) because of an emergency department visit and you refuse to be transferred to a network facility once your condition is stable. Your out-of-pocket costs will also include the charges from the out-of-network facility under these circumstances. If there are no network practitioners to provide the specialty care you need or located within a certain driving distance from you, we may consider approving that out-of-network care on a case-by-case basis before it is provided to you.

Out-of-network emergency care services

In a medical emergency when you think you need immediate treatment go directly to a hospital emergency room or call 911. Emergency care is care needed for the treatment of serious or life-threatening medical conditions that require immediate care. Emergency care is covered. You or your designated representative should contact Highmark Member Service at the number on the back of your member ID card and your PCP/POR after the crisis has passed. When emergency care is provided at an out-of-network facility, if you require hospitalization as

an inpatient, you may be stabilized and transferred to a network facility for care to be covered at the network level of benefits.

Please note: If you seek emergency care from an out-of-network provider, Highmark will ensure that you are not responsible for any amounts in excess of the Highmark payment, except for applicable deductible, coinsurance, and/or copayment required by your plan (i.e., pre-defined member responsibility). Providers may not balance bill you for charges beyond pre-defined member responsibility amounts, as required by your plan. If you should receive such a balance bill from an out-of-network provider for emergency care services, please contact Highmark immediately.

Out-of-network services requiring prior authorization
If you have a condition that is not life threatening but must be treated and cannot reasonably be postponed, your care that is medically necessary and appropriate will be covered - even if that provider is out-of-network. However, if the service or treatment requires authorization, you or your family may need to contact UM for medical necessity review.

Out-of-network providers are not obligated to contact UM. If they do, they do not have to accept UM's decision, if not approved. As a result, you may receive services that are considered not medically necessary and appropriate under your plan and therefore, may not covered. You could be responsible for the cost of those services, so it is important to understand your health plan coverage.

You or your designated representative should ask the out-of-network provider to request an authorization for these services. However, if your provider refuses that request, you or your designated representative should contact Highmark at the Member Service number on the back of your ID card.

Get Quality Service

How We Decide if a Technology or Drug Is Experimental

Medical researchers constantly experiment with new medical equipment, drugs, and other technologies. They also look for new applications for existing technologies. These could be for medical and behavioral health procedures, drugs, and devices.

A panel of medical professionals must evaluate these new technologies and new applications for existing technologies for:

- Safety
- Effectiveness
- Product efficiency

After these evaluations are completed, Highmark may recommend that the technology be considered a medical practice and a covered benefit. Or the technology may be considered "experimental or investigative." This technology is not generally covered. We may also reevaluate it in the future.

Evaluating New Drugs

A Pharmacy and Therapeutics (P&T) Committee composed of pharmacists and physicians evaluates new FDA-approved drugs based on items such as:

- National and international data
- Current research
- Opinions from leading clinicians

The review process addresses factors such as:

- Safety
- Drug effectiveness
- Unique value
- Patient compliance
- Local physician and specialist input
- Financial impact of the drug

The P&T Committee then makes a recommendation on the new FDA-approved drug.

You may decide to pursue an experimental or investigative treatment. If a service you are going to receive may be experimental or investigational, find out if it's covered. You, the hospital, or a professional provider can call Member Service about coverage for experimental or investigational medications.

If You Suspect Fraud or Provider Abuse

If you think that a provider is committing fraud, please let us know. Examples of fraud include, but are not limited to, the following:

- Submitting claims for services that you did not get.
- Adding extra charges for services that you did not get.
- Giving you treatment for services you did not need.

Please call the toll-free Fraud Hotline at 1-800-438-2478.

Your Rights and Responsibilities

As a Highmark member, you have certain rights and responsibilities as a part of your membership. These rights and responsibilities can enhance your health care benefits:

Your Rights

1. You have the right to get information about the following:
   - Our company, products, and services
   - Our doctors, facilities, and other professional providers
   - Your rights and responsibilities
2. You have the right to be treated with respect. You have the right to have your dignity and right to privacy recognized.
3. You have the right to make decisions about your health care with your providers. This includes identifying your problem, illness, or disease and treatment plan in words you can understand. You have the right to help make decisions about your care.
4. You have the right to openly discuss treatment decisions that are right and necessary for you. You have the right to do this without concern for cost or coverage. We do not restrict information shared between you and your providers. We have policies telling providers to openly discuss all treatment options with you.
5. You have the right to voice a complaint or appeal about your coverage or care. You have the right to get a reply in a reasonable amount of time.
6. You have the right to recommend rights and responsibilities to us.

Your Responsibilities

1. You have the responsibility to give us as much information as you can. We need this information to make care available to you. It's also what providers need to take care of you.
2. You have the responsibility to follow the plans and instructions for care that you agree to with your providers.
3. You have the responsibility to talk openly with the provider you choose. Ask questions. Make sure you understand explanations and instructions you get. Help develop treatment goals you agree to with your providers. Develop a trusting and cooperative relationship with your providers.

If you have any questions, please call Member Service at the number on the back of your identification card.

How We Protect Your Right to Privacy

We have policies and procedures to protect your privacy. This includes your Protected Health Information (PHI). PHI may be oral, written, or electronic.

- We do not discuss PHI outside of our offices.
- We confirm who you are before we discuss PHI on the phone.
- Our employees sign privacy agreements.
- Our employees use computer passwords to limit PHI access.
- We include privacy language in our provider contracts.

Highmark Notice of Privacy Practices

The Notice of Privacy Practices describes:

- How your medical information may be used and disclosed.
- How you can get access to this information.
- How we collect, use, and disclose non-public personal financial information.

To review our complete notice of privacy practices, please see the next page.

Sí necesita ayuda para traducir esta información, por favor comuníquese con el departamento de Servicios a miembros de Highmark al número al réves de su tarjeta de identificación de Highmark. Estos servicios están disponibles de lunes a viernes, de 8:00 a 19:00, y los sábados de 8:00 a 17:00.

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 Inc. ("Highmark"), we are committed to protecting the privacy of your "Protected Health Information" (PHI). PHI 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 are also required to notify affected individuals following a breach of unsecured health information.

We will inform you of these practices the first time you become a Highmark customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice becomes effective September 23, 2013, 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. Any change to this notice will be posted on our website and we will further notify you of any changes in our annual mailing.

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/payments 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.

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 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. **Miltary 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.

O. Underwriting

We may disclose your protected health information for underwriting purposes; however, we are prohibited from using or disclosing your genetic information for these purposes.

P. Health Information Exchange

We will participate in a Health Information Exchange (HIE). An HIE is primarily a secure electronic data sharing network. In accordance with federal and state privacy regulations, regional health care providers participate in the HIE to exchange patient information in order to facilitate health care, avoid duplication of services, such as tests, and to reduce the likelihood that medical errors will occur.

The HIE allows your health information to be shared among authorized participating healthcare providers, such as health systems, hospitals and physicians, for the purposes of Treatment, Payment or Healthcare Operations purposes. Examples of this health information may include:

- General laboratory, pathology, transcribed radiology reports and EKG Images.
- Results of outpatient diagnostic testing (GI testing, cardiac testing, neurological testing, etc.)
- Health Maintenance documentation/Medication
- Allergy documentation/Immunization profiles
- Progress notes/Urgent Care visit progress notes
- Consultation notes
- Inpatient operative reports
- Discharge summary/Emergency room visit discharge summary notes

All participating providers who provide services to you will have the ability to access your information. Providers that do not provide services to you will not have access to your information. Information may be provided to others as necessary for referral, consultation, treatment or the provision of other healthcare services, such as pharmacy or laboratory services. All participating providers have agreed to a set of standards relating to their use and disclosure of the information available through the HIE. Your health information shall be available to all participating providers through the HIE.

You cannot choose to have only certain providers access your information. Patients who do not want their health information to be accessible through the HIE may choose not to participate or may "opt-out."

In order to opt-out, you must call the customer service number located on the back of your membership card. You should be aware, if you choose to opt-out, your health care providers will not be able to access your health information through the HIE. Even if you

chose to opt-out, your information will be sent to the HIE, but providers will not be able to access this information. Additionally, your opt-out does not affect the ability of participating providers to access health information entered into the HIE prior to your opt-out submission.

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 Sometimes we are required to obtain your written authorization for use or disclosure of your health information. The uses and disclosures that require an authorization under 45 C.F.R. § 164.508(a) are:

1. For marketing purposes
2. If we intend to sell your PHI
3. For use of Psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. An Authorization for use of psychotherapy notes is required unless:

   a. Used by the person who created the psychotherapy note for treatment purposes, or

b. Used or disclosed for the following purposes:
   (i) the provider's own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;
   (ii) for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;
   (iii) if required for enforcement purposes;
   (iv) if mandated by law;
   (v) if permitted for oversight of the provider that created the note,
   (vi) to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or
   (vii) if needed to avert a serious and imminent threat to health or safety.

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, if you request the information in an electronic format that is not readily producible, we will provide the information in a readable electronic format as mutually agreed upon. 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. <u>Right to an Accounting</u>

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, 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222. 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. <u>Right to Request a Restriction</u>

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. We have a right to terminate this restriction, however if we do so, we must inform you of this restriction.

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, 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222. 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/ payments to the subscriber of the health plan in which you participate.

In the event that a Confidential Communication is placed against you, then you will no longer have the ability to access any of your health and/ or policy information online.

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: 1-412-544-4320
Address: 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222

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

Highmark Inc. 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 member 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/payments (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

<u>Information we may disclose and the purpose</u>: 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.

<u>How we protect information</u>: 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: 1-412-544-4320
Address: 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222

RCD-028 (12-18)

HIGHMARK BENEFITS GROUP INC.

An independent licensee of the Blue Cross Blue Shield Association

(hereinafter called "the Plan")

19 North Main Street
Wilkes-Barre, Pennsylvania 18711

INDIVIDUAL COMPREHENSIVE MAJOR MEDICAL EXCLUSIVE PROVIDER SUBSCRIPTION AGREEMENT IDENTIFIED AS MY PRIORITY BLUE FLEX EPO

("Agreement")

Required Outline of Coverage

Discrimination is Against the Law

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

The Plan:

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

If a member needs these services, the member should contact the Civil Rights Coordinator.

If a member believes that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, the member can file a grievance with: Civil Rights Coordinator, P.O. Box

22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. The member can file a grievance in person or by mail, fax, or email. If the member needs help filing a grievance, the Civil Rights Coordinator is available to help the member. The member can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

LANGUAGE ASSISTANCE SERVICES

If you speak English, language assistance services, free of charge, are available to you. Call 1-800-876-7639.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-800-876-7639.

如果您说中文，可向您提供免费语言协助服务。 請致電 1-800-876-7639.

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-800-876-7639.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-800-876-7639 로 전화.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-800-876-7639.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-800-876-7639.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-800-876-7639.

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-800-876-7639.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-800-876-7639.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-800-876-7639.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-800-876-7639.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-800-876-7639.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.

日本語が母国語の方は言語アシスタンス・ サービスを無料でご利用いただけます。 1−800−876−7639 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-800-876-7639 .

I. **READ YOUR AGREEMENT CAREFULLY** - This outline provides a very brief description of the important features of your Agreement. This is not the insurance contract and only the actual Agreement provisions will control. The Agreement itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR AGREEMENT CAREFULLY!

II. **COMPREHENSIVE MAJOR MEDICAL EXCLUSIVE PROVIDER EXPENSE COVERAGE** - Agreements of this category are designed to provide coverage for hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided at the network level of benefits with cost-sharing options such as deductibles, copayments, coinsurance amounts and benefit maximums.

Except for emergency care services and urgent care services, benefits are only provided for services received from network providers. Benefits for covered services are based on the network level at which the provider rendering such services is participating. Additionally, certain network services received from a network provider participating at the enhanced value level of benefits are provided at a higher level than network services received from a network provider participating at the standard value level of benefits. Network services are limited to the First Priority Life PPO Network, the ACA Select Network, the PremierBlue Shield Preferred Professional Provider Network and/or the Local PPO Network, depending upon where the member receives services.

Covered pediatric dental services are limited to the United Concordia Advantage Plus Provider Network and vision care services are limited to the Davis Vision Network. Benefits are subject to the Health Care Management Services Provision with possible loss of benefits for non-compliance. Benefits for emergency care services and urgent care services are provided at the network level of benefits.

III. **A BRIEF DESCRIPTION OF THE BENEFITS COVERED UNDER THE AGREEMENT IS AS FOLLOWS:**

A. ***Daily Hospital Room and Board*** - including a room with two (2) or more beds or a private room, when medically necessary and appropriate, and general nursing services.

B. ***Miscellaneous Hospital Services*** - including the use of medical equipment and specialty rooms, transplant services, services related to surgery and other usual and customary covered services such as drugs and medicines, diagnostic services, habilitative and rehabilitative services and therapy services not specifically excluded by the Agreement.

C. ***Surgical Services*** - including pre- and post-operative services, assistant at surgery, second surgical opinion and special surgical procedures which include oral surgery and mastectomy and breast cancer reconstruction.

D. ***Anesthesia Services*** - including the administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or

assistant at surgery. Benefits are provided for the administration of anesthesia for covered oral surgical procedures in an outpatient setting when ordered and administered by the attending professional provider.

E. ***In-Hospital Medical Services*** - including inpatient medical care visits, intensive medical care, concurrent care, consultations; mental health care and substance abuse treatment and routine newborn care.

F. ***Out-of-Hospital Care*** - including outpatient medical care visits and telemedicine services and specialist virtual visits; surgery of a non-dental nature; diagnostic services; chemotherapy; radiation therapy; pulmonary therapy; respiratory therapy; dialysis treatment; physical medicine; speech therapy; occupational therapy; infusion therapy; oral surgery; routine adult and pediatric care; pediatric immunizations; routine gynecological examinations and papanicolaou smears; annual screening mammograms for members age forty (40) and over, and for any physician recommended mammograms for members under age forty (40); well-woman care; services for mastectomy and breast cancer reconstructive surgery; diabetes treatment for all types of diabetes; preventive medications and prescription drugs when purchased from a participating pharmacy provider; and mental health care and substance abuse treatment. Out-of-hospital care also includes urgent care services, which are the treatment for an unexpected illness or injury, which is not life threatening, but which cannot be reasonably postponed.

G. ***Prosthetic Appliances*** - including the purchase, fitting, adjustments, repairs and replacements of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses); initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof; the purchase, fitting, adjustments, repairs and replacement of supportive device which restricts or eliminates motion of a weak or diseased body part; and the rental purchase, adjustment, repairs and replacement of durable medical equipment.

H. ***Other Benefits*** **-** including home health agency covered services for eligible members; inpatient care in a skilled nursing facility; birthing center coverage for prenatal, labor, delivery and postpartum care, pediatric vision care services when provided by a vision provider who is a network provider; orthodontic treatment for congenital cleft palates; dental services related to accidental injury; and general anesthesia and associated services normally related to the administration of general anesthesia rendered in connection with covered and non-covered dental procedures or non-covered oral surgery as mandated by law; pediatric dental services when provided by a dentist who is a network provider; and mental health care and substance abuse treatment.

I. ***Emergency Care Services*** - including the treatment of bodily injuries resulting from an accident, following the sudden onset of a medical condition or, following, in the case of a chronic condition, a sudden and unexpected medical event that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who

possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one or more of the following: 1) placing the member's health, or with respect to a pregnant member, the health of the member or the unborn child in serious jeopardy, 2) causing serious impairment to bodily functions, 3) causing serious dysfunction of any bodily organ or part and for which care is sought as soon as possible after the medical condition becomes evident to the member or the member's parent or guardian.

Transportation and other emergency services provided by an ambulance service shall constitute emergency ambulance services 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 does not satisfy the criteria above will not be covered as emergency ambulance services.

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

When the member requires emergency services, all benefits will be provided at the network services level of benefits. The member will not be responsible for any difference between the Plan payment and the provider's charge. In the event of an inpatient admission, either the member, provider or a family member must notify the Plan within forty-eight (48) hours of the admission, or as soon as reasonably possible. Once a member is stabilized, the Plan reserves the right to transfer the member's care from an out-of-network provider to a network provider.

J. ***Benefit Amounts, Durations, Maximums and Cost-Sharing for Covered Services Under the Agreement*** *-*

1. **Payment of Benefits**

   Benefit amounts are determined based on the plan allowance for covered services. The plan allowance is the allowance that the Plan utilizes to represent the value of covered services provided to a member based on the type of service and the provider who renders such service, or as required by law. The plan allowance is the portion of the provider's billed charge that is used by the Plan to calculate the Plan's payment to that provider and the member's liability.

   Benefit amounts for outpatient prescription drugs are determined based on the provider's allowable price for covered medications. The provider's allowable price is the amount at which the participating pharmacy provider has agreed with the Plan to provide covered medications and covered maintenance prescription drugs to members covered under the Agreement.

2. **Benefit Period, Deductible and Out-of-Pocket Maximum**

Subject to the exclusions, conditions, and limitations of the Agreement, including those specifically set forth in **SECTION HC - HEALTH CARE MANAGEMENT SERVICES** in the Agreement, a member is entitled to benefits for covered services during a benefit period as set forth in Paragraph 3 below. Benefits are also subject to deductible, copayment and coinsurance, if any, in the amounts described in Paragraph 3 below.

a. *Benefit Period* - the specified period of time during which charges for covered services must be incurred in order to be eligible for payment by the Plan. For this program, the benefit period is a calendar year. A member's effective date is the date on which coverage under this program commences for the member.

b. *Deductible*

Except where exempted by law or indicated in Paragraph 3 below, deductible amounts are applied to all covered services provided to a member during a benefit period.

i) The deductible applies to all covered services received during a benefit period from a network provider, except where exempted by law or as set forth in Paragraph 3 below.

ii) The Plan will begin to pay benefits for each member who satisfies their own individual deductible whether or not the entire family deductible is satisfied. The entire family deductible must be satisfied in one (1) benefit period by two (2) or more family members in order for the family to satisfy the family deductible. No individual member may satisfy the entire family deductible. Once the entire family deductible amount has been satisfied, the Plan will pay benefits for all remaining family members.

c. *Out-of-Pocket Maximum*

All out-of-pocket maximum amounts are based on plan allowance.

i) Individual Out-of-Pocket Maximum

When a member incurs deductible, copayment and/or coinsurance expenses for covered services furnished to the member in one (1) benefit period in the amount set forth in Paragraph 3 below, the benefits payable for claims received by the Plan for that member during the remainder of the benefit period will increase to one hundred percent (100%) of the plan allowance.

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

ii) Family Out-of-Pocket Maximum

When members under the same family coverage incur deductible, copayment and/or coinsurance expenses for covered services furnished to the members in one (1) benefit period in the amount set forth in Paragraph 3 below, the benefits payable for claims received by the Plan thereafter for all members under that same family coverage during the remainder of the benefit period will increase to one hundred percent (100%) of the plan allowance.

In the case of family coverage, no individual member may contribute deductible and coinsurance expenses greater than their individual out-of-pocket maximum. However, as each member reaches their individual out-of-pocket maximum, the benefits payable for that member will increase to one hundred percent (100%) of the plan allowance for the remainder of the benefit period, whether or not the family out-of-pocket maximum has been met.

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

3. **Schedule of Benefits for Covered Services and Cost-Sharing Amount**s

Benefits for covered services are based upon the plan allowance and include, but are not limited to, those covered services listed in this Schedule. See **SECTION DB - DESCRIPTION OF BENEFITS** in the Agreement for further explanation and additional limitations.

The deductible applies to all covered services, except where exempted by law or as otherwise indicated in this Schedule. Subject to the provisions of the Agreement, a member is responsible for payment of any cost-sharing amounts due to the provider after the amounts paid by the Plan hereunder.

The payment amount is based on the plan allowance at the time Services are rendered. The payments to a hospital or facility provider may be adjusted from time to time based on settlements with the providers. Such adjustments will not affect the member's deductible or coinsurance obligation.

SCHEDULE OF BENEFITS AND COST-SHARING AMOUNTS

PLAN: MY PRIORITY BLUE FLEX EPO GOLD 0		
BENEFIT PERIOD	Calendar Year	
DEDUCTIBLE		
Individual Deductible	$0	
Family Deductible	$0	
OUT-OF-POCKET MAXIMUM		
Individual Out-of-Pocket Maximum	$7,500	
Family Out-of-Pocket Maximum	$15,000	
COINSURANCE		
Plan Payment – payment based on the plan allowance or provider's allowable price	60% Plan Allowance	40% Plan Allowance

COVERED SERVICES	**NETWORK SERVICES**	
	ENHANCED VALUE	**STANDARD VALUE**
AMBULANCE SERVICES		
Emergency Ambulance Service	60% Plan Allowance Benefits for Emergency Ambulance Services rendered by an out-of-network provider will be paid at the network services level. The member will not be responsible for any amounts billed by the out-of-network provider that are in excess of the Plan Allowance.	
Non-Emergency Ambulance Service	60% Plan Allowance	40% Plan Allowance
ARTIFICIAL INSEMINATION	60% Plan Allowance	40% Plan Allowance
AUTISM SPECTRUM DISORDERS	NOTE: Certain Services for the treatment of Autism Spectrum Disorders described in **SECTION DB - DESCRIPTION OF BENEFITS**, **<u>AUTISM SPECTRUM DISORDERS</u>** Subsection of the Agreement, including but not limited to diagnostic services, pharmacy care, psychiatric and psychological care, rehabilitative care and therapeutic care, are also described as Services covered under other benefits as set forth in **SECTION DB - DESCRIPTION OF BENEFITS**. When Members receive such Services, they will be paid under the Agreement as specified in such other benefits. However, Services described as covered under the Agreement only when received in connection with the treatment of Autism Spectrum Disorders will be paid as set forth in this Paragraph.	
	60% Plan Allowance	40% Plan Allowance
DENTAL SERVICES		
Services for Accidental Injury and Covered and Non-Covered Dental Procedures	60% Plan Allowance	40% Plan Allowance
Pediatric Dental Services		
Pediatric Oral Examinations, Prophylaxis (Cleanings), Radiographs (x-rays), Fluoride Treatments, Sealants and Space Maintainers	100% Plan Allowance; Not subject to the deductible	
Palliative Treatment (Emergency)	60% Plan Allowance	
Other Pediatric Dental Services	50% Plan Allowance; Not subject to the deductible	
Important: See **SECTION DB - DESCRIPTION OF BENEFITS, <u>DENTAL SERVICES</u>** Subsection, Paragraph 3. Pediatric Dental Services, of the Agreement for the conditions and limitations which affect a member's pediatric dental coverage.		
DIABETES TREATMENT		
Equipment and Supplies	60% Plan Allowance	40% Plan Allowance
Diabetes Education Program	60% Plan Allowance	Not Applicable
Outpatient Prescription Drugs	Prescription Drugs are covered in accordance with the **<u>OUTPATIENT PRESCRIPTION DRUGS</u>**	

COVERED SERVICES	NETWORK SERVICES	
	ENHANCED VALUE	**STANDARD VALUE**
required for the treatment of Diabetes	section in this Outline of Coverage.	
DIAGNOSTIC SERVICES		
Advanced Imaging Services	100% Plan Allowance after $600 copayment	100% Plan Allowance after $800 copayment
Basic Imaging/Diagnostic Medical	100% Plan Allowance after $35 copayment	100% Plan Allowance after $50 copayment
Basic Lab/Pathology/Allergy Testing	100% Plan Allowance after $35 copayment	100% Plan Allowance after $50 copayment
The deductible and coinsurance amount, if any, does not apply to basic diagnostic services provided for preventive purposes in accordance with a predefined schedule based on age and sex described in **SECTION DB - DESCRIPTION OF BENEFITS**, **PREVENTIVE SERVICES** subsection of the Agreement.		
DURABLE MEDICAL EQUIPMENT	60% Plan Allowance	40% Plan Allowance
EMERGENCY CARE SERVICES	100% Plan Allowance after $300 copayment; Copayment is waived if the member is admitted as an inpatient. Benefits for Emergency Care Services rendered by an out-of-network provider will be paid at the network services level. The member will not be responsible for any amounts billed by the out-of-network provider that are in excess of the Plan Allowance	
ENTERAL FOODS	60% Plan Allowance	
HABILITATIVE AND REHABILITATIVE SERVICES		
Cardiac Rehabilitation	60% Plan Allowance	40% Plan Allowance
	Cardiac Rehabilitation does not include services provided for habilitative purposes	
Occupational Therapy and Physical Medicine	100% Plan Allowance after $45 copayment	100% Plan Allowance after $65 copayment
	Limited to a combined total of thirty (30) Outpatient Visits for rehabilitative purposes per Benefit Period and a combined total of thirty (30) Outpatient Visits for habilitative purposes per Benefit Period. This limit does not apply when services for habilitative purposes are prescribed for the treatment of Mental Illness or Substance Abuse	
Speech Therapy	100% Plan Allowance after $45 copayment	100% Plan Allowance after $65 copayment
	Limited to thirty (30) Outpatient Visits for rehabilitative purposes per Benefit Period and thirty (30) Outpatient Visits for habilitative purposes per Benefit Period. This limit does not apply when services for habilitative purposes are prescribed for the treatment of Mental Illness or Substance Abuse	
HOME HEALTH CARE SERVICES	60% Plan Allowance	40% Plan Allowance
	Limited to sixty (60) visits per benefit period.	
HOSPICE CARE SERVICES	60% Plan Allowance	40% Plan Allowance
	Respite Care is limited to seven (7) days every six (6) consecutive months	
HOSPITAL SERVICES		
Inpatient Services	60% Plan Allowance	40% Plan Allowance
Private Room Allowance	60% Plan Allowance For the most common semiprivate room charge; Private Room covered when Medically Necessary and Appropriate	40% Plan Allowance For the most common semiprivate room charge; Private Room covered when Medically Necessary and Appropriate
Surgery	60% Plan Allowance	40% Plan Allowance
Outpatient Services	60% Plan Allowance	40% Plan Allowance
Pre-Admission Testing		
Tests and studies other than Basic Diagnostic Services	60% Plan Allowance	40% Plan Allowance
Basic Imaging/ Diagnostic Medical Services performed as Preadmission Testing	100% Plan Allowance after $35 copayment	100% Plan Allowance after $50 copayment

COVERED SERVICES	NETWORK SERVICES	
	ENHANCED VALUE	**STANDARD VALUE**
Basic Lab/Pathology/Allergy Testing Services	100% Plan Allowance after $35 copayment	100% Plan Allowance after $50 copayment
Surgery	100% Plan Allowance after $250 copayment per visit	100% Plan Allowance after $300 copayment per visit
MATERNITY SERVICES	60% Plan Allowance	40% Plan Allowance
Maternity Home Health Care Visit	One (1) maternity home health care visit within forty-eight (48) hours of discharge when 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 is exempt from Coinsurance amounts.	
MEDICAL SERVICES		
Inpatient Medical Care Services		
Inpatient Medical Care Visits and Intensive Medical Care	60% Plan Allowance	40% Plan Allowance
Concurrent Care	60% Plan Allowance	40% Plan Allowance
Consultations	60% Plan Allowance	40% Plan Allowance
Newborn Care	60% Plan Allowance	40% Plan Allowance
Outpatient Medical Care Services Members may be responsible for a facility or clinic based coinsurance in addition to the professional provider charge if an office visit or service is provided at a hospital, facility provider, ancillary provider, retail clinic or urgent care center.		
Allergy extracts	60% Plan Allowance	40% Plan Allowance
Allergy injections	60% Plan Allowance	40% Plan Allowance
Medical Care Visits		
Primary Care Provider	100% Plan Allowance after $20 copayment per visit	100% Plan Allowance after $30 copayment per visit
Retail Clinic	100% Plan Allowance after $20 copayment per visit	100% Plan Allowance after $30 copayment per visit
Specialist Visit	100% Plan Allowance after $20 copayment	100% Plan Allowance after $30 copayment
Specialist Virtual Visit	100% Plan Allowance after $20 copayment	100% Plan Allowance after $30 copayment
Specialist Virtual Visit Provider Originating Site Fee	60% Plan Allowance	40% Plan Allowance
Urgent Care Center	100% Plan Allowance after $40 copayment per visit Benefits for urgent care services rendered by an out-of-network provider will be paid at the network services level. The member will not be responsible for any amounts billed by the out-of-network provider that are in excess of the Plan Allowance.	
Telemedicine Services	100% Plan Allowance	
Therapeutic Injections	60% Plan Allowance	40% Plan Allowance
Surgical Services		
Anesthesia	60% Plan Allowance	40% Plan Allowance
Assistant at Surgery	60% Plan Allowance	40% Plan Allowance
Second Surgical Opinion Services	60% Plan Allowance	40% Plan Allowance
Special Surgery	60% Plan Allowance	40% Plan Allowance
Surgery	100% Plan Allowance after $250 copayment per visit	100% Plan Allowance after $300 copayment per visit
MENTAL HEALTH CARE SERVICES		
Inpatient Care		
Facility Services	60% Plan Allowance	
Medical Services	60% Plan Allowance	
Outpatient Care	100% Plan Allowance after $20 copayment	
ORTHOTIC DEVICES	60% Plan Allowance	40% Plan Allowance
OUTPATIENT PRESCRIPTION DRUGS		
Retail Covered Medications		

COVERED SERVICES	NETWORK SERVICES	
	ENHANCED VALUE	STANDARD VALUE
NOTE: Certain retail participating pharmacy providers may have agreed to make maintenance prescription drugs available pursuant to the same terms and conditions, including cost-sharing and quantity limits, as the mail service coverage set forth in the Agreement. Members may contact the plan at the toll-free number or the website appearing on the back of the member's identification card for a listing of those retail participating pharmacy providers who have agreed to do so. NOTE: No Member cost-sharing will apply to self-administered chemotherapy medications including oral chemotherapy medications.		
Tier 1	100% provider's allowable price	
Tier 2	100% provider's allowable price after $30 copayment For each separate prescription order or refill, the member's copayment obligation is based on the day supply or the cost of the covered medication, whichever is lower. 31 day supply - 100% provider's allowable price after $30 copayment 32-60 day supply - 100% provider's allowable price after $60 copayment 61-90 day supply - 100% provider's allowable price after $90 copayment	
Tier 3	100% provider's allowable price after $150 copayment For each separate prescription order or refill, the member's copayment obligation is based on the day supply or the cost of the covered medication, whichever is lower. 31 day supply - 100% provider's allowable price after $150 copayment 32-60 day supply - 100% provider's allowable price after $300 copayment 61-90 day supply - 100% provider's allowable price after $450 copayment	
Tier 4	50% provider's allowable price; The member's minimum coinsurance obligation is $250 or the cost of the covered medication, whichever is lower, and the member's maximum coinsurance obligation is $1,000. For each separate prescription order or refill, the member's coinsurance obligation is based on the day supply or the cost of the covered medication, whichever is lower. 31 day supply - 50% provider's allowable price; The member's minimum coinsurance obligation is $250 or the cost of the covered medication, whichever is lower, and the member's maximum coinsurance obligation is $1,000. 32-60 day supply 50% provider's allowable price; The member's minimum coinsurance obligation is $500 or the cost of the covered medication, whichever is lower, and the member's maximum coinsurance obligation is $2,000. 61-90 day supply 50% provider's allowable price; The member's minimum coinsurance obligation is $750 or the cost of the covered medication, whichever is lower, and the member's maximum coinsurance obligation is $3,000.	
Continuous Glucose Monitoring Devices (Retail)	100% provider's allowable price after $150 copayment For each separate prescription order or refill for a sensor kit or transmitter kit up to a 90 day supply, the member's copayment obligation is based on the day supply or the cost of the covered medication, whichever is lower.	

COVERED SERVICES	NETWORK SERVICES	
	ENHANCED VALUE	STANDARD VALUE
	The receiver kit, which is limited to one (1) per Benefit Period, is subject to a copayment or the cost of the receiver, whichever is lower.	
Mail Ordered Covered Medication		
Tier 1	100% provider's allowable price	
Tier 2	100% provider's allowable price after $60 copayment For each separate prescription order or refill for up to a 90 day supply, the member's obligation is limited to this copayment or the cost of the medication, whichever is lower.	
Tier 3	100% provider's allowable price after $300 copayment For each separate prescription order or refill for up to a 90 day supply, the member's obligation is limited to this copayment or the cost of the medication, whichever is lower.	
Tier 4	50% provider's allowable price For each separate prescription order or refill for up to 90 day supply, the member's minimum coinsurance obligation is $500 or the cost of the covered medication, whichever is lower and the member's maximum coinsurance obligation is $2,000 Certain specialty prescription drugs, including those which must be obtained through an exclusive pharmacy provider, are limited to a day supply up to 31 days.	
Continuous Glucose Monitoring Devices (Mail Order)	100% provider's allowable price after $300 copayment For each separate prescription order or refill for a sensor kit or transmitter kit for up to a 90 day supply, the member's obligation is limited to this copayment or the cost of the sensor kit or transmitter kit, whichever is lower. The receiver kit, which is limited to one (1) per Benefit Period, is subject to this copayment or the cost of the receiver kit, whichever is lower.	
Important: The outpatient prescription drug coverage is subject to the conditions and limitations set forth in SECTION DB - DESCRIPTION OF BENEFITS of the Agreement.		
PREVENTIVE SERVICES Benefits are provided in accordance with a predefined schedule which is reviewed and updated periodically by the Plan based on the requirements of the Affordable Care Act and the advice of the American Academy of Pediatrics, U.S. Preventive Services Task Force, the Blue Cross Blue Shield Association and medical consultants. Accordingly, the frequency and eligibility of services is subject to change. Preventive Services benefits are exempt from deductibles, copayments and coinsurance.		
Adult Care	100% Plan Allowance	
Adult Immunization	100% Plan Allowance	
Diabetes Prevention Program	100% Plan Allowance	
Mammographic screenings	100% Plan Allowance	
Pediatric Care	100% Plan Allowance	
Pediatric Immunizations	100% Plan Allowance	
Preventive Covered Medications	100% Provider's Allowable Price NOTE: For the purposes of this Preventive Covered Medication Benefit Schedule, Network Services are those Services received from a Participating Pharmacy Provider	
Routine Gynecological Examination and Papanicolaou Smear	100% Plan Allowance	
Tobacco Use Counseling and Interventions	100% Plan Allowance	
Well-Woman Care	100% Plan Allowance	
PROSTHETIC APPLIANCES	60% Plan Allowance	40% Plan Allowance

COVERED SERVICES	NETWORK SERVICES	
	ENHANCED VALUE	**STANDARD VALUE**
SKILLED NURSING FACILITY SERVICES	60% Plan Allowance	40% Plan Allowance
	Limited to 120 days per Benefit Period	
SPINAL MANIPULATIONS	100% Plan Allowance after $45 copayment	100% Plan Allowance after $65 copayment
	Limited to 20 visits per Benefit Period	
SUBSTANCE ABUSE SERVICES		
Inpatient Care		
Facility Services	60% Plan Allowance	
Medical Services	60% Plan Allowance	
Outpatient Care	100% Plan Allowance after $20 copayment	
THERAPY SERVICES		
Chemotherapy	60% Plan Allowance	40% Plan Allowance
Dialysis Treatment	60% Plan Allowance	40% Plan Allowance
Infusion Therapy	60% Plan Allowance	40% Plan Allowance
Pulmonary Therapy	60% Plan Allowance	40% Plan Allowance
Radiation Therapy	60% Plan Allowance	40% Plan Allowance
Respiratory Therapy	60% Plan Allowance	40% Plan Allowance
TRANSPLANT SERVICES	60% Plan Allowance	40% Plan Allowance
VISION CARE SERVICES		
Pediatric Vision Care Services	100% Plan Allowance	
Comprehensive Routine Eye Examination	Limited to One (1) every twelve (12) consecutive months	
Eyeglass Frames	Limited to One (1) every twelve (12) consecutive months	
Eyeglass Lenses	Limited to One (1) every twelve (12) consecutive months	

IV. **EXCEPTIONS, REDUCTIONS, AND LIMITATIONS OF THE AGREEMENT**

A. ***Medically Necessary and Appropriate*** - "Medically necessary and appropriate" means services, medications 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: 1) in accordance with generally accepted standards of medical practice; 2) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and 3) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service, sequence of services or site of service at least as likely to produce equivalent therapeutic or diagnostic results given the nature of the patient's diagnosis, treatment, illness, injury or disease, the severity of the patient's symptoms, or other clinical criteria. Benefits under the Agreement for services, medications or supplies will be provided only when the Plan, utilizing the criteria set forth in the paragraph above, determines that such service, medication or supply is medically necessary and appropriate.

"Dentally necessary" means dental services determined by a dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the dentist and the prevailing standards of care in the professional community. This determination will be made by the dentist in accordance with guidelines established by the Plan.

B. ***Experimental/Investigative Treatments*** - The Plan does not cover services which it determines are experimental or investigative in nature, except as provided in the Agreement for routine patient costs incurred in connection with an approved clinical trial, because those services are not accepted by the medical community as effective treatments.

C. ***Health Care Management Services*** - A complete Health Care Management Service (HMS) Program requires review prior to non-emergency inpatient admissions and outpatient procedures or services to determine the medical necessity and appropriateness of the admission, place of services, or covered services ("precertification").

D. ***Plan Payment and Member Liability*** -

The Plan uses the plan allowance to calculate the benefit payable and the financial liability of the member for medically necessary and appropriate services covered under the Agreement. In the case of outpatient prescription drug benefits, the Plan uses the provider's allowable price. Plan allowance and the provider's allowable price are set forth in Section III, Subsection ***J. Benefit Amounts, Durations, Maximums and Cost-Sharing for Covered Services Under the Agreement.***

1. **Plan Payment**

The Plan's payment is determined by first subtracting any deductible and/or copayment from the plan allowance. The coinsurance percentage of the plan allowance set forth in Section III., Subsection ***J. Benefit Amounts, Durations, Maximums and Cost-Sharing for Covered Services Under the Agreement*** is then applied to that amount. This amount represents the Plan's payment. Any remaining coinsurance amount is the member's responsibility.

2. **Member Liability**

The member's total liability is the sum of any deductible, copayment and/or member coinsurance obligation. Network providers will accept the Plan's payment plus the member's total liability as payment in full for the covered services provided to the member. When a member receives services from an out-of-network provider, the out-of-network provider may hold the member responsible for the entire out-of-network provider's billed amount.

There may be instances when a network facility provider participating at the enhanced value level of benefits may have an arrangement with a professional provider participating in the network at the standard value level of benefits to render certain professional covered services to the patients of the network facility provider. The selection of a professional provider participating in the network at the standard value level of benefits may be beyond the patient's control. In such case, claims for covered services rendered by the professional provider will be subject to member cost-sharing amounts applicable to the enhanced value level of benefits.

In the event that a member requires non-emergency covered services that are not available within the network, the Plan may refer the member to an out-of-network provider. In such cases, services will be covered at the enhanced value level of benefits and the liability of the member will be limited to the enhanced value coinsurance amount plus any deductible and/or copayment obligations. The member will not be responsible for any difference between the Plan payment and the provider's charge. Additionally, there are some instances where a member may not have the opportunity to make a provider selection. In such cases, claims for covered services will be processed to apply enhanced value level of benefits cost-sharing amounts and the Plan will prohibit balance billing by the provider to the member.

3. **Outpatient Prescription Drug Benefits**

   The Plan's payment for covered medications from a participating pharmacy provider is determined by first subtracting any deductible and/or copayment liability from the provider's allowable price. The coinsurance percentage of the provider's allowable price set forth in Section III., Subsection ***J. Benefit Amounts, Durations, Maximums and Cost_Sharing for Covered Services Under the Agreement*** is then based on that amount once the deductible, if any, has been satisfied. Any remaining coinsurance amount is the member's responsibility subject to any minimum and maximum coinsurance amount set forth in Subsection J. The member's total liability is the sum of any deductible, copayment and coinsurance obligations, if any. The Plan's payment for preventive covered medications is 100% of the provider's allowable price. No benefits are payable for covered medications purchased from a pharmacy provider who is not a network provider. Coverage is not provided for prescription drugs and over-the-counter drugs not appearing on the formulary, unless an exception has been granted pursuant to the prescription drug exceptions process described in the Agreement.

4. **Plan Payment for Vision Care Services**

   The plan allowance for vision providers who are network providers within or outside of Pennsylvania is the amount agreed to by such vision provider as payment in full, as set forth in the agreement between the provider and the Plan.

5. **Plan Payment for Pediatric Dental Services**

   The plan allowance for dentists who are network providers within or outside Pennsylvania is the amount agreed to by such dentist as payment in full, as set forth in the agreement between the dentist and the Plan.

E. ***Exclusions*** - Except as specifically provided in the Agreement, or as the Plan is mandated or required to pay based on state or federal law, no benefits will be provided for services, supplies, prescription drugs or charges:

1. Which are not medically necessary and appropriate as determined by the Plan;

2. Which are not prescribed by or performed by or upon the direction of a professional provider;

3. Rendered by other than providers and suppliers;

4. Which are experimental/investigative in nature, except as provided in the Agreement for routine patient costs incurred in connection with an approved clinical trial;

5. Rendered prior to the member's effective date;

6. Incurred after the date of termination of the member's coverage except as provided in the **BENEFITS AFTER TERMINATION OF COVERAGE** Subsection of **SECTION GP - GENERAL PROVISIONS** of the Agreement;

7. For loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of an act of war whether declared or undeclared;

8. For which a member would have no legal obligation to pay;

9. Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;

10. To the extent payment has been made under Medicare when Medicare is primary;

11. For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease, or similar type legislation. This exclusion applies whether or not the member files a claim for said benefits or compensation;

12. To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service-connected illness or injury, unless the member has a legal obligation to pay;

13. For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such 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;

14. For nicotine cessation support programs and classes for nicotine cessation purposes, except as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule in this Outline of Coverage;

15. Which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same member;

16. Rendered by a provider who is a member of the member's immediate family;

17. Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program;

18. For ambulance services, except as provided in Section III, Subsection ***J.*** in this Outline of Coverage;

19. For a cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except: a) as otherwise provided in **SECTION DB – DESCRIPTION OF BENEFITS** of the Agreement; b) when required to correct a condition directly resulting from an accident; c) when necessary to correct a functional impairment which directly results from a covered disease or injury; or d) to correct a congenital birth defect;

20. For telephone consultations which do not involve telemedicine services, charges for failure to keep a scheduled visit, or charges for completion of a claim form;

21. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider;

22. For inpatient admissions which are primarily for diagnostic studies or for physical medicine;

23. For custodial care, domiciliary care, protective and supportive care including educational services, rest cures and convalescent care;

24. For respite care, except as provided in Section III, Subsection ***J.*** in this Outline of Coverage;

25. 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 including, but not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except as provided in **SECTION DB - DESCRIPTION OF BENEFITS** of the Agreement;

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

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

28. For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;

29. Related to treatment provided specifically for the purpose of assisted reproductive technology, including pharmacological or hormonal treatments used in conjunction with assisted reproductive technology;

30. For sterilization, except as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule in this Outline of Coverage;

31. For reversal of sterilization;

32. For impotency treatment drugs;

33. For oral impotency drugs;

34. For fertility drugs except as provided in the **ARTIFICIAL INSEMINATION** subsection of the **SECTION DB - DESCRIPTION OF BENEFITS** of the Agreement;

35. For contraceptive services including contraceptive prescription drugs, contraceptive devices, implants and injections and all related services, except when provided for purposes other than birth control, or as set forth in a predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule in this Outline of Coverage;

36. Except for preventive covered medications set forth in a predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule in this Outline of Coverage and which are prescribed for preventive purposes, the following drugs or services are not covered:

    a. Drugs and supplies that can be purchased without a prescription order;

    b. Over-the-counter drugs which are not set forth in a predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule in this Outline of Coverage and are not prescribed for preventive purposes;

    c. Topical antifungals;

    d. Antitussives (cough/cold);

    e. Charges for administration of prescription drugs and/or injectable insulin whether by a physician or other person;

f. Charges for a prescription drug when such drug or medication is used for unlabeled or unapproved indications where such use has not been approved by the Food and Drug Administration (FDA);

g. Topical acne retinoid products when prescribed for cosmetic purposes such as to minimize the appearance of facial wrinkles, facial mottled hyperpigmentation, hypopigmentation associated with photoaging, and facial skin roughness;

h. Hair growth stimulants;

i. Compounded medications;

37. For services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments and prenatal/delivery/postnatal services;

38. For private duty nursing services;

39. For weight control drugs and services intended to produce weight loss, except as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule in this Outline of Coverage;

40. For nutritional counseling, except as provided herein or as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule in this Outline of Coverage;

41. For weight reduction programs, including all diagnostic testing related to weight reduction programs, except as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule in this Outline of Coverage;

42. For the treatment of obesity, except as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule in this Outline of Coverage;

43. For prescription vitamins, except vitamins prescribed during pregnancy, and fluoride legend vitamins, or as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule in this Outline of Coverage;

44. For any eye examinations or vision care services, except as provided herein and for any eye examinations or vision care services rendered by a physician or professional provider who is not a vision provider who is a network provider;

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

46. For any food including, but not limited to, enteral foods, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis, except as provided in the **ENTERAL FOODS** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** in the Agreement;

47. For preventive care services, wellness services or programs, except as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule in this Outline of Coverage;

48. For allergy testing, except as provided in Section III, Subsection ***J*** in this Outline of Coverage, or as mandated by law;

49. For routine or periodic physical examinations, except as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule in this Outline of Coverage, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, except as mandated by law;

50. For immunizations required for foreign travel or employment, except as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule in this Outline of Coverage;

51. For outpatient habilitative and rehabilitative services for which there is no expectation of acquiring, restoring, improving or maintaining a level of function;

52. For treatment of sexual dysfunction not related to organic disease or injury;

53. For any care that is related to conditions such as learning disabilities, behavioral problems or intellectual disabilities, but not including care related to autism spectrum disorders, which extends beyond traditional medical management or medically necessary and appropriate inpatient confinement. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education, 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 related to the treatment of learning disorders or learning disabilities; and d) services provided primarily for social or environmental change or for respite care;

54. For any care that is related to autism spectrum disorders which extends beyond traditional medical management, except as otherwise provided in **SECTION DB - DESCRIPTION OF BENEFITS** of the Agreement. Care which extends beyond

traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education, 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; and c) services provided primarily for respite care;

55. For any care, treatment, or service which has been disallowed under the provisions of the Health Care Management Services Program;

56. For any care, treatment or service for any loss sustained or contracted in consequence of the member's being intoxicated, or under the influence of any narcotic unless administered on the advice of a physician;

57. For any care, treatment or service for any loss to which a contributing cause was the member's commission of or attempt to commit a felony or to which a contributing cause was the member's being engaged in an illegal occupation;

58. For otherwise covered services ordered by a court or other tribunal unless medically necessary and appropriate or if the reimbursement of such services is required by law;

59. For acupuncture services;

60. For elective abortions, except those abortions necessary to avert the death of the member or terminate pregnancies caused by rape or incest;

61. For the following services or charges related to pediatric dental services, except as specifically provided in the Agreement:

    a. For treatment started prior to the member's effective date or after the termination date of coverage under the Agreement, (including, but not limited to, multi-visit procedures such as endodontics, crowns, fixed partial dentures, inlays, onlays, and dentures);

    b. For house or hospital calls for dental services and for hospitalization costs (including, but not limited to, facility-use fees);

    c. For prescription and non-prescription drugs, vitamins or dietary supplements;

    d. Cosmetic in nature as determined by the Plan (including, but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures);

    e. Elective procedures (including, but not limited to, the prophylactic extraction of third molars);

f. For congenital mouth malformations or skeletal imbalances (including, but not limited to, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment). This exclusion does not apply to the treatment of medically diagnosed congenital defects or birth abnormalities of a newborn child or newly adopted children, regardless of age;

g. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Agreement. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint;

h. For treatment of fractures and dislocations of the jaw;

i. For treatment of malignancies or neoplasms;

j. Services and/or appliances that alter the vertical dimension (including, but not limited to, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method;

k. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances;

l. Periodontal splinting of teeth by any method;

m. For duplicate dentures, prosthetic devices or any other duplicative device;

n. Maxillofacial prosthetics;

o. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions;

p. For treatment and appliances for bruxism (night grinding of teeth);

q. For any claims submitted to the Plan by the member or on behalf of the member in excess of twelve (12) months after the date of service;

r. Incomplete treatment (including, but not limited to, patient does not return to complete treatment) and temporary services (including, but not limited to, temporary restorations);

s. Procedures that are:

   i) part of a service but are reported as separate services;

ii) reported in a treatment sequence that is not appropriate; or

iii) misreported or which represent a procedure other than the one reported.

t. Specialized procedures and techniques (including, but not limited to, precision attachments, copings and intentional root canal treatment);

u. Service not dentally necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Plan will apply;

v. Fees for broken appointments;

w. For other pediatric dental services not set forth in **SECTION DB - DESCRIPTION OF BENEFITS** of the Agreement; and

x. For the following orthodontic services:

i) Treatments that are primarily for cosmetic reasons;

ii) Treatments for congenital mouth malformations or skeletal imbalances (including, but not limited to, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment); and

iii) Diagnostic services and treatment of jaw joint problems by any method unless specifically covered as set forth in **SECTION DB - DESCRIPTION OF BENEFITS** of the Agreement. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jawbone and the complex of muscles, nerves and other tissues related to the joint;

62. For oral surgery procedures, except as provided in **SECTION DB - DESCRIPTION OF BENEFITS** of the Agreement;

63. For prescription drugs and over-the-counter drugs not appearing on the formulary, except where an exception has been granted pursuant to the procedure set forth in **SECTION HC - HEALTH CARE MANAGEMENT SERVICES**, Subsection D. **HEALTH CARE MANAGEMENT SERVICES**, Paragraph 10. **Prescription Drug Exceptions** in the Agreement;

64. For bariatric surgery including reversal, revision, repeat and staged surgery, except for the treatment of sickness or injury resulting from such bariatric surgery;

65. For a diabetes prevention program offered by other than a network diabetes prevention provider;

66. For any tests, screenings, examinations or any other services solely required by an employer or governmental agency or entity in order to begin or to continue working or as a condition to performing the functions of any employment in a particular setting or location; and

67. For any other medical or dental service or treatment or prescription drug except as provided in this Outline of Coverage or as mandated by law.

V. TERMS AND CONDITIONS OF THE RENEWABILITY OF THE AGREEMENT

A. ***Guaranteed Renewable*** - The Agreement is guaranteed renewable. Coverage begins on the effective date of the Agreement and continues until the end of the calendar year. Thereafter, the coverage renews annually. The Agreement will remain in effect until terminated in accordance with the terms and conditions of the Agreement. Non-renewal shall not be based on the deterioration of the mental or physical health of any individual, covered under the Agreement, or on a member's medically necessary and appropriate utilization of services covered under the Agreement

B. ***Termination*** -

1. The Agreement may be terminated by the subscriber by giving appropriate written notice to the Plan. Notice should be given no less than fourteen (14) days prior to the requested termination date.

2. The Agreement is guaranteed renewable and cannot be terminated without consent of the subscriber except in the following instances:

   a. If payment of the appropriate premium is not made when due, or during the grace period, coverage will terminate on the last day of the grace period unless an earlier date is required by law.

      When coverage under the Agreement is provided pursuant to enrollment through the exchange and the subscriber receives advance payments of premium tax credits (APTCs), failure of the Plan to receive payment of APTCs shall not be grounds for terminating the Agreement when the subscriber has made payment of his or her portion of the premium when due.

   b. If a subscriber in obtaining coverage, or in connection with coverage hereunder, has performed an act or practice constituting fraud or intentional misrepresentation of a material fact (e.g., misuse of the member identification card), coverage will terminate immediately. However, the Plan will not terminate the Agreement because of a subscriber's medically necessary and appropriate utilization of services covered under the Agreement.

c. Coverage will terminate upon ninety (90) days' notice to the subscriber when the Plan discontinues this coverage, and offers to each individual the option to purchase any other individual health insurance coverage then available from the Plan in the geographic area where the subscriber resides, or upon one hundred eighty (180) days' notice to the member when the Plan discontinues all individual coverage within the plan service area.

d. In the event the subscriber no longer lives in the geographic area in which the product represented by the Agreement is available from the plan, coverage will terminate on the last day of the month for which the premium has been accepted.

3. When coverage provided under the Agreement is provided pursuant to enrollment through the exchange, coverage will terminate in the following additional circumstances:

   a. The subscriber provides appropriate notice of voluntary termination to the exchange in which case coverage will terminate effective on the date specified by the exchange.

   b. The subscriber is no longer eligible for coverage through the exchange in which case coverage will terminate effective:

      i) the last day of the month following the month in which notice of ineligibility is sent by the exchange, unless an earlier termination date is requested by the member; or

      ii) in the case where the subscriber is determined to be newly eligible for Medicaid, CHIP or basic health plan coverage, the last day of coverage under the Agreement shall be the day before such new coverage begins.

   c. The qualified health plan through which coverage under the Agreement is provided terminates or is decertified.

   d. The subscriber elects to enroll in a different qualified health plan during an applicable annual open enrollment period, limited open enrollment period or special enrollment period in which case coverage under the Agreement will terminate the day before coverage under the new qualified health plan begins.

4. If the Agreement is terminated at the option of either party, the Plan shall refund to the subscriber the amount of any unearned prepaid premium held by the Plan. Unearned prepaid premium in any amount less than one ($1.00) dollar shall not be refunded unless specifically requested by the subscriber.

C. ***Modification/Premium Subject to Change*** - Coverage begins on the effective date of the Agreement and continues until the end of the calendar year. Thereafter, the coverage

renews annually at the premium for the age which each member has attained on the date of each subsequent renewal. The Plan, subject to the approval of the Pennsylvania Insurance Department, may alter or revise the terms of the Agreement or the premiums. Any such alteration or revision of the terms of the Agreement shall become applicable for all members on the effective date of the alteration or revision, whether or not the subscriber has paid the premium in advance.

HIGHMARK BENEFITS GROUP INC.*

19 North Main Street
Wilkes-Barre, Pennsylvania 18711

INDIVIDUAL COMPREHENSIVE MAJOR MEDICAL EXCLUSIVE PROVIDER SUBSCRIPTION AGREEMENT IDENTIFIED AS MY PRIORITY BLUE FLEX EPO

("Agreement")

GUARANTEED RENEWABLE PREMIUM SUBJECT TO CHANGE ON A CLASS BASIS

(see Page 83 of this Agreement)

DESCRIPTION OF COVERAGE: This Agreement sets forth a comprehensive program of inpatient and outpatient facility, professional and ancillary provider benefits. Cost-sharing options are available such as deductible, copayments, and/or coinsurance. Except for emergency care services and urgent care services, benefits are only provided for services performed by network providers as defined in this Agreement. If covered services other than emergency care services and urgent care services are not available from a network provider, preauthorization from the plan must be obtained to receive services from an out-of-network provider. Benefits for covered services are based on the network level at which the provider rendering such services is participating. Additionally, certain network services received from a network provider participating at the enhanced value level of benefits are provided at a higher level than network services received from a network provider participating at the standard value level of benefits. Network providers can participate at the standard value or enhanced value levels and benefits are increased at each level, respectively. Network services are limited to the First Priority Life PPO Network, the ACA Select Network, the Premier Blue Shield Preferred Professional Provider Network and/or the Local PPO Network, depending upon where the member receives services. Benefits for pediatric dental services are only available through the United Concordia Advantage Plus Provider Network and benefits for pediatric vision care services are only available through the Davis Vision Network. A gatekeeper is not required to access benefits. This program includes individual and family deductibles, coinsurance and copayment amounts. Benefits are subject to the Health Care Management Services provisions with possible loss of benefits for non-compliance. This Agreement is non-participating in any divisible surplus of premium.

Subscriber's Right to Examine Agreement for Ten (10) Days

The Subscriber shall have the right to return the Agreement within ten (10) days of its delivery and to have the premium rate refunded if, after examination of the Agreement, the Subscriber is not satisfied for any reason.

Brian D. Setzer
Executive Vice-President,
Government Markets & Portfolio Management

*An independent licensee of the Blue Cross Blue Shield Association

Discrimination is Against the Law

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

The Plan:

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

    If a Member needs these services, the Member should contact the Civil Rights Coordinator.

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

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

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

LANGUAGE ASSISTANCE SERVICES

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

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

请注意： 如果您说中文， 可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY： 711）。

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

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

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

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

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

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

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

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

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

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

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

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

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

INDIVIDUAL COMPREHENSIVE MAJOR MEDICAL
EXCLUSIVE PROVIDER SUBSCRIPTION AGREEMENT
IDENTIFIED AS MY PRIORITY BLUE FLEX EPO

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Highmark Benefits Group Inc.

(hereinafter called "the Plan")

Individual Comprehensive Major Medical
Exclusive Provider Subscription Agreement
Identified as my Priority Blue Flex EPO

In consideration for and upon payment of the appropriate premium, the persons covered under this Agreement are entitled to health care benefits set forth herein in accordance with the terms and conditions of this Agreement. A newborn child of a Member, whether natural born, adopted, or placed for adoption will also be entitled to health care benefits set forth herein in accordance with the terms and conditions of this Agreement from the moment of birth to a maximum of thirty-one (31) days from the date of birth.

Guaranteed Renewable Premium Subject to Change on a Class Basis

Subject to the approval of the Pennsylvania Insurance Department, the Plan may adjust premiums on a class basis. Premium amounts due under this Agreement are based on the attained age of each Member as of the Effective Date and on the date of each subsequent renewal. Premiums are payable in advance on a monthly basis. Members may submit amounts in excess of the specific premium amount. However, such excess amounts will be applied on a monthly basis and the application of such excess amounts will not guarantee the continuation of coverage in the event of the loss of eligibility in accordance with **SECTION SE - SCHEDULE OF ELIGIBILITY** of this Agreement. Coverage will be subject to premium increases on the date the increase becomes effective.

Coverage begins on the Effective Date and continues until the end of the calendar year. Thereafter, the coverage renews annually. The Agreement will remain in effect until terminated by the Subscriber or the Plan in accordance with the **TERMINATION OF THE MEMBER'S COVERAGE UNDER THE AGREEMENT** Subsection of **SECTION GP - GENERAL PROVISIONS**. Non-renewal shall not be based on the deterioration of mental or physical health of any individual covered under this Agreement.

IMPORTANT NOTICE

Regarding Treatment Which the Plan Determines is Not Medically Necessary and Appropriate

The Plan only provides benefits for Covered Services which it determines to be Medically Necessary and Appropriate. Medical Necessity and Appropriateness of Covered Services may be determined either prior to the service being rendered or after the service has been rendered.

A Network Provider located In-Area will accept the Plan's determination of Medical Necessity and Appropriateness and not bill the Member for Services which the Plan determines are not Medically Necessary and Appropriate, except when the Member elects to receive the Services after being advised that the Services have been determined not to be Medically Necessary and Appropriate. A Provider who is not a Network Provider is not obligated to accept the Plan's determination and therefore may bill the Member for all Services regardless of whether such services are Medically Necessary and Appropriate. The Member is solely responsible for payment of such Services. The Member can avoid this responsibility by choosing a Network Provider. If a Member has a concern about a Service being covered, the Member should contact the Plan prior to the Service being rendered.

For any questions regarding the Medical Necessity and Appropriateness of a service, the Member may contact the Plan at the toll-free telephone number on the Member Identification Card.

See **SECTION DE - DEFINITIONS** of this Agreement for the definition of Medically Necessary and Appropriate and **SECTION HC - HEALTH CARE MANAGEMENT SERVICES** of this Agreement for additional information.

Regarding Experimental/Investigative Treatments

The Plan does not cover services which it determines are Experimental or Investigative in nature, except as provided herein for Routine Patient Costs Incurred in connection with an Approved Clinical Trial, because those services are not accepted by the medical community as effective treatments. However, the Plan acknowledges that situations exist when a patient and the patient's Professional Provider agree to pursue an Experimental treatment. If the Member's Provider performs an Experimental procedure, the Member is responsible for the charges. The Member or the Member's Professional Provider may contact the Plan to determine whether a service is considered Experimental or Investigative.

See **SECTION DE - DEFINITIONS** of this Agreement for the definition of Experimental/ Investigative.

SECTION DE - DEFINITIONS

1. **ACA SELECT NETWORK** - all ACA Select Network Providers approved as a network by the Pennsylvania Department of Health that have entered into a network agreement, either directly or indirectly, with the Plan to provide health care Services to Members under this Agreement.

2. **ACA SELECT NETWORK PROVIDER** - an Ancillary Provider, Professional Provider or a Facility Provider that has an agreement, either directly or indirectly, with the Plan pertaining to payment as a Network participant for Covered Services rendered to a Member.

3. **ACA SELECT NETWORK SERVICE AREA** - the geographic area consisting of the following counties in Pennsylvania:

Allegheny	Clarion	Franklin	Schuylkill
Armstrong	Crawford	Greene	Somerset
Beaver	Cumberland	Lancaster	Warren
Berks	Dauphin	Lebanon	Washington
Blair	Erie	Lehigh	Westmoreland
Butler	Fayette	Northampton	
Cambria	Forest	Perry	

4. **ADVANCE PAYMENT OF PREMIUM TAX CREDITS (APTCs)** - tax credit payments made on behalf of the Member to the Plan, on an advance basis and in amounts as determined by the Exchange, which are applied to the premium amounts due under this Agreement.

5. **AFFORDABLE CARE ACT (ACA)** - the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) and its implementing regulations.

6. **AGREEMENT** - this Agreement, including the application and endorsements, if any, between the Plan and the Subscriber, the Member's enrollment confirmation letter, the Member's current Identification Card, the Outline of Coverage and the Highmark Preventive Schedule, as amended from time to time.

7. **AMBULANCE SERVICE** - an Ancillary Provider licensed by the state which, for compensation from its patients, provides local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured. Ambulance Service includes an emergency medical services (EMS) agency licensed by the state.

8. **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.

9. **ANCILLARY PROVIDER** - a person or entity licensed where required and performing services within the scope of such licensure. Ancillary Providers include, but are not limited to:

   Ambulance Service
   Clinical Laboratory
   Diabetes Prevention Provider
   Home Infusion Therapy Provider
   Independent Diagnostic Testing Facility (IDTF)
   Suite Infusion Therapy Provider
   Supplier

10. **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.

11. **ANNUAL OPEN ENROLLMENT PERIOD** - the annual period during which an eligible individual may enroll for coverage under this Agreement.

12. **APPLIED BEHAVIORAL ANALYSIS** - the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

13. **APPROVED CLINICAL TRIAL** - a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that has been federally funded, authorized or approved by one of the following:

   a. the National Institutes of Health (NIH), including the National Cancer Institute (NCI);

   b. the United States Food and Drug Administration (FDA) in the form of an investigational new drug (IND) exemption;

   c. the United States Department of Defense (DOD);

d. the United States Department of Veterans Affairs (VA);

e. the Centers for Disease Control and Prevention (CDC);

f. the Agency for Healthcare Research and Quality (AHRQ);

g. the Centers for Medicare and Medicaid Services (CMS);

h. the Department of Energy; or

i. a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support.

The Plan may, at its discretion, approve other clinical trials that do not satisfy the above criteria.

14. **ARTIFICIAL INSEMINATION** - a procedure, also known as intrauterine insemination (IUI) or intracervical/intravaginal insemination (ICI), by which sperm is directly deposited into the vagina, cervix or uterus to achieve fertilization and pregnancy.

15. **ASSISTED REPRODUCTIVE TECHNOLOGY** - includes all treatments or procedures that involve the in vitro (i.e., outside of the living body) handling of both human oocytes (eggs) and sperm, or embryos, for the purpose of establishing a pregnancy. Treatments and procedures include, but are not limited to, in vitro fertilization (IVF) and embryo transfer, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), tubal embryo transfer (TET), peritoneal ovum sperm transfer, zona drilling, sperm microinjection, gamete and embryo cryopreservation (freezing), oocyte and embryo donation, and gestational surrogacy or carrier, but does not include artificial insemination in which sperm are placed directly into the vagina, cervix or uterus.

16. **AUTISM SERVICE PROVIDER** - a Professional Provider and Facility Provider licensed or certified, where required, and performing within the scope of such license or certification providing treatment for Autism Spectrum Disorders, pursuant to a treatment plan, as set forth in **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement.

17. **AUTISM SPECTRUM DISORDERS** - any disorder defined as an autism spectrum disorder by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor.

18. **BARIATRIC SURGERY** - an operation on the stomach and/or intestines intended to help promote weight loss including, but not limited to, vertical banded gastroplasty, gastric stapling, laparoscopic adjustable gastric banding, mini-gastric bypass, gastric bypass with Roux-en-Y, biliopancreatic diversion, biliopancreatic diversion with duodenal switch, long-limb gastric bypass, intestinal gastric bypass, or any other surgical procedure designed to restrict an individual’s ability to assimilate food.

19. **BEHAVIOR SPECIALIST** - an individual licensed or certified, where required, and performing within the scope of such licensure or certification, who designs, implements or evaluates a behavior modification intervention component of a treatment plan for the treatment of Autism Spectrum Disorders, including those based on Applied Behavioral Analysis, to produce socially significant improvements in human behavior or to prevent loss of attained skill or function through skill acquisition and the reduction of problematic behavior.

20. **BENEFIT PERIOD** - the specified period of time during which this Agreement provides health care coverage for Members, and during which charges for Covered Services must be Incurred in order to be eligible for payment by the Plan. For purposes of this Agreement, a Benefit Period is a calendar year.

21. **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 is under the supervision of a Nurse-Midwife.

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

23. **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 the Plan.

24. **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.

25. **CHEMOTHERAPY MEDICATION** - a medication prescribed to kill or slow the growth of cancerous cells.

26. **CLAIM** - a request made by or on behalf of a Member for Precertification or prior approval of a Covered Service, as required under this Agreement, 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 provided under this Agreement include:

    a. Pre-service Claim - a request for Precertification or prior approval of a Covered Service which, as a condition to the payment of benefits under this Agreement, must be approved by the Plan before the Covered Service is received by the Member.

    b. Urgent Care Claim - a Pre-service Claim which, if decided within the time periods established by the Plan for making non-urgent care Pre-service Claim decisions,

could seriously jeopardize the life or health of the Member, the ability of the Member to regain maximum function or, in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the Service requested. Whether a request involves an Urgent Care Claim will be determined by the Member's attending Physician or Provider.

c. Post-service Claim - a request for payment or reimbursement of the charges or costs associated with a Covered Service that has been received by a Member.

For purposes of the Claim determination and appeal procedure provisions of this Agreement, whether a Claim or an 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 appeal is filed with the Plan in accordance with its procedures for filing Claims and appeals.

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

28. **CLINICAL SOCIAL WORKER** - a licensed Clinical Social Worker performing within the scope of such licensure. Where there is no licensure law, the Clinical Social Worker must be certified by the appropriate professional body.

29. **COINSURANCE** - the percentage of the Plan Allowance for Covered Services that is the responsibility of the Member. The remaining percentage is the responsibility of the Plan, subject to the provisions of the Agreement.

30. **COPAYMENT** - a specified dollar amount of eligible expenses which the Member is required to pay for a specified Covered Service and which will be deducted from the Plan Allowance before the determination of the benefits payable under this Agreement is made.

31. **COST-SHARING REDUCTIONS** - reductions as determined by the Exchange in the cost-sharing amounts for which the Member is otherwise responsible to pay under this Agreement.

32. **COVERED MEDICATIONS** - Prescription Drugs and Over-the-Counter Drugs ordered by a Professional Provider by means of a valid Prescription Order which the Plan is contractually obligated to pay or provide as a benefit to a Member.

33. **COVERED SERVICE** - a Service or supply, including vision care services, specified in this Agreement which is eligible for payment when rendered by a Provider or Supplier.

34. **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. Multiple non-Skilled Nursing Services/non-Skilled Rehabilitation Services in the aggregate do not constitute Skilled Nursing

Services/Skilled Rehabilitation Services. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparing special diets and supervising the administration of medications not requiring Skilled Nursing Services/Skilled Rehabilitation Services provided by trained and licensed medical personnel.

35. **DEDUCTIBLE** - a specified dollar amount of liability for Covered Services that must be Incurred before the Plan will assume any liability for all or part of the remaining Covered Services.

36. **DENTALLY NECESSARY** - dental services determined by a Dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the Dentist and the prevailing standards of care in the professional community. The determination will be made by the Dentist in accordance with guidelines established by the Plan.

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

38. **DEPENDENT** - a Member other than the Subscriber as specified in **SECTION SE - SCHEDULE OF ELIGIBILITY** of this Agreement.

39. **DESIGNATED AGENT** - an entity that has contracted with the Plan, either directly or indirectly, to perform a function and/or Service in the administration of this Agreement. Such function and/or Service may include, but is not limited to, medical management.

40. **DESIGNATED MAIL-ORDER PHARMACY PROVIDER** - a Participating Pharmacy Provider which has been selected by the Plan as a Designated Mail-Order Pharmacy Provider and has entered into an agreement, either directly or indirectly, with the Plan to provide Covered Prescription Drugs to Members under the Agreement at a contractually agreed upon price (Provider's Allowable Price).

41. **DETOXIFICATION SERVICES (WITHDRAWAL MANAGEMENT SERVICES)** - Inpatient and Outpatient Services for the treatment of withdrawal from alcohol or drugs. Inpatient Services must include twenty-four hour nursing care and Physician oversight.

42. **DIABETES EDUCATION PROGRAM** - an Outpatient program of self-management training and education, including medical nutrition therapy, for the treatment of diabetes. Such Outpatient program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education Services will be covered subject to the criteria of the Plan. These criteria are based on the certification programs for Outpatient diabetes education developed by the American Diabetes Association and the Pennsylvania Department of Health.

43. **DIABETES PREVENTION PROGRAM** - a twelve (12) month program utilizing a curriculum approved by the Centers for Disease Control to deliver a prevention lifestyle intervention for individuals at high risk of developing type 2 diabetes. The Diabetes Prevention Program includes behavioral and motivational content focusing on moderate changes in both diet and physical activity.

44. **<u>DIABETES PREVENTION PROVIDER</u>** - an entity that offers a Diabetes Prevention Program.

45. **<u>DIAGNOSTIC SERVICE</u>** - a testing procedure ordered by a Professional Provider because of specific symptoms to determine a definite condition or disease or for the purpose of routine screening. Diagnostic Services covered under this Agreement are set forth in **SECTION DB - DESCRIPTION OF BENEFITS**.

46. **<u>DIETICIAN-NUTRITIONIST</u>** - a licensed dietician-nutritionist performing within the scope of such licensure. Where there is no licensure law, the dietician-nutritionist must be certified by the appropriate professional body.

47. **<u>DOMESTIC PARTNER</u>** - a member of a Domestic Partnership consisting of two (2) partners, each of whom has registered with a domestic partner registry in effect in the municipality/governmental entity within which the domestic partner currently resides or who meets the definition of a domestic partner as defined by the state or local government where the individual currently resides or meets all of the following:

    a. is unmarried, at least eighteen (18) years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time;

    b. is not related to the other partner by adoption or blood;

    c. is the sole domestic partner of the other partner and has been a member of this Domestic Partnership for the last six (6) months;

    d. agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and

    e. meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for Domestic Partnerships which are currently enacted, or which may be enacted in the future.

48. **<u>DOMESTIC PARTNERSHIP</u>** - a voluntary relationship between two (2) Domestic Partners.

49. **<u>DURABLE MEDICAL EQUIPMENT</u>** - items which can withstand repeated use, are primarily and customarily used to serve a productive medical purpose, are generally not useful to a person in the absence of illness, injury or disease, are appropriate for use in the home and do not serve as comfort or convenience items.

50. **<u>EFFECTIVE DATE</u>** - according to **SECTION SE - SCHEDULE OF ELIGIBILITY**, the date on which coverage for a Member begins under this Agreement.

51. **<u>EMERGENCY CARE SERVICES</u>** - the treatment:

    a. of bodily injuries resulting from an accident;

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 layperson 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:

i) placing the Member's health or, with respect to a pregnant Member, the health of the Member or the unborn child in serious jeopardy;

ii) causing serious impairment to bodily functions; or

iii) causing serious dysfunction of any bodily organ or part;

and for which care is sought as soon as possible after the medical condition becomes evident to the Member, or the Member's parent or guardian.

Transportation and other emergency services provided by an Ambulance Service shall constitute Emergency Ambulance Services 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 does not satisfy the criteria above will not be covered as Emergency Ambulance Services.

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

52. **ENHANCED VALUE** – the level of Network benefits characterized by reduced Member cost-sharing for Covered Services.

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

54. **EXCHANGE (HEALTH INSURANCE MARKETPLACE)** - the approved governmental agency or non-profit entity performing required public exchange functions as set forth in the Affordable Care Act. The term includes state exchanges, regional exchanges, subsidiary exchanges, and a federally-facilitated exchange.

55. **EXCLUSIVE PHARMACY PROVIDER** - a Pharmacy Provider performing within the scope of its license that has an agreement, either directly or indirectly, with the Plan pertaining to the payment and exclusive dispensing of selected Prescription Drugs as set forth in this Agreement, provided to a Member.

56. **EXPERIMENTAL/INVESTIGATIVE** - the use of any treatment, Service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by the Plan to be medically effective for the condition being treated.

The Plan will consider an intervention to be Experimental/Investigative if:

a. the intervention does not have FDA approval to be marketed 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 and 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 to be in accordance with the above criteria at a later date.

57. **FACILITY PROVIDER** - an entity which is licensed, where required and performing within the scope of such licensure, to render Covered Services. Facility Providers include:

Ambulatory Surgical Facility
Birthing Facility
Freestanding Dialysis Facility
Freestanding Nuclear Magnetic Resonance Facility/Magnetic Resonance Imaging Facility
Home Health Care Agency
Hospice
Hospital
Outpatient Physical Rehabilitation Facility
Outpatient Psychiatric Facility
Outpatient Substance Abuse Treatment Facility
Pharmacy Provider
Psychiatric Hospital
Rehabilitation Hospital
Residential Treatment Facility
Skilled Nursing Facility
State-Owned Psychiatric Hospital
Substance Abuse Treatment Facility

58. **FAMILY COUNSELING** - counseling with family members in the assessment of the patient's diagnosis and treatment. Such counseling may assist family members to gain insight into the patient's illness and serve as an adjunct of the treatment regimen. Nevertheless, the Services must primarily relate to the management of the patient's illness.

59. **FAMILY COVERAGE** - coverage for the Subscriber and one (1) or more Dependents.

60. **FAMILY DEDUCTIBLE** - a specified dollar amount of liability for Covered Services that must be Incurred by one (1) or more family members, who are covered under this

Agreement, before the Plan will assume any liability for all or part of the remaining Covered Services. Once the Family Deductible is met, no further Deductible amounts must be satisfied by any covered family member.

61. **FIRST PRIORITY LIFE PPO NETWORK** – all First Priority Life PPO Providers, approved as a network by the Pennsylvania Department of Health, that have entered into a network agreement, either directly or indirectly, with the Plan to provide health care Services to Members under this Agreement.

62. **FIRST PRIORITY LIFE PPO PROVIDERS** – an Ancillary Provider, Professional Provider or a Facility Provider that has an agreement, either directly or indirectly, with the Plan pertaining to payment as a Network participant for Covered Services rendered to a Member.

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

64. **FREESTANDING DIALYSIS FACILITY** - a Facility Provider licensed and approved by the appropriate governmental agency 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.

65. **FREESTANDING NUCLEAR MAGNETIC RESONANCE FACILITY/ MAGNETIC RESONANCE IMAGING FACILITY** - a Facility Provider which, for compensation from its patients, is primarily engaged in providing, through an organized professional staff, nuclear magnetic resonance/magnetic resonance imaging scanning. These facilities do not include Inpatient beds, medical or health-related Services.

66. **GENERIC DRUG** - a drug that is available from more than one (1) 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 the Plan.

67. **HABILITATIVE AND REHABILITATIVE SERVICES** - the following Services or supplies ordered by a Professional Provider to promote the restoration, maintenance or improvement in the level of function following disease, illness or injury. This also includes therapies to achieve functions or skills never acquired due to congenital and developmental anomalies. Habilitative and Rehabilitative Services are covered to the extent specified in the Outline of Coverage.

    a. Cardiac Rehabilitation - the physiological rehabilitation of patients with cardiac conditions through regulated exercise, diet and other lifestyle modification programs.

    b. Occupational Therapy - the treatment by means of constructive activities designed and adapted to promote the ability to satisfactorily accomplish the ordinary tasks of daily living and those required by a particular occupational role.

c. 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.

d. Speech Therapy - the treatment for the correction of a speech impairment.

68. **HEALTH CARE MANAGEMENT SERVICES** - a program which integrates all activity related to managing a Member's medical care from the time that an admission, surgical or diagnostic procedure, or certain services become necessary. The program consists of any applicable pre-admission Certification, Certification of Emergency Admissions, Outpatient Procedure or Covered Service Precertification, Continued Stay Review, Discharge Planning, and Individual Case Management.

69. **HIGHMARK BLUE SHIELD** - an independent licensee of the Blue Cross Blue Shield Association. Any reference to Highmark Blue Shield may also include its designated agents with whom Highmark Blue Shield has contracted to perform a function or service.

70. **HIGHMARK INC. (HIGHMARK**) - an independent licensee of the Blue Cross Blue Shield Association. The Plan is a wholly owned subsidiary of Highmark.

71. **HOME HEALTH CARE AGENCY** - a Facility Provider or Hospital 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.

72. **HOME INFUSION THERAPY PROVIDER** - an Ancillary Provider licensed by the state, accredited by The Joint Commission, if appropriate, and organized to provide Infusion Therapy to patients at their place of residence.

73. **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.

74. **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.

75. **HOSPITAL** - a duly licensed Facility Provider that is a general or special Hospital which has been approved by Medicare, The Joint Commission or by the American Osteopathic Hospital Association, and 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, and

b. provides twenty-four (24)-hour nursing services by or under the supervision of Registered Nurses.

76. **IDENTIFICATION CARD** - the currently effective card issued to the Member by the Plan.

77. **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, son-in-law, grandchild, grandparent, stepparent, stepbrother or stepsister.

78. **IN-AREA** – the geographic area covering the Plan Service Area and the ACA Select Network Service Area.

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

80. **INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF)** - an Ancillary Provider operating from a fixed or mobile location, which performs diagnostic testing services, other than clinical laboratory or pathology testing, using diagnostic testing and imaging equipment including, but not limited to, sleep centers/home sleep testing providers, mobile x-ray providers and cardiac event monitoring providers, and other diagnostic imaging providers. Such technical services do not include the interpretation of test results by a Professional Provider.

81. **INDIAN** – an individual that meets the requirements of section 4(d) of the Indian Self-Determination and Education Assistance Act (Pub. L. 93-638).

82. **INDIAN HEALTH SERVICE (IHS) PROVIDER** - the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization as defined in 25 U.S.C. §1603.

83. **INFUSION THERAPY** - the administration of Medically Necessary and Appropriate fluid or medication via a central or peripheral vein to patients.

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

85. **INTENSIVE OUTPATIENT PROGRAM** - a time-limited, separate and distinct Outpatient program that includes individual therapy, family therapy, group therapy and medication management following an individualized treatment plan. Participation in an Intensive Outpatient Program may involve two (2) or more hours of programming a week. The program may be offered during the day or evening hours and can be a step-

down from a higher level of care or a step-up to prevent the need for a higher level of care. The goals of an Intensive Outpatient Program are to prevent or reduce the need for Inpatient hospitalization and to reduce or stabilize symptoms and functional impairment of a psychiatric or co-occurring substance use disorder. Medically necessary treatment is provided within a structured therapeutic milieu.

86. **LIMITED OPEN ENROLLMENT PERIOD** - a period during which an eligible individual who experiences certain qualifying events may enroll or change enrollment in the coverage provided under this Agreement when such coverage is not provided pursuant to enrollment through the Exchange. Limited Open Enrollment Periods are provided to individuals who experience qualifying events, which applicable federal law, regulations and guidance have determined result in limited open enrollment period rights.

87. **LOCAL PPO NETWORK** - all Ancillary Providers, Facility Providers, Professional Providers and Suppliers who have an agreement, either directly or indirectly, with any licensee of the Blue Cross Blue Shield Association located Out-of-Area pertaining to payment as a participant in that licensee's PPO network for Covered Services rendered to a Member under this Agreement.

88. **MAINTENANCE PRESCRIPTION DRUG** - a Prescription Drug ordered by a Physician by means of a valid Prescription Order to be taken on a regular basis to stabilize an on-going condition, such diabetes or hypertension. Maintenance Prescription Drugs exclude those Prescription Drugs where home delivery through a Designated Mail-Order Pharmacy Provider is not appropriate such as, but not limited to, acute care medications.

89. **MARRIAGE AND FAMILY THERAPIST** - a licensed Marriage and Family Therapist performing within the scope of such licensure. Where there is no licensure law, the Marriage and Family Therapist must be certified by the appropriate professional body.

90. **MAXIMUM** - the greatest amount for which the Plan may be liable for Covered Services within a prescribed period of time. This could be expressed in number of days or number of Services.

91. **MEDICAL CARE** - professional services rendered by a Professional Provider for the treatment of an illness or injury.

92. **MEDICALLY NECESSARY AND APPROPRIATE (MEDICAL NECESSITY AND APPROPRIATENESS)** – Services, medications 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, sequence of services or site of service at least as likely to produce equivalent therapeutic or diagnostic results given the nature of the patient's diagnosis, treatment, illness, injury or disease, the severity of the patient's symptoms, or other clinical criteria.

The Plan reserves the right, utilizing the criteria set forth in this Definition, to render the final determination as to whether a Service, medication or supply is Medically Necessary and Appropriate. No benefits hereunder will be provided unless the Plan determines that the Service, medication or supply is Medically Necessary and Appropriate.

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

94. **MEDICATION SYNCHRONIZATION** - the coordination of Prescription Drug filling or refilling by a pharmacist or dispensing Physician for a Member taking two or more Maintenance Prescription Drugs for the purpose of improving medication adherence.

95. **MEMBER** - an individual who meets the eligibility requirements specified in **SECTION SE - SCHEDULE OF ELIGIBILITY** of this Agreement.

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

97. **NETWORK** – depending on where the Member receives Services, the network is designated as one (1) of the following:

a. When the Member receives Services within the Plan Service Area, the designated network for Professional Providers, Facility Providers and Ancillary Providers is the First Priority Life PPO Network.

b. When the Member receives Services within the ACA Select Network Service Area, the designated network for Professional Providers, Facility Providers and Ancillary Providers is the ACA Select Network.

c. When the Member receives Services in Bucks, Chester, Delaware, Montgomery and Philadelphia Counties in eastern Pennsylvania, the designated network for Professional Providers is the PremierBlue Shield Preferred Professional Provider Network and the designated network for Facility Providers is the Local PPO Network. Also included are Ancillary Providers who have an agreement, directly or indirectly, with the Plan pertaining to payment for Covered Services rendered to a Member as a network participant.

d. When the Member receives Services outside Pennsylvania, the designated network for Professional Providers and Facility Providers is the Local PPO Network. Also included are Ancillary Providers who have an agreement, directly or indirectly, with the Plan pertaining to payment for Covered Services rendered to a Member as a network participant.

e. Notwithstanding the above, when a Member receives Pediatric Dental Services, the designated network is the United Concordia Advantage Plus Provider Network. When a Member receives vision care services, the designated network is the Davis Vision Network. When a Member receives Outpatient Prescription Drugs or Telemedicine Services, the network is designated by the Plan.

For the purposes of this definition, when a Member receives services from a Clinical Laboratory, the Member is deemed to receive Services at the site where the specimen is collected from the Member.

Within Pennsylvania, no network is available outside of the Plan Service Area, the ACA Select Network Service Area and Bucks, Chester, Delaware, Montgomery and Philadelphia Counties.

98. **NETWORK DIABETES PREVENTION PROVIDER** - a Diabetes Prevention Provider that contracts with:

a. the Plan to offer a Diabetes Prevention Program based on a digital model; or

b. the Plan or the local licensee of the Blue Cross Blue Shield Association to offer a Diabetes Prevention Program based on an in-person/onsite model.

99. **NETWORK FACILITY PROVIDER** - a Facility Provider that has an agreement, either directly or indirectly, with the Plan pertaining to payment as a Network participant for Covered Services rendered to a Member.

100. **NETWORK PROVIDER** - an Ancillary Provider, Professional Provider or Facility Provider that has entered into an agreement, either directly or indirectly, with the Plan pertaining to payment as a Network participant for Covered Services rendered to a Member.

101. **NETWORK SERVICE** - a Service, treatment or care that is provided by a Network Provider. For purposes of this Agreement this includes Covered Medications provided by a Participating Pharmacy Provider.

102. **NURSE-MIDWIFE** - a licensed Nurse-Midwife. Where there is no licensure law, the Nurse-Midwife must be certified by the appropriate professional body.

103. **OCCUPATIONAL THERAPIST** - a licensed Occupational Therapist performing within the scope of such licensure. Where there is no licensure law, the Occupational Therapist must be certified by the appropriate professional body.

104. **OFFICE BASED OPIOID TREATMENT PROGRAM** - an Outpatient treatment program for the treatment of opioid use disorder. This program is also known as medication assisted treatment.

105. **OPIOID TREATMENT PROGRAM** - an Outpatient treatment program for the treatment of severe opioid use disorder. The program consists of daily or several times

weekly medication and counseling available to maintain stability for those with severe opioid use disorder.

106. **OUTLINE OF COVERAGE** - the document provided by the Plan to the Member summarizing some of the more significant provisions of the Agreement and which set forth applicable cost-sharing for benefits.

107. **OUT-OF-AREA** - the geographic area comprised of Bucks, Chester, Delaware, Montgomery and Philadelphia Counties in Pennsylvania and the geographic area outside of Pennsylvania.

108. **OUT-OF-NETWORK PROVIDER** - a Provider who does not have an agreement, either directly or indirectly, with the Plan pertaining to payment as a Network participant for Covered Services provided to a Member.

109. **OUT-OF-NETWORK SERVICE** - a Service, treatment or care that is provided by an Out-of-Network Provider.

110. **OUT-OF-POCKET-MAXIMUM** - a specified dollar amount of Deductible, Coinsurance, and Copayment expenses, if any, Incurred by a Member for Covered Services in a Benefit Period, after which the level of benefits payable by the Plan is increased to one hundred percent (100%) of the Plan Allowance such that the Member will not be liable for any additional Deductible, Coinsurance or Copayment expenses in that Benefit Period.

111. **OUTPATIENT** - a Member who receives Services or supplies while not an Inpatient.

112. **OUTPATIENT PHYSICAL REHABILITATION FACILITY** - a Facility Provider which, for compensation from its patients, is primarily engaged in providing a variety of Habilitative and Rehabilitative services on an Outpatient basis.

113. **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.

114. **OUTPATIENT SUBSTANCE ABUSE TREATMENT FACILITY** - a Facility Provider which, for compensation from its patients, is primarily engaged in providing Detoxification Services and/or rehabilitative counseling services for the treatment of Substance Abuse and Diagnostic and Therapeutic Services for the treatment of Substance Abuse on an Outpatient basis. This facility must also meet the minimum standards set by the Pennsylvania Department of Health, the Pennsylvania Office of Drug and Alcohol Programs, or another appropriate governmental agency.

115. **OVER-THE-COUNTER DRUG** - a select non-prescription Brand or Generic Drug which is therapeutically similar to available federal legend products or such non-prescription drug that the Plan deems clinically appropriate.

116. **PARTIAL HOSPITALIZATION -** the provision of medical, nursing, counseling or therapeutic Mental Health Care Services or Substance Abuse Services on a planned and

regularly scheduled basis in a Facility Provider, designed for a patient or client who would benefit from more intensive services than are generally offered through Outpatient treatment but who does not require Inpatient care.

117. **PARTIAL HOSPITALIZATION PROGRAM -** a time-limited, Outpatient treatment program that is offered in the day or evening hours for a minimum of four (4) hours per day, three (3) days per week. A Partial Hospitalization Program is a less restrictive alternative to Inpatient hospitalization for individuals presenting with acute symptoms of a severe psychiatric disorder who cannot be effectively or safely treated in a lower level of care, and would otherwise require Inpatient treatment. The goals of a Partial Hospitalization Program are to prevent or reduce the need for Inpatient hospitalization or re-hospitalization following discharge from Inpatient treatment and to reduce or stabilize symptoms and functional impairment of a psychiatric or co-occurring substance use disorder. Medically necessary treatment is provided within a structured therapeutic milieu.

118. **PARTICIPATING PHARMACY PROVIDER** - a Pharmacy Provider that has an agreement, either directly or indirectly, with the Plan pertaining to the payment of Covered Medications or specific devices provided to a Member. To the extent permitted by state and federal law, Participating Pharmacy Providers with the capability to provide certain immunizations as specified by the Plan, may also receive payment under the agreement for such immunizations and for the administration thereof, provided to Members.

119. **PHARMACY PROVIDER** - a Facility Provider licensed by the state and performing within the scope of such licensure, which is engaged in dispensing Prescription Drugs through a licensed pharmacist.

120. **PHYSICAL THERAPIST** - a licensed Physical Therapist. Where there is no licensure law, the Physical Therapist must be certified by the appropriate professional body.

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

122. **PLAN** - refers to Highmark Benefits Group Inc., which is an independent licensee of the Blue Cross Blue Shield Association. Any reference to the Plan may also include its Designated Agent as defined herein and with whom the Plan has contracted to perform a function or service in the administration of this Agreement.

123. **PLAN ALLOWANCE** - the amount used to determine payment by the Plan for Covered Services provided to a Member as set forth in the Outline of Coverage, and to determine Member liability. Plan Allowance is based on the type of Provider who renders such Services or as required by law.

In the case of a Network Provider, the Plan Allowance is the contractual allowance for Covered Services rendered by a Network Provider in a specific geographic region. A Network Provider will accept the Plan Allowance, plus any Member liability, as payment in full for Covered Services.

In the case of a Provider located Out-of-Area, the Plan Allowance shall be determined, for other than pediatric dental and vision care and telemedicine Covered Services, based on prices received from the local licensee of the Blue Cross Blue Shield Association in accordance with the Plan's participation set forth in the **INTER-PLAN ARRANGEMENTS** Subsection in **SECTION GP - GENERAL PROVISIONS** of this Agreement.

The Plan Allowance for a Facility Provider that is a State-Owned Psychiatric Hospital is what is required by law.

The Plan Allowance for a VA Facility Provider is what is required by law.

124. **PLAN SERVICE AREA** - the geographic area consisting of the following counties in northeastern Pennsylvania:

Bradford	Lycoming	Susquehanna
Carbon	Monroe	Tioga
Clinton	Pike	Wayne
Lackawanna	Sullivan	Wyoming
Luzerne		

125. **PRECERTIFICATION (CERTIFICATION)** - a process whereby the Medical Necessity and Appropriateness of Inpatient admissions, Services or place of Services is determined by the Plan prior to, or after, an admission or the performance of a procedure or Service.

126. **PREMIERBLUE SHIELD PREFERRED PROFESSIONAL PROVIDER** - a Professional Provider who has an agreement, either directly or indirectly, with the Plan or Highmark Blue Shield pertaining to payment as a Network participant for Covered Services rendered to a Member.

127. **PREMIERBLUE SHIELD PREFERRED PROFESSIONAL PROVIDER NETWORK** – all PremierBlue Shield Preferred Professional Providers, approved as a network by the Pennsylvania Department of Health, who have an agreement, either directly or indirectly, with the Plan or Highmark Blue Shield to provide health care Services to Members.

128. **PRESCRIPTION DRUG** - any drug or medication ordered by a Professional Provider by means of a valid Prescription Order, bearing the federal legend: "Caution - Federal law prohibits dispensing without a prescription," or a legend drug under applicable state law and dispensed by a licensed pharmacist. Also included are prescribed insulin and other pharmacological agents used to control blood sugar, diabetic supplies and insulin syringes, as well as compounded medications, consisting of the mixture of at least two (2) ingredients other than water, one of which must be a legend drug.

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

130. **PRIMARY CARE PROVIDER (PCP)** - a Physician whose practice is limited to family practice, general practice, internal medicine or pediatrics, or a certified registered nurse practitioner each of whom has an agreement with the Plan pertaining to payment as a Network participant and has specifically contracted with the Plan to: a) be designated as a PCP; b) supervise, coordinate and provide specific basic medical services to Members; and c) maintain continuity of patient care.

131. **PROFESSIONAL COUNSELOR -** a licensed Professional Counselor performing within the scope of such licensure. Where there is no licensure law, the Professional Counselor must be certified by the appropriate professional body.

132. **PROFESSIONAL PROVIDER** - a person or practitioner licensed where required and performing Services within the scope of such licensure. The Professional Providers are:

Audiologist
Behavior Specialist
Certified Registered Nurse
Chiropractor
Clinical Social Worker
Dentist
Dietician-Nutritionist
Licensed Practical Nurse
Marriage and Family Therapist
Nurse-Midwife
Occupational Therapist
Optometrist
Physical Therapist
Physician
Podiatrist
Professional Counselor
Psychologist
Registered Nurse
Respiratory Therapist
Speech-Language Pathologist

133. **PROVIDER** - an Ancillary Provider, Facility Provider or Professional Provider, licensed where required and performing within the scope of such licensure.

134. **PROVIDER'S ALLOWABLE PRICE (PAP)** - the amount at which the Participating Pharmacy Provider has agreed with the Plan, either directly or indirectly, to provide Covered Medications to Members covered under this Agreement.

135. **PSYCHIATRIC HOSPITAL** - a Facility Provider approved by The Joint Commission, the American Osteopathic Hospital Association, Council on Accreditation or Commission on Accreditation of Rehabilitation Facilities which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

136. **PSYCHOLOGIST** - a licensed Psychologist. When there is no licensure law, the psychologist must be certified by the appropriate professional body.

137. **QUALIFIED HEALTH PLAN** - a health plan, including coverage provided under this Agreement, which has been certified by the Exchange as meeting the standards of a qualified health plan as defined under the Affordable Care Act.

138. **REHABILITATION HOSPITAL** - a Facility Provider approved by The Joint Commission or by the Commission on Accreditation of Rehabilitation Facilities or

certified by Medicare which, for compensation from its patients, is primarily engaged in providing Skilled Rehabilitation Services on an Inpatient basis.

139. **RESIDENTIAL TREATMENT FACILITY** - a licensed psychiatric residential facility that provides medical monitoring and twenty-four hour individualized treatment to a group of individuals. The treatment is provided by paid staff unrelated to the individual.

A Residential Treatment Program must provide the following:

a. Awake adult supervision twenty-four hours per day;

b. Clinical assessment at least once a day;

c. Individual, group, or family therapy at least three times per week;

d. Medical history and physical examination of patient within six months prior to admission or within thirty days after admission;

e. Review of patient's current medication(s) initiated within twenty-four hours;

f. Initiation of a multidisciplinary treatment plan within one week;

g. Nursing staff on-site or on-call twenty-four hours per day;

h. Parent training for patient's parents/guardians or family if return to family is expected;

i. Discharge planning initiated with twenty-four hours;

j. Psychiatric evaluation/updated (initial within one business day, updates at least once a week);

k. Psychosocial assessment and substance evaluation within forty-eight hours;

l. School or vocational program as per the clinical needs and/or age of the patient; and

m. Toxicology screen, quantitative drug analysis, self-help, 12-step, or education group as needed.

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

141. **RETAIL CLINIC** - a retail-based clinic that provides basic and preventive health care services seven (7) days a week, including evenings and weekends. A Retail Clinic is generally staffed by Certified Registered Nurses that diagnose and treat minor health problems and triage patients to appropriate levels of care.

142. **ROUTINE PATIENT COSTS** - costs associated with Covered Services furnished to a Member participating in an Approved Clinical Trial and that the Plan has determined are Medically Necessary and Appropriate. Such costs do not include:

a. the costs of investigational drugs or devices themselves;

b. the costs of non-health services required by a Member receiving treatments or interventions in the course of participating in an Approved Clinical Trial (e.g. transportation, lodging, meals and other travel expenses);

c. items or services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Member; and

d. a service clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

143. **SERVICE** - each treatment rendered by an Ancillary Provider, Facility Provider or Professional Provider to a Member for a Covered Service.

144. **SKILLED NURSING FACILITY** - a Facility Provider approved by the state, certified by Medicare which, for compensation from its patients, is primarily engaged in providing Skilled Nursing Services on an Inpatient basis to patients requiring twenty-four (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.

145. **SKILLED NURSING SERVICES/SKILLED REHABILITATION SERVICES** - Services which have been ordered by and under the direction of a Physician or Member's PCP, 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 Pathologist, or Audiologist with the treatment described and documented in the patient's medical records. Unless otherwise determined in the sole discretion of the Plan, 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. the Skilled Rehabilitation Services must be provided with the expectation that the patient has restorative potential and that 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 classified as Custodial Care.

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

146. **SKILLED REHABILITATION SERVICES** - 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.

147. **SPECIAL ENROLLMENT PERIOD** - a period during which an eligible individual who experiences certain qualifying events may enroll or change enrollment in the coverage provided under this Agreement when provided pursuant to enrollment through the Exchange. Special enrollment periods also apply to individuals eligible to enroll during a Limited Open Enrollment Period or who experience such other events in connection with which applicable federal laws, regulations and guidance have determined results in special enrollment rights.

148. **SPECIALIST** - a Physician, other than a Primary Care Provider, whose practice is limited to a particular branch of medicine or Surgery.

149. **SPECIALIST VIRTUAL VISIT** - a real-time office Visit with a Specialist at a remote location, conducted via interactive audio and streaming video telecommunications.

150. **SPECIALTY PRESCRIPTION DRUGS** - selected Prescription Drugs which are typically used to treat rare or complex conditions and which may require special handling, monitoring and/or special or limited distribution systems, including dispensing through an Exclusive Pharmacy Provider.

151. **STATE-OWNED PSYCHIATRIC HOSPITAL** - a Facility Provider, that is owned and operated by the Commonwealth of Pennsylvania, which is primarily engaged in providing treatment and/or care for the Inpatient treatment of Mental Illness for individuals aged eighteen (18) and older whose hospitalization is ordered by a court of competent jurisdiction through a civil commitment proceeding.

152. **STANDARD VALUE** – the level of Network benefits characterized by Member cost-sharing which is higher than the Enhanced Value level of benefits.

153. **SUBSCRIBER** - an applicant who has satisfied the specifications of **SECTION SE - SCHEDULE OF ELIGIBILITY** of this Agreement, signed the Application, and with whom the Plan has entered into this Agreement.

154. **SUBSTANCE ABUSE** - any use of alcohol 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.

155. **SUBSTANCE ABUSE TREATMENT FACILITY** - a Facility Provider licensed by the state and approved by an external accreditation body (i.e., The Joint Commission, Commission on Accreditation of Rehabilitation Facilities, Council on Accreditation) 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 another appropriate governmental agency.

156. **SUITE INFUSION THERAPY PROVIDER** - an Ancillary Provider licensed by the state, accredited by The Joint Commission, if appropriate, and organized to provide Infusion Therapy to patients at an infusion suite.

157. **SUPPLIER** - an individual or entity that is in the business of leasing and selling Durable Medical Equipment and supplies. Suppliers include, but are not limited to, the following: Durable Medical Equipment Suppliers, vendors/fitters, orthotic and prosthetic Suppliers, and pharmacy/Durable Medical Equipment Suppliers.

158. **SURGERY** -

    a. the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures;

    b. the correction of fractures and dislocations; or

    c. usual and related Inpatient pre-operative and post-operative care.

159. **TELEMEDICINE PROVIDER** - a Physician, licensed where required and performing within the scope of such licensure, who provides Telemedicine Services.

160. **TELEMEDICINE SERVICE** - a real time interaction between a Member and a Telemedicine Provider who is a Network Provider conducted by means of telephonic or audio and video telecommunications, for the purpose of providing specific Outpatient Covered Services.

161. **THERAPY SERVICES** - the following Services or supplies ordered by a Professional Provider to promote the recovery of the Member. Therapy Services are covered to the extent specified in the Outline of Coverage.

    a. Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.

    b. Dialysis Treatments - the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body through hemodialysis or peritoneal dialysis. Dialysis treatment includes home dialysis.

    c. Infusion Therapy - the treatment, by the administration of Medically Necessary and Appropriate fluid or medication via a central or peripheral vein.

d. Pulmonary Therapy - the treatment of chronic pulmonary diseases through a multidisciplinary program which combines Physical Medicine with an educational process directed towards the stabilization of pulmonary diseases and the improvement of functional status.

e. Radiation Therapy - the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

f. Respiratory Therapy - the introduction of dry or moist gases into the lungs for treatment purposes.

162. **URGENT CARE CENTER** - a formally structured hospital-based or freestanding full-service, walk-in health care clinic, outside of a hospital-based emergency room, that is open twelve (12) hours a day, Monday through Friday and eight (8) hours a day on Saturdays and Sundays, that primarily treats patients who have an injury or illness that requires immediate care, but is not serious enough to warrant a visit to an emergency room. An Urgent Care Center can also provide the same services as a family Physician or Primary Care Provider, such as treatment of minor illnesses and injuries, physicals, x-rays and immunizations.

163. **URGENT CARE SERVICES** – the treatment for an unexpected illness or injury, which is not life threatening but which cannot be reasonably postponed.

164. **VISION PROVIDER** - a Physician or Professional Provider licensed, where required, and performing services related to the examination, diagnosis and treatment of conditions of the eye and associated structures.

165. **VISIT** -

a. the physical presence of a Member at a location designated by the Provider for the purpose of providing Covered Services;

b. an interaction between a Member and a PCP or Retail Clinic for the purpose of providing Outpatient Covered Services for treatment of a condition not related to Surgery, pregnancy or Mental Illness conducted by means of an audio and video telecommunications system; or

c. an interaction between a Member and a Specialist for the purpose of providing Outpatient Covered Services conducted by means of:

i) an audio and video telecommunications system for the treatment of Mental Illness or Substance Abuse; or

ii) the internet or similar electronic communications for the treatment of skin conditions or diseases.

SECTION SE - SCHEDULE OF ELIGIBILITY

A. **ELIGIBILITY**

1. **Eligible Subscriber**

To be eligible to enroll as a Subscriber for coverage under this Agreement, an individual must:

a. be a U.S. citizen, national or other individual lawfully present in the United States;

b. not be entitled for benefits under Medicare Part A or be enrolled in Medicare Part B, Medicaid or CHIP;

c. not be incarcerated (other than incarceration pending the disposition of charges);

d. reside in the geographic area in which the product represented by this Agreement is available from the Plan; and

2. **Eligible Dependent**

An eligible Dependent is a U.S. citizen, national or other individual lawfully present in the United States:

a. not entitled for benefits under Medicare Part A or enrolled in Medicare Part B, Medicaid or CHIP;

b. not incarcerated (other than incarceration pending the disposition of charges);

c. who has been identified by the Subscriber through the appropriate enrollment process or on an application form accepted by the Plan as:

i) The Subscriber's spouse under a legally valid existing marriage.

ii) The Subscriber's Domestic Partner for the duration of the Domestic Partnership. In addition, the child(ren) of the Domestic Partner shall be considered, for eligibility purposes, as if they were the child(ren) of the Subscriber as long as the Domestic Partnership exists.

iii) The Subscriber's child, including a newborn child, step-child, child legally placed for adoption, child awarded coverage pursuant to an order of court, and legally adopted child of the Subscriber or Subscriber's spouse. The limiting age for a covered child is twenty-six (26), unless the period of eligibility for such Dependent is otherwise extended pursuant to applicable state or federal law.

Eligibility will be continued past the date that a Dependent child turns age twenty-six (26) for the Subscriber's unmarried child who, as medically certified by a Physician,

is incapable of self-support due to intellectual disability or physical disability, mental illness or developmental disability that started before age twenty-six (26). The Plan may require proof of such Dependent's disability from time to time.

NOTE: To the extent mandated by the requirements of Pennsylvania Act 83 of 2005, eligibility will be continued past the date that a Dependent child turns age twenty-six (26) for unmarried children who are enrolled as Dependents under their parent's coverage at the time they are called or ordered into active military duty. The Dependent must be a member of the Pennsylvania National Guard or any reserve component of the armed forces of the United States, who is called or ordered to active duty, other than active duty for training, for a period of thirty (30) or more consecutive days, or be a member of the Pennsylvania National Guard ordered to active state duty for a period of thirty (30) or more consecutive days. If the Dependent becomes a full-time student for the first term or semester starting sixty (60) or more days after the Dependent's release from active duty, the Dependent shall be eligible for coverage as a Dependent past the date that the Dependent child turns age twenty-six (26) for a period equal to the duration of the Dependent's service on active duty or active state duty.

For the purposes of this Note, full-time student shall mean a Dependent who is enrolled in, and regularly attending, an accredited school, college or university, or a licensed technical or specialized school for fifteen (15) or more credit hours per semester, or, if less than fifteen (15) credit hours per semester, the number of credit hours deemed by the school to constitute full-time student status.

A Dependent child who takes a medically necessary leave of absence from school, or who changes his or her enrollment status (such as changing from full-time to part-time) due to a serious illness or injury may continue coverage for one (1) year from the first day of the medically necessary leave of absence or other change in enrollment or, if earlier, until the date coverage would otherwise terminate under the terms of the Agreement. The Plan may require a certification from the Dependent child's treating Physician in order to continue such coverage.

3. **Newborn Children**

A newborn child, whether natural born, adopted, or placed for adoption, of the Subscriber or eligible Dependent is covered under this Agreement from the moment of birth to a maximum of thirty-one (31) days from the date of birth. To be covered as a Dependent beyond the thirty-one (31) day period, the newborn child must be enrolled as a Dependent under this Agreement and appropriate premium payment must be received within such period. In the event that a newborn child is not eligible for continuing coverage as a Dependent under this Agreement, the eligible Dependent may enroll or apply for a separate Agreement to be issued by the Plan.

B. NOTICE OF INELIGIBILITY

It shall be the responsibility of the Member to immediately notify the Plan or the Exchange, if applicable, of any changes that will affect the Member's eligibility for coverage under this Agreement.

C. ENROLLMENT

Subject to the terms and conditions of this Agreement, the Plan must receive, within the applicable enrollment period, a completed application for or other appropriate request for enrollment, documentation of eligibility, if required, and the applicable premium payment by the Member before coverage will be provided under this Agreement.

Eligible individuals may enroll in coverage under this Agreement during the Annual Open Enrollment Period. When applicable, enrollment is also permitted during a Limited Open Enrollment Period or Special Enrollment Period.

Coverage under this Agreement shall become effective on the date established by the ACA or, when appropriate, as determined by the Plan.

The Effective Date of coverage under this Agreement shall appear on the Member's enrollment confirmation letter and Identification Card. A Member may also obtain confirmation of the Effective Date of the coverage by contacting the Member Service Department of the Plan at the toll-free telephone number listed on the Member's Identification Card.

SECTION HC - HEALTH CARE MANAGEMENT SERVICES

The receipt of Covered Services is subject to all terms, definitions and exclusions specified in this Agreement. Except as provided herein, benefits are not provided for Out-of-Network Services. Specific payment provisions are outlined in the Outline of Coverage, as well as in this Section. Members may contact the Plan at the toll-free telephone number or the website appearing on the back of the Member's Identification Card to locate a Network Provider or to obtain a Provider Directory.

A. BENEFITS AFTER PROVIDER TERMINATION FROM THE NETWORK

If, at the time a Member is receiving medical care from a Network Provider, notice is received from the Plan that it intends to terminate or has terminated the contract of that Network Provider for reasons other than cause, the Member may opt to continue an active course of treatment with that Provider until the treatment is complete or for a period of up to ninety (90) days from the date the notification of the termination or pending termination is received, whichever is shorter. For purposes of this Subsection, active course of treatment means:

1. an ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;

2. an ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the Member is currently receiving, such as chemotherapy, radiation therapy or post-operative visits;

3. the second or third trimester of pregnancy, through the postpartum period; or

4. an ongoing course of treatment for a health condition for which a treating Physician or health care provider attests that discontinuing care by that Physician or health care provider would worsen the condition or interfere with anticipated outcomes.

If, however, the Network Provider is terminated for cause and a Member continues to seek treatment from that Provider, the Plan will not be liable for payment for health care services provided to the Member following the date of termination.

Any Services authorized under this Subsection will be covered in accordance with the same terms and conditions as applicable to a Network Provider. Nothing in this Subsection shall require the Plan to pay benefits for health care services that are not otherwise provided under the terms and conditions of this Agreement.

B. BLUES ON CALL (Health Education and Support Program)

The Blues On Call Program addresses the total health care needs of Members rather than focusing on one (1) specific disease, condition or illness through interaction with both the patient and the Physician. Blues On Call promotes the philosophy of shared decision-making

by helping Members work with their Physicians in the task of choosing treatment options that take into account the Member's values and preferences. The Program provides Members with health care support services, including assistance in the self-management of certain health conditions. Members have twenty-four (24) hour access, seven (7) days a week, to health information and personalized support for health decisions.

Support services may include:

1. assessment of the Member's functional and health status, including co-morbidities, risk factors, motivation and confidence in managing their health, and receptivity for change;

2. assessment of the Member's knowledge of their particular condition and their understanding and adherence to the recommendations and instructions of the Member's health care Provider;

3. Member education and training on health-related topics that can be helpful in improving the Member's overall health status, such as appropriate diet and nutrition, smoking cessation and exercise; and

4. ongoing monitoring (coaching) to optimize the Member's health status, ensuring adherence to the Physician's treatment plan, identifying and addressing barriers preventing or hindering adherence to the Physician's treatment plan, and assessing the need for case management services.

Members may contact Blues On Call at the toll-free telephone number listed on the Member's Identification Card.

C. EMERGENCY CARE SERVICES AND URGENT CARE SERVICES – NO PRIOR APPROVAL REQUIREMENT

1. Emergency Care Services

When the Member requires Emergency Care Services, all benefits for such Covered Services will be provided at the Network Services level of benefits even if the Covered Services are not received from a Network Provider. The Member will not be responsible for any difference between the Plan payment and the Provider's charge. In the event of an Inpatient admission, the Member, Provider, or a family member must notify the Plan within forty-eight (48) hours of the admission, or as soon as reasonably possible. Once a Member is stabilized, the Plan reserves the right to transfer the Member's care from an Out-of-Network Provider to a Network Provider.

2. Urgent Care Services

In the event that the Member requires Urgent Care Services, all benefits for such Covered Services will be provided at the Network Services level of benefits even if the Covered Services are not received from a Network Provider. The Member will not be responsible for any difference between the Plan payment and the Provider's charge.

D. HEALTH CARE MANAGEMENT SERVICES

A Member is entitled to benefits for Covered Services under this Agreement, subject to exclusions, conditions and limitations of this Agreement, and subject to Health Care Management Services administered by the Plan.

When Precertification/Certification, as set forth in this Agreement, is required, Medical Necessity and Appropriateness for Covered Services will be determined prior to the Covered Service being rendered. However, when Precertification/Certification is not required, the Plan may determine that a Covered Service was not Medically Necessary and Appropriate after the Covered Service has been rendered.

When a Member seeks Covered Services from a Network Provider located Out-of-Area, the Member is required to call the Precertification toll-free number on the back of the Member's Identification Card, prior to the receipt of the Covered Services, to determine what, if any, Precertification requirements they must follow.

1. Pre-Admission Certification

When a Member requires Hospital, Psychiatric Hospital, Rehabilitation Hospital, Residential Treatment Facility, Substance Abuse Treatment Facility or Skilled Nursing Facility care, benefits for Covered Services will be provided subject to the following:

a. In-Area Network Services

In the event of a proposed Inpatient stay to a Network Facility Provider located in-Area, for other than an emergency, it shall be the responsibility of the Network Facility Provider to contact the Plan prior to a proposed admission, in accordance with procedures established by the Plan, to obtain Precertification of the admission.

The Member will be held harmless and will not be financially responsible for payment for admissions which have been determined not to be Medically Necessary and Appropriate, except when the Plan provides prior written notice to the Member that the admission will not be covered. In such case, the Member will be financially responsible for charges for such admission.

b. Out-of-Area Network Services

In the event of a proposed Inpatient stay to a Network Facility Provider located Out-of-Area, for other than an emergency, it shall be the responsibility of the Network Facility Provider to contact the Plan prior to a proposed admission to obtain Precertification of the admission. In addition, the Member must contact the Plan to confirm the Plan's determination of Medical Necessity and Appropriateness prior to the admission.

i) If Precertification for a Medically Necessary and Appropriate Inpatient admission has been obtained, as required under this Agreement, benefits will be paid in accordance with this Agreement.

ii) If a Member elects to be admitted after receiving written notification from the Plan that any portion of the proposed admission is not Medically Necessary and Appropriate, the Member will be financially responsible for all charges associated with care that has been determined not to be Medically Necessary and Appropriate.

iii) If a Network Facility Provider DOES NOT CONTACT the Plan for Precertification, as required under this Agreement, any claim for benefits will be reviewed for Medical Necessity and Appropriateness.

It is important that the Member confirm the Plan's determination of Medical Necessity and Appropriateness, otherwise if such admission is determined not to be Medically Necessary and Appropriate, no benefits will be provided and the Member will be financially responsible for the full amount of the Network Facility Provider's charge.

If the admission is determined to be Medically Necessary and Appropriate, benefits will be paid in accordance with this Agreement.

2. **Certification of Emergency Admissions**

When a Member requires an emergency admission to a Hospital, Psychiatric Hospital, Rehabilitation Hospital, Residential Treatment Facility or Substance Abuse Treatment Facility, benefits for Covered Services will be provided subject to the following:

a. In-Area Network Services

In the event of an emergency admission to a Network Facility Provider located In-Area, it shall be the responsibility of the Network Facility Provider to contact the Plan within forty-eight (48) hours, or as soon as reasonably possible, after such admission to obtain Certification of the admission.

The Member will be held harmless and will not be financially responsible for payment for admissions which are determined not to be Medically Necessary and Appropriate, except when the Plan provides prior written notice to the Member that any portion of the admission will not be covered. In such case, the Member will assume financial responsibility for such Inpatient charges.

b. Out-of-Area Network Services

In the event of an emergency admission to a Network Facility Provider located Out-of-Area, it shall be the responsibility of the Network Facility Provider to contact the Plan within forty-eight (48) hours, or as soon as reasonably possible, after such admission to obtain Certification of the emergency admission. In addition, the Member must contact the Plan within forty-eight (48) hours, or as soon as reasonably possible, to confirm the Plan's determination of Medical Necessity and Appropriateness.

i) If Certification for a Medically Necessary and Appropriate emergency

admission has been obtained, as required under this Agreement, and the admission has been determined to be Medically Necessary and Appropriate, benefits will be paid in accordance with this Agreement.

ii) If a Member elects to remain hospitalized after receiving written certification from the Plan that such level of care is no longer Medically Necessary and Appropriate, the Member will be financially responsible for the full amount of the Network Facility Provider's charges from the date appearing on the written notification.

iii) If a Network Facility Provider DOES NOT CONTACT the Plan for Certification, as required under this Agreement, any claim for benefits will be reviewed for Medical Necessity and Appropriateness.

It is important that the Member confirm the Plan's determination of Medical Necessity and Appropriateness, otherwise, if such admission is determined not to be Medically Necessary and Appropriate, no benefits will be provided and the Member will be financially responsible for the full amount of the Network Facility Provider's charge.

If the admission is determined to be Medically Necessary and Appropriate, benefits will be paid in accordance with this Agreement.

3. **Outpatient Procedure or Covered Service Precertification Requirements**

Precertification may be required to determine the Medical Necessity and Appropriateness of certain Outpatient procedures or Covered Services as determined by the Plan prior to the receipt of services.

a. In-Area Network Services

The Network Provider located In-Area is responsible for the Precertification of such procedure or Covered Service. The Member will not be financially responsible whenever Certification for such procedure or Covered Service is not obtained by the Network Provider. If the procedure or Covered Service is determined not to be Medically Necessary and Appropriate, the Member will not be financially responsible, except when the Plan provides prior written notice to the Member that charges for the procedure or Covered Service will not be covered. In such case, the Member will be financially responsible for such procedure or Covered Service.

b. Out-of-Area Network Services

Whenever a Member utilizes a Network Provider located Out-of-Area, it is the responsibility of the Member to first contact the Plan to confirm the Medical Necessity and Appropriateness of such procedure or Covered Service.

If the Member DOES NOT CONTACT the Plan for Precertification, that procedure or Covered Service may be reviewed after it is received to determine Medical Necessity and Appropriateness.

If the procedure or Covered Service is determined to be Medically Necessary and Appropriate, benefits will be paid in accordance with this Agreement. If the procedure or Covered Service is determined not to be Medically Necessary and Appropriate, no benefits will be provided. The Member will be financially responsible for the full amount of the charge of the Network Provider located Out-of-Area.

4. **Continued Stay Review**

The medical progress of patients is reviewed to identify the continued Medical Necessity and Appropriateness of the Inpatient stay.

If a Member elects to continue to receive Inpatient Services after receipt of written notification from the Plan that such level of care is no longer Medically Necessary and Appropriate, the Member will be financially responsible for the full amount of the Provider's charges from the date appearing on the written notification.

5. **Discharge Planning**

Discharge Planning is a collaborative effort on the part of the Plan, the Facility Provider, the Professional Provider, the Member, and their family to assure that the patient receives safe and uninterrupted care when needed at the time of discharge.

6. **Individual Case Management**

Case Management is the process by which the Plan, in its sole discretion, identifies alternative treatment modalities commensurate with the Member's diagnosis profile and consults with the patient and attending Professional Provider(s). Notwithstanding the foregoing, all decisions regarding the treatment to be provided to a Member shall remain the responsibility of the treating Professional Provider(s) and the Member working with the Plan.

The Plan shall provide such alternative benefits, in its sole discretion, only when, and for so long as, it determines that the procedures/Services are Medically Necessary and Appropriate, cost effective, and that the total benefits paid for such procedures/Services do not exceed the total benefits to which the Member would otherwise be entitled under this Agreement in the absence of alternative benefits.

Such alternative benefits may include offering the Member a home recovery care option so that treatment for specific medical conditions can be provided in the Member's home when it is determined that the Member can be safely treated for such condition in that setting. In connection with the home recovery care option, case management will largely focus on stepped-up care coordination services and may include, in the Plan's sole discretion, non-emergency transportation to provider locations.

The Plan will provide Individual Case Management Services for those Members identified by the Plan as falling into one (1) or more of the following diagnosis profiles of illnesses or injuries, or such other diagnosis profiles as deemed appropriate from time to time by the Plan:

Illnesses

Acquired Immune Deficiency Syndrome	Cystic Fibrosis
Amyotrophic Lateral Sclerosis	Diabetes Mellitus
Autism Spectrum Disorders	Multiple Sclerosis
Carcinoma	Muscular Dystrophy
Cardiac Surgery	Neonatal High Risk Infants
Cerebral Palsy	Osteomyelitis
Cerebrovascular Accident	Psychiatric Diagnoses
Chronic Obstructive Pulmonary Disease	Sickle Cell Anemia
Complications of Chronic Disease Processes	Spina Bifida

Injuries

Amputations	Paralytic Syndromes
Major Head Trauma	Severe Burns
Multiple Fractures	Spinal Cord Injury

The Plan, in its sole discretion, reserves the right to limit access and/or modify benefit(s) for any individual Member, regardless of disease or condition, when the Plan identifies utilization patterns that could potentially result in harm to such Member or the public.

7. **Authorized Representative**

Nothing in this Subsection shall preclude a duly authorized representative of the Member from filing or otherwise pursuing a Precertification request or other Pre-service Claim on behalf of a Member. The Plan reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member. Such procedures as adopted by the Plan shall, in the case of an Urgent Care Claim, permit a Professional Provider with knowledge of the Member's medical condition to act as the Member's authorized representative.

8. **Notification of Precertification and Other Pre-Service Claim Determinations**

Precertification of Covered Services, when required under this Agreement, and all other Pre-service Claims including requests to extend a previously approved course of treatment will be processed and notice of the Plan's determination, whether adverse or not, will be given to the Member within the following time frames unless otherwise extended by the Plan for reasons beyond its control:

a. In the case of an Urgent Care Claim, as soon as possible, taking into account the medical exigencies involved, but not later than seventy-two (72) hours following the Plan's receipt of the Urgent Care Claim. Similarly, when the Urgent Care Claim seeks to extend a previously approved course of treatment and the request is made at

least twenty-four (24) hours prior to the expiration of such previously approved course of treatment, notice of the Plan's determination will be given to the Member as soon as possible, taking into account the medical exigencies involved, but no later than twenty-four (24) hours following receipt of the request; and

b. In the case of a non-urgent care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days following the Plan's receipt of the non-urgent care Pre-service Claim.

   Notice of the Plan's approval of a Pre-service Claim will include information sufficient to apprise the Member that the request has been approved. In the event that the Plan renders an adverse determination on a Pre-service Claim, the notification shall include, among other items, the specific reason or reasons for the adverse determination and a statement describing the right of the Member to file an internal appeal or request an external review.

9. **Prescription Drug Precertification**

   Certain Covered Medications, as designated by the Plan, may require Precertification to ensure the Medical Necessity and Appropriateness of the Prescription Order. The Member's Physician must obtain Certification from the Plan prior to the dispensing of the drug at a Participating Pharmacy Provider or through mail-order, if applicable. If it is determined by the Plan that the Covered Medication is Medically Necessary and Appropriate, the Covered Medication will then be dispensed by the Participating Pharmacy Provider or through mail-order, if applicable.

10. **Prescription Drug Exceptions**

    Coverage is not provided for Prescription Drugs and Over-the-Counter Drugs not appearing on the Formulary, unless an exception has been granted by the Plan. The Member, the Member's authorized representative or the Member's prescribing physician may request coverage of a Prescription Drug not appearing on the Formulary. The Plan will review the exception request and notify the Member of its determination within seventy-two (72) hours of receiving sufficient information to begin its review of the request.

    If the Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a non-formulary drug, the Member, the Member's authorized representative, or the Member's prescribing physician may request an expedited review based on exigent circumstances. In the case of such an exigent circumstance, the Plan will notify the Member, the Member's authorized representative, or the Member's prescribing physician of its coverage determination within twenty-four (24) hours of receiving sufficient information to begin its review of the request.

    In the event that the Plan denies a request for exception, the Member, the Member's authorized representative, or the Member's prescribing physician may request that the exception request and subsequent denial of the request be reviewed by an independent review organization. Plan must make its determination on the external exception request

and notify the Member, Member's authorized representative or the Member's prescribing physician of its coverage determination no later than seventy-two (72) hours following its receipt of sufficient information to begin its review or the request, or if the request was an expedited exception request, no later than twenty-four (24) hours following its receipt of sufficient information to begin its review of the request.

If the Plan grants the request for an exception, the Prescription Drug will be covered for the duration of the prescription, or if pursuant to an expedited exception request, for the duration of the exigency. Coverage will be provided in accordance with the Outpatient Prescription Drugs schedule of benefits in the Outline of Coverage.

E. HEALTH IMPROVEMENT SERVICES AND SUPPORT

From time to time, the Plan may directly or indirectly make available to Members information and access to non-medical items, services and support programs designed to address underlying social and environmental factors that may negatively impact the Member's health status. Such information, items, services and support programs furnished directly by the Plan will be provided without charge and shall not alter the benefits provided under this Agreement.

F. SELECTION OF PROVIDERS

A Member covered under this Agreement must receive Covered Services from Network Providers, except in the following circumstances:

1. for Emergency Care Services and Emergency Ambulance Services;
2. for Urgent Care Services;
3. when a Member receives preauthorization to receive Services from an Out-of-Network Provider;
4. as required by law; or
5. as otherwise provided herein.

In the event that a Member requires non-emergency or non-urgent Covered Services that are not available within the Network, the Plan may refer the Member to an Out-of-Network Provider. The Member must notify the Plan prior to receiving a Covered Service from an Out-of-Network Provider in order for the Plan to facilitate this arrangement. In such cases, Services will be covered at the Enhanced Value level of benefits so that the Member will not be responsible for any greater out-of-pocket amount than if Services had been rendered by a Network Provider. The Member will not be responsible for any difference between the Plan payment and the Out-of-Network Provider's billed charge. Additionally, there are some instances where a Member may not have the opportunity to make a provider selection. In such cases, Claims for Covered Services will be processed to apply the Enhanced Value level of cost-sharing amounts and the Plan will prohibit balance billing by the Provider to the Member.

G. **WELLNESS PROGRAMS**

The Plan may offer Members the opportunity to participate in programs of health promotion and/or disease prevention. When offered, these programs will be available to Members without regard to health status. Whether or not Members decide to participate in such programs will not affect their continued eligibility, benefits, premiums, or cost-sharing obligations under this Agreement.

At times, the Plan may offer rewards for Member participation in certain of these programs. Any reward provided by the Plan in connection with these programs will not be offered or conditioned upon the Member satisfying a standard that is based on a health related factor.

SECTION DB - DESCRIPTION OF BENEFITS

Subject to the exclusions, conditions, and limitations of this Agreement, and subject to **SECTION HC - HEALTH CARE MANAGEMENT SERVICES** of this Agreement, a Member is entitled to the benefits of this Section for Medically Necessary and Appropriate Services rendered by a Provider and/or Supplier in the amounts specified in the Outline of Coverage. A different level of benefits may be provided based on the place of treatment as set forth in the Outline of Coverage.

A. **AMBULANCE SERVICE**

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

    a. from a Member's home or the scene of an accident or medical emergency to a Hospital, or Skilled Nursing Facility;

    b. between Hospitals; or

    c. between a Hospital and a Skilled Nursing Facility

    when such facility is the closest institution that can provide Covered Services appropriate to the Member's condition. If there is no facility in the local area that can provide Covered Services appropriate to the Member's condition, then Ambulance Service means transportation to the closest facility outside the local area that can provide the necessary service.

    Transportation and other emergency services provided by an Ambulance Service shall constitute Emergency Ambulance Services if the injury or the condition satisfies the criteria as described in the **EMERGENCY CARE SERVICES** Definition of **SECTION DE - DEFINITIONS** of this Agreement. Benefits are provided for Emergency Care Services rendered by an Ambulance Service even when transport is not required or refused by the Member.

    Use of an ambulance as transportation to an emergency room of a Facility Provider for an injury or condition that does not satisfy the criteria set forth in the **EMERGENCY CARE SERVICES** Definition will not be covered as Emergency Ambulance Services.

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

    a. from a Hospital to the Member's home; or

    b. from a Skilled Nursing Facility to the Member's home.

B. **ARTIFICIAL INSEMINATION**

Benefits will be provided for Artificial Insemination and associated diagnostic, medical and surgical services and pharmacological or hormonal treatments used in conjunction with Artificial Insemination when ordered by a Physician and determined to be Medically Necessary and Appropriate.

C. AUTISM SPECTRUM DISORDERS

Benefits are provided for all Members under twenty-one (21) years of age for the following:

1. Diagnostic Assessment of Autism Spectrum Disorders

Medically Necessary and Appropriate assessments, evaluations or tests performed by a Physician, licensed physician assistant, Psychologist or certified registered nurse practitioner to diagnose whether an individual has an Autism Spectrum Disorder.

2. Treatment of Autism Spectrum Disorders

Services must be specified in a treatment plan developed by a Physician or Psychologist following a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. The Plan may review a treatment plan for Autism Spectrum Disorders once every six (6) months, or as agreed upon between the Plan and the Physician or Psychologist developing the treatment plan.

Treatment of Autism Spectrum Disorders may include the following Medically Necessary and Appropriate Services:

a. Habilitative and Rehabilitative care

Professional services and treatment programs, including Habilitative and Rehabilitative Services related to Applied Behavioral Analysis, provided by an Autism Service Provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.

b. Pharmacy care

Prescription Drugs approved by the Food and Drug Administration and designated by the Plan for the treatment of Autism Spectrum Disorders and which are prescribed by a Physician, licensed physician assistant or certified registered nurse practitioner. Additionally, pharmacy care for Autism Spectrum Disorders includes any assessment, evaluation or test prescribed or ordered by a Physician, licensed physician assistant or certified registered nurse practitioner to determine the need or effectiveness of such Prescription Drugs.

c. Psychiatric and psychological care

Direct or consultative services provided by a Psychologist or by a Physician who specializes in psychiatry.

d. Therapeutic care

Services that are provided by a Speech Language Pathologist, Occupational Therapist, or Physical Therapist.

D. DENTAL SERVICES

1. **Related to Accidental Injury**

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

2. **Services Related to Covered and Non-Covered Dental Procedures**

General Anesthesia and associated Hospital and medical Services normally related to the administration of general Anesthesia which are rendered in connection with:

a. non-covered dental procedures or non-covered oral surgery; and

b. Pediatric Dental Services to the extent such anesthesia services are not covered under Paragraph 3 below.

Benefits are provided for Members age seven (7) or under and for developmentally disabled Members when determined by the Plan to be Medically Necessary and Appropriate and when a successful result cannot be expected for treatment under local Anesthesia, or when a superior result can be expected from treatment under general Anesthesia.

3. **Pediatric Dental Services**

Benefits are provided for Members for the following when rendered by a Dentist who is a Network Provider:

a. Oral Evaluations:

i) Comprehensive, periodic and limited problem focused

ii) Consultations

iii) Detailed problem focused

b. Radiographs - Full mouth x-rays - one (1) every three (3) years. Bitewing x-rays - one (1) set per six (6) months.

c. Prophylaxis - one (1) per six (6) months. One (1) additional for Members under the care of a medical professional during pregnancy.

d. Fluoride treatments:

    i) Topical fluoride treatment - two (2) per twelve (12) months through age eighteen (18).

    ii) Fluoride varnish - two (2) per twelve (12) months through age eighteen (18).

e. Palliative treatment (emergency)

f. Sealants - one (1) per tooth per three (3) years on permanent first and second molars.

g. Space maintainers - through age eighteen (18) when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never, develop.

h. Preventive resin restorations

i. Periodontal Services:

    i) Full mouth debridement

    ii) Periodontal maintenance following active periodontal therapy - four (4) per twelve (12) months in addition to routine prophylaxis.

    iii) Periodontal scaling and root planing - one (1) per twenty-four (24) months per area of the mouth.

    iv) Surgical periodontal procedures - one (1) per twenty-four (24) months per area of the mouth.

    v) Guided tissue regeneration

j. Basic Restorations - amalgam or composite

k. Crowns - ceramic, porcelain-fused to metal and metal alloy - one (1) every five (5) years.

l. Inlays and onlays - one (1) every five (5) years.

m. Prefabricated stainless steel crowns.

n. Replacement of restorative services only when they are not, and cannot be made, serviceable:

    i) Basic restorations (including, but not limited to stainless steel crowns).

    ii) Single crowns, inlays, onlays - one per tooth within a five (5) year period.

iii) Buildups and post and cores - one per tooth within a five (5) year period.

iv) Full and partial dentures - one (1) per arch within a five (5) year period.

o. Oral and maxillofacial surgical services:

i) Simple extractions.

ii) Surgical extractions.

iii) Oral surgery.

iv) Apicoectomy/Periradicular surgery.

p. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within six (6) months of insertion by the same Dentist. Subsequent denture relining or rebasing limited to one (1) every three (3) years thereafter.

q. Pulpal therapy - through age five (5) on primary anterior teeth and through age eleven (11) on primary posterior teeth.

r. Root canal retreatment - one (1) per tooth per lifetime.

s. Recementation - one (1) per five (5) years. Recementation during the first twelve (12) months following insertion by the same Dentist is included in the prosthetic service benefit.

t. Administration of IV sedation, nitrous oxide or general anesthesia is limited to covered oral surgical procedures involving one or more impacted teeth (soft tissue, partial bony or complete bony impactions).

u. Therapeutic drug injections - only covered in unusual circumstances, by report.

v. Orthodontics
Covered Services which are intended to treat a severe dentofacial abnormality and are the only method capable of preventing irreversible damage to the Member's teeth or their supporting structures, and restoring the Member's oral structure to health and function.

Limitations

a. Orthodontic treatment limitations:

i) All pediatric orthodontic treatment is subject to Precertification by the Plan, and must be part of an approved written plan of care.

ii) To be eligible for pediatric orthodontic treatment, a Member must:

(a) continue to be enrolled during the duration of treatment; and

(b) have a fully erupted set of permanent teeth.

b. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the Dentist. The ABP does not commit the Member to the less costly treatment. However, if the Member and the Provider choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed under this ABP.

c. Coverage terminates for Pediatric Dental Services at the end of the Benefit Period in which the Member reaches age nineteen (19).

E. 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:

1. **Equipment and Supplies**

   Blood glucose monitors, monitor supplies, injection aids, and insulin infusion devices.

2. **Diabetes Education Program**

   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:

   a. Visits Medically Necessary and Appropriate upon the diagnosis of diabetes; and

   b. Subsequent Visits under circumstances whereby a Member's physician:

      i) identifies or diagnoses a significant change in the Member's symptoms or conditions that necessitates changes in a Member's self-management; or

      ii) identifies, as Medically Necessary and Appropriate, a new medication or therapeutic process relating to the Member's treatment and/or management of diabetes.

3. Prescription Drugs required for the treatment of diabetes are covered in accordance with the **OUTPATIENT PRESCRIPTION DRUGS** Subsection in this Section.

F. DIAGNOSTIC SERVICES

Benefits will be provided for the following Covered Services on an Inpatient or Outpatient basis only when such Covered Services are ordered by a Professional Provider:

1. **Advanced Imaging Services**

   Include, but are not limited to, computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET scan), positron emission tomography/computed tomography (PET/CT scan).

2. **Basic Diagnostic Services**

   a. Standard Imaging Services - procedures such as skeletal x-rays, ultrasound and fluoroscopy;

   b. Laboratory and Pathology Services - procedures such as non-routine Papanicolaou (PAP) smears, blood tests, urinalysis, biopsies and cultures;

   c. Diagnostic Medical Services - procedures such as electrocardiograms (ECG), electroencephalograms (EEG), echocardiograms, pulmonary studies, stress tests, audiology testing; and

   d. Allergy Testing Services - allergy testing procedures such as percutaneous, intracutaneous, and patch tests.

   Basic Diagnostic Services provided for preventive purposes in accordance with a predefined schedule based on age and sex described in the **PREVENTIVE SERVICES** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement are exempt from Deductibles, Copayments and Coinsurance.

G. **DURABLE MEDICAL EQUIPMENT**

The rental (but not to exceed the total cost of purchase) or, at the option of the Plan, the purchase, adjustment, repairs and replacement of Durable Medical Equipment when prescribed by a Professional Provider and required for therapeutic use.

H. **EMERGENCY CARE SERVICES**

Services and Supplies for the Outpatient emergency treatment of bodily injuries resulting from an accident or a medical condition, as described in the **EMERGENCY CARE SERVICES** Definition of **SECTION DE - DEFINITIONS** of this Agreement, including a medical screening examination and ancillary services necessary to evaluate such injury or emergency medical condition, and such further medical examination and treatment as required to stabilize the patient.

Transportation and other emergency services provided by an Ambulance Service shall constitute Emergency Ambulance Services if the injury or the condition satisfies the criteria as described in the **EMERGENCY CARE SERVICES** Definition of **SECTION DE - DEFINITIONS** of this Agreement.

I. **ENTERAL FOODS**

Coverage is provided for Enteral Foods when administered on an Outpatient basis for the following:

1. Amino acid-based elemental medical formulae ordered by a Physician for infants and children for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short bowel syndrome.

2. Nutritional supplements administered under the direction of a Physician 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 the disorders set forth in paragraphs 1 and 2 above. Benefits are exempt from all Deductible requirements.

J. **HABILITATIVE AND REHABILITATIVE SERVICES**

Benefits will be provided for the following Covered Services only when such Services are ordered by a Physician:

1. Cardiac Rehabilitation (does not include services provided for habilitative purposes);

2. Occupational Therapy and Physical Medicine; and

3. Speech Therapy.

K. **HOME HEALTH CARE SERVICES**

Services rendered by a Home Health Care Agency or a Hospital program for Home Health Care for which benefits are available as follows:

1. Skilled Nursing Services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN)*;

2. Physical Medicine, Speech Therapy and Occupational Therapy 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; and

6. Health aide Services to a Member who is receiving covered nursing Services or Habilitative and Rehabilitative Services or Therapy Services.

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* The services of a Licensed Practical Nurse (LPN) shall be made available only when the services of a Registered Nurse are not available and only when Medically Necessary and Appropriate. Services of a LPN are only reimbursable through a Facility Provider.

7. No Home Health Care benefits will be provided for:

   a. Dietitian Services;

   b. Homemaker Services;

   c. Maintenance therapy;

   d. Dialysis treatment;

   e. Custodial Care; and

   f. Food or home delivered meals.

L. **<u>HOSPICE CARE SERVICES</u>**

Services rendered by a Home Health Care Agency or a Hospital program for Hospice Care for which benefits are available as follows:

1. Skilled Nursing Services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN)*;

2. Physical Medicine, Speech Therapy and Occupational Therapy Services;

3. Medical and surgical supplies provided by the Home Health Care Agency or Hospital Program for Hospice Care;

4. Oxygen and its administration;

5. Medical social service consultations;

6. Health aide Services to a Member who is receiving covered nursing Services or Habilitative and Rehabilitative Services or Therapy Services;

7. Family Counseling related to the Member's terminal condition;

8. Respite Care; and

9. Hospice Care Services will be provided to Members with a life expectancy of one hundred eighty (180) days or less, as certified by a Physician.

10. No Hospice Care benefits will be provided for:

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* The services of a Licensed Practical Nurse (LPN) shall be made available only when the services of a Registered Nurse are not available and only when Medically Necessary and Appropriate. Services of a LPN are only reimbursable through a Facility Provider.

a. Dietitian Services;

b. Homemaker Services;

c. Maintenance therapy;

d. Dialysis treatment;

e. Custodial Care; and

f. Food or home delivered meals.

M. <u>HOSPITAL SERVICES</u>

1. **Inpatient Services**

a. Bed, board and general nursing Services in a Facility Provider when the Member occupies:

i) a room with two (2) or more beds;

ii) a private room; or

iii) a bed in a Special Care Unit - a designated unit which has concentrated all facilities, equipment, and supportive Services for the provision of an intensive level of care for critically ill patients.

b. Ancillary Services

Hospital services and supplies including, but not restricted to:

i) Use of operating and treatment rooms and equipment;

ii) Drugs and medicines provided to a Member who is an Inpatient in a Facility Provider;

iii) Whole blood, administration of blood, blood processing, and blood derivatives;

iv) Anesthesia, Anesthesia supplies and Services rendered in a Facility Provider by an employee of the Facility Provider. Administration of Anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at surgery;

v) Medical and surgical dressings, supplies, casts, and splints;

vi) Diagnostic Services;

vii) Habilitative and Rehabilitative Services; and

viii) Therapy Services.

2. **Outpatient Services**

a. Ancillary Services

Hospital services and supplies including, but not restricted to:

i) Use of operating and treatment rooms and equipment;

ii) Drugs and medicines provided to a Member who is an Outpatient in a Facility Provider. However, benefits for certain therapeutic injectables and Infusion Therapy Prescription Drugs as identified by the Plan and which are appropriate for self-administration, will be provided only when received from a Participating Pharmacy Provider as set forth under the **OUTPATIENT PRESCRIPTION DRUGS** Subsection of this Section;

iii) Whole blood, administration of blood, blood processing, and blood derivatives;

iv) Anesthesia, Anesthesia supplies and Services rendered in a Facility Provider by an employee of the Facility Provider, including the administration of Anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at surgery;

v) Medical and surgical dressings, supplies, casts, and splints;

vi) Diagnostic Services;

vii) Habilitative and Rehabilitative Services; and

viii) Therapy Services.

b. Pre-Admission Testing

Tests and studies, including those set forth in the Basic Diagnostic Services paragraph of the **DIAGNOSTIC SERVICES** Subsection in this Section, when such Services are required in connection with the Member's admission and are rendered or accepted by a Hospital on an Outpatient basis prior to a scheduled admission to the Hospital as an Inpatient.

c. Surgery

Hospital services and supplies for Outpatient Surgery including removal of sutures, Anesthesia, Anesthesia supplies and Services rendered by an

employee of the Facility Provider other than the surgeon or assistant at Surgery.

N. MATERNITY SERVICES

Hospital Services and medical/surgical services rendered by a Facility Provider or Professional Provider for:

1. **Complications of Pregnancy**

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

2. **Maternity Home Health Care Visit**

   Benefits for one (1) maternity home health care visit will be provided at the Member's home 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. This visit shall be made by a Professional Provider whose scope of practice includes postpartum care. The visit includes parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests, and the performance of any necessary maternal and neonatal physical assessments. The visit may, at the mother's sole discretion, occur at a Facility Provider. The maternity home health care visit is subject to all the terms of this Agreement and is exempt from any Deductible, Copayment and Coinsurance amounts.

3. **Newborn Care**

   Covered Services will be provided to the newborn child of a Member from the moment of birth and shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Routine nursery care includes Inpatient medical visits by a Professional Provider. Such Benefits shall continue for a maximum of thirty-one (31) days from birth, subject to the termination provisions set forth in the **BENEFITS AFTER TERMINATION OF COVERAGE** Subsection of **SECTION GP - GENERAL PROVISIONS** of this Agreement.

4. **Normal Pregnancy**

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

O. MEDICAL SERVICES

1. **Inpatient Medical Care Services**

Medical Care rendered by a Professional Provider to a Member who is an Inpatient for a condition not related to Surgery, pregnancy, Mental Illness or Substance Abuse, except as specifically provided.

a. Inpatient Medical Care Visits

b. Intensive Medical Care

Medical care rendered to a Member whose condition requires a Professional Provider's constant attendance and treatment for a prolonged period of time.

c. Concurrent Care

i) Medical care rendered concurrently with Surgery during one (1) Inpatient stay by a Professional Provider other than the operating surgeon for treatment of a medical condition separate from the condition for which Surgery was performed.

ii) Medical care by two (2) or more Professional Providers rendered concurrently during one (1) Inpatient stay when the nature or severity of the Member's condition requires the skills of separate physicians.

d. Consultation

Consultation Services rendered to an Inpatient by another Professional Provider at the request of the attending Professional Provider. Consultation does not include staff consultations which are required by the Facility Provider's rules and regulations.

e. Routine Newborn Care

Professional Provider visits to examine the newborn.

2. **Outpatient Medical Care Services**

Medical care rendered by a Professional Provider to a Member who is an Outpatient for a condition not related to Surgery, pregnancy or Mental Illness, except as specifically provided, including allergy extracts, allergy injections, medical care Visits, Telemedicine Services, therapeutic injections and consultations for the examination, diagnosis and treatment of an injury or illness, and Covered Services provided by Professional Providers at a Retail Clinic or Urgent Care Center. However, benefits for certain therapeutic injectables as identified by the Plan and which are appropriate for self-administration will be provided only when received from a Participating Pharmacy Provider as set forth under the **<u>OUTPATIENT PRESCRIPTION DRUGS</u>** Subsection of this Section.

Benefits are provided for a Specialist Virtual Visit when a Member communicates with the Specialist from any location such as their home, office or another mobile location, or the Member travels to a Provider based location referred to as the "Provider

originating site". If the Member communicates with the Specialist from a Provider originating site, that service will be subject to the Deductible, if any, and the Member will be responsible for the Specialist Virtual Visit Provider Originating Site Fee Coinsurance amount, if any, specified in the Outline of Coverage. Benefits will not be provided for a Specialist Virtual Visit if such Visit is related to the treatment of Mental Illness or Substance Abuse.

Benefits for Outpatient Medical Care Services will be provided in the amounts specified and are subject to additional limitations in the Outline of Coverage.

3. **Surgical Services**

a. Anesthesia

Administration of Anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at surgery. Benefits are also provided for the administration of Anesthesia for covered oral surgical procedures in an Outpatient setting when ordered and administered by the attending Professional Provider.

b. Assistant at Surgery

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

c. Second Surgical Opinion

i) Services

A consulting opinion and directly related Diagnostic Services to confirm the need for recommended elective Surgery.

ii) Specifications

(a) The second opinion consultant must not be the Physician who first recommended elective Surgery.

(b) Elective Surgery is covered Surgery that may be deferred and is not an emergency.

(c) Use of a second surgical opinion is at the Member's option.

(d) If the first opinion for elective Surgery and the second opinion conflict, then a third opinion and directly related Diagnostic Services are Covered Services.

(e) If the consulting opinion is against elective Surgery and the Member decides to have the elective Surgery, the Surgery is a Covered Service. In

such instances, the Member will be eligible for a maximum of two (2) such consultations involving the elective surgical procedure in question, but limited to one (1) consultation per consultant.

d. Special Surgery

i) Oral Surgery

Benefits are provided for the following limited oral surgical procedures in an Outpatient setting when preauthorized by the Plan or in an Inpatient setting if determined to be Medically Necessary and Appropriate:

(a) extraction of impacted teeth when partially or totally covered by bone;

(b) extraction of teeth in preparation for cardiac Surgery, organ transplantation or radiation therapy;

(c) mandibular staple implant, provided the procedure is not done in preparation of the mouth for dentures;

(d) lingual frenectomy, frenotomy or frenoplasty (to correct tongue-tie) and mandibular frenectomy;

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

(f) accidental injury to the jaw or structures contiguous to the jaw except teeth;

(g) the correction of a non-dental physiological condition which has resulted in a severe functional impairment;

(h) treatment for tumors and cysts requiring pathological examination and for infections of the jaw, cheeks, lips, tongue, roof and floor of mouth; and

(i) 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.

ii) Mastectomy and Breast Cancer Reconstruction

Benefits are provided for a mastectomy performed on an Inpatient or Outpatient basis 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.

Benefits are also provided for one (1) home health care visit, as determined by the Member's Physician, when received within forty-eight (48) hours after discharge, if such discharge occurred within forty-eight (48) hours after an admission for a mastectomy.

e. Surgery

i) Surgery performed by a Professional Provider. Separate payment will not be made for pre- and post-operative Services.

ii) If more than one (1) surgical procedure is performed by the same Professional Provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure, plus fifty percent (50%) of the amount that would have been payable for each of the additional procedures, had those procedures been performed alone.

P. MENTAL HEALTH CARE SERVICES

1. Inpatient Facility Services

Hospital Services are provided for the Inpatient treatment of Mental Illness by a Facility Provider. Inpatient Facility Services must be provided twenty-four hours a day, seven days a week by or under the direction of a psychiatrist, a psychiatric nurse practitioner or a Psychologist when legally authorized by the state. Inpatient Facility Services are recommended for patients who are an acute danger to themselves or others or who are unable to provide required self-care and lack available support.

2. Inpatient Medical Services

The following Services are provided for the Inpatient treatment of Mental Illness by a Professional Provider:

a. individual psychotherapy;

b. group psychotherapy;

c. psychological testing;

d. Family Counseling;

Counseling with family members to assist in the Member patient's diagnosis and treatment.

e. convulsive therapy treatment; and

Electroshock treatment or convulsive drug therapy including Anesthesia when administered concurrently with the treatment by the same Professional Provider.

f. medication management.

3. **Partial Hospitalization Program**

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 shall be deemed an Outpatient care Visit subject to Outpatient care cost-sharing amounts.

4. **Outpatient Mental Health Care Services**

Inpatient Facility Services and Inpatient Medical Services Benefits as described in this Subsection are also available when provided for the Outpatient treatment of Mental Illness by a Facility Provider or a Professional Provider. Benefits are also provided for Mental Health Care Services received through an Intensive Outpatient Program.

Benefits are subject to provisions set forth in the **<u>HEALTH CARE MANAGEMENT SERVICES</u>** Subsection of **SECTION HC - HEALTH CARE MANAGEMENT SERVICES** of this Agreement.

Q. <u>ORTHOTIC DEVICES</u>

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

R. <u>OUTPATIENT PRESCRIPTION DRUGS</u>

1. Benefits are provided for Covered Medications appearing on the Formulary when prescribed by a Professional Provider in connection with a Covered Service, when purchased at a Participating Pharmacy Provider upon presentation of a valid Identification Card and when dispensed on or after the Member's Effective Date for Outpatient use. Benefits for Covered Medications are provided in the amounts specified in the Outline of Coverage.

   Covered Medications are placed into cost-sharing tiers by the Plan based on an analysis of clinical efficacy, unique value, safety, and pharmacoeconomic impact. Each tier is subject to periodic review and modification by the Plan or a designated committee of Physicians or pharmacists.

   Coverage is provided for:

   a. Prescription Drugs, including Specialty Prescription Drugs, obtained from a retail Participating Pharmacy Provider or through a mail service program from a Designated Mail-Order Pharmacy Provider; and

b. Selected Prescription Drugs within, but not limited to, the following drug classifications only when such drugs are Covered Medications and when dispensed through an Exclusive Pharmacy Provider:

   i) Oncology related therapies;

   ii) Interferons;

   iii) Agents for multiple sclerosis and neurological related therapies;

   iv) Antiarthritic therapies;

   v) Anticoagulants;

   vi) Hematinic agents;

   vii) Immunomodulators;

   viii) Growth hormones; and

   ix) Hemophilia related therapies.

   These selected Prescription Drugs may be ordered by a Physician or other health care Provider on behalf of the Member, or the Member may submit the Prescription Order directly to the Exclusive Pharmacy Provider. In either situation, the Exclusive Pharmacy Provider will deliver the Prescription Drug to the Member.

Members may contact the Plan at the toll-free telephone number or the website appearing on the back of the Member's Identification Card to verify whether a particular Prescription Drug: a) appears on the Formulary, and if so, in which tier; or b) is a Specialty Prescription Drug and whether it may be purchased from a Participating Pharmacy Provider or must be obtained through an Exclusive Pharmacy Provider.

2. Benefits are provided for continuous glucose monitoring devices when prescribed by a Professional Provider in connection with a Covered Service, when purchased at a Participating Pharmacy Provider upon presentation of a valid Identification Card and when dispensed on or after the Member's Effective Date for Outpatient use.

3. **Limitations**

   a. No coverage is provided for Covered Medications purchased at a Pharmacy Provider that is not a Network Provider.

   b. Each Covered Medication from a retail Participating Pharmacy Provider is limited to a 31, 60 or 90-day supply. Maintenance Prescription Drugs obtained from a retail Participating Pharmacy Provider or from a Designated Mail-Order Pharmacy Provider are limited to a 90-day supply. Certain Specialty Prescription Drugs,

including those which must be obtained from an Exclusive Pharmacy Provider, are limited to a 31-day supply.

A partial supply of a Maintenance Prescription Drug will be provided for the purpose of Medication Synchronization if the pharmacist or Physician determines that the fill or refill is in the best interest of the Member and the Member agrees to such a partial supply. Member cost-sharing will be prorated accordingly for each partial supply provided. A partial fill in excess of three (3) times per year for each Maintenance Prescription Drug will be provided at the discretion of the Plan.

NOTE: Certain retail Participating Pharmacy Providers may have agreed to make Maintenance Prescription Drugs available pursuant to the same terms and conditions, including cost-sharing and quantity limits, as the mail service coverage set forth in this Agreement. Members may contact the Plan at the toll-free number or the website appearing on the back of the Member's Identification Card for a listing of those retail Participating Pharmacy Providers who have agreed to do so.

c. Except for the purposes of Medication Synchronization, no coverage is provided for any refill of a Covered Medication that is dispensed before the date of the Member's predicted use of at least ninety percent (90%) of the days' supply of the previously dispensed Covered Medication, unless the Member's Physician obtains Precertification from the Plan for an earlier refill.

d. Quantity level limits may be imposed on certain Prescription Drugs by the Plan. Such limits are based on the manufacturer's recommended daily dosage or as determined by the Plan. Quantity level limits control the quantity covered each time a new Prescription Order or refill is dispensed for selected Prescription Drugs. Each time a Prescription Order or refill is dispensed, the Participating Pharmacy may limit the amount dispensed.

e. The quantity level limit of Covered Medications for which benefits are payable hereunder for each initial Prescription Order may be reduced, dependent upon the particular medication, to a quantity level necessary to establish that the Member can tolerate the Covered Medication. Consequently, the amounts set forth in the Outline of Coverage will be prorated based upon the initial quantity dispensed. If the Member is able to tolerate the Covered Medication, the remainder of the available days supply for the initial Prescription Order will be filled and the Member will be charged the balance of the amount applicable to the initial Prescription Order.

f. Insulin syringes, needles, and/or disposable diabetic testing materials will be covered by the same payment 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 payment when dispensed.

g. The selected Prescription Drugs dispensed through an Exclusive Pharmacy Provider are subject to the cost-sharing provisions set forth in the Outline of Coverage, and

to the day supply quantity limitations for non-Maintenance Prescription Drugs as set forth in this Paragraph 3. **Limitations**, Subparagraph b.

h. Benefits are provided for certain specified drugs when dispensed to Members on a “stepped basis”, referred to as the “Step Therapy” Program. Within selected drug categories, benefits are only provided for specified Prescription Drugs when one (1) or more alternative drugs prove ineffective or intolerable and the following criteria are met: (1) the Member has used alternative drug(s) within the same therapeutic class/category as the specified Prescription Drug; (2) the Member has used the alternative drugs for a length of time necessary to constitute an adequate trial; and (3) the specified Prescription Drug is being used for an FDA approved indication. If these criteria are met, the Participating Pharmacy Provider will dispense the specified Prescription Drug to the Member. The Member shall be responsible for any cost-sharing amounts and will be subject to any quantity limit requirements or other limitations set forth in this Agreement. When these criteria are not met, the treating Physician may submit a request for authorization to dispense a specified Prescription Drug to the Member for the Plan’s consideration. The Step Therapy Program will not apply to Covered Medications prescribed for the treatment of stage 4 advanced metastatic cancer if: (1) the specified Prescription Drug is approved by the FDA for this indication, and (2) the specified Prescription Drug is consistent with the best clinical practices for the treatment of stage 4 advanced metastatic cancer or a severe adverse health condition experienced as a result of stage 4 advanced metastatic cancer.

i. Continuous glucose monitoring devices are available from a retail Participating Pharmacy Provider or a Designated Mail-Order Pharmacy Provider. Receiver kits are limited to one (1) per Benefit Period. Sensor kits are limited to one (1) refill every thirty (30) days. Transmitter kits are limited to one (1) refill every ninety (90) days.

j. Benefits provided under this Subsection are not subject to the provisions of the **COORDINATION OF BENEFITS** Subsection of **SECTION GP - GENERAL PROVISIONS** of this Agreement.

Important: See **SECTION EX - EXCLUSIONS** of this Agreement for additional conditions, limitations, and exclusions which affect a Member’s Outpatient Prescription Drug coverage.

S. PREVENTIVE SERVICES

Benefits are provided for the following Covered Services and Covered Medications in the amounts specified in the Outline of Coverage, in accordance with a predefined schedule*

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

based on age and sex, and are exempt from the Deductible Coinsurance, and Copayment amounts.

1. **Adult Care**

   Benefits are provided for routine physical examinations and routine vision and hearing screenings when performed by a PCP regardless of Medical Necessity and Appropriateness. The routine physical examination includes a complete medical history, and other items and Services.

2. **Adult Immunizations**

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

3. **Diabetes Prevention Program**

   Benefits are provided for those Members meeting certain medical criteria of having a high risk of developing type 2 diabetes when enrolled in a Diabetes Prevention Program that is offered through a Network Diabetes Prevention Provider. Coverage is limited to one (1) enrollment in a Diabetes Prevention Program per year, regardless of whether the Member completes the Diabetes Prevention Program.

4. **Mammographic Screenings**

   Benefits are provided for the following Covered Services in amounts specified in the Outline of Coverage:

   a. One (1) annual routine mammographic screening starting at forty (40) years of age or older pursuant to the 2002 recommendations by the United States Preventive Services Task Force; and

   b. Mammographic screenings for all Members, regardless of age, when such Services are prescribed by a Physician.

   Benefits for mammographic screenings 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.

5. **Pediatric Care**

   Benefits are provided for routine physical examinations and diagnostic Services regardless of Medical Necessity and Appropriateness, and other items and Services.

6. **Pediatric Immunizations**

   Benefits are provided to Members under twenty-one (21) years of age for those pediatric immunizations, including the immunizing agents which, as determined by the

Pennsylvania Department of Health, conform with 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.

7. **Preventive Covered Medications**

   Coverage will be provided for Prescription Drugs and Over-the-Counter Drugs which are prescribed for preventive purposes, upon presentation of a written Prescription Order. Preventive Covered Medications include all Food and Drug Administration approved tobacco cessation medications. Preventive Covered Medications are subject to the terms and conditions set forth in the **OUTPATIENT PRESCRIPTION DRUGS** Subsection of this **SECTION DB - DESCRIPTION OF BENEFITS**.

8. **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 year.

9. **Tobacco Use Counseling and Interventions**

   Benefits are provided for screenings for tobacco use and, for those who use tobacco products, two (2) tobacco cessation attempts per year. A tobacco cessation attempt includes four (4) tobacco cessation counseling sessions and Covered Medications as set forth in the Paragraph 7. **Preventive Covered Medications** of this Subsection.

10. **Well-Woman Care**

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

T. PROSTHETIC APPLIANCES

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

U. SKILLED NURSING FACILITY SERVICES

1. Services rendered in a Skilled Nursing Facility to the same extent benefits are available to an Inpatient of a Hospital.

Benefits for Skilled Nursing Facility Services cannot exceed the Maximum number of days shown in the Outline of Coverage of this Agreement.

2. No benefits are payable:

   a. after the Member has reached the maximum level of recovery possible for the Member's 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 assist the Member with the activities of daily living or to provide an institutional environment for the convenience of a Member; and

   c. for the treatment of Substance Abuse or Mental Illness.

V. SPINAL MANIPULATIONS

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

W. SUBSTANCE ABUSE SERVICES

Benefits are provided for Detoxification Services, individual and group counseling and psychotherapy, psychological testing, and Family Counseling for the treatment of Substance Abuse when rendered to a Member by a Facility Provider or Professional Provider and include the following:

1. Detoxification Services rendered:

   a. on an Inpatient basis in a Hospital or Substance Abuse Treatment Facility; or

   b. on an Outpatient basis;

2. Substance Abuse Treatment Facility Services for non-Hospital Inpatient residential treatment and rehabilitation Services. Residential treatment and rehabilitation Services include medically monitored high intensity Inpatient Services with twenty-four hour nursing care and Physician availability and medically managed intensive Inpatient Services with twenty-four hour nursing care and daily Physician oversight; and

3. Outpatient Services rendered in a Hospital or Substance Abuse Treatment Facility or through an Intensive Outpatient Program or Partial Hospitalization Program, and Outpatient Substance Abuse Treatment Facility Services for rehabilitation therapy. For purposes of this benefit, a Substance Abuse Service provided on a Partial Hospitalization basis shall be deemed an Outpatient care Visit subject to Outpatient care cost-sharing amounts. Benefits are also provided for Substance Abuse Services rendered through an Opioid Treatment Program or Office Based Opioid Treatment Program.

Benefits are subject to provisions set forth in the **HEALTH CARE MANAGEMENT SERVICES** Subsection of **SECTION HC - HEALTH CARE MANAGEMENT SERVICES** of this Agreement.

X. THERAPY SERVICES

Benefits will be provided for the following Covered Services only when such Services are ordered by a Physician.

1. **Chemotherapy**

2. **Dialysis Treatment**

3. **Infusion Therapy**

   Benefits will be provided when Covered Services are performed by a Provider on an Outpatient basis or if the components are furnished and billed by a Provider. Covered Services include pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with Infusion Therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with Infusion Therapy. Benefits for certain Infusion Therapy Prescription Drugs as identified by the Plan and which are appropriate for self-administration, will be provided only when received from a Participating Pharmacy Provider as set forth under the **OUTPATIENT PRESCRIPTION DRUGS** Subsection of this Section.

4. **Pulmonary Therapy**

5. **Radiation Therapy**

6. **Respiratory Therapy**

Y. TRANSPLANT SERVICES

Subject to the provisions of this Agreement, benefits will be provided for Covered Services furnished by a Hospital which are directly and specifically related to transplantation of organs, bones, tissue or blood stem cells.

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

1. When both the recipient and the donor are Members, each is entitled to the benefits of this Agreement;

2. When only the recipient is a Member, both the donor and the recipient are entitled to the benefits of this Agreement subject to the following additional limitations:

   a. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, or other Blue Cross or Blue Shield coverage or any government program, and

b. Benefits provided to the donor will be charged against the recipient's coverage under this Agreement to the extent that benefits remain and are available under this Agreement after benefits for the recipient's own expenses have been paid;

3. When only the donor is a Member, the donor is entitled to the benefits of this Agreement, subject to the following additional limitations:

   a. 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 Agreement, and

   b. No benefits will be provided to the non-Member transplant recipient;

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

Z. VISION CARE SERVICES

Pediatric Vision Care Services

Benefits are provided for Members every twelve (12) consecutive months for the following when rendered by a Vision Provider who is a Network Provider:

a. one (1) comprehensive eye examination (including dilation as professionally indicated);

b. one (1) pair of single vision, bifocal, trifocal or lenticular lenses (including glass, plastic or oversized lenses); and

c. one (1) pair of frames from a selection designated by the Plan.

Coverage for Pediatric Vision Care Services terminates at the end of the month in which the Member reaches age nineteen (19).

Benefits provided under this Subsection are not subject to the provisions of the **COORDINATION OF BENEFITS** Subsection of **SECTION GP - GENERAL PROVISIONS** of this Agreement.

SECTION EX - EXCLUSIONS

Except as specifically provided in this Agreement, or as the Plan is mandated or required to pay based on state or federal law, no benefits will be provided for services, supplies, Prescription Drugs or charges:

1. Which are not Medically Necessary and Appropriate as determined by the Plan;

2. Which are not prescribed by or performed by or upon the direction of a Professional Provider;

3. Rendered by other than Providers and Suppliers identified herein;

4. Which are Experimental/Investigative in nature, except as provided herein for Routine Patient Costs Incurred in connection with an Approved Clinical Trial;

5. Rendered prior to the Member's Effective Date;

6. Incurred after the date of termination of the Member's coverage except as provided in the **BENEFITS AFTER TERMINATION OF COVERAGE** Subsection of **SECTION GP - GENERAL PROVISIONS** of this Agreement;

7. For loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of an act of war whether declared or undeclared;

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

9. Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;

10. To the extent payment has been made under Medicare when Medicare is primary;

11. For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease, or similar type legislation. This exclusion applies whether or not the Member files a claim for said benefits or compensation;

12. To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service-connected illness or injury, unless the Member has a legal obligation to pay;

13. For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such 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;

14. For nicotine cessation support programs and classes for nicotine cessation purposes, except as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

15. Which are submitted by a Certified Registered Nurse and another Professional Provider for the same services performed on the same date for the same Member;

16. Rendered by a Provider who is a member of the Member's Immediate Family;

17. Performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program;

18. For ambulance services, except as provided in **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

19. For a cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except: a) as otherwise provided in **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement; b) when required to correct a condition directly resulting from an accident; c) when necessary to correct a functional impairment which directly results from a covered disease or injury; or d) to correct a congenital birth defect;

20. For telephone consultations which do not involve Telemedicine Services, charges for failure to keep a scheduled Visit, or charges for completion of a claim form;

21. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a Professional Provider;

22. For Inpatient admissions which are primarily for diagnostic studies or for Physical Medicine;

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

24. For Respite Care, except as provided in the **HOSPICE CARE SERVICES** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

25. 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 including, but not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except as provided in **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

26. For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the

occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma;

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

28. For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;

29. Related to treatment provided specifically for the purpose of Assisted Reproductive Technology, including pharmacological or hormonal treatments used in conjunction with Assisted Reproductive Technology;

30. For sterilization, except as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

31. For reversal of sterilization;

32. For impotency treatment drugs;

33. For oral impotency drugs;

34. For fertility drugs except as provided in the **ARTIFICIAL INSEMINATION** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

35. For contraceptive services including contraceptive Prescription Drugs, contraceptive devices, implants and injections and all related services, except when provided for purposes other than birth control, or as set forth in a predefined schedule described in the **PREVENTIVE SERVICES** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

36. Except for Preventive Covered Medications set forth in a predefined schedule described in the **PREVENTIVE SERVICES** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement and which are prescribed for preventive purposes, the following drugs or services are not covered:

    a. Drugs and supplies that can be purchased without a Prescription Order;

    b. Over-the-Counter Drugs which are not set forth in a predefined schedule described in the **PREVENTIVE SERVICES** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement and are not prescribed for preventive purposes;

    c. Topical antifungals;

    d. Antitussives (cough/cold);

e. Charges for administration of Prescription Drugs and/or injectable insulin whether by a Physician or other person;

f. Charges for a Prescription Drug when such drug or medication is used for unlabeled or unapproved indications where such use has not been approved by the Food and Drug Administration (FDA);

g. Topical acne retinoid products when prescribed for cosmetic purposes such as to minimize the appearance of facial wrinkles, facial mottled hyperpigmentation, hypopigmentation associated with photoaging, and facial skin roughness;

h. Hair growth stimulants;

i. Compounded medications;

37. For services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments and prenatal/delivery/postnatal services;

38. For private duty nursing services;

39. For weight control drugs and services intended to produce weight loss, except as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

40. For nutritional counseling, except as provided herein or as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

41. For weight reduction programs, including all diagnostic testing related to weight reduction programs, except as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

42. For the treatment of obesity, except as set forth in the predefined schedule described in the **PREVENTIVE SERVICES** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

43. For prescription vitamins, except vitamins prescribed during pregnancy, and fluoride legend vitamins, or as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

44. For any eye examinations or vision care services, except as provided in **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement, or as mandated by law, and for any eye examinations or vision care services rendered by a Physician or Professional Provider who is not a Vision Provider who is a Network Provider;

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

46. For any food including, but not limited to, Enteral Foods, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an Outpatient basis, except as provided in the **ENTERAL FOODS** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

47. For preventive care services, wellness services or programs, except as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

48. For allergy testing, except as provided in **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement or as mandated by law;

49. For routine or periodic physical examinations, except as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, except as mandated by law;

50. For immunizations required for foreign travel or employment, except as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

51. For Outpatient Habilitative and Rehabilitative Services for which there is no expectation of acquiring, restoring, improving or maintaining a level of function;

52. For treatment of sexual dysfunction not related to organic disease or injury;

53. For any care that is related to conditions such as learning disabilities, behavioral problems or intellectual disabilities, but not including care related to Autism Spectrum Disorders which extends beyond traditional medical management or Medically Necessary and Appropriate Inpatient confinement. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education, 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 related to the treatment of learning disorders or learning disabilities; and d) services provided primarily for social or environmental change or for respite care;

54. For any care that is related to Autism Spectrum Disorders which extends beyond traditional medical management, except as otherwise provided in **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic

skills training or those for remedial education, 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; and c) services provided primarily for respite care;

55. For any care, treatment, or service which has been disallowed under the provisions of the Health Care Management Services Program;

56. For any care, treatment or service for any loss sustained or contracted in consequence of the Member's being intoxicated, or under the influence of any narcotic unless administered on the advice of a Physician;

57. For any care, treatment or service for any loss to which a contributing cause was the Member's commission of or attempt to commit a felony or to which a contributing cause was the Member's being engaged in an illegal occupation;

58. For otherwise Covered Services ordered by a court or other tribunal unless Medically Necessary and Appropriate or if the reimbursement of such services is required by law;

59. For acupuncture services;

60. For elective abortions, except those abortions necessary to avert the death of the Member or terminate pregnancies caused by rape or incest;

61. For the following services or charges related to pediatric dental services, except as specifically provided in this Agreement:

    a. For treatment started prior to the Member's Effective Date or after the termination date of coverage under this Agreement, (including, but not limited to, multi-visit procedures such as endodontics, crowns, fixed partial dentures, inlays, onlays, and dentures);

    b. For house or Hospital calls for dental services and for hospitalization costs (including, but not limited to, facility-use fees);

    c. For Prescription and non-Prescription Drugs, vitamins or dietary supplements;

    d. Cosmetic in nature as determined by the Plan (including, but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures);

    e. Elective procedures (including, but not limited to, the prophylactic extraction of third molars);

    f. For congenital mouth malformations or skeletal imbalances (including, but not limited to, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment). This exclusion does not apply to the treatment of medically diagnosed congenital defects or birth abnormalities of a newborn child or newly adopted children, regardless of age;

g. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under this Agreement. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint;

h. For treatment of fractures and dislocations of the jaw;

i. For treatment of malignancies or neoplasms;

j. Services and/or appliances that alter the vertical dimension (including, but not limited to, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method;

k. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances;

l. Periodontal splinting of teeth by any method;

m. For duplicate dentures, prosthetic devices or any other duplicative device;

n. Maxillofacial prosthetics;

o. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions;

p. For treatment and appliances for bruxism (night grinding of teeth);

q. For any claims submitted to the Plan by the Member or on behalf of the Member in excess of twelve (12) months after the date of service;

r. Incomplete treatment (including, but not limited to, patient does not return to complete treatment) and temporary services (including, but not limited to, temporary restorations);

s. Procedures that are:

   i) part of a service but are reported as separate Services;

   ii) reported in a treatment sequence that is not appropriate; or

   iii) misreported or which represent a procedure other than the one reported;

t. Specialized procedures and techniques (including, but not limited to, precision attachments, copings and intentional root canal treatment);

u. Service not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Plan will apply;

v. Fees for broken appointments;

w. For other pediatric dental services not set forth in **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement; and

x. For the following orthodontic services:

   i) Treatments that are primarily for cosmetic reasons;

   ii) Treatments for congenital mouth malformations or skeletal imbalances (including, but not limited to, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment); and

   iii) Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Schedule of Benefits. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint;

62. For oral Surgery procedures, except as provided in **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

63. For Prescription Drugs and Over-the-Counter Drugs not appearing on the Formulary, except where an exception has been granted pursuant to the procedure set forth in **SECTION HC - HEALTH CARE MANAGEMENT SERVICES**, the **<u>HEALTH CARE MANAGEMENT SERVICES</u>**, Subsection, Paragraph 10. **Prescription Drug Exceptions**;

64. For Bariatric Surgery including reversal, revision, repeat and staged Surgery, except for the treatment of sickness or injury resulting from such Bariatric Surgery;

65. For a Diabetes Prevention Program offered by other than a Network Diabetes Prevention Provider;

66. For any tests, screenings, examinations or any other Services solely required by an employer or governmental agency or entity in order to begin or to continue working or as a condition to performing the functions of any employment in a particular setting or location; and

67. For any other medical or dental service or treatment or Prescription Drug except as provided in this Agreement or as mandated by law.

SECTION GP - GENERAL PROVISIONS

A. APPEAL PROCEDURE

1. Internal Appeal Process

a. The Plan maintains an internal appeal process involving one (1) level of review.

b. At any time during the appeal process, a Member may choose to designate an authorized representative to participate in the appeal process on the Member's behalf. The Member or the Member's authorized representative shall notify the Plan, in writing, of the designation. For purposes of the appeal process, authorized representative 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. The Plan reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member. Such procedures as adopted by the Plan shall, in the case of an Urgent Care Claim, permit a Professional Provider with knowledge of the Member's medical condition to act as the Member's authorized representative.

   At any time during the appeal process, a Member may contact the Member Service Department at the toll-free telephone number listed on the Member's Identification Card to inquire about the filing or status of an appeal.

c. If a Member has received notification that a Claim has been denied by the Plan, in whole or in part, the Member may appeal the decision. For purposes of this Subsection, determinations made by the Plan to rescind a Member's coverage, to not continue the coverage of an Eligible Dependent child past the limiting age based on a disability, or to deny the enrollment request of an individual that the Plan has determined is ineligible for coverage under this Agreement, can also be appealed in accordance with the procedures set forth in this Subsection. The Member's appeal must be submitted within one hundred eighty (180) days from the date of the Member's receipt of notification of the adverse decision.

d. The Member, upon request to the Plan, may review all documents, records and other information relevant to the appeal and shall have the right to submit or present additional evidence or testimony which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of the appeal.

e. The appeal will be reviewed by a representative from the Member Grievance and Appeals Department. The representative shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the Claim or matter which is the subject of the Member's appeal. In rendering a decision on the appeal, the Member Grievance and Appeals Department will take into account all evidence, comments, testimony, documents, records and other information submitted by the Member without regard to whether such information was previously submitted to or considered by the Plan. The Member Grievance and Appeals

Department will afford no deference to any prior adverse decision on the Claim which is the subject of the appeal.

f. Each appeal will be promptly investigated and the Plan will provide written notification of its decision within the following time frames:

   i) when the appeal involves a non-urgent care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances involved not to exceed thirty (30) days following receipt of the appeal;

   ii) when the appeal involves an Urgent Care Claim, as soon as possible taking into account the medical exigencies involved but not later than seventy-two (72) hours following receipt of the appeal; or

   iii) when the appeal involves a Post-service Claim, or a decision by the Plan to rescind coverage or deny an enrollment request because the individual is not eligible for coverage, within a reasonable period of time not to exceed thirty (30) days following receipt of the appeal.

g. If the Plan fails to provide notice of its decision within the above-stated time frames or otherwise fails to strictly adhere to these appeal procedures, the Member shall be permitted to request an external review and/or pursue any applicable right to arbitration.

h. In the event that the Plan renders an adverse decision on the internal appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding the right of the Member to request an external review and/or pursue any applicable right to arbitration.

2. **External Review Process**

A Member shall have four (4) months from the receipt of notice of the Plan's decision to appeal the denial resulting from the Internal Appeal Process by requesting external review of the decision. To be eligible for external review, the decision of the Plan to be reviewed must involve:

i) a Claim that was denied involving medical judgment, including application of the Plan's requirements as to medical necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Service or a determination that the treatment is experimental or investigational; or

ii) a determination made by the Plan to rescind a Member's coverage or to deny the enrollment request of an individual due to ineligibility for coverage under this Agreement.

In the case of a denied Claim, the request for external review may be filed by either the Member or a health care Provider, with the written consent of the Member in the format required by or acceptable to the Plan. The request for external review should

include any reasons, material justification and all reasonably necessary supporting information as part of the external review filing.

a. Preliminary Review and Notification

Within five (5) business days from receipt of the request for external review, the Plan will complete a preliminary review of the external review request to determine:

i) in the case of a denied Claim, whether the Member is or was covered under this Agreement at the time the Covered Service which is the subject of the denied Claim was or would have been received;

ii) whether the Member has exhausted the Plan's Internal Appeal Process, unless otherwise not required to exhaust that process; and

iii) whether the Member has provided all of the information and any applicable forms required by the Plan to process the external review request.

Within one (1) business day following completion of its preliminary review of the request, the Plan shall notify the Member, or health care Provider filing the external review request on behalf of the Member, of its determination.

In the event that the external review request is not complete, the notification will describe the information or materials needed to complete the request in which case the Member, or health care Provider filing the external review request on behalf of the Member, must correct and/or complete the external review request no later than the end of the four (4) month period in which the Member was required to initiate an external review of the Plan's decision or, alternatively, forty-eight (48) hours following receipt of the Plan's notice of its preliminary review, whichever is later.

In the event that the external review request is complete but not eligible for external review, notification by the Plan will include the reasons why the request is ineligible for external review and contact information that the Member may use to receive additional information and assistance.

b. Final Review and Notification

Requests that are complete and eligible for external review will be assigned to an Independent Review Organization (IRO) to conduct the external review. The assigned IRO will notify the Member, or health care Provider filing the external review request on behalf of the Member, that the request has been accepted and is eligible for external review. The notice will further state that the IRO has been assigned to conduct the external review and that any additional information which the Member or health care Provider may have in support of the request must be submitted, in writing, within ten (10) business days following receipt of the notice. Any additional information timely submitted by the Member or health care Provider and received by the assigned IRO will be forwarded to the Plan. Upon receipt of the information, the Plan shall be permitted an opportunity to reconsider its prior decision

regarding the Claim that was denied or the matter which is the subject of the external review request.

The assigned IRO will review all of the information and documents that it timely received and make a decision on the external review request. The decision shall be made without regard or deference to the decision that was made in the Plan's Internal Appeal Process. The assigned IRO shall provide written notice of its final external review decision to the Plan and Member, or the health care Provider filing the external review request on behalf of the Member, within forty-five (45) days from receipt by the IRO of the external review request. Written notice of the decision shall provide, among other information, a statement of the principal reasons for the decision including the rationale and standards relied upon by the IRO, a statement that arbitration may be available to the Member and current contact information for the Pennsylvania Insurance Department Office of Consumer Services or such other applicable office of health insurance consumer assistance or ombudsman.

c. Expedited External Review
(Applies to Urgent Care Claims only)

If the initial decision of the Plan or the denial resulting from the Plan's Internal Appeal Process involves an Urgent Care Claim, a Member or health care Provider on behalf of the Member may request an expedited external review of the Plan's decision. Requests for expedited external review are subject to review by the Plan to determine whether they are timely, complete and eligible for external review. When the request involves a denied Urgent Care Claim, the Plan must complete the preliminary review and provide notice of its eligibility determination immediately upon receipt of the request for expedited external review. If the request is eligible for expedited external review, the Plan must then transmit all necessary documents and information that was considered in denying the Urgent Care Claim involved to an assigned IRO in an expeditious manner. The assigned IRO will conduct the review and provide notice of its final external review decision as expeditiously as the Member's medical condition or circumstances require, but in no event more than seventy-two (72) hours following receipt by the IRO of the request for expedited external review. If notice of the decision by the IRO is not provided in writing, the IRO must provide within forty-eight (48) hours following initial notice of its final external review decision written confirmation of that decision to the Plan and the Member, or health care Provider filing the expedited external review request on behalf of the Member.

3. **Member Assistance Services**

Members may obtain assistance with the Plan's claim and internal appeal and external review procedures set forth in this Section by contacting the Pennsylvania Insurance Department Office of Consumer Services or such other applicable office of health insurance consumer assistance or ombudsman.

B. **BENEFITS AFTER TERMINATION OF COVERAGE**

1. If a Member is continuously disabled on the day this Agreement is terminated by the Plan, benefits will be provided under the terms of this Agreement while the Member is so continuously disabled. For purposes of this Subsection, continuously disabled means that the Member is an Inpatient in a Facility Provider. Continuation of benefits under this Paragraph will not be provided if this Agreement is terminated by the Plan for fraud or intentional misrepresentation of a material fact.

   Benefits will be provided, for charges Incurred for the inpatient confinement, until the earlier of:

   a. the Maximum level of benefits has been reached; or

   b. the end of the Benefit Period.

   Any such continuation of benefits after the date this Agreement is terminated is conditioned upon the continuous inpatient confinement of the Member and the providing of documentation as required by the Plan which evidences such continued inpatient confinement.

2. If a Member is pregnant on the date coverage terminates, except for non-payment of premium, fraud or intentional misrepresentation of a material fact, benefits will be provided for Covered Services related to that pregnancy until the Maximum amount of benefits has been paid.

3. If a newborn child is not otherwise eligible for continuing benefits beyond the first thirty-one (31) days as a Dependent under this or any other current agreement, benefits may be continued for such child if, within said thirty-one (31) day period, the Member applies for and is issued an Agreement for said newborn either individually or as a Dependent, subject to Paragraph 1 of this Subsection.

   If this Agreement terminates as the result of non-payment of premiums, fraud or intentional misrepresentation of a material fact, the liability of the Plan shall cease as of the date of such termination, and no benefits will be provided for newborn care Incurred after that date, subject to Paragraph 1 of this Subsection.

C. **BENEFITS TO WHICH MEMBERS ARE ENTITLED**

1. The benefit liability of the Plan is limited to the benefits specified in this Agreement.

2. Except as provided in the **TRANSPLANT SERVICES** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** no person other than a Member is entitled to receive benefits under this Agreement. Such right to benefits and coverage is not transferable.

3. Benefits for Covered Services specified in this Agreement will be provided only for Services and supplies rendered by a Provider as defined in **SECTION DE - DEFINITIONS** and regularly included in such Provider's charges.

D. COMPLIANCE WITH THE LAW; AMENDMENT

Anything contained herein to the contrary notwithstanding, the Plan shall have the right to modify this Agreement, including any endorsements hereto, at any time during the term of this Agreement, for the following purposes:

a. to comply with the provisions of any law, regulation or lawful order; and/or

b. to reflect the loss or discontinuation of payments made or to be made by the federal government or any state or local government.

These amendments may include, but are not limited to, the modification of premium rates and the increase, reduction or elimination of any of the benefits provided for any one (1) or more eligible Members enrolled under the terms of this Agreement.

Each party hereby agrees to any amendment of this Agreement which is necessary in order to accomplish such purpose.

E. CONTINUATION UPON DEATH OF SUBSCRIBER OR TERMINATION OF SUBSCRIBER'S COVERAGE

Unless coverage under this Agreement is provided pursuant to enrollment through the Exchange, coverage may continue under this Agreement for the covered Dependents upon termination of the Subscriber's coverage under this Agreement due to enrollment in a Medicare Supplemental or Medicare Advantage plan, or due to the death of the Subscriber, for any period for which premium has already been paid. The Subscriber's spouse or Domestic Partner, if covered under this Agreement, shall thereafter become the Subscriber upon notice to the Plan of the termination of the Subscriber's coverage or the Subscriber's death. If the Subscriber's spouse or Domestic Partner was not covered under this Agreement, a Dependent child may become a Subscriber but only under the Dependent child's own agreement.

F. COORDINATION OF BENEFITS

Except as otherwise stated, all benefits provided under this Agreement are subject to the following provisions of this Subsection and will not be increased by virtue of this Subsection.

1. Definitions

In addition to the Definitions of this Agreement, the following definitions apply to this Subsection:

a. Other Agreement - any individual, group or group-type coverage, whether insured or uninsured, providing health care benefits or Services, other than school/student accident-type coverage, or a group or group-type hospital indemnity Agreement of one hundred dollars ($100) per day or less, including:

i) Blue Cross, Blue Shield, health maintenance organization and other prepayment coverage;

ii) coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and

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

"Other Agreement" 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 Agreements into consideration in determining its benefits and that portion which does not.

b. Dependent - for any Other Agreement, any person who qualifies as a Dependent under that Agreement.

c. Allowable Expense - a health care expense, including any Deductibles, Copayments and Coinsurance for a Service or supply specified in this Agreement, to the extent that such Service or supply is covered by this and/or the Other Agreement. When benefits are provided in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by this and/or the Other Agreement is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

i) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless this or the Other Agreement provides coverage for private hospital room expenses.

ii) If a Member is covered by this and one (1) or more Other Agreements that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

iii) If a Member is covered by this and one (1) or more Other Agreements that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

iv) If a Member is covered by this and an Other Agreement, one (1) of which calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and the other of which provides its benefits or services on the basis of negotiated fees, the payment arrangement of the Primary Agreement will be deemed the Allowable Expense. However, if a provider under the Secondary Agreement provides benefits or services for a specific negotiated fee or payment amount that is different than the payment arrangement under the Primary Agreement and if the provider's contract permits, the negotiated fee or

payment shall be the Allowable Expense used by the Secondary Agreement to determine its benefits.

v) The amount of any benefit reduction under the Primary Agreement because a Member has failed to comply with the plan provisions is not an Allowable Expense. Examples of these types of provisions include, but are not limited to, second surgical opinions, precertification of admissions, and preferred provider arrangements.

d. Primary/Secondary Agreement **-** the order of benefit determination rules state whether this Agreement is a Primary Agreement or a Secondary Agreement.

i) When this Agreement is a Primary Agreement, its benefits are determined before those of the Other Agreement and without considering the Other Agreement's benefits.

ii) When this Agreement is a Secondary Agreement, its benefits are determined after those of the Other Agreement and may be reduced because of the benefits of the Other Agreement.

iii) When there are more than two (2) Other Agreements covering the person, this Agreement may be a Primary Agreement as to one (1) or more Other Agreements, and may be a Secondary Agreement as to a different agreement or agreements.

2. **Effect On Benefits**

a. This Subsection shall apply in determining the benefits payable under this Agreement if, for the Covered Services received, the sum of the benefits payable under this Agreement and the benefits payable under Other Agreements would exceed the total Allowable Expense.

b. Except as provided in Paragraph 2.c. of this Subsection, when this Agreement is a Secondary Agreement, benefits will be calculated based on what the Plan would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under this Agreement that is unpaid under the Primary Agreement. The Plan may reduce its payment by the amount so that, when combined with the amount paid under the Primary Agreement, the total benefits paid or provided under all agreements for the claim do not exceed the total Allowable Expense for that claim. In addition, the Plan shall credit to the applicable Deductible any amounts it would have credited to that Deductible in the absence of other health care coverage. Benefits payable under Other Agreements include the benefits that would have been payable had claim been made.

c. If,

i) an Other Agreement contains a provision coordinating its benefits with those of this Agreement and its rules require the benefits of this Agreement to be determined first; and

ii) the rules set forth in Paragraph 2.d. of this Subsection require the benefits of this Agreement to be determined first;

then the benefits of the Other Agreement will be disregarded in determining the benefits under this Agreement.

d. In accordance with the National Association of Insurance Commissioners, this Agreement determines its order of benefits using the first of the following rules which apply:

i) the benefits of an agreement which covers the person as other than a Dependent shall be determined first;

ii) when this Agreement and an Other Agreement cover the person as a Dependent child whose parents are married or are living together, whether or not they have ever been married:

(a) the benefits of the agreement which covers the person as a Dependent of the parent whose birthday (month and day) falls earliest in the year shall be determined first; but,

(b) if both parents have the same birthday, the benefits of the agreement which covered the parent longer are determined before those of the Agreement which covered the other parent for a shorter period of time.

iii) when this Agreement and an Other Agreement cover the person as a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(a) if a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage, that agreement is the Primary Agreement;

(b) if a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of d. ii) (a) above shall determine the order of benefits;

(c) if a court decree states that parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of d. ii) (a) above shall determine the order of benefits; or

(d) if there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

i. the agreement covering the custodial parent;

ii. the agreement covering the spouse of the custodial parent;

iii. the agreement covering the non-custodial parent; and then

iv. the agreement covering the spouse of the non-custodial parent.

iv) The benefits of the agreement covering the person as an employee other than a laid-off or retired employee or as a Dependent of such person shall be determined before the benefits of the agreement covering the same person as a laid-off or retired employee or as a Dependent of such person. If an Other Agreement does not have this provision regarding laid-off or retired employees and, as a result, the agreements do not agree on the order of benefits, then this rule is ignored.

v) If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under an Other Agreement, the agreement covering the person as an employee, member, subscriber or retiree or covering the person as a Dependent of an employee, member, subscriber or retiree is the Primary Agreement and the COBRA or state or other federal continuation coverage is the Secondary Agreement. If an Other Agreement does not have this rule, and as a result, the agreements do not agree on the order of benefits, then this rule is ignored. This rule does not apply if the rule set forth in d. i) above can determine the order of benefits.

vi) If none of the above rules determines the order of benefits, the benefits of the agreement which has covered the person for the longest period of time shall be determined first.

e. If an Other Agreement does not contain provisions establishing the same order of benefit determination rules, the benefits under that agreement will be determined before the benefits under this Agreement.

3. **Facility of Payment**

Whenever payments should have been made under this Agreement in accordance with this Subsection, but the payments have been made under any Other Agreement, the Plan has the right to pay to any organization that has made such payment any amount it determines to be warranted to satisfy the intent of this Subsection. Amounts so paid shall be deemed to be benefits paid under this Agreement and, to the extent of the payments for Covered Services, the Plan shall be fully discharged from liability under this Agreement.

4. **Right of Recovery**

a. Whenever payments have been made by the Plan 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, the Plan shall have the right to recover the excess from among the following, as the Plan shall determine: any person to or for whom such payments were made, any insurance company, or any other organization.

b. The Member and the Plan will cooperate fully to make every reasonable effort under the circumstances, to help secure the Plan’s rights to recover these excess payments.

5. **Benefits Payable**

The Plan shall not be required to determine the existence of any Other Agreement or amount of benefits payable under any Other Agreement except this Agreement. The payment of benefits under this Agreement shall be affected by the benefits payable under any and all Other Agreements only to the extent that the Plan is furnished with information relative to such Other Agreements by the Member or any other insurance company or organization or person.

G. FORCE MAJEURE

1. No failure, delay, or default in performance of any obligation of the Plan required under this Agreement shall constitute an event of default or breach of the Agreement to the extent that such failure to perform, delay or default arises out of a cause, existing or future, that is beyond the reasonable control and not the result of the negligence of the Plan. Such events include, by way of illustration and not limitation, Acts of God, war (declared or undeclared), government regulation, acts or inaction of governmental authority, civil or military authority, unforeseen disruptions caused by suppliers, subcontractors, vendors, or carriers, terrorism, disaster, strikes, civil disorder, curtailment of transportation facilities, fire, floods, blizzards, epidemics, pandemics, viral or communicable disease outbreaks, National Emergency, quarantines, disruption of the labor force and/or any other cause which is beyond the reasonable control of the Plan (hereinafter a "Force Majeure Event"), that makes it impossible, illegal, or commercially impracticable for the Plan to perform its obligations under this Agreement, in whole or in part.

2. Upon the occurrence of a Force Majeure Event, the Plan shall take action to minimize the consequences of the Force Majeure Event. If the Plan relies on any of the foregoing as an excuse for failure, default or delay in performance, it shall give prompt written notice of the facts that constitute such Force Majeure Event, when it arose, and when it is expected to cease to the Subscriber.

H. GOVERNING LAW

This Agreement is entered into and is 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 Agreement shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

I. IDENTIFICATION CARDS

The Plan shall furnish to the Member an Identification Card to be presented to Providers when a service is requested.

J. INTER-PLAN ARRANGEMENTS

1. **Out-of-Area Services**

The Plan has a variety of relationships with other Blue Cross and/or Blue Shield Licensees, referred to generally as “Inter-Plan Arrangements”. These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever Members access health care services outside the geographic area served by Highmark Inc. within Pennsylvania, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the Highmark geographic area within Pennsylvania, Members obtain care from health care providers that have a contractual agreement (“participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, Members may obtain care from health care providers in the Host Blue geographic area that do not have a contractual agreement (“non-participating providers”) with the Host Blue. The Plan remains responsible for fulfilling its contractual obligations to the Member. The Plan payment practices in both instances are described below.

2. **BlueCard® Program**

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services outside the Highmark geographic area within Pennsylvania, the Host Blue will be responsible for contracting and handling all interactions with its participating health care providers. The financial terms of the BlueCard Program are described generally below.

<u>Liability Calculation Method Per Claim</u>

Unless subject to a fixed dollar copayment, the calculation of the Member liability on claims for Covered Services will be based on the lower of the participating provider’s billed charges for Covered Services or the negotiated price made available to the Plan by the Host Blue.

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

i) an actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases, or

ii) an estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

iii) an average price. An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed representing the aggregate

payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e. prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by the Plan in determining your premiums.

3. **Return of Overpayments**

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

4. **Non-Participating Providers Outside of the Highmark Geographic Area Within Pennsylvania**

a. Member Liability Calculation

When Covered Services are provided outside of the Highmark geographic area within Pennsylvania by non-participating providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable law. In these situations, the Member may be responsible for the difference between the amount that the non-participating provider bills and the payment the Plan will make for the Covered Services as set forth in this Subsection. Payments for out-of-network emergency services are governed by applicable federal and state law.

b. Exceptions

In some exception cases, the Plan may pay claims from non-participating health care providers outside of the Highmark geographic area within Pennsylvania based on the provider's billed charge. This may occur in situations where a Member did not have reasonable access to the participating provider, as determined by the Plan in the Plan's sole and absolute discretion or by applicable law. In other exception cases, the Plan may pay such claims based on the payment the Plan would make if the Plan were paying a non-participating provider inside the Plan service area. This may occur

where the Host Blue's corresponding payment would be more than the Plan in-service area non-participating provider payment. The Plan may choose to negotiate a payment with such provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the non-participating health care provider bills and payment the Plan will make for the Covered Services as set forth in this Subsection.

5. **Blue Cross Blue Shield Global® Core**

a. General Information

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

b. Inpatient Services

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

c. Outpatient Services

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

d. Submitting a Blue Cross Blue Shield Global Core Claim

When Members pay for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center address on the form to initiate claims processing. The claim form is available from the Plan, the service center or online at www.bcbsglobalcore.com. If Members need assistance with their claim submissions,

they should call the service center at 1-(800)-810-BLUE (2583) or call collect at 1-(804)-673-1177, 24 hours a day, seven days a week.

K. MEMBER/PROVIDER RELATIONSHIP

1. The choice of a Provider and Supplier is solely that of the Member.

2. The Plan does not furnish Covered Services but only makes payment for Covered Services received by Members. The Plan is not liable for any act or omission of any Provider and Supplier. The Plan has no responsibility for a Provider's and Supplier's failure or refusal to render Covered Services to a Member.

3. The use or non-use of an adjective such as ancillary, network, out-of-network, participating or non-participating in modifying any Provider is not a statement as to the ability of the Provider. Similarly, the use or non-use of an adjective such as contracting or non-contracting in modifying any Supplier is not a statement as to the ability of the Supplier.

4. Network Professional Providers maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services. The relationship between the Plan and any Network Provider is an independent contract relationship. Network Providers are not agents or employees of the Plan, nor is any employee of the Plan an employee or agent of a Network Provider. The Plan 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.

L. OVERPAYMENT OF PLAN BENEFITS

The Plan and the Member will cooperate fully to make every reasonable effort under the circumstances, considering the chances of successful recovery and costs thereof, to recover any payment made to a Member or Provider which is in excess of the amount entitled to be received under the Plan.

M. PAYMENT OF BENEFITS

1. The Plan is authorized by the Member to make payments directly to Providers and Suppliers furnishing Covered Services for which benefits are provided under this Agreement. However, the Plan reserves the right to make the payments directly to the Member.

   The right of a Member to receive payment is not assignable, except to the extent required by law, nor may benefits of this Agreement be transferred either before or after Covered Services are rendered.

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

N. PLAN PAYMENT AND MEMBER LIABILITY

The Plan uses the Plan Allowance to calculate the benefit payable and the financial liability of the Member for Medically Necessary and Appropriate Services covered under this Agreement. In the case of Outpatient Prescription Drug benefits, the Plan uses the Provider's Allowable Price for this calculation. See **SECTION DE - DEFINITIONS** of this Agreement for the definitions of "Plan Allowance" and "Provider's Allowable Price".

1. Plan Payment

The Plan's payment is determined by first subtracting any Deductible and/or Copayment liability from the Plan Allowance. The Coinsurance percentage of the Plan Allowance set forth in the Outline of Coverage is then applied to that amount. This amount represents the Plan's payment. Any remaining Coinsurance amount is the Member's responsibility.

2. Member Liability

The Member's total liability is the sum of any applicable Deductible, Copayment and/or Member Coinsurance obligations. Network Providers, will accept the Plan's payment plus the Member's total liability as payment in full for the Covered Services provided to the Member.

There may be instances when a Network Facility Provider participating at the Enhanced Value level of benefits may have an arrangement with a Professional Provider participating in the Network at the Standard Value level of benefits to render certain professional Covered Services to the patients of the Network Facility Provider. The selection of a Professional Provider participating in the Network at the Standard Value level of benefits may be beyond the patient's control. In such case, claims for Covered Services rendered by the Professional Provider will be subject to Member cost-sharing amounts applicable to the Enhanced Value level of benefits.

In very limited circumstances, Members may also not be liable for charges for non-emergency Covered Services received from certain Professional Providers who are not part of the Network. A Network Facility Provider may have an arrangement with a Professional Provider who is not part of the Network to render certain professional services (such as, but not limited to, anesthesiology, radiology or pathology services) to the patients of the Network Facility Provider. The selection of such Professional Providers may be beyond the patient's control. In that situation, the Member will not be liable, except for applicable Deductible, Copayment or Coinsurance obligations, for the charges of that Professional Provider.

Except for Emergency Care Services, Urgent Care Services or as otherwise set forth herein, in the event a Member receives Covered Services from an Out-of-Network Provider without the required preauthorization, the Member will be responsible for all charges associated with those Services regardless of whether the services received were Medically Necessary and Appropriate

3. **Plan Payment and Member Liability for Covered Medications**

The Plan's payment for Covered Medications purchased from a Participating Pharmacy Provider is determined by first subtracting any Deductible and/or Copayment liability from the Provider's Allowable Price. The Coinsurance percentage of the Provider's Allowable Price as set forth in the Outline of Coverage is then based on that amount once the Deductible, if any, has been satisfied. Any remaining Coinsurance amount is the Member's responsibility subject to any minimum and maximum Coinsurance amount set forth in the Outline of Coverage. The Member's total liability is the sum of any Deductible, Copayment and Coinsurance obligations, if any. Preventive Medications are exempt from any Deductible, Copayment and/or Coinsurance obligation. No benefits are payable for Covered Medications purchased from an Out-of-Network Provider. Coverage is not provided for Prescription Drugs and Over-the-Counter Drugs not appearing on the Formulary, unless an exception has been granted pursuant to the prescription drug exceptions process described in **SECTION HC - HEALTH CARE MANAGEMENT SERVICES** of this Agreement.

4. **Plan Payment for Vision Care Services**

The Plan Allowance for Vision Providers who are Network Providers within or outside Pennsylvania is the amount agreed to by such Vision Provider as payment in full, as set forth in the agreement between the Vision Provider and the Plan.

5. **Plan Payment for Pediatric Dental Services**

The Plan Allowance for Dentists who are Network Providers within or outside Pennsylvania is the amount agreed to by such Dentist as payment in full, as set forth in the agreement between the Dentist and the Plan.

O. PLAN/PROVIDER RELATIONSHIP

The agreement between the Plan and a Network Facility Provider may be terminated by either party upon the giving of ninety (90) days prior written notice to the other party. However, during any Member's Agreement year which began prior to the 30th day after the date of termination of the agreement between the Plan and a Network Facility Provider, the Network Facility Provider shall continue to provide services under the terms of the Member's Agreement until the expiration of the Member's Agreement year.

P. PREMIUM/MODIFICATION

1. Each Agreement is maintained at a premium for which the Subscriber and the Subscriber's enrolled Dependents, if applicable, are eligible.

2. The amount of the premium for the Subscriber, and the Subscriber's Dependents, as applicable, at any time is the rate set forth in the schedule of rates on file with and approved by the Insurance Department of the Commonwealth of Pennsylvania.

3. Coverage under this Agreement begins on the Effective Date and continues until the end of the calendar year. Thereafter, this coverage renews annually. The premium is payable

in advance directly to the Plan on a monthly basis. Members may, for their convenience, submit amounts in excess of the specific monthly premium. However, such excess amounts will only be applied on a monthly basis by the Plan. Acceptance of the excess remittance by the Plan does not convert the term of this Agreement from an annual contract to some other term.

4. The Plan, subject to the approval of the Insurance Department of the Commonwealth of Pennsylvania, may alter or revise the terms of this Agreement or the premiums. Any such alteration or revision of the terms of this Agreement shall become effective for all Members on the effective date of the alteration or revision whether or not the Subscriber has paid the premium in advance.

   Any change in the premiums shall become applicable for Members upon the expiration of the period covered by the Subscriber's current payment at the time of such change. In the event of such alteration or revision of the premium, the Subscriber shall be notified in advance of the new premium and the effective date, and payment of the new premium shall be considered receipt of notice and acceptance of the change in premium.

   Any notice shall be considered to have been given when mailed to the Subscriber at the address on the records of the Plan.

Q. **RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD PLANS**

The Subscriber is hereby notified:

This Agreement is between the Subscriber and the Plan only. Highmark Benefits Group is an independent Corporation operating under a license from the Blue Cross Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield plans throughout the United States. Although all of these independent Blue Cross and Blue Shield plans operate from a license with the Association, each of them is a separate and distinct corporation. The Association allows the Plan to use the familiar Blue words and symbols. The Plan, upon entering into this Agreement, is not contracting as an agent of the national Association. Only the Plan shall be liable to the Subscriber for any of the Plan's obligations under this Agreement. This paragraph does not add any obligations to this Agreement.

R. **RELEASE AND PROTECTION OF MEMBER INFORMATION**

All personally identifiable information about individual Members ("Protected Health Information") is subject to various statutory privacy standards, including state insurance regulations implementing Title V of the Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and regulations adopted thereunder by the Department of Health and Human Services (45 CFR Parts 160, 162, 164). In accordance with those standards, the Plan may use and disclose Protected Health Information to facilitate payment, treatment and health care operations as described in the Highmark Notice of Privacy Practices ("NPP"). Copies of Highmark's current NPP are available on the Highmark internet site, or from the Highmark Privacy Office.

At its sole discretion, the Plan may make available, either directly or through a designated vendor, Member identity theft protection services. Any decision to accept or not accept such services will not affect the continued eligibility, benefits, premiums or cost-sharing of the Member under this Agreement. The Plan shall not be liable for, and the Member shall hold the Plan harmless from, any matters arising from or relating to such services.

S. REPORTS AND RECORDS

Each Member, in connection with the administration of, or delivery or receipt of benefits under this Agreement a) authorizes any insurer, employer, organization and health care service Provider to release to the Plan all personal health information relating to past, present and future health care examinations, treatments and diagnoses and b) authorizes the Plan to release the personal health information described above, including medical records, claims, benefits and other administrative data to insurers, health care service providers, and outside vendors.

The information will only be released in connection with the following purposes: treatment decisions, appeals, complaints and grievances, coordination of care, quality assessment and measurement, quality improvement, preventive measures, audits, utilization management, case management, pharmacy management, physician review, research, fraud investigations, reviews by regulatory and accrediting bodies, claims processing, billing and reimbursement.

Each Member further agrees that approval by the Plan of benefits for any services rendered under this Agreement is contingent upon the furnishing of such information or records or copies of records.

The Member is responsible for maintaining all claims information and correspondence. If the Member requests claims information from the Plan with an incurred date of more than twelve (12) months prior to the request, it will be the Member’s responsibility to pay for the cost of retrieval of such information.

T. REQUIRED PROVISIONS

1. Entire Agreement; Changes

This Agreement, the Subscriber’s application and any Endorsements, the Outline of Coverage, the Member’s enrollment confirmation letter, the Subscriber’s current Identification Card and the Highmark Preventive Schedule, as amended from time to time, constitute the entire Agreement between the Member and the Plan. No change in this benefit agreement shall be valid until approved by an executive officer of the Plan and unless such approval be endorsed hereon or attached hereto. No agent or representative of the Plan, other than a Plan officer, may otherwise change this Agreement or waive any of its provisions. All statements made by a Member shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to a claim under this Agreement, unless it is contained in a written instrument signed by and furnished to the Subscriber.

2. **Time Limit On Certain Defenses**

After three (3) years from the date of issue of this Agreement, no misstatements, except intentional misrepresentations of material fact or fraudulent misstatements, made by the Subscriber in the application for such Agreement shall be used to void the Agreement or to deny a claim for loss incurred or disability commencing after the expiration of such three (3)-year period.

Intentional misrepresentations of material fact or fraudulent misstatements will, at the option of the Plan, render this Agreement void from inception, provided such material misrepresentations or misstatements are discovered by the Plan within three (3) years of the Effective Date. In the event the Plan elects to void this Agreement, the Subscriber will be given at least thirty (30) days advance written notice and will forfeit any charges paid to the extent of any liability incurred by the Plan.

3. **Grace Period**

A grace period of thirty-one (31) days from the due date will be granted for the payment of each premium. During the grace period, the Agreement will stay in force; however, no benefits will be paid for services Incurred subsequent to the Agreement's then current paid date, subject to the **BENEFITS AFTER TERMINATION OF COVERAGE** Subsection of this Section. If appropriate payment is not received at the end of thirty-one (31) days, this Agreement automatically terminates as of the then current paid date without written notification to the Member.

Notwithstanding the above, when coverage under this Agreement is provided pursuant to enrollment through the Exchange and the Subscriber:

a. is receiving APTCs; and

b. has made payment of at least one full monthly premium;

a grace period of three (3) consecutive months shall be provided under this Agreement for the payment of premium. Benefits will only be provided by the Plan under this Agreement for Covered Services received during the first (1st) month of the three (3) month grace period if payment of the appropriate premium amount by the Member is not received prior to the end of the grace period.

4. **Reinstatement**

If this Agreement is terminated due solely to nonpayment of the premium, coverage will be reinstated if the Subscriber, within thirty-six (36) days from the end of the Grace Period, tenders and the Plan receives payment of the premium required for reinstatement. The Member(s) and the Plan have the same rights under the reinstated Agreement as they had under the Agreement immediately before the due date of the defaulted premium. The right of the Subscriber to have this Agreement reinstated is limited to one (1) reinstatement during any twelve (12)-month period and to two (2) reinstatements during the Subscriber's lifetime.

When coverage under this Agreement is provided pursuant to enrollment through the Exchange, the right to reinstate coverage shall not apply.

5. **Notice of Claim and Proof of Loss (Applies to Post-service Claims Only)**

Network Providers have entered into an agreement with the Plan pertaining to the payment for Covered Services rendered to a Member. When a Member receives Covered Services from a Network Provider, it is the responsibility of the Network Provider to submit its claim to the Plan in accordance with the terms of its participation agreement. Should the Network Provider fail to submit its claim in a timely manner or otherwise satisfy the Plan's requirements as they relate to the filing of claims, the Member will not be liable and the Network Provider shall hold the Member harmless relative to payment of the Covered Services received by the Member. When Covered Services are received from other than a Network Provider, the Member is responsible for submitting the claim to the Plan. In such instances, the Member must submit the claim in accordance with the following procedures:

a. Notice of Claim

The Plan will not be liable for any claims under this Agreement unless proper notice is furnished to the Plan that Covered Services in this Agreement have been rendered to a Member. Written notice of a claim must be given to the Plan 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 the Plan that includes information sufficient to identify the Member that received the Covered Services shall constitute sufficient notice of a claim to the Plan. The Member can give notice to the Plan by writing to the Member Service Department. The 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 Service or supply for which the charge is made.

b. Claim Forms

Proof of loss for benefits under this Agreement must be submitted to the Plan on the appropriate claim form. The Plan, upon receipt of a notice of a claim will, within fifteen (15) days following the date a notice of a 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 Paragraph as to filing a proof of loss upon submitting, within the time fixed in this Paragraph for filing proofs of loss, itemized bills for Covered Services as described below. The proof of loss may be submitted to the Plan at the address appearing on the Member's Identification Card.

c. Proof of Loss

Claims cannot be paid until a written proof of loss is submitted to the Plan. Written proof of loss must be provided to the Plan within ninety (90) days after the date of such loss. Proof of loss must include all data necessary for the Plan to determine

benefits. Failure to submit a proof of loss to the Plan 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 in no event, except in the absence of legal capacity, will the Plan be required to accept a proof of loss later than one (1) year from the time proof is otherwise required.

d. Submission of Claim Forms

The completed claim form, with all itemized bills attached, must be forwarded to the Plan at the address appearing on the Member's Identification Card in order to satisfy the requirement of submitting a written proof of loss and to receive payment for benefits provided under this Agreement.

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:

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

Professional Provider bills must show specific treatment dates. Drug and medicine bills must show prescription number, date of purchase, and the patient's name. The Member's attending Professional Provider must include a signature on all bills as certification that Services have been prescribed, except for doctor bills, Hospital bills, or Prescription Drug bills. (Some bills requiring a signature of the Professional Provider include ambulance, prosthetic devices, rental of Durable Medical Equipment, etc.). Itemized bills cannot be returned.

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

Notice of the Plan'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 the Plan for an additional period of time not to exceed fifteen (15) days provided the extension is due to matters outside the control of the Plan and a written explanation for the delay is provided to the Member.

In the event that the Plan 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 an appeal.

e. Time of Payment of Claims

Claim payments for benefits payable under this Agreement will be processed immediately upon receipt of a proper proof of loss.

f. Authorized Representative

Nothing in this Paragraph shall preclude a duly authorized representative of the Member from filing or otherwise pursuing a claim on behalf of the Member. The Plan reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of the Member.

6. **Physical Examinations and Autopsy**

The Plan, at its own expense, shall have the right and opportunity to examine the person of the Member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

7. **Legal Actions**

No action at law or in equity shall be brought to recover on this Agreement prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Agreement. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

8. **Misstatement of Age**

If the age of the Member has been misstated, all amounts payable under the Agreement shall be such as the premium paid would have purchased at the correct age.

U. SUBROGATION

1. To the extent that benefits for Covered Services are provided or paid under this Agreement, the Plan 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 the Plan may require to secure such rights, as permitted by law. The Member shall do nothing to prejudice the rights given the Plan by this paragraph without its consent.

3. These provisions shall not apply where subrogation is specifically prohibited by law.

V. TERMINATION OF THE MEMBER'S COVERAGE UNDER THE AGREEMENT

1. This Agreement may be terminated by the Subscriber by giving appropriate written notice to the Plan. In such case, the termination effective date shall be the first of the month following the date of the request for termination or such other date as may be permitted or required under applicable law.

2. This Agreement is guaranteed renewable and cannot be terminated without consent of the Subscriber except in the following instances:

   a. If payment of the appropriate premium is not made when due, or during the grace period, coverage will terminate on the last day of the grace period unless an earlier date is required by law.

      When coverage under this Agreement is provided pursuant to enrollment through the Exchange and the Subscriber receives APTCs, failure of the Plan to receive payment of APTCs shall not be grounds for terminating this Agreement when the Subscriber has made payment of the Subscriber's portion of the premium when due.

   b. If a Subscriber in obtaining coverage, or in connection with coverage hereunder, has performed an act or practice constituting fraud or intentional misrepresentation of a material fact (e.g., misuse of the Member Identification Card), coverage will terminate immediately. However, the Plan will not terminate this Agreement because of a Subscriber's Medically Necessary and Appropriate utilization of services covered under this Agreement.

   c. Coverage will terminate upon ninety (90) days notice to the Subscriber when the Plan discontinues this coverage, and offers to each individual the option to purchase any other individual health insurance coverage then available from the Plan in the geographic area where the Subscriber resides, or upon one hundred eighty (180) days notice to the Member when the Plan discontinues all individual coverage.

   d. In the event the Subscriber no longer lives in the geographic area in which the product represented by this Agreement is available from the Plan, coverage will terminate on the last day of the month for which the premium has been accepted.

3. When coverage provided under this Agreement is provided pursuant to enrollment through the Exchange, coverage will terminate in the following additional circumstances:

   a. The Subscriber provides appropriate notice of voluntary termination to the Exchange in which case coverage will terminate effective on the date specified by the Exchange.

   b. The Subscriber is no longer eligible for coverage through the Exchange in which case coverage will terminate effective:

      i) the last day of the month following the month in which notice of ineligibility is sent by the Exchange, unless an earlier termination date is requested by the Member; or

ii) in the case where the Subscriber is determined to be newly eligible for Medicaid, CHIP or basic health plan coverage, the last day of coverage under this Agreement shall be the day before such new coverage begins.

c. The Qualified Health Plan through which coverage under this Agreement is provided terminates or is decertified.

d. The Subscriber elects to enroll in a different Qualified Health Plan during an applicable Annual Open Enrollment Period, Limited Open Enrollment Period or Special Enrollment Period in which case coverage under this Agreement will terminate the day before coverage under the new Qualified Health Plan begins.

4. If this Agreement is terminated at the option of either party, the Plan shall refund to the Subscriber the amount of any unearned prepaid premium held by the Plan. Unearned prepaid premium in any amount less than one ($1.00) dollar shall not be refunded unless specifically requested by the Subscriber.

W. THIRD PARTY PAYMENTS

The Subscriber has an ongoing obligation under this Agreement to disclose to the Plan any full or partial premium payment made, directly or indirectly, by third party payers on behalf of the Subscriber or any Dependent. These payments, referred to as "third party payments" are those made by any means including, but not limited to, cash, check, money order, pre-paid debit card, credit card and electronic fund transfers.

The Plan, in its sole discretion and in accordance with applicable law and regulatory guidance, reserves the right to refund and/or refuse to accept premium payments made by ineligible third party payers. "Ineligible third party payers" include any person or entity from which the Plan is not required by law to accept such third party payments. The Subscriber remains liable for all premium payments due under this Agreement for which a disallowed third party payment was made or attempted to be made on behalf of the Subscriber or any Dependent.