Your Health Benefits

Swarthmore College
Effective Date: August 17, 2016
Student PPO Plan
For simplicity, the Student PPO Plan has been described in a rather
general manner in this booklet. The extent of the insurance for each
individual is governed at all times by the complete terms of the master
Student PPO Plan Contract or Contracts issued by QCC Insurance
Company.
This booklet describes your Swarthmore College Student PPO Plan.

Swarthmore College has entered into a Contract with QCC Insurance Company d/b/a Independence Administrators ("Independence Administrators") which provides for Independence Administrators to process benefit claims and provide certain other services for the Swarthmore College’s student health plan ("Plan") which is underwritten by QCC Insurance Company (the "Carrier") and which offers health care benefits to eligible students and their dependents ("Subscribers").

Protection against the hardship that so often accompanies sickness or accident is important to all of us.

We have arranged for a Benefit Plan in order to make this protection available to you. On the following pages you will find a brief description of the Plan.

We believe this Plan represents worthwhile protection to you.

Independence Administrators is an independent licensee of the Blue Cross and Blue Shield Association.
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IMPORTANT NOTICES

REGARDING EXPERIMENTAL/INVESTIGATIONAL TREATMENT

The Carrier does not cover treatment it determines to be Experimental/Investigational in nature because that treatment is not accepted by the general medical community for the condition being treated or not approved as required by federal or governmental agencies. However, the Carrier acknowledges that situations exist when a Subscriber and his or her physician agree to utilize Experimental/Investigational treatment. If a Subscriber receives Experimental/Investigational treatment, the Subscriber shall be responsible for the cost of the treatment. A Subscriber or his or her physician should contact the Carrier to determine whether a treatment is considered Experimental/Investigational. The term “Experimental/Investigational” is defined in the Definitions section.

REGARDING TREATMENT WHICH IS NOT MEDICALLY NECESSARY

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

REGARDING TREATMENT FOR COSMETIC PURPOSES

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

REGARDING COVERAGE FOR EMERGING TECHNOLOGY

While the Carrier does not cover treatment it determines to be Experimental/Investigational, it routinely performs technology assessments in
In order to determine when new treatment modalities are safe and effective. A technology assessment is the review and evaluation of available clinical and scientific information from expert sources. These sources include but are not limited to articles published by governmental agencies, national peer review journals, national experts, clinical trials, and manufacturer’s literature.

The Carrier uses the technology assessment process to assure that new drugs, procedures or devices (“emerging technology”) are safe and effective before approving them as Covered Services. When new technology becomes available or at the request of a practitioner or Subscriber, the Carrier researches all scientific information available from these expert sources. Following this analysis, the Carrier makes a decision about when a new drug, procedure or device has been proven to be safe and effective and uses this information to determine when an item becomes a Covered Service for the condition being treated or not approved as required by federal or governmental agencies. A Subscriber or his or her Provider should contact the Carrier to determine whether a proposed treatment is considered “emerging technology”.

REGARDING USE OF NON-PREFERRED PROVIDERS

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

In addition, your PPO program allows you to obtain Covered Services from Non-Preferred Providers. If you use a Non-Preferred Provider you will be reimbursed for Covered Services but will incur significantly higher out-of-pocket expenses including Deductibles, Coinsurance. In certain instances, the Non-Preferred Provider also may charge you for the balance of the provider’s bill. This is true whether you use a Non-Preferred Provider by choice, for level of expertise, for convenience, for location, because of the nature of the services or based on the recommendation of a provider. For payment of Covered Services provided by a Non-Preferred Provider, please refer to the definition of Covered Expense.

For specific terms regarding Non-Preferred Providers, please refer to the following sections: Defined Terms; including but not limited to the definition of Covered Expense and Non-Preferred Provider, Payment of Providers and Payment Methods.

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

In the event the treatment is not covered by the Carrier, the Subscriber can make an informed decision about whether to pursue alternative treatment options or be financially responsible for the non-covered service.

For more information on when to contact the Carrier for coverage determinations, please see the Precertification requirements in the Patient Care Management section.

REGARDING NONDISCRIMINATION

QCC Insurance Company d/b/a Independence Administrators 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. Coverage for medically necessary health services is made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. QCC Insurance Company d/b/a Independence Administrators 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. QCC Insurance Company d/b/a Independence Administrators 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.
**SCHEDULE OF BENEFITS**

This Schedule of Benefits describes benefits, maximums, and allowances of the coverage provided in the Contract for each Subscriber.

Subject to the exclusions, conditions and limitations of this Plan, a Subscriber is entitled to benefits for the Covered Services described in this *Schedule of Benefits* during a Benefit Period, subject to any Copayment, Deductible, Coinsurance, Out-of-Pocket Limit or Lifetime Maximum. The percentages for Coinsurance and Covered Services shown in this *Schedule of Benefits* are not always calculated on actual charges.

**NOTICE:** This Plan contains Patient Care Management provisions for all inpatient admissions and certain outpatient procedures. If you do not comply with these provisions, benefits may be reduced or considered not eligible. Please read the section entitled *Patient Care Management* carefully. The number to call for Patient Care Management is listed on the back of your identification (ID) card.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>If the Subscriber uses a Preferred Provider or a BlueCard Provider, the Plan will pay:</th>
<th>If the Subscriber uses a Non-Preferred Provider, the Plan will pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Period Plan Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Maximum Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible <em>(Subscriber’s Responsibility)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subscriber’s Deductible</td>
<td>None</td>
<td>$100</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>None</td>
<td>$100</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket Expense <em>(per Plan Year; includes deductible, coinsurance, and copayments)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Subscriber</td>
<td>$3,000</td>
<td>None</td>
</tr>
<tr>
<td>Per Family</td>
<td>$6,000</td>
<td>None</td>
</tr>
<tr>
<td><strong>Primary and Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Visit</td>
<td>100%</td>
<td>80% deductible waived</td>
</tr>
<tr>
<td>Primary Care Visit</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Pediatric Preventive Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subscribers age up to age 20</td>
<td>100%</td>
<td>80% deductible waived</td>
</tr>
<tr>
<td>Pediatric Immunizations</td>
<td>100%</td>
<td>80% deductible waived</td>
</tr>
<tr>
<td>Adult Preventive Care</td>
<td>100%</td>
<td>80% deductible waived</td>
</tr>
<tr>
<td>Routine annual Gynecological Examination, Pap Smear</td>
<td>100%</td>
<td>80% deductible waived</td>
</tr>
<tr>
<td>Mammograms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Period Maximum: 1 per plan year for female subscribers 40 years of age and older</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>SERVICE</td>
<td>If the Subscriber uses a Preferred Provider or a BlueCard Provider, the Plan will pay:</td>
<td>If the Subscriber uses a Non-Preferred Provider, the Plan will pay:</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>Inpatient Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Services&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Preferred Benefit Period Maximum: 365 Inpatient days.</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Benefit Period Maximum: 70 Inpatient days. This maximum is part of, not separate from, Preferred days maximum</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Skilled Nursing Care Facility&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Benefit Period Maximum: 120 Inpatient days per</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Inpatient /Outpatient Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Services</td>
<td>Respite Care: Maximum of 10 days every benefit period.</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Colonoscopy&lt;sup&gt;3&lt;/sup&gt;</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Outpatient Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance emergency services</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Ambulance non-emergency services</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Autism Spectrum Disorders</td>
<td>Same cost-sharing as any other medical service within the applicable medical service (e.g. Therapy Services, Diagnostic Services, etc.).</td>
<td>Same cost-sharing as any other medical service within the applicable medical service (e.g. Therapy Services, Diagnostic Services, etc.).</td>
</tr>
<tr>
<td>Diabetic Education Program</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Diabetic Equipment and Supplies</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Maternity/Ob-Gyn/Family Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity / Obstetrical Care</td>
<td>Professional service 90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td></td>
<td>Facility service 90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Elective Abortions</td>
<td>Outpatient Facility Charges 90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Newborn Care</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Mental Health / Psychiatric Care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup> Precertification required for all Inpatient admissions other than admission for Emergency Care or Maternity Care.

<sup>2</sup> Precertification required for all Skilled Nursing Care Facility Inpatient Admissions.

<sup>3</sup> Non-preventive.
<table>
<thead>
<tr>
<th>SERVICE</th>
<th>If the Subscriber uses a Preferred Provider or a BlueCard Provider, the Plan will pay:</th>
<th>If the Subscriber uses a Non-Preferred Provider, the Plan will pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Treatment for Mental Illness and Serious Mental Illness</strong></td>
<td><strong>Preferred Benefit Period Maximum:</strong> 365 Inpatient days. <strong>Non-Preferred Benefit Period Maximum:</strong> 70 Inpatient days. This maximum is part of, not separate from, Preferred days maximum</td>
<td></td>
</tr>
<tr>
<td>Professional service</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Facility service</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Treatment for Mental Illness and Serious Mental Illness</strong></td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Treatment of Alcohol or Drug Abuse and Dependency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital Detoxification and Rehabilitation</strong></td>
<td><strong>Preferred Benefit Period Maximum:</strong> 365 Inpatient days. <strong>Non-Preferred Benefit Period Maximum:</strong> 70 Inpatient days. This maximum is part of, not separate from, Preferred days maximum</td>
<td></td>
</tr>
<tr>
<td>Professional service</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Facility service</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Hospital and Non-Hospital Residential Care</strong></td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Treatment</strong></td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Surgical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Facility Charges</strong></td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Professional Charge</strong></td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Inpatient Anesthesia</strong></td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Inpatient Facility Charges</strong></td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Inpatient Professional Charge</strong></td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Inpatient Second Surgical Opinion</strong></td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Transplant Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Facility Charges</strong></td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Facility Charges</strong></td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Diagnostic Services</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4 Precertification required for all Intensive Outpatient Program and Partial Hospitalization Program services.
<table>
<thead>
<tr>
<th>SERVICE</th>
<th>If the Subscriber uses a Preferred Provider or a BlueCard Provider, the Plan will pay:</th>
<th>If the Subscriber uses a Non-Preferred Provider, the Plan will pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Diagnostic / Radiology Services</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Non-Routine Diagnostic / Radiology Services (including MRI/MRA, CT scans, PET scans)</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Laboratory and Pathology Tests</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Lab work for sexually transmitted disease testing&lt;sup&gt;5&lt;/sup&gt; Preferred/Non-Preferred Benefit Period Maximum: 1 per plan year</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>

**Miscellaneous Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>If the Subscriber uses a Preferred Provider or a BlueCard Provider, the Plan will pay:</th>
<th>If the Subscriber uses a Non-Preferred Provider, the Plan will pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Emergency Care Services (Commencing within 72 hours of following the onset of the medical emergency)</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Benefit Period Maximum: 120 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injectable Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biotech/Specialty Injectable</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Standard Injectable</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Medical Foods and Nutritional Formulas</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Non-Surgical Dental Services</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>(Dental Services as a result of Accidental Injury) Preferred/Non-Preferred Benefit Period Maximum: $1,000 per plan year</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Orthotics</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Podiatric Care</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Private Duty Nursing Services</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Preferred/Non-Preferred Benefit Period Maximum: 360 hours</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Specialist Office Visits</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Spinal Manipulation Services</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>

<sup>5</sup> Non-preventive.
<table>
<thead>
<tr>
<th>SERVICE</th>
<th>If the Subscriber uses a Preferred Provider or a BlueCard Provider, the Plan will pay:</th>
<th>If the Subscriber uses a Non-Preferred Provider, the Plan will pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred/Non-Preferred Benefit Period Maximum: 20 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>THERAPY SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehabilitation Therapy</td>
<td>Preferred/Non-Preferred Benefit Period Maximum: 36 sessions</td>
<td>90%</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Dialysis</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Orthotics / Pleoptic Therapy</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Pulmonary Rehabilitation Therapy</td>
<td>Preferred/Non-Preferred Benefit Period Maximum: 12 sessions</td>
<td>90%</td>
</tr>
<tr>
<td>Physical Therapy / Occupational Therapy</td>
<td>Preferred/Non-Preferred Benefit Period Maximum: 20 sessions of Physical Therapy and Occupational Therapy. Benefit Period Maximum amounts that apply to Physical Therapy do not apply to the treatment of lymphedema related to mastectomy.</td>
<td>90%</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>Preferred/Non-Preferred Benefit Period Maximum: 20 sessions</td>
<td>90%</td>
</tr>
<tr>
<td>Prescription Drug Benefit</td>
<td>Administered by Future Scripts(^6)</td>
<td></td>
</tr>
<tr>
<td>Retail</td>
<td>(up to a 34 day supply)</td>
<td>90%</td>
</tr>
<tr>
<td>Generic</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td>Brand</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td>Mail Order</td>
<td>(up to a 90 day supply)</td>
<td>90%</td>
</tr>
<tr>
<td>Generic</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td>Brand</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>90%</td>
<td>80%</td>
</tr>
</tbody>
</table>

\(^6\) Plan Covers: Oral Contraceptives, Insulin, Needles and Syringes
<table>
<thead>
<tr>
<th>SERVICE</th>
<th>If the Subscriber uses a Preferred Provider or a BlueCard Provider, the Plan will pay:</th>
<th>If the Subscriber uses a Non-Preferred Provider, the Plan will pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Dental Services</td>
<td>Benefits available through United Concordia. For more information, please contact United Concordia at 1-866-568-5994</td>
<td></td>
</tr>
<tr>
<td>Ages 0-18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administered by United Concordia</td>
<td></td>
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<tr>
<td>Pediatric Vision Benefits</td>
<td></td>
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<tr>
<td>Ages 0-18</td>
<td></td>
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</tr>
<tr>
<td><strong>Eye Examination</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td>(including dilation)</td>
<td><strong>Preferred/Non-Preferred Benefit</strong></td>
<td></td>
</tr>
<tr>
<td>Period Maximum: 1 examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Spectacle Lenses</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td>(includes oversize lenses, tinting of plastic lenses, scratch-resistant coating, polycarbonate lenses)</td>
<td><strong>Preferred/Non-Preferred Benefit</strong></td>
<td></td>
</tr>
<tr>
<td>Period Maximum: 1 set</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses</td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td>Period Maximum: 1 set</td>
<td><strong>Preferred/Non-Preferred</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Medically Necessary Contact Lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(with prior authorization)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Materials, Evaluation, Fitting &amp; Follow-Up Care</td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**DAVIS VISION® DISCOUNT PROGRAM ADMINISTERED BY DAVIS VISION**

| www.DavisVision.com            | For more information, please contact Davis Vision at 1-877-393-7804 or www.davisvision.com (enter client code 3077) |
| Vision Care Advantage Program  |                                                                                                                     |
| Administered by Davis Vision   |                                                                                                                     |
| Discounts available on eye examinations, eyeglasses and contact lenses |                                                                                                                     |

While the PPO Plan has an extensive network, it may not contain every provider that a Subscriber elects to see. To receive the maximum benefits available under this program, a Subscriber must obtain Covered Services from Preferred Providers that participate in
the PPO Network or is a Blue Card PPO Provider. A Subscriber may obtain Covered Services from participating Professional Providers who are not part of the PPO Network but have agreed to accept contracted rates as payment in full and will not balance bill you. However, a Subscriber will be subject to Non-Preferred “Out-of-Network" Coinsurance and Deductibles.

In addition, this PPO Plan allows a Subscriber to obtain Covered Services from Non-Preferred Providers. If a Subscriber uses a Non-Preferred Provider he or she will be reimbursed for Covered Services but will incur significantly higher out-of-pocket expenses including Deductibles, Coinsurance. In certain instances, the Non-Preferred Provider also may charge a Subscriber for the balance of the provider's bill. This is true whether a Subscriber uses a Non-Preferred Provider by choice, for level of expertise, for convenience, for location, because of the nature of the services or based on the recommendation of a provider. For payment of Covered Services provided by a Non-Preferred Provider, please refer to the definition of Covered Expense.

All Pennsylvania state mandated benefits will be provided to all Covered Students and eligible Dependents, if applicable.

**COST OF THE INSURANCE**

You will be informed of the amount of your contribution when you are asked to enroll.
ELIGIBILITY

CLASS(ES) ELIGIBLE FOR COVERAGE

The following classes are eligible for coverage under the terms of the Contract:

Covered Student’s Coverage:

All enrolled Covered Students

The dependents of an eligible Covered Student may also participate. Eligible Dependents include:

- A legal spouse unless legally separated from the Covered Student.
- A child from birth to age twenty-six (26).
- An unmarried child who is unable to earn his or her living due to physical or mental illness or handicap and is at or reaches a terminating age under the terms of the Plan will be eligible if the Carrier receives proof, satisfactory to the Carrier, that he or she is unable to earn his or her own living. Such proof must be received:
  1. within thirty-one (31) days of the dependent’s eligibility date, or
  2. Within thirty-one (31) days of the date the dependent reaches a terminating age under the terms of the Plan.

If satisfactory proof of such incapacity is received more than thirty-one (31) days after the dependent’s eligibility date or terminating age, the Covered Student must apply for coverage for the child during the open enrollment period. The Carrier reserves the right to require subsequent proof of incapacity during the time the dependent’s coverage is in effect. Such proof will not be required more than once a year.

The term child includes:

- a natural child,
- a stepchild by legal marriage,
- a foster child,
- a child who has been placed with the Covered Student for adoption by a court of competent jurisdiction or who has been legally adopted, or
- A child who is the subject of a Qualified Medical Child Support Order (QMCSO) dated on or after August 10, 1993. To be “qualified” a state court medical child support order must specify the name and last known address of the plan participant and each alternate recipient covered by the order, a reasonable description of the type of coverage or benefit to be provided to the alternate recipient, the period to which the QMCSO applies, and each plan to which the order applies.
If the Covered Student or the spouse of a Covered Student has a child while covered under the Contract, that child will be eligible for the same coverage as any other dependent. Coverage will take effect from birth but will not exceed a period of thirty-one (31) days from birth unless, if necessary, the Covered Student makes any required contributions under the Contract for Covered Student plus Dependent coverage.

No one who is on active duty with the armed forces of any country will be an eligible dependent.

Dependents not eligible for coverage include:

- A grandchild, except that a child of a Dependent child shall be covered from birth as required by law.

**NOTICE OF SPECIAL ENROLLMENT RIGHTS**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within thirty (30) days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) because you or your dependents were enrolled in Medicaid or your state’s State Children's Health Insurance Program and you or your dependent cease to be enrolled in such program as a result of no longer being eligible for the program, you may be able to enroll yourself or your dependents in this Plan in the future, provided that you request enrollment within sixty (60) days after coverage ends. If you or your dependents become eligible for premium assistance for this Plan from Medicaid or your state’s State Children's Health Insurance Program and choose to enroll in this Plan, you must request coverage under this Plan within sixty (60) days after the date you or your dependent become eligible for premium assistance.
EFFECTIVE DATE OF COVERAGE

Covered Student and/or Dependent coverage shall become effective on the applicable date set forth below.

CONTRIBUTORY FUNDING

If contribution from a Covered Student toward the cost of Covered Student or Dependent coverage is required, and the Covered Student agrees to make the required contribution, coverage will become effective, upon the payment of such contribution, on the date shown below:

a. the date of eligibility if the application is made and is received by the Carrier on or before that date; or

b. the date the Carrier receives application, if the application is made within thirty-one (31) days after the date of eligibility; or

c. the date the application is approved by the Carrier if the application is made more than thirty-one (31) days after the date of eligibility.

DEPENDENT(S)

No Dependents’ coverage will become effective for a Covered Student unless the eligible Covered Student is, or simultaneously becomes, covered.

Coverage of a newborn child will become effective immediately for routine nursery care, treatment for prematurity, birth abnormalities, congenital defects or any other illnesses. The newborn child will be entitled to receive all benefits in accordance with the terms of the Contract from birth for thirty-one (31) days. Upon application within the thirty-one (31) day period, the Covered Student may continue coverage beyond that period for a newborn child who qualifies as an eligible Dependent, subject to payment of any additional premium if required by the Contract.
THE PREFERRED PROVIDER NETWORK

The PPO Network Plan is a program, which allows you to maximize your health care benefits by utilizing the PPO Network, which is comprised of Providers that have a contractual arrangement with the Carrier. These Providers are called “Preferred Providers.” You may think of them as “in-network” providers. Preferred Providers are Doctors, Hospitals and other health care professionals and institutions that are part of the PPO Network, which is designed to provide access to care through a selected managed network of providers. Services by Preferred Providers are delivered through a selected, managed network of providers designed to provide quality care. The PPO Network includes hospitals, primary care physicians and specialists, and a wide range of ancillary providers, including suppliers of Durable Medical Equipment, Hospice care and Home Health Care agencies, Skilled Nursing Facilities, Free Standing Dialysis Facilities and Ambulatory Surgical Facilities.

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

A directory of the Preferred Providers who belong to the PPO Network is available to you upon request. It will identify the Professional Providers who have agreed to become Preferred Professional Providers and will also identify the Hospitals in the Network with which the Preferred Professional Providers are affiliated. Also included in the directory is a listing of the ancillary providers affiliated with the PPO Network. The directory is updated periodically throughout the year, and the Carrier reserves the right to add or delete physicians and/or hospitals at any given time. It is important to know that continued participation of any one doctor, hospital or other provider cannot be guaranteed. A list of the Preferred Providers who belong to the PPO Network is also available on Independence Administrators’ web site at http://www.myibxtpastudent.com

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

Some of the services you receive through this Plan must be precertified before you receive them, to determine whether they are Medically Necessary. Failure to precertify services to be provided by a Non-Preferred Provider, when required, may result in a reduction of benefits. Precertification of services is a vital program feature that reviews the Medical Necessity of certain procedures/admissions. In certain cases, Precertification helps determine whether a different treatment may be available that is equally effective. Precertification also helps determine the most appropriate setting for certain services. Innovations in health care enable doctors to provide services, once provided exclusively
in an inpatient setting, in many different settings – such as an outpatient department of a hospital or a doctor’s office.

When you need seek medical treatment that requires Precertification, you are not responsible for obtaining the Precertification if treatment is provided by a Preferred Provider, i.e., a Provider in the PPO Network. In addition, if the Preferred Provider fails to obtain a required Precertification of services, you will be held harmless from any associated financial penalties assessed by the Plan as a result. If the request for Precertification is denied, you will be notified in writing that the admission/service will not be paid because it is considered to be medically inappropriate. If you decide to continue treatment or care that has not been approved, you will be asked to do the following:

1. Acknowledge this in writing.
2. Request to have services provided.
3. State your willingness to assume financial liability.

When you seek treatment from a Non-Preferred Provider or a Blue Card Provider, you are responsible for initiating the Precertification process. You or your provider should call the Precertification number listed on the back of your Identification Card, and give your name, facility’s name, diagnosis, and procedure or reason for admission. Failure to precertify required services may result in a reduction of benefits payable to you.

**PAYMENT OF PROVIDERS**

1. PREFERRED PROVIDER REIMBURSEMENT

PPO reimbursement programs for health care providers are intended to encourage the provision of quality, cost-effective care for PPO members. Set forth below is a general description of PPO reimbursement programs, by type of PPO Network health care provider.

Please note that these programs may change from time to time, and the arrangements with particular Providers may be modified as new contracts are negotiated. If you have any questions about how your health care Provider is compensated, please speak with your healthcare Provider directly or contact Customer Services.

a. Doctors

PPO Network Doctors, including Primary Care Provider (PCPs) and specialists, are paid on a fee-for-service basis, meaning that payment is made according to the Carrier’s PPO fee schedule for the specific medical services that the physician performs.

b. Institutional Providers

Hospitals: For most Inpatient medical and surgical services, Hospitals are paid per diem rates, which are specific amounts paid for each day a Subscriber is in the Hospital. These rates usually vary according to the intensity of the Covered Services provided. Some Hospitals are also paid case rates, which are set
dollar amounts paid for a complete Hospital stay related to a specific procedure or diagnosis, e.g., transplants. For most Outpatient and Emergency Services and procedures, most Hospitals are paid specific rates based on the type of Covered Service performed. For a few Covered Services, Hospitals are paid based on a percentage of billed charges. Most Hospitals are paid through a combination of the above payment mechanisms for various services.

The Carrier implemented a quality incentive program with a few Hospitals. This program provides increased reimbursement to these Hospitals based on them meeting specific quality criteria, including “Patient Safety Measures”. Such patient safety measures are consistent with recommendations by the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry and are designed to help reduce medical and medication errors. Other criteria are directed at improved patient outcomes, higher nursing staff ratios, and electronic submissions. This is a new incentive program that is expected to evolve over time.

Skilled Nursing Facilities, Rehabilitation Hospitals, and other care facilities: Most Skilled Nursing Facilities and other special care facilities are paid per diem rates, which specific amounts are paid for each day a Subscriber is in the facility. These amounts may vary according to the intensity of the Covered Services provided.

Ambulatory Surgical Facilities (ASFs): Most ASFs are paid specific rates based on the type of Covered Service performed. For a few services, some ASFs are paid based on a percentage of billed charges.

c. Physician Group Practices, Physician Associations and Integrated Delivery Systems

Certain physician group practices, independent physician associations (IPAs) and integrated hospital/physician organizations called Integrated Delivery Systems (IDS) employ or contract with individual physicians to provide medical services. These groups are paid as described in the physicians reimbursement section outlined above. These groups may pay their affiliated physicians a salary and/or provide incentives based on production, quality, service, or other performance standards.

d. Ancillary Service Providers, certain Facility Providers and Mental Health/Substance Abuse Providers

Ancillary service providers, such as Durable Medical Equipment Providers, laboratory Providers, Home Health Care Agencies, and mental health/psychiatric care and Alcohol and Drug Abuse Providers are paid on the basis of fee-for-service payments according to the Carrier’s PPO fee schedule for the specific Covered Services performed. In some cases, such as for mental health/psychiatric care and Alcohol and Drug Abuse benefits, one (1) vendor arranges for all such services through a contracted set of providers. The Carrier reimburses the contracted Providers of these vendors on a fee-for-
service basis. An affiliate of Independence Blue Cross has less than a three percent ownership interest in this mental health/psychiatric care and Alcohol and Drug Abuse vendor.

2. PAYMENT METHODS

The Subscriber or the Provider may submit bills directly to the Carrier, and, to the extent that benefits are payable within the terms and conditions of this booklet, reimbursement will be furnished as detailed below.

The Subscriber's benefits for Covered Services are based on the rate of reimbursement as set forth under “Covered Expense” in the Definitions section of this booklet.

FACILITY PROVIDERS

Preferred Facility Providers

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

Non-Preferred Facility Providers

Non-Preferred Facility Providers include facilities that are not part of the PPO Network. The Carrier may have a contractual arrangement with a facility even if it is not part of the PPO Network.

The Carrier will provide benefits for Covered Services provided by a Non-Preferred Facility Provider at the Non-Preferred Coinsurance level specified in the Schedule of Benefits. The reimbursement rate is specified under “Covered Expense” in the Definitions section of this booklet.

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

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

PROFESSIONAL PROVIDERS

Preferred Providers
The Carrier is authorized by the Subscriber to make payment directly to the Preferred and Participating Professional Providers furnishing Covered Services for which benefits are provided under this coverage. Preferred and Participating Professional Providers have agreed to accept the rate of reimbursement determined by a contract as payment in full for Covered Services. Blue Card PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. Preferred and Participating Professional Providers will make no additional charge to Subscribers for Covered Services except in the case of certain Copayments, Coinsurance or other cost sharing features as specified under this program.

The Subscriber is responsible within 60 days of the date in which Independence Administrators finalizes such services to pay, or make arrangements to pay, such amounts to the Preferred and Participating Professional Provider.

Benefit amounts, as specified in the Schedule of Benefits of this coverage, refer to Covered Services rendered by a Professional Provider which are regularly included in such Provider’s charges and are billed by and payable to such Provider. Any dispute between the Preferred Professional Provider and a Subscriber with respect to balance billing shall be submitted to the Carrier for determination. The decision of the Carrier shall be final.

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

**EMERGENCY CARE BY NON-PREFERRED PROVIDERS**

If Independence Administrators determines that Covered Services provided by a Non-Preferred Provider were for Emergency Care, the Subscriber will be subject to the preferred cost-sharing levels. Penalties that ordinarily would be applicable to Non-Preferred Covered Services will not be applied. For Emergency Care, the Carrier will reimburse the Subscriber for Covered Services at the Non-Preferred Provider reimbursement rate. For payment of Covered Services provided by a Non-Preferred Provider, please refer to the definition of Covered Expense in the Definitions section of this booklet. Inpatient admissions for Emergency Care must be certified within two business days of admission, or as soon as reasonably possible, as determined by the Carrier.

A Non-Preferred Provider who provided Emergency Care can bill you directly for their services, for either the Provider’s charges or amounts in excess of the Carrier’s payment for the Emergency Care, i.e., “balance billing.” In such situations, you will need to contact Independence Administrators at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, Independence Administrators will resolve the balance-billing.

**Non-Preferred Hospital-Based Provider Reimbursement**

When you receive Covered Services from a Non-Preferred Hospital-Based Provider while you are an Inpatient at a Preferred Hospital or other Preferred Facility Provider and are
being treated by a Preferred Professional Provider, you will receive the preferred cost-sharing level of benefits for the Covered Services provided by the Non-Preferred Hospital-Based Provider. For such Covered Services, payment will be made to the Subscriber, who will be responsible for reimbursing the Non-Preferred Hospital-Based Provider. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the Definitions section of this booklet.

A Non-Preferred Hospital–Based Provider can bill you directly for their services, for either the Provider’s charges or amounts in excess of the Carrier’s payment to the Non-Preferred Hospital-Based Providers, i.e., “balance billing.”

In such situations, you will need to contact Independence Administrators at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, Independence Administrators will resolve the balance billing.

Note that when you elect to see a Non-Preferred Hospital-Based Provider for follow-up care or any other service where you have the ability to select a Preferred Provider, the Covered Services will be covered at a Non-Preferred benefit level. Except for Emergency Care, if a Non-Preferred Provider admits you to a Hospital or other Facility Provider, Covered Services provided by a Non-Preferred Hospital-Based Provider will be reimbursed at the Non-Preferred benefit level. For such Covered Services, payment will be made to the Subscriber and the Subscriber will be responsible for reimbursing the Non-Preferred Hospital Based Provider. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the Definitions section of this booklet.

**Inpatient Hospital Consultations by a Non-Preferred Professional Provider**

When you receive Covered Services for an Inpatient hospital consultation from a Non-Preferred Professional Provider while you are Inpatient at a Preferred Facility Provider, and the Covered Services are referred by a Preferred Professional Provider, you will receive the preferred cost-sharing level of benefits for the Inpatient hospital consultation.

For such Covered Services, payment will be made to the Subscriber and the Subscriber will be responsible for reimbursing the Non-Preferred Professional Provider. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the Definitions section of this booklet.

A Non-Preferred Professional Provider can bill you directly for their services, for either the Provider’s charges or amounts in excess of the Carrier’s payment to the Non-Preferred Professional Providers, i.e., “balance billing.” In such situations, you will need to contact Independence Administrators at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, Independence Administrators will resolve the balance billing.

Note that when you elect to see a Non-Preferred Professional Provider for follow-up care or any other service when you have the ability to select a Preferred Provider, the Covered Services will be covered at a Non-Preferred benefit level. Except for Emergency Care, if a Non-Preferred Professional Provider admits you to a Hospital or other Facility Provider,
services provided by Non-Preferred Professional Provider will be reimbursed at the Non-Preferred benefit level. For such Covered Services, payment will be made to the Subscriber and the Subscriber will be responsible for reimbursing the Non-Preferred Professional Provider. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the Definitions section of this booklet.

Non-Preferred Professional Provider Reimbursement

Except as set forth above, when a Subscriber seeks care from a Non-Preferred Professional Provider, benefits will be provided to the Subscriber at the Non-Preferred coinsurance level specified in the Schedule of Benefits.

For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the Definitions section of this booklet. When a Subscriber seeks care and receives Covered Services from a Non-Preferred Professional Provider, the Subscriber will be responsible to reimburse the Non-Preferred Professional Provider for the difference between the Carrier’s payment and the Non-Preferred Professional Provider’s charge.

ANCILLARY PROVIDERS

Preferred Ancillary Providers

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

Non-Preferred Ancillary Providers

Non-Preferred Ancillary Providers are not members of the PPO Network. Benefits will be provided to the Subscriber at the Non-Preferred coinsurance level specified in the Schedule of Benefits. The Subscriber will be penalized by the application of higher cost sharing as detailed in the Schedule of Benefits. For payment of Covered Services provided by a Non-Preferred Ancillary Provider, please refer to the definition of Covered Expense in the Definitions section of this Booklet. When a Subscriber seeks care and receives Covered Services from a Non-Preferred Ancillary Provider, the Subscriber will be responsible to reimburse the Non-Preferred Ancillary Provider for the difference between the Carrier’s payment and the Non-Preferred Ancillary Provider’s charge.

ASSIGNMENT OF BENEFITS TO PROVIDERS

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

When you receive health care services from a Blue Card® PPO Provider, the amount you pay for Covered Services is calculated on the lower of:

- The Blue Card PPO Provider’s charges for your Covered Services, or
- The amount negotiated by the Blue Card PPO Provider and the applicable Blue Cross a Blue Shield Plan (“Host Plan”).

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

Certain state laws may require the Host Plan to use a basis for calculating a Subscriber’s liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. If any state law require liability calculation methods for a Subscriber that differs from the Blue Card method noted above in paragraph one of this section or require a surcharge, the Carrier would then calculate your liability for any covered health care services in accordance with the applicable Host Plan state law in effect at the time you received your care.
PAYMENT OF COVERED MEDICAL CHARGES

1. The Plan Year Deductible is as shown in the Schedule of Benefits. A Subscriber must incur covered medical charges of at least this amount within a Plan Year before any benefits are payable during that year, unless otherwise stated in the Schedule of Benefits.

   Each Subscriber must satisfy the individual deductible amount only once during a Plan Year.

2. If two (2) or more Subscribers in a Family Unit are injured in the same accident, only one individual deductible amount will be applied for all family members for covered medical charges Incurred as a result of the accident.

3. When a Subscriber is confined in a Hospital, Rehabilitation Facility or Skilled Nursing Facility, benefits payable will be determined by the condition primarily being treated. Determination will be made by Independence Administrators based on the Subscriber’s medical history and will be conclusive.

4. In counting the number of days of medical care furnished to a Subscriber while confined in a Hospital, Rehabilitation Facility or Skilled Nursing Facility, either the day of admission or the day of discharge will be counted, but not both.

5. No benefits will be payable under the Contract for charges Incurred after the Hospital’s regular discharge hour, provided the Subscriber has been advised by his or her attending Doctor prior to such discharge that further confinement is not required.

6. Pregnancy benefits will be provided under the same conditions and limitations as any other illness.

7. This Plan does not restrict benefits for any hospital length of stay in connection with childbirth, for the mother or newborn child, to less than the following:
   a. 48 hours following a normal vaginal delivery or
   b. 96 hours following a caesarean section.

   This Plan does not require that a Provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay that does not exceed these periods.
COVERED MEDICAL CHARGES

Subject to Exceptions and Exclusions which follows, covered medical charges include the charges described below that are Medically Necessary and incurred while covered under the Contract (a charge is deemed Incurred as of the date of the service, treatment or purchase giving rise to the charge).

FACILITY SERVICES

1. Room and Board
   a. Semiprivate Accommodations — Includes special diets and general nursing care.
   b. Private Accommodations — In a Facility having primarily private accommodations, the Subscriber is entitled to either the Facility’s most common semiprivate room charge, if any, or an allowance agreed upon by the Carrier and the Facility. The difference between the Carrier’s allowance and the Facility’s charge is the responsibility of the Subscriber.
   c. Special Care Accommodations — Special care accommodations include intensive care, cardiac care, and burn treatment or such other special care accommodations approved by the Carrier.

2. Ancillary Services — Includes those services and Supplies that are regularly provided and billed by a Facility, such as:
   a. use of operating, delivery and treatment rooms, and equipment;
   b. administration of blood and blood processing including blood and blood plasma to the extent that it is not donated or otherwise replaced;
   c. oxygen and other gases and their administration;
   d. prescribed drugs and medications that are dispensed for use in the Facility;
   e. anesthesia and the administration of anesthetics when performed by an employee of the Facility;
   f. medical and surgical dressings, Supplies, casts, and splints; and
g. Diagnostic services.

When counting the number of days of care furnished to an Inpatient, either the day of admission or the day of discharge will be counted, but not both. Charges Incurred after a Facility’s regular discharge hour are not covered provided the Subscriber has been advised by his attending Professional Provider prior to such discharge that further confinement is not required.
MEDICAL CARE

Medical care and Facility services rendered to an Inpatient by the Doctor in charge of the case for a condition not related to Surgery, or pregnancy, except as specifically provided. Such care includes Inpatient intensive medical care rendered to a Subscriber whose condition requires a Professional Provider’s constant attendance and treatment for a prolonged period.

1. Concurrent Care

Medical care rendered to an Inpatient by a Professional Provider who is not in charge of the case, but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Subscriber, standby services, routine preoperative physical examinations, or medical care routinely performed in the preoperative or postoperative or prenatal or postnatal periods, or medical visits required by a Facility’s rules and regulations.

2. Consultation Services

Consultation services rendered to an Inpatient by a Professional Provider at the request of the attending Professional Provider. Consultation services do not include staff consultations that are required by a Facility’s rules and regulations.

Benefits are provided for one consultation per consultant during each period of confinement.

REHABILITATION HOSPITAL CONFINEMENTS

Facility services and medical care rendered to an Inpatient in a Rehabilitation Hospital.

No benefits are provided for services in a Rehabilitation Facility:

1. once the Subscriber reaches the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment; or

2. when the services are primarily provided to maintain the Subscriber’s level of functioning; or to assist the Subscriber with the activities of daily living; or to provide an institutional environment for the convenience of the Subscriber.

In no way shall this provision deny or limit Substance Abuse benefits required under Pennsylvania State law, Act 106 of 1989.

SKILLED NURSING FACILITY CONFINEMENTS

Facility services and medical care rendered to an Inpatient in a Skilled Nursing Facility.
Benefits for medical care in a Skilled Nursing Facility are provided for up to two visits during the first week of confinement and one visit a week for each consecutive week of confinement thereafter.

No benefits are provided for services in a Skilled Nursing Facility:

1. once the Subscriber reaches the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment; or

2. When the services are primarily provided to maintain the Subscriber’s level of functioning; or to assist the Subscriber with the activities of daily living; or to provide an institutional environment for the convenience of the Subscriber.

SURGICAL SERVICES

Surgery for the treatment of Illness or Accidental Injury.

Covered Surgery includes sterilization procedures regardless of their Medical Necessity.

If more than one surgical procedure is performed by the same Professional Provider during the same operative session, benefits will be provided for the highest paying procedure plus an allowance of 50% of eligible charges for the additional procedure(s), plus any additional payment beyond the 50% which is deemed appropriate due to the nature or circumstances of the procedure. No additional allowance will be provided for those surgical procedures determined by Independence Administrators to be incidental to or an integral part of another surgical procedure performed during the same operative session.

1. Preoperative and Postoperative Medical Care

   The payment allowance for Surgery includes related preoperative care rendered by the surgeon within the 30 day period immediately prior to the Surgery and postoperative care normally provided by the surgeon as part of the surgical procedure.

2. Maternity Delivery

   The payment for maternity delivery includes prenatal and postpartum care normally provided by a Doctor for the care and management of pregnancy. In the event of early post-partum discharge, benefits are provided for home health care as shown in section L. Home Health Care Services.

3. Surgical Assistance

   Services rendered by an assistant surgeon who actively assists the operating surgeons in the performance of Surgery.

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

4. Anesthesia

Anesthesia and the administration of anesthetics in connection with the performance of covered medical services when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon, or attending Professional Provider.

5. Second Surgical Opinion Consultation

Consultation services rendered by a surgeon or specialist to determine the Medical Necessity of an Elective Surgery. Such services must be performed and billed by a surgeon or specialist who is not in association with the one who initially recommended the Surgery.

Benefits are provided for one additional consultation, as a third opinion, in cases where the second opinion disagrees with the first recommendation. In such instances, benefits will be provided for a maximum of two (2) consultations, but limited to one (1) consultation per consultant.

6. Transplant Services

If a human organ or tissue transplant is provided from a donor to a human transplant recipient:

a. When both the donor and recipient are covered by the Carrier, each is entitled to the benefits of the Contract.

b. When only the recipient is covered by the Carrier, both the donor and recipient are entitled to the benefits of the Contract. 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, coverage by the Carrier, or any government program. Benefits provided to the donor will be charged against the recipient’s coverage under the Contract.

c. If any organ or tissue is sold rather than donated to the Subscriber recipient, no benefits will be payable for the purchase price of such organ or tissue. However, other costs related to evaluation and procurement is covered up to the Subscriber recipient’s Contract limit.

PREADMISSION TESTING

Diagnostic tests and studies performed on an Outpatient basis prior to Elective Surgery. Benefits are provided for preadmission testing if:

1. the Subscriber was scheduled for Surgery prior to the testing;
2. the Surgery is not delayed beyond the 14 day period immediately following the testing; and

3. The Surgery to which the testing is related is covered by the Carrier.

**EMERGENCY ACCIDENT TREATMENT**

Ancillary services and medical services by a Professional Provider rendered on an Outpatient basis in connection with the initial treatment of an Emergency Accident, as defined.

Benefits are provided for emergency treatment that commences within 72 hours following the accident.

**EMERGENCY MEDICAL TREATMENT**

Ancillary services and medical services by a Professional Provider rendered on an Outpatient basis in connection with the initial treatment of a condition with acute symptoms of sufficient severity that the absence of immediate medical attention could:

1. permanently place the Subscriber’s health in jeopardy;
2. cause other serious medical consequences;
3. cause serious impairment to bodily functions; or
4. Cause serious and permanent dysfunction of any bodily organ or part.

Benefits are provided for emergency treatment that commences within 72 hours following the onset of the medical emergency.

Should any dispute arise as to whether an emergency condition existed, the determination by Independence Administrators will be final.

**HOME VISITS, OFFICE VISITS, AND OTHER OUTPATIENT VISITS**

Medical visits and consultation services for the examination, diagnosis, and treatment of a condition not related to Surgery, or pregnancy, except as specifically provided.

1. Well Baby Care and Immunizations
   
   Well baby care including routine physical examinations and immunizations. Benefits are provided for these services as prescribed by the American Pediatric Association.
   
   Well Baby Care and Immunizations are subject to a maximum described in the Schedule of Benefits. These benefits are not subject to the deductible or Coinsurance.

2. Routine Physical Examinations
Examinations including a complete medical history.

Benefits are provided for these services as prescribed by the American Medical Association. Services provided under a Vision Care program or plans are not covered.

Routine Physical Examinations are subject to a maximum described in the Schedule of Benefits. This benefit is not subject to the deductible or Coinsurance.

3. Pediatric Vision

Benefits are available for Pediatric Vision services as described in the Schedule of Benefits.

100% coverage for certain designated Preventive Care services. There will be no cost sharing (copayments, coinsurance, and deductibles) for the following Preventive Care Services if provided by a Participating Provider:

1. Evidence-based items/services with a rating of “A” or “B” in the current recommendations of the U.S. Preventative Services Task Force.
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
3. Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents.
4. With respect to women, additional preventive care and screenings provided for in guidelines supported by HRSA.

You can find online links to these lists of services at www.Healthcare.gov. Click the Learn about Prevention tab

Be aware that you may be required to pay some costs of the office visit if the preventive service is not the primary purpose of the visit, or if a doctor bills you for the preventive services separately from the office visit.

DIAGNOSTIC SERVICES

The following procedures when ordered by a Professional Provider to determine a definite condition because of specific symptoms:

1. Diagnostic X-ray consisting of radiology, ultrasound, and other diagnostic X-ray procedures. Benefits are also provided for one routine mammogram each year for female Subscribers forty years of age and older as well as any mammogram based on a Doctor’s recommendation for women under forty years of age.

2. diagnostic laboratory and pathology tests;

3. diagnostic medical procedures consisting of EKG, EEG, and other diagnostic medical procedures; and
4. Allergy testing consisting of percutaneous, intracutaneous and patch tests.

**THERAPY SERVICES**

The following Therapy Services:

1. Radiation Therapy, including the cost of radioactive materials;

2. Chemotherapy by intravenous, intraarterial, or intracavity injection, infusion or perfusion, subcutaneous and intramuscular routes. Oral chemotherapy, including its administration, is also covered. The cost of drugs approved by the Food and Drug Administration (FDA) as antineoplastic agents is covered, provided they are administered as described in this paragraph;

3. Dialysis Treatment;

4. Physical Therapy;

5. Respiratory Therapy, when performed by a Professional Provider or when prescribed by a Doctor and performed by a Respiratory Therapist;

6. Occupational Therapy, when performed by a Professional Provider or when prescribed by a Doctor and performed by an Occupational Therapist;

7. Speech Therapy, when performed by a Professional Provider or when prescribed by a Doctor and performed by a Speech Therapist;

8. Allergen immunotherapy;

9. Any other therapy services Independence Administrators determines necessary to treat Accidental Injury or Illness.

**HOME HEALTH CARE SERVICES**

The following services when provided to an essentially homebound Subscriber by a Home Health Care Agency:

1. Skilled Nursing Care; and

2. Therapy Services.

Benefits are also provided for certain other medical services when furnished along with a primary service. Such other services include Prescription Drugs, diagnostic services, Supplies, and other Medically Necessary services.

No benefits are provided for services in connection with:

1. Custodial Care, food, housing, homemaker services, home delivered meals, and supplementary dietary assistance;

2. services provided by a member of the Subscriber’s Immediate Family;

3. patient transportation, including Ambulance services;
4. visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional occupational therapy or social services;

5. services provided to Subscribers who are not essentially homebound for medical reasons; or

6. Visits solely for the purpose of assessing the Subscriber’s condition and determining whether or not the Subscriber requires and qualifies for home health care services.

HOSPICE SERVICES

Hospice benefits are provided when the Subscriber’s attending Doctor certifies that the Subscriber has a terminal Illness with a medical prognosis of six (6) months or less to live.

Hospice benefits are provided for the following services when rendered by a Hospice or under arrangements made by a Hospice in accordance with a Hospice care program and approved by the Carrier.

1. Medical care by a Doctor affiliated with the Hospice care program;

2. Nursing care by an R.N., or L.P.N., or home health aide;

3. Medical social services;

4. Therapy services except for dialysis treatments;

5. Dietary services;

6. Laboratory services;

7. Prescribed drugs and medicines;

8. Family counseling services;

9. Ambulance services when Medical Necessary to transport the Subscriber to and from the nearest Inpatient Hospice Facility;

10. Bereavement counseling;

11. The following medical services, Supplies, and equipment;

   a. oxygen, including the rental of oxygen equipment;

   b. artificial limbs or other prosthetic devices, but not including their replacement;

   c. rental of Durable Medical Equipment;

12. Inpatient Hospice care when needed to control pain and other symptoms associated with the terminal Illness, but only if the Subscriber’s attending
Doctor certifies that it is Medically Necessary for the care to be provided on an Inpatient basis rather than in a home setting or on an Outpatient basis:

13. Inpatient respite care in a Hospice. Benefits for respite care are provided for up to ten days during each benefit period.

Special Exclusions and Limitations:

1. The Hospice care program must deliver Hospice care in accordance with a treatment plan approved by and periodically reviewed by the Carrier.

2. No Hospice care benefits will be provided for:
   a. Medical care rendered by the Subscriber’s private Doctor;
   b. Volunteers who do not regularly charge for services;
   c. Pastoral services;
   d. Homemaker services;
   e. Food or home delivered meals;
   f. Legal or financial services or counseling;
   g. Curative treatment or services.

PRIVATE DUTY NURSING SERVICES

The following services when provided by an actively practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) and ordered by a Doctor. Prior Authorization of services is required.

1. Inpatient Services

   Nursing services that Independence Administrators determines are of such a nature or degree of complexity or quantity that they could not be or are not usually provided by the regular nursing staff of the Facility or a special care unit, such as intensive care, cardiac care, or burn treatment.

2. Home Services

   Nursing services that Independence Administrators determines require the skills of an R.N. or L.P.N. No benefits are provided for the services of a nurse who ordinarily resides in the Subscriber’s home or is a member of the Subscriber’s Immediate Family.

AMBULANCE SERVICES

Ambulance service by an authorized agency or a Facility providing local transportation of a sick or injured Subscriber:

1. from the site of injury or medical emergency to the nearest Facility; or
2. From the first Facility to the nearest Facility that can provide services Medically Necessary for the treatment of the Subscribers condition, but only if the services necessary to treat the condition are not available at the first Facility.

Benefits are provided for air Ambulance transportation only if Independence Administrators determines that the Subscriber’s condition, and the type of service required for the treatment of the Subscriber’s condition, and the type of Facility required to treat the Subscriber’s condition justify the use of air Ambulance instead of another means of transport.

DURABLE MEDICAL EQUIPMENT, ORTHOTICS, AND PROSTHETIC APPLIANCES

1. Durable Medical Equipment

The rental or purchase of Durable Medical Equipment when prescribed by a Doctor and required for therapeutic use.

   a. Rental — Benefits are provided for rental fees up to an amount that equals, but does not exceed, the purchase price of the equipment.

   b. Purchase — Benefits may be provided for the purchase of Durable Medical Equipment at the option of the Carrier.

Where a Claim is filed for equipment containing features of an aesthetic nature or features of a medical nature that are not required by the Subscriber’s condition or where there exists a reasonable or feasible and medically appropriate alternative piece of equipment that is less costly than the equipment furnished, the benefit provided is based on the charge for the equipment that meets the Subscriber’s medical needs.

Payments for the purchase or rental of Durable Medical Equipment requires preauthorization by Independence Administrators by calling Independence Administrators’ Patient Care Management Department at (877) 385-6243.

A Subscriber may also contact Independence Administrators in writing for preauthorization of Durable Medical Equipment prior to its purchase or rental.

2. Orthotics

The first purchase and fitting of orthopedic braces and other rigid or semi-rigid devices to restrict motion (excluding dental appliances).

3. Prosthetic Appliances

The first purchase and fitting of artificial limbs, eyes, and other prosthetic appliances that replace all or part of an absent or inoperative or malfunctioning body organ but only if required for the replacement of natural parts of the body
lost or becoming inoperative while covered by the Carrier (excluding dental appliances).

4. Replacement and Modification

Benefits are provided for the replacement or modification of Durable Medical Equipment, orthotics, and prosthetic appliances when Medically Necessary due to a change in the Subscriber’s physical condition. Benefits for the replacement of such items are provided to the extent that the cost of the purchase is less expensive than the modification. In no event will the Carrier pay for contact lenses other than the initial pair of contact lenses following cataract surgery.

**DENTAL SERVICES**

1. Dental treatment performed within six months following Accidental Injury to sound natural teeth, but only if such injury occurs while covered by the Carrier. Accidental Injury does not include injuries that result from biting or chewing.

2. Oral Surgery performed for the removal of impacted teeth partially or totally covered by bone.

3. Pediatric dental services are administered by and available through United Concordia Companies, Inc. For more information, please contact United Concordia at 1-866-568-5994.

**ROUTINE NEWBORN CARE**

Professional visits to examine the newborn while an Inpatient in a Hospital or Birthing Center. Facility charges for ordinary nursery care of the newborn as well as routine newborn circumcisions are also covered.

**PSYCHIATRIC BENEFITS**

Treatment of Mental Illness is eligible anywhere when performed by a Professional Provider as follows:

1. Psychiatric Visits
2. Electro-Convulsive Therapy
3. Individual Psychotherapy
4. Group Psychotherapy
5. Psychological Testing
6. Family Counseling
   
   Counseling with family members to assist in the Subscriber’s diagnosis and treatment. Such charges will be applied to the patient’s Mental Illness maximums.
Facility Services for Mental Illness

1. Inpatient Services
   Services provided for Inpatient treatment of Mental Illness by a Facility.

2. Partial Hospitalization services
   Treatment of Mental Illness in a planned therapeutic program when such services are rendered during the day only or during the night only.

3. Outpatient Mental Illness services
   Services provided to an Outpatient by a Facility.

See the section entitled Facility Services for Substance Abuse.

**ROUTINE PATIENT COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS**

Benefits are provided for Routine Patient Costs Associated With Qualifying Clinical Trials (see the Definitions section). To ensure coverage and appropriate claims processing, Independence Administrators must be notified in advance of the Subscriber’s participation in a Qualifying Clinical Trial. Benefits are payable if the Qualifying Clinical Trial is conducted by a Preferred Professional Provider, and conducted in a Preferred Facility Provider. If there is no comparable Qualifying Clinical Trial being performed by a Preferred Professional Provider, and in a Preferred Facility Provider, then Independence Administrators will consider the services by a Non-Preferred Provider, participating in the clinical trial, as covered if the clinical trial is deemed a Qualifying Clinical Trial (see the Definitions section) by Independence Administrators.

**AUTISM SPECTRUM DISORDERS (ASD)**

Benefits are provided for the diagnostic assessment and treatment of Autism Spectrum Disorders (ASD) for Subscribers less than twenty-one (21) years of age subject to the Annual Benefit Maximum specified in the Schedule of Benefits.

Diagnostic assessment is defined as medically necessary assessments, evaluations or tests performed by a licensed physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner, or Autism Service Provider to diagnose whether an individual has an Autism Spectrum Disorder.

Results of the diagnostic assessment shall be valid for a period of not less than twelve (12) months, unless a licensed physician or licensed psychologist determines an earlier assessment is necessary.

Treatment of autism spectrum disorders shall be identified in an ASD Treatment Plan and shall include any medically necessary Pharmacy Care, Psychiatric Care, Psychological Care, Rehabilitative Care and Therapeutic Care that is: (i)
prescribed, ordered or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner, (ii) provided by an autism service provider, including a Behavior Specialist, or (iii) provided by a person, entity or group that works under the direction of an autism service provider. An ASD Treatment Plan shall be developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. Depending on the service that is being requested, members, or a health care provider on their behalf, may be required to submit a treatment plan to Independence Administrators prior to receiving treatment. This plan may need to be reviewed and approved by Independence Administrators every six months.

Treatment of Autism Spectrum Disorders will include any of the following Medically Necessary services that are listed in an ASD Treatment Plan developed by a licensed physician or licensed psychologist:

1. 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.

2. Pharmacy Care – Medications prescribed by a licensed physician, licensed physician assistant or certified registered nurse practitioner and any assessment, evaluation or test prescribed or ordered by a licensed physician, licensed physician assistant or certified registered nurse practitioner to determine the need or effectiveness of such medications. The ASD medications may be purchased at a pharmacy, subject to the cost-sharing arrangement applicable to the prescription drug coverage. Benefits for ASD medications are subject to the ASD Annual Benefit Maximum.

3. Psychiatric Care – Direct or consultative services provided by a physician who specializes in psychiatry.

4. Psychological Care – Direct or consultative services provided by a psychologist.

5. Rehabilitative Care – Professional services and treatment programs, including applied behavioral analysis, provided by an Autism Service Provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.

6. Therapeutic Care – Services provided by speech language pathologists, occupational therapists or physical therapists.

Upon full or partial denial of coverage for any Autism Spectrum Disorders benefits, a Subscriber shall be entitled to file an appeal. The appeal process will: 1) provide
internal review followed by independent external review; and, 2) have levels, expedited and standard appeal time frames, and other terms established by the Carrier consistent with applicable Pennsylvania and federal law. Appeal filing procedures will be described in notices denying any Autism Spectrum Disorders benefits.
PRESCRIPTION DRUG COVERAGE

You are responsible for a copayment for each prescription drug or refill. You may also be responsible for a prescription drug deductible that must first be met before any benefits are payable. This amount is shown in the Schedule of Benefits.

If you purchase your prescription at a pharmacy that accepts Future Scripts, simply present your ID card and pay the copayment and/or deductible.

If you purchase your prescription at a Doctor’s office or pharmacy that does not accept Future Scripts, pay the full cost of the prescription and have the Doctor or pharmacist complete their portion of a “Direct Reimbursement” form. Submit this form to Future Scripts and they will reimburse you for the cost of the prescription minus your copayment and/or deductible.

Prior authorization

Your health benefits program requires prior authorization of certain covered drugs to ensure that the drug prescribed is medically necessary and appropriate and is being prescribed according to the Food and Drug Administration (FDA) guidelines. The approval criteria were developed and endorsed by Future Scripts Pharmacy and Therapeutics Committee, which is an established group of medical directors and practicing physicians and pharmacists.

Using these approved criteria, clinical pharmacists evaluate requests for these drugs based on: clinical data; information submitted by the Subscriber’s prescribing physician; and the Subscriber’s available prescription drug therapy history. Their review includes a determination that: there are no drug interactions or contraindications; that dosing and length of therapy are appropriate; and that other drug therapies, if necessary, were utilized.

Without prior authorization, the Subscriber’s prescription will not be covered at your health benefits program’s retail or mail order pharmacy. The prior authorization process may take up to two working days once Future Scripts receives complete information from the prescribing physician. Incomplete information will result in a delayed decision.

Prior authorization approvals for some drugs may be limited to 6 to 12 months. If the prior authorization for a drug is limited to a certain time frame, an expiration date will be given at the time the approval is made. If the physician wants a Subscriber to continue the drug therapy after the expiration date, a new prior authorization request will need to be submitted and approved in order for coverage to continue.

You will be issued a separate list of prescription drugs that require prior authorization, which is subject to change from time to time.
PATIENT CARE MANAGEMENT

You MUST CALL the telephone number on the back of your identification (ID) card to fulfill the requirements of Patient Care Management.

UTILIZATION REVIEW PROCESS

A basic condition of the Carrier’s benefit plan coverage is that in order for a health care service to be covered or payable, the service must be Medically Appropriate/Medically Necessary. To assist Independence Administrators in making coverage determinations for requested health care services, the Carrier uses established medical policies and medical guidelines based on clinically credible evidence to determine the Medical Appropriateness/Medical Necessity of the requested services. The appropriateness of the requested setting in which the services are to be performed is part of this assessment. The process of determining the Medical Appropriateness/Medical Necessity of requested health care services for coverage determinations based on the benefits available under a Subscriber’s benefit plan is called utilization review.

It is not practical to verify Medical Appropriateness/Medical Necessity on all procedures on all occasions; therefore, certain procedures may be determined by the Carrier to be Medically Appropriate/Medically Necessary and automatically approved based on the accepted Medical Appropriateness/Medical Necessity of the procedure itself, the diagnosis reported, or an agreement with the performing Provider. An example of such automatically approved services is an established list of services received in an emergency room which has been approved by the Carrier based on the procedure meeting emergency criteria and the severity of diagnosis reported (e.g. rule out myocardial infarction, or major trauma). Other requested services, such as certain elective Inpatient or Outpatient procedures may be reviewed on a procedure specific or setting basis.

Utilization review generally includes several components which are based on when the review is performed. When the review is required before a service is performed, it is called a precertification review. Reviews occurring during a Hospital stay are called a concurrent review, and those reviews occurring after services have been performed are called either retrospective or post-service reviews. The Carrier follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.

Generally, where a requested service is not automatically approved and must undergo Medical Appropriateness/Medical Necessity review, nurses perform the initial case review using medical policies, established guidelines and evidence-based clinical criteria and protocols; however, only a medical director employed by the Carrier or its delegate may deny coverage for a procedure based on Medical Appropriateness/Medical Necessity. The evidence-based clinical protocols evaluate the Medical Appropriateness/Medical Necessity of specific procedures and the majority is computer-based. Information provided in support of the request is entered into the computer-based system and evaluated against the clinical protocols. Nurses apply applicable guidelines and evidence-based clinical criteria
and protocols, taking into consideration the Subscriber’s condition and applying sound professional judgment. When the clinical criteria are not met, the given service request is referred to a medical director for further review for approval or denial. Independent medical consultants may also be engaged to provide clinical review of specific cases or for specific conditions. Should a procedure be denied for coverage based on lack of Medical Appropriateness/Medical Necessity, a letter is sent to the requesting Provider and the Subscriber in accordance with applicable law.

The Carrier’s utilization review program encourages peer dialogue regarding coverage decisions based on Medical Appropriateness/Medical Necessity by providing physicians with direct access to the Carrier or its delegate’s medical directors to discuss coverage of a case. Medical directors and nurses receive salaries. Contracted external physicians and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. Neither the Carrier nor its delegates specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization. The precertification process reviews the Medical Appropriateness/Medical Necessity of the requested services only. Precertification is not a guarantee of eligibility for the coverage or payment of a Claim. Coverage and payment are dependent upon, among other things, the Subscriber being eligible, i.e., actively enrolled in the health benefits plan when the services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request.

**CLINICAL CRITERIA, GUIDELINES AND RESOURCES**

The following guidelines, clinical criteria and other resources are used to help make Medically Appropriate/Medically Necessary coverage decisions.

**Clinical Decision Support Criteria** — Clinical Decision Support Criteria is an externally validated and computer-based system used to assist the Carrier or its delegate in determining Medical Appropriateness/Medical Necessity. This evidence-based, Clinical Decision Support Criteria is nationally recognized and validated. Using a model based on evaluating intensity of service and severity of Illness, these criteria assist clinical staff in evaluating the Medical Appropriateness/Medical Necessity of services based on a Subscriber’s specific clinical needs. Clinical Decision Support Criteria helps promote consistency in plan determinations for similar medical issues and requests, and reduces practice variation among the Carrier or its delegate’s clinical staff to minimize subjective decision-making.

Clinical Decision Support Criteria may be applied for Covered Services including but not limited to the following: some elective Surgeries — settings for Inpatient and Outpatient procedures (e.g., hysterectomy and sinus surgery), Inpatient hospitalizations, Inpatient and Outpatient rehabilitation, diagnostic procedures, Home Health Care, Durable Medical Equipment, and Skilled Nursing Facility.
Medical Policies — The Carrier and its delegates maintain an internally developed set of policies, which document the coverage and conditions for certain medical/surgical procedures and ancillary services.

Covered Services for which Medical Policies are applied include, but are not limited to: Ambulance, Infusion, Speech Therapy, Occupational Therapy, Durable Medical Equipment, and review of potential cosmetic procedures.

Internally Developed Guidelines — A set of guidelines developed with input by clinical experts based on accepted practice guidelines within the specific fields and reflecting medical policies for coverage.

DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA

The Carrier delegates its utilization review process to AmeriHealth Administrators, Inc., a state licensed utilization review entity, where required, and a URAC (Utilization Review Accreditation Commission) accredited utilization management program, who is responsible for the Carrier’s utilization review process. In certain instances, AmeriHealth Administrators has delegated certain utilization review activities, including precertification review, concurrent review, and case management, to entities with an expertise in medical management of certain conditions and services (such as, Mental Illness/Substance Abuse), or certain membership populations (such as, neonates/premature infants), or after-hours precertification services. In such instances, a formal delegation and oversight process is established in accordance with applicable law and nationally-recognized accreditation standards. In such cases, the delegate’s utilization review criteria are generally used, with the Carrier’s approval.

PRECERTIFICATION REVIEW

When required, precertification review evaluates the Medical Necessity, including the Medical Appropriateness of the setting, of proposed services for coverage under the Subscriber’s benefit plan. Examples of these services include planned or elective Inpatient admissions and selected Outpatient procedures. Precertification review may be initiated by a Provider; however, it is the Subscriber’s responsibility to obtain precertification review. Where precertification review is required, the Carrier’s coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties may be applied where precertification review is required for a procedure but is not obtained.

While the majority of services requiring precertification review are reviewed for Medical Appropriateness of the requested procedure setting (e.g., Inpatient, short procedure unit, or Outpatient setting), other elements of the Medical Appropriateness/Medical Necessity of the procedure may not always be evaluated and may be automatically approved based on the procedure or diagnosis for which the procedure is requested or an agreement with the performing Provider. Precertification review is not required for emergency services. The following are general examples of current precertification review requirements under the benefit plan; however, these requirements are subject to change: hysterectomy, nasal
Surgery Procedures, bariatric Surgery, potentially cosmetic or Experimental/Investigational procedures.

Specific information is provided below about this benefit plan’s precertification requirements. A complete list of Precertification requirements is shown in the “Services Requiring Precertification” below.

1. INPATIENT PRE-ADMISSION REVIEW

In accordance with the criteria and procedures described above, Inpatient admissions, other than an emergency admission, must be precertified in accordance with the standards of the Carrier as to the Medical Appropriateness/Medical Necessity of the admission. The precertification requirements for emergency admissions are set forth in the “Emergency Admission Review” subsection immediately following below. The Subscriber is responsible to have the admission (other than an emergency or maternity admission) certified in advance as an approved admission.

a. To obtain precertification, the Subscriber is responsible to contact or have the admitting Doctor or Facility contact Independence Administrators, prior to admission to the Hospital, Skilled Nursing Facility, or other Facility. Independence Administrators will notify the Subscriber, admitting Doctor and the Facility of the determination.

b. If precertification is denied, the Subscriber, the Doctor or the Facility may appeal the determination and submit information in support of the Claim for Inpatient benefits. A final determination concerning eligibility for Inpatient benefits will be made and the Subscriber, the Doctor, or the Facility will be so notified.

2. EMERGENCY ADMISSION REVIEW

a. Subscribers are responsible for notifying Independence Administrators of an emergency admission within two (2) business days of the admission, or as soon as reasonably possible, as determined by Independence Administrators.

b. If the Subscriber elects to remain hospitalized after Independence Administrators and the attending Doctor have determined that an Inpatient level of care is not Medically Appropriate/Medically Necessary, the Subscriber will be financially liable for non-covered Inpatient charges from the date of notification.

3. CONCURRENT AND RETROSPECTIVE/POST-SERVICE REVIEW, PRENOTIFICATION AND DISCHARGE PLANNING

Concurrent review may be performed while services are being performed. If concurrent review is performed during an Inpatient stay, the expected and current length of stay is evaluated to determine if continued hospitalization is Medically Appropriate/Medically Necessary. When performed, the review
assesses the level of care provided to the Subscriber and coordinates discharge planning. Concurrent review continues until the patient is discharged. Not all Inpatient stays are reviewed concurrently. Concurrent review may not be performed where an Inpatient Facility is paid based on a per case or diagnosis-related basis, or where an agreement with a Facility does not require such review.

**Retrospective/post-service review** occurs after services have been provided. This may be for a variety of reasons, including when Independence Administrators has not been notified of a Subscriber’s admission until after discharge, or where medical charts are unavailable at the time of a concurrent review. Certain services are only reviewed on a retrospective/post-service basis.

In addition to these standard utilization reviews, the Carrier may determine coverage of certain procedures and other benefits available to Subscribers through prenotification as required by the Subscriber’s benefit plan and discharge planning.

**Pre-notification** is advance notification to Independence Administrators of an Inpatient admission or Outpatient service where no Medical Appropriateness/Medical Necessity review is required, such as maternity admissions/deliveries. Pre-notification is primarily used to identify Subscribers for concurrent review needs, to ascertain discharge planning needs proactively, and to identify Subscribers who may benefit from case management programs.

**Discharge planning** is performed during an Inpatient admission and is used to identify and coordinate a Subscriber’s needs and benefit coverage following the Inpatient stay, such as covered home care, ambulance transport, acute rehabilitation, or Skilled Nursing Facility placement. Discharge planning involves the Carrier’s authorization of covered post-Hospital services along with identifying and referring Subscribers for disease management or case management services.

**OTHER PRECERTIFICATION REQUIREMENTS**

Precertification is required by the Carrier in advance for Home Health Care, Hospice Care, certain surgical and diagnostic procedures, Inpatient and Partial Hospitalization services for Substance Abuse, Mental Illness and Serious Mental Illness. A complete list of precertification requirements is shown in the “Services Requiring Precertification” below. When a Subscriber plans to receive any of these listed procedures, Independence Administrators will review the Medical Appropriateness/Medical Necessity for the procedure or treatment in accordance with the criteria and procedures described above and grant prior approval of benefits accordingly.

Surgical, diagnostic and other procedures, listed in the “Services Requiring Precertification” below, that are performed during an emergency, as determined
by the Carrier, do not require precertification. However, Independence Administrators should be notified within two (2) business days of emergency services for such procedures, or as soon as reasonably possible, as determined by the Carrier.

The Subscriber is responsible to have the Provider performing the service contact Independence Administrators to initiate precertification. Independence Administrators will notify the Subscriber, the Doctor and the Facility, if applicable, of the determination.

If such prior approval is not obtained and the Subscriber undergoes the Surgical Procedure, diagnostic or other procedure, or treatment, listed in the “Services Requiring Precertification” below, and then benefits will be provided for Medically Appropriate/Medically Necessary treatment.

SERVICES REQUIRING PRECERTIFICATION

For a complete list of services requiring Precertification please call the number for Patient Care Management listed on your identification (ID) card.

CASE MANAGEMENT

Case management serves individuals who have been diagnosed with a complex, catastrophic, or chronic illness or injury. The objectives of case management are to facilitate access by the patient to ensure the efficient use of appropriate health care resources, link Subscribers with appropriate health care or support services, assist Providers in coordinating prescribed services, monitor the quality of services delivered, and improve outcomes of Subscribers. Case management supports Subscribers and Providers by locating, coordinating, and/or evaluating services for a Subscriber who has been diagnosed with a complex, catastrophic or chronic illness and/or injury across various levels and sites of care.

The Carrier will provide case management services for those identified Subscribers that would benefit from:

- Support during the continuum of care;
- Improved self-management skills;
- Improved transition and coordination among multiple Providers and/or levels of care;
- Assistance to maximize the effective use of health plan benefits;
- Reduction of acute exacerbation of a chronic illness; and,
- Reduction of preventable complications.

Subscribers may be identified for case management through the precertification process or through claims review. External referrals are also accepted from
Subscribers’ Providers or family members. Subscribers referred to case management are screened and accessed prior to acceptance into the program. Only those Subscribers likely to benefit from case management are accepted into case management.

A case manager will consult with the patient; the patient’s authorized representative, the caregiver and the attending Doctor in order to develop a plan of care for approval by the patient’s attending Doctor and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the care giver to offer assistance and support;
- monitoring Inpatient care;
- identifying available resources for appropriate care;
- determining alternative care options; and
- Assisting in obtaining any necessary equipment and services.

The case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The attending Doctor, the patient and the patient’s caregiver must all agree to the alternate treatment plan. Once agreement has been reached, the Carrier may reimburse necessary expenses in the treatment plan, even if some expenses normally would not be paid by the benefit plan.

Case management is a voluntary service. Subscribers must provide their consent for enrollment into case management. There is no reduction in benefits if the patient and the patient’s family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.
WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998

In accordance with this law, the required mastectomy coverage includes:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of a mastectomy, including lymphedemas.

The benefits for these services must be provided in a manner determined in consultation with the attending doctor and the patient. These services may be subject to the deductibles and coinsurance amounts applicable to your group health plan.

CHILD IMMUNIZATION COVERAGE

Coverage will be provided for those child immunizations, including the immunizing agents, which, as determined by the Department of Health, conform with standards of the Advisory Committee on Immunization Practices of the Center of Disease Control, U.S. Department of Health and Human Services. Benefits will be exempt from deductibles or dollar limits.

ANNUAL GYNECOLOGICAL EXAMINATION AND ROUTINE PAP SMEARS

- Annual gynecological examination, including a pelvic examination and clinical breast examination; and
- Routine pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

These gynecological examination/pap smear benefits are exempt from any deductible or dollar limit provisions in the contract. However, they may be subject to any copayment or coinsurance amount applicable to your group health plan.
COLORECTAL CANCER SCREENING COVERAGE

Coverage for colorectal cancer screening may be subject to annual deductibles, coinsurance, and co-payment requirements. Benefits for preventive care colorectal cancer screening are subject to the requirements as established by the U.S. Preventive Services Task Force Recommendations and may be different from the benefits detailed below. For more information on preventive care colorectal cancer screening, please visit www.healthcare.gov.

Symptomatic individuals:
- Colonoscopy
- Sigmoidoscopy
- Colorectal Screening Tests (any combination thereof a determined by the treating physician)

Non-symptomatic individuals covered over age 50:
- Annual Fecal Occult Blood Test
- Sigmoidoscopy – a screening barium enema test once every five years
- Colonoscopy once every 10 years
- Colon Cancer test at least once every 5 years

Non-symptomatic coverage for individuals at high or increased risk of colorectal cancer under age 50:
- Colonoscopy
- Any combination of colorectal cancer screening tests.
EXCEPTIONS AND EXCLUSIONS

Covered medical charges do not include any charges:

1. for any service, treatment, Surgery, Supply, drug or medicine that:
   a. is not Medically Necessary for the care or treatment of an Accidental Injury or Illness; or
   b. is not recommended by a Doctor; or
   c. is Experimental/Investigative in nature, except, a) as approved by the Carrier, or b) Routine Patient Costs Associated With Qualifying Clinical Trials that meets the definition of a Qualifying Clinical Trial under the Contract;

2. Incurred prior to the effective date of coverage under the Contract;

3. Incurred on or after the date coverage terminates under the Contract, except as provided in Termination of Coverage;

4. for routine physicals, immunizations and screening (except for mandated benefits as provided herein), premarital or pre-employment examinations, rest cures, research studies or any other services or Supplies which are not necessary for the diagnosis, care or treatment of an Illness or Accidental Injury unless specifically included herein;

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

6. for Custodial Care, Maintenance Care or palliative care or treatment, unless specifically included herein;

7. for developmental delays or learning disabilities not related to an organic origin;

8. for professional services for weight control programs or diet centers unless it is an essential part of the treatment for an Illness or injury covered by the Contract;

9. for blood, blood components or blood plasma that is donated or otherwise replaced;

10. for medical or surgical Supplies, except as specifically provided herein;

11. for personal hygiene, convenience items and non-medical items such as, but not limited to, air conditioners, humidifiers, physical fitness equipment, television, beauty/barber shop services or guest tray, whether or not recommended by a Doctor;

12. for orthodontics (or braces) or any other dental services, treatment, surgery or Supplies, except as specifically provided herein;
13. for treatment of temporomandibular joint syndrome with intra-oral devices, or other method to alter vertical dimension;

14. for hearing aids or examinations for the prescription or fitting of hearing aids;

15. for local infiltration anesthesia when billed separately;

16. for eye examinations, eyeglasses, sunglasses (including cataract sunglasses), safety glasses, and examinations for the fitting or prescription except, as stated in the Schedule of benefits, pediatric vision care;

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

18. for routine foot care, for treatment of bunions (except capsular or bone surgery), toenails (except surgery for ingrown toenails), corns, calluses, fallen arches, flat feet, weak feet, chronic foot strain, symptomatic complaints of the feet, or non-rigid foot orthotics. This exclusion does not apply to Subscribers with peripheral vascular and/or peripheral neuropathic diseases, including but not limited to diabetes;

19. for Cosmetic Surgery except those performed to correct a condition resulting from an accident or illness which occurs while covered under the Contract;

20. for the treatment of infertility, including drugs or medication other than those services necessary to diagnose the cause of infertility and surgical correction;

21. for the reversal of elective sterilization;

22. for artificial insemination;

23. for in-vitro fertilization or in-vivo fertilization;

24. for treatment of sexual dysfunction not related to organic disease;

25. for any service, treatment, Surgery, Supply, drug or medicine furnished by a spouse, parent or child of a Subscriber for whom the charge is being made;

26. for any service, treatment, Surgery, Supply or drug and medicine furnished for the care of any Accidental Injury or Illness which is covered by Workers' Compensation or Occupational Disease Law;

27. for any service, treatment, Surgery, Supply, drug or medicine furnished for the treatment of an Accidental Injury or Illness due to an act of war, declared or undeclared, participation in a riot or illegal occupation, commission of or attempt to commit a felony;

28. for volunteer services;

29. for services of which there is no legal obligation to pay;
30. for any service, treatment, Surgery, Supply, drug or medicine that a Subscriber is eligible to receive from the Veterans Administration Hospital for which the Subscriber has no legal obligation to pay or the Department of Defense for active military personnel for which a Subscriber is eligible. This exclusion applies even if the Subscriber has not taken the necessary action to obtain such benefits;

31. for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under a state’s Motor Vehicle Financial Responsibility law or similar law;

32. for payment made under Medicare when Medicare is primary or would have been made if the Subscriber had been enrolled for Medicare and claimed Medicare benefits, however, this exclusion shall not apply when the Educational Institution is obligated by law to offer the Subscriber all the benefits of the Contract and the Subscriber so elects this coverage as primary;

33. for well-baby care, unless specifically included in this booklet;

34. for expenses incurred for services or Supplies provided by the Educational Institution’s health service, infirmary or hospital, or by health care providers employed by the Educational Institution;

35. for expenses incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, (except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route); or skydiving;

36. for expenses incurred for Accidental Injury resulting from the travel to, or play or practice of interscholastic, intercollegiate or professional sports activity unless specifically included in this book;

37. for expenses related to organ donation for non-member recipients;

38. for cranial prostheses including wigs to replace hair;

39. for music therapy, equestrian therapy, and hippotherapy;

40. For alternative therapies/complementary medicine.
FACILITY SERVICES FOR SUBSTANCE ABUSE

Each Subscriber is entitled to the benefits described below for Facility services for the treatment of Substance Abuse and dependency. These are the only benefits provided for Facility Services for the treatment of Substance Abuse and dependency and are subject to all other Contract provisions.

INPATIENT DETOXIFICATION SERVICES

Benefits are payable for a detoxification program provided either in a Hospital or in a licensed Alcoholism or Substance Abuse Treatment Facility.

1. Covered Services include:
   a. room and board;
   b. Doctor, psychologist, nurse, certified addictions counselor, and trained staff services;
   c. diagnostic X-ray;
   d. psychiatric, psychological, and medical laboratory testing; and
   e. drugs, medicines, equipment, and Supplies.

INPATIENT REHABILITATION SERVICES

Benefits are payable for Inpatient services provided in a licensed Alcoholism or Substance Abuse Treatment Facility provided the Subscriber: (a) has been certified by a Doctor or psychologist as a person who suffers from Substance Abuse or dependency; and (b) is referred for treatment by such Doctor or psychologist.

1. Covered Services include:
   a. room and board;
   b. Doctor, psychologist, nurse, certified addictions counselor, and trained staff services;
   c. rehabilitation therapy and counseling;
   d. family counseling and intervention;
   e. psychiatric, psychological, and medical laboratory testing; and
   f. Drugs, medicines, equipment, and Supplies.

OUTPATIENT REHABILITATION SERVICES

Benefits are payable for Outpatient services provided in a licensed Alcoholism or Substance Abuse Treatment Facility, provided the Subscriber: (a) has been certified by a Doctor or psychologist as a person who suffers from Substance Abuse or dependency; and (b) is referred for treatment by such Doctor or psychologist.

1. Covered Services include:
   a. Doctor, psychologist, nurse, certified addictions counselor, and trained staff services;
   b. rehabilitation therapy and counseling;
c. family counseling and intervention;
d. psychiatric, psychological, and medical laboratory testing; and
e. Drugs, medicines, use of equipment, and Supplies.
COORDINATION OF BENEFITS

APPLICABILITY

1. This Coordination of Benefits ("COB") provision applies to This Plan when a Covered Student or the Covered Student’s covered Dependent has health care coverage under more than one Plan. “Plan” and “This Plan” are defined below.

2. If this COB provision applies, the Order Of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

   a. shall not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another Plan; but

   b. May be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in “Effect on the Benefits of This Plan”.

DEFINITIONS

1. “Plan” is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

   a. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It does not include school accident-type coverage, group or group-type hospital indemnity benefits of $100 per day or less.

   b. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid. It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

      Each contract or other arrangement for coverage under a. or b. is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. “This Plan” is the part of the group contract that provides benefits for health care expenses.

3. “Primary Plan/Secondary Plan”. The Order of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

   When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan’s benefits.

   When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits.
When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. “Allowable Expense” means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an Allowable Expense under the above definition unless the patient’s stay in a private hospital room is medically necessary either in terms of generally accepted medical practice or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

5. “Claim Determination Period” means a Plan year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

**ORDER OF BENEFIT DETERMINATION RULES**

1. **General.** When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

   a. the other Plan has rules coordinating its benefits with those of This Plan; and

   b. Both those rules and This Plan’s rules, in subparagraph 2 below, require that This Plan’s benefits be determined before those of the other Plan.

2. **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:

   a. **Non-dependent/Dependent.** The benefits of the Plan which covers the person as other than a dependent are determined before those of the Plan which covers the person as a dependent.

   b. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in subparagraph 2 (c) below, when This Plan and another Plan cover the same child as a dependent of different persons, called “parents”:

      (1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but
(2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period.

However, if the other Plan does not have the rule described in (1) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. **Dependent Child/Parents Separated or Divorced.** If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) first, the Plan of the parent with custody of the child;

(2) then, the Plan of the spouse of the parent with custody of the child; and

(3) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered a Covered Student longer are determined before those of the Plan which covered that person for the shorter time.

### EFFECT ON THE BENEFITS OF THIS PLAN

1. **When this Section Applies.** This section applies when, in accordance with the “Order of Benefit Determination Rules,” This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as “the other Plans” in 2 immediately below.

2. **Reduction in This Plan’s Benefits.** The benefits of This Plan will be reduced when the sum of:

   a. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
b. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION
The Carrier has the right to release or obtain benefit information in order to implement this provision.

FACILITY OF PAYMENT
If payments should have been made under this Plan but were made under any other Plan(s), the Carrier may make payments to such other Plan(s) to satisfy the intent of the provision. Benefits under this Plan will then be deemed paid. The Carrier will no longer be liable for such payments.

RIGHT OF RECOVERY
The Carrier has the right to recover any excess payments made to satisfy the intent of this provision.
TERMINATION OF COVERAGE

COVERED STUDENT
Coverage for a Covered Student will end on the earliest of:

1. the date the Contract terminates;

2. The end of the period covered by the last contribution made by the Covered Student for coverage under this Contract;

3. The date the Covered Student begins full-time active duty as a member of any military organization;

4. the end of the month in which the Covered Student becomes eligible to enroll in Medicare Part A and/or Part B whether or not the Covered Student enrolls in Medicare Part A and/or Part B. This does not apply to anyone who remains a Full-time Covered Student.

A Covered Student who withdraws from the Educational Institution during the first thirty-one (31) days following the effective date of coverage shall be entitled to a refund of contributions toward coverage provided that no claims have been incurred under the coverage. If a Covered Student withdraws from the Educational Institution after thirty-one (31) days following the effective date of coverage will remain in force until the end of the period for which contributions have been made and the Covered Student shall not be entitled to any refund of contributions.

DEPENDENT(S)
Coverage for a Dependent will end on the earliest of:

1. the date the Covered Student’s coverage terminates under the Contract;

2. the date in which the Dependent no longer satisfies the eligibility requirements for coverage as a Dependent under the Contract;

3. the end of the period covered by the last contribution made by the Covered Student for Dependent coverage; or

4. The end of the month in which the Dependent becomes eligible to enroll in Medicare Part A and/or Part B whether or not the Dependent enrolls in Medicare Part A and/or Part B. This does not apply to any Dependent governed by any conflicting federal law.

COVERED STUDENT AND DEPENDENT(S)
Coverage for Covered Student s and Dependents will terminate:

1. Effective the last day of the month following the month in which the Educational Institution no longer satisfies the Minimum Participation Requirements of the Contract.
2. Effective the first day following the end of the grace period if the Educational Institution fails to pay any premium on any due date and if payment is not received during the grace period.

**CONVERSION OF COVERAGE**

1. If an individual ceases to be a Subscriber under the Contract, the individual is eligible for coverage under an individual conversion contract then available from the Carrier. The coverage may be different from the coverage provided under the Contract. Evidence of insurability is not required. This option is not available to Subscribers who have been covered under the Educational Institution’s plan for less than three months, to Subscribers whose termination of coverage under the group contract was for failure to pay any required contribution, or to Subscribers who obtain replacement group coverage within 31 days.

2. The Educational Institution will give a Subscriber written notice of the privilege of conversion to a conversion contract and its duration within fifteen (15) days before or after the date of termination of coverage under the Contract.

3. Direct payment for coverage under the conversion contract must be made from the date the person ceases to be a Subscriber under the Contract.

4. The conversion contract will be effective on the date of termination of the Subscriber’s coverage under the Contract.

5. Written application for the conversion contract must be made to the Carrier no later than 31 days after termination under the Contract.

6. If the Subscriber is eligible for another health insurance plan which is available to the Educational Institution where the Subscriber is employed or with which the Subscriber is affiliated, a conversion contract will not be available.

7. The conversion contract will not be available to any Subscriber where the Educational Institution terminates the Contract in favor of group coverage by another organization or where the Educational Institution terminates the Subscriber in anticipation of terminating the Contract in favor of group coverage by another organization.
GENERAL PROVISIONS

SUBROGATION
In the event of any payments under the terms of the Contract, the Carrier will be subrogated to all the Subscriber’s rights of recovery with respect to the involved services or Supplies provided to the Subscriber, against any person, party, or organization except against insurers on policies of insurance issued to, and in the name of, the Subscriber.

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

Notwithstanding anything contained in the Contract to the contrary, the right of subrogation is not enforceable where prohibited by law or regulation.

LIMITATION OF LIABILITY
The Carrier will not be liable for any injury (ies) or damage(s) resulting from acts or omissions of any person, institution or other Provider furnishing services or supplies to the Subscriber.

No legal action may be taken to recover from the Carrier benefits provided by the Contract until 30 days after the Carrier has received a properly completed claim. In no event may such action be taken later than one year after services or Supplies were performed or provided.

NOTICE OF CLAIM
The Carrier will not be liable under the Contract unless proper notice is furnished to the Carrier that covered expenses have been provided to a Subscriber. **Written notice must be given within 60 days after expenses are Incurred for covered expenses.**

Failure to give notice to the Carrier within the specified time period will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but **in no event will the Carrier be required to accept notice more than one (1) year after covered expenses are Incurred.**

PAYMENT OF BENEFITS
The Carrier is authorized by the Subscriber to make payment directly to Facilities and Participating Professional Providers furnishing Covered Services for which benefits are provided under the Contract. However, the Carrier reserves the right to make the payments directly to the Subscriber. The right of the Subscriber to receive payment is not otherwise assignable unless required by Pennsylvania State law.

If any benefit remains unpaid at the death of the Covered Student, payment will be made to the Covered Student’s estate. If no estate is probated or expected to be probated, the Carrier will have the right to make payment to a third party who has paid covered expenses for the Covered Student, upon receipt of proper
documentation of such payment. The Carrier will incur no liability due to such payment made pursuant to this provision.

A request for payment of benefits will be deemed to authorize the Carrier to institute an investigation and to have access to all pertinent data, including all records of a Hospital and/or Doctor pertaining to the Subscriber.

SUBSCRIBER/PROVIDER RELATIONSHIP
The choice of a Provider or choice of treatment by a Provider is solely that of the Subscriber.

The Carrier does not furnish Covered Services but only makes payment for Covered Services received by a Subscriber. The Carrier is not liable for any act or omission of any Provider. The Carrier has no responsibility for a Provider’s rendering of, failure or refusal to render Covered Services to a Subscriber.

PARTICIPATING AND NON-PARTICIPATING PROFESSIONAL PROVIDER REIMBURSEMENT
Benefit amounts, as specified in the Schedule of Benefits, refer to Covered Services provided by a Participating Provider which are regularly included in such Provider’s charges and are billed by and payable to such Provider.

The allowance for Covered Services provided by a Non-Participating Provider which are regularly included in such Provider’s charges and are billed by and payable for such Provider is the same as for a Participating Provider.

When Covered Services are performed by a Non-participating Provider, the Carrier reserves the right to make payment to the Subscriber. Any difference between the Non-participating Provider’s charge and the Carrier’s payment shall be the personal responsibility of the Subscriber.

SERVICE BENEFITS PROVISION
Service Benefits apply to Subscribers who utilize Participating Professional Providers. Participating Professional Providers have agreed to accept the Provider’s negotiated charge as payment in full for Covered Services. Participating Professional Providers will make no additional charge to Service Benefit Subscribers for Covered Services, except in the case of Deductible and Coinsurance amounts and amounts exceeding the maximums referred to in the Contract. Such Deductible and Coinsurance amounts must be paid to, or arrangements must be made to pay, the Participating or Preferred Professional Provider by the Subscriber within 60 days of the date in which the Carrier finalizes such services.

Any dispute between the Participating Professional Provider and a Subscriber with respect to balance billing will be submitted to the Carrier for final determination. The decision by the Carrier will be final.
RIGHT TO RECOVER EXCESS PAYMENTS
The Carrier reserves the right to recover claim payments made in excess of the benefits payable for Covered Services under the Contract. The Carrier may request that the payee, either a Subscriber or Provider, return the excess payment to the Carrier.
WHEN YOU HAVE A CLAIM

FROM A DOCTOR OR FACILITY
If you are treated for a covered Accidental Injury or Illness at a Facility or a participating doctor’s office, present your Independence Administrators identification card. The Carrier will pay the provider directly for covered expenses.

If you are required to pay the Facility or the Doctor, be sure to get a receipted, itemized bill. Besides the itemized charges it should show:

- your name and address
- patient’s name and age
- doctor’s or hospital’s name and address
- Provider or Facility identification number
- date of admission or treatment

ADVERSE DETERMINATIONS
An adverse determination is a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part*) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on: a determination that a benefit is not a covered benefit; source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or a determination that a benefit is experimental, investigational, or not medically necessary or appropriate. This can include both pre-service claims as well as post-service claims. The scope of adverse benefit determination eligible for internal claims and appeals includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).

*Including a denial of part of the claim due to the terms of a plan or health insurance coverage regarding copayments, deductibles, or other cost-sharing requirements.

Complaint Process
The Carrier has a process for a Subscriber to express complaints. To register a complaint, the Subscriber should call the Customer Service Department at the telephone number on their identification card or write to Independence Administrators at the address listed below.

Independence Administrators
P.O. Box 21974
Eagan, MN 55121

Most Subscribers’ concerns are resolved informally at this level. However, if the Carrier is unable to immediately resolve the complaint, it will be investigated, and the Subscriber will receive a response within thirty (30) days.

Appeal Process
**Filing an Appeal** the Carrier's maintains procedures for the resolution of appeals. Appeals may be filed within 180 days of the receipt of a decision from the Carrier stating an adverse benefit determination. An appeal occurs when the Subscriber or another authorized representative requests a change of a previous decision made by the Carrier by following the procedures described here. In order to authorize someone else to be your representative for the appeal, you must complete a valid authorization form.

Contact Independence Administrators at the address listed above or access your online services at the address on your identification card to obtain a form to authorize an appeal by a provider or other representative or for questions regarding the requirements for an authorized representative.

The Subscriber or other authorized person on behalf of the Subscriber, may request an appeal by calling or writing to Independence Administrators, as stated in the letter notifying the Subscriber of the decision.

**Types of Appeals** The following are the two types of appeals and the issues they address.

- **Medical Necessity Appeal** – An appeal by or on behalf of a Subscriber that focuses on issues of Medical Appropriateness/Medical Necessity and requests the Carrier to change its decision to deny or limit the provision of a Covered Service. Medical Necessity appeals include appeals of adverse benefit determinations based on failure to meet established medical guidelines and peer review of medical appropriateness. It may also include the exclusions for Experimental/Investigational services or cosmetic services. Internal and External Appeals apply.*

- **Administrative Appeal** – An appeal by or on behalf of a Subscriber that focuses on unresolved disputes or objections regarding the Carrier's decision that concerns coverage terms such as exclusions and non-covered benefits, exhausted benefits, and claims payment issues. Although an administrative appeal may present issues related to Medical Appropriateness/Medical Necessity, these are not the primary issues that affect the outcome of the appeal. Internal Appeals apply.*

  * **First Step — Internal Appeal** – An appeal filed with your health plan/plan administrator for evaluation and determination.

  * **Second Step — External Appeal** – An appeal filed with your health plan/plan administrator for evaluation and determination by an independent review organization (IRO).

**Timeframe Classifications** The timeframes described below for completing a review of each appeal depend on whether the appeal is classified as standard appeal or an expedited appeal for urgent care.

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- Standard appeal timeframes apply to both pre-service appeals and post-service appeals that concern claims for non-urgent care.

**Standard pre-service appeal** – An appeal for benefits that, under the terms of the Plan, must be pre-certified or pre-approved (either in whole or in part) before medical care is obtained in order for coverage to be available.

**Standard post-service appeal** – An appeal for benefits that is not a pre-service appeal. (Post-service appeals concerning claims for services that the Subscriber has already obtained do not qualify for review as expedited/urgent appeals.)

- Urgent-care/Expedited appeal timeframes may apply to pre-service or on-going requests for urgent care.

**Expedited appeal for urgent care** – An appeal that provides faster review, according to the procedures described below, on a pre-service issue. Independence Administrators will conduct an urgent-care/expedited appeal on a pre-service issue when it determines, based on applicable guidelines, that delay in decision-making would seriously jeopardize the Subscriber’s life, health or ability to regain maximum function or would subject the Subscriber to severe pain that cannot be adequately managed while awaiting a standard appeal decision.

**Information for the Appeal Review including Matched Specialist’s Report** the Subscriber or other authorized person on behalf of the Subscriber, may submit to the Carrier additional information pertaining to your case. You may specify the remedy or action being sought. Upon request at any time during the appeal process, Independence Administrators will provide you or your authorized representative, free of charge, access to, and copies of, all relevant documents and records, including any additional information received and reviewed by the decision maker(s) on the appeal.

Input from a matched specialist is obtained for certain Medical Necessity Appeals. A matched specialist is a licensed physician or psychologist in the same or similar specialty as typically manages the care under review. The matched specialist cannot be the person who made the initial adverse benefit determination nor can they be a subordinate of the person who made that determination.

**Appeal Decision Makers** The Carrier has representatives that have been designated to act as decision maker(s) on the appeal. The decision maker(s) did not make the initial adverse benefit determination at issue in the appeal. Each decision maker will review all relevant information for the appeal, whether from the Subscriber or his authorized representative, or obtained from other sources during the investigation of the appeal issues. If the additional information meets plan guidelines the appeal may be overturned by the decision maker(s). To avoid conflict of interest and for compliance with regulatory and accreditation requirements, the Carrier also utilizes peer medical reviewers including contracted external review organizations for matched-specialty (peer) reviews, and for review
of administrative and medical necessity external appeal review requests. Matched specialty /peer reviewers were not involved in the initial review process and are not subordinates of the person who made the initial determination.

**Full and Fair Review** If the reviewer upholds the original decision, Independence Administrator’s will provide the Subscriber with the rational and new or additional evidence considered or relied upon in connection with the appeal. This is to give the Subscriber a reasonable opportunity to respond prior to the final determination.

**Right to Pursue Civil Action** If you are enrolled in a group health plan that is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you have the right to bring a civil action under Section 502(a) of the Act after completing the appeal processes described here.

**Other Resources to Help You** For questions about your appeal rights, this notice, or for assistance, you can contact the Pennsylvania Insurance Department, Bureau of Consumer Services Room 1209, Strawberry Square Harrisburg, PA 17120 http://www.portal.state.pa.us/portal/server.pt/community/file_a_complaint/9258.

**Changes in Appeal Processes** Please note that the Appeal processes described here may change due to changes that the Carrier makes to comply with applicable state and federal laws and regulations and/or accreditation standards or to improve the appeal processes.

**External Review of Adverse Determination/Appeals** You are entitled to the external review process described below for all appeals of adverse determination (denials) concerning:

- Rescission of coverage;
- Medical judgment (including, based on the plans requirements, medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer.

**Standard External Review Procedures** External appeals may be filed up to four (4) months after receipt of the notice from Independence Administrators of an adverse determination (denial) or final adverse determination (denial) for appeals involving the above stated issues.

You or your authorized representative can file an external appeal by calling the number listed on your ID card.

The Subscriber may be responsible for a nominal fee for the administrative duties performed in order to process the appeal for the external review.

**Preliminary Review** Within five (5) business days following the date of receipt of the external review request, we will complete a preliminary review of the request to determine eligibility for the external review. Within one (1) business day after completion of this preliminary review, we will issue a written notification informing
you if it is eligible for external review and if not, the reason why not and additional contact information. If your request is incomplete, we will inform you of the additional information needed to make the request for external review complete. If your request is eligible for external review you may submit, within ten (10) business days following the date of receipt of the notice, additional information that the Independent Review Organization (IRO) will consider when conducting the external review.

**Referral to Independent Review Organization (IRO)** Eligible external review requests will be referred to a contracted, accredited independent review organization.

Final external review decisions are made by the external review organization within 45 days and will be forwarded in writing to the claimant and the Plan (Plan Administrator). The external decision is binding on the Carrier.

If you have any questions or concerns during the external review process or if you want to initiate an urgent care claim review, you (or your authorized representative) can call the toll-free number 1-888-234-2393.

**Expedited External Review Process** If you (the claimant) have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your (claimant’s) life or health or would jeopardize the ability to regain maximum function or if the matter concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility then you or your authorized representative (including your healthcare provider with knowledge of your condition) may request an expedited external review.

You may make a written or oral request for the expedited (urgent) external review.

- Urgent care reviews may be initiated by calling toll free at 1-888-234-2393.

**Preliminary Review** Immediately upon receipt, the Carrier will determine whether the request meets the eligible review requirements for an expedited (urgent) external review and will notify you of the eligibility for expedited (urgent) review or standard external review.

**Referral to Independent Review Organization (IRO)** Upon the determination that a request is eligible for expedited (urgent) external review following the preliminary review the Carrier will assign an independent review organization and provide them all necessary documents and information considered in making the adverse determination or final adverse benefit determination.

If during the external review process, we (or the Plan) reconsiders and decides to provide coverage, we (or the Plan) will provide oral notice followed by written notice within 48 hours.

**Notice of the Final External Review Decision**
• The IRO/external examiner provides notice of the final external review decision.
• The decision is completed as expeditiously as the claimant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for the expedited external review.
• If the notice is not in writing, the assigned IRO must provide written confirmation of the decision to you (the claimant) and the Plan. within 48 hours after the date of providing that notice.

The external decision is binding on the Carrier.

**If the Adverse Determination (denial) is Reversed** Upon our receipt of the notice of the external review decision, we immediately will authorize to provide the coverage or payment for the claim as required by federal rule set under the Patient Protection and Affordable Care Act.

**NOTICE:** Please see the subsection entitled “NOTICE OF CLAIMS” found under the **General Provisions** section of this booklet.
## DEFINITIONS

**ACCIDENTAL INJURY** — A sudden, unforeseen and identifiable event causing injury to a Subscriber which is the direct result of the injury and which occurs while coverage under the Contract for the Subscriber is in force.

**AMBULANCE** — A specially designed and medically equipped vehicle used solely for the transportation of the sick and/or injured.

**AMBULATORY SURGICAL CENTER** — A Facility that: (a) has permanent facilities and equipment for the primary purpose of performing Surgery on an Outpatient basis; and (b) provides such treatment by or under the supervision of a staff of organized Doctors; and (c) provides nursing services whenever the patient is in the Facility; and (d) does not provide Inpatient accommodations; and (e) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by Medicare, or by the Carrier; and (f) is not, other than incidentally, a Facility used as an office or clinic for the private practice of a Professional Provider.

**ANCILLARY PROVIDER** — An individual or entity that provides services, supplies or equipment (such as, but not limited to, home infusion therapy services, Durable Medical Equipment and ambulance services), for which benefits are provided under the Plan.

**AMENDMENT** — A supplement made a part of the Contract which alters the benefits or terms of the Contract.

**ANESTHESIA** — The administration of regional or local 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.

**AUTISM SERVICE PROVIDER** — A person, entity or group providing treatment of Autism Spectrum Disorders, pursuant to an ASD Treatment Plan, that is either (i) licensed or certified in Pennsylvania, or (ii) enrolled in Pennsylvania's medical assistance program on or before the effective date of the Pennsylvania Autism Spectrum Disorders law. An Autism Service Provider shall include a Behavior Specialist.

**AUTISM SPECTRUM DISORDERS (ASD)** — Any of the Pervasive Developmental Disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified.

**AUTISM SPECTRUM DISORDERS TREATMENT PLAN (ASD TREATMENT PLAN)** — A plan for the treatment of autism spectrum disorders developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent
clinical report or recommendations of the American Academy of Pediatrics.

**BEHAVIOR SPECIALIST** — An individual who designs, implements or evaluates a behavior modification intervention component of an ASD Treatment Plan, 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.

**BIRTHING CENTER** — A Facility that: (a) is primarily organized and staffed to provide maternity care by a Nurse Midwife; and (b) is licensed as a Birthing Center under the laws of the state where it is located; or (c) is approved by the Carrier.

**BLUECARD PPO PROGRAM** — A program that allows a Subscriber travelling or living outside of their plan’s area to receive coverage for services at an in-network benefit level if the Subscriber receives services from Blue Cross Blue Shield providers that participate in the Blue Card PPO Program.

**BLUECARD PPO PROVIDER** — A Provider that participates in the Blue Card PPO Program as a Preferred Participating Provider.

**CERTIFIED REGISTERED NURSE** — A Professional Provider who: (a) is 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; and (b) is certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing.

**CLAIM** — A request for payment of benefits for services rendered or Supplies received which is presented to the Carrier for payment. Such request must be submitted to the Carrier on a form approved by the Carrier including all statements, questionnaires, certifications, instruments, documents and affidavits requested by Independence Administrators which are necessary to properly process the request for benefits.

**COINSURANCE** — The specified percentage of covered expenses the Subscriber is required to pay.

**CONDITIONS FOR DEPARTMENTS** (for Qualifying Clinical Trials) — The conditions described in this paragraph, for a study or investigation conducted by the Department of Veteran Affairs, Defense or Energy, are that the study or investigation has been reviewed and approved through a system of peer review that the Government determines:

A. To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and

B. Assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review.
CONTRACT — The agreement including the Group Application, riders, and Amendments (if any) between the Educational Institution and the Carrier; also referred to as the Group Contract.

COVERED SERVICE — A service, Supply, equipment, device or drug specified in the Contract for which benefits will be provided when billed for by a Professional Provider, Facility or Supplier.

COVERED EXPENSE — Refers to the basis on which a Subscriber’s Deductibles, Coinsurance, benefit Maximums and benefits are calculated.

A. For Covered Services provided by a Facility Provider, the term “Covered Expense” may not refer to the actual amounts paid by the Carrier to a Provider. Under the Carrier’s contracts, the Carrier pays Facility Providers using bulk purchasing arrangements that permit it to pay less for services. The result is that the Carrier is able to offer a guaranteed discount to its local PPO customers that receive Covered Services from Facility Providers located in the Carrier’s “local service area,” i.e. in the five southeastern Pennsylvania counties of Bucks, Chester, Delaware, Montgomery and Philadelphia. The amount the Carrier pays at the time of any given claim may be more and it may be less than the amount used to calculate the Subscriber’s liability. Rather, “Covered Expense” means the following:

i. For Covered Services provided by a Preferred Facility Provider located within the Carrier’s local service area, “Covered Expense” means the Facility Provider’s charges for the Covered Services reduced by the Guaranteed Discount in effect at the time the services were rendered.

ii. For Covered Services provided by a Preferred Facility Provider located outside the Carrier’s local service area, “Covered Expense” means the amount payable to the Provider under the contractual arrangement in effect with the Carrier.

iii. For Covered Services provided by a Non-Preferred Facility Provider, “Covered Expense” for Outpatient services means the lesser of the Medicare Allowable Payment for Facilities or the Facility Provider’s charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Carrier’s applicable proprietary fee schedule or the Provider’s charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Carrier’s applicable proprietary fee schedule, the amount is determined by reimbursing fifty percent (50%) of the Facility Provider’s charges for Covered Services.

iv. For Covered Services provided by a Non-Preferred Facility Provider, “Covered Expense” for Inpatient services means the Medicare Allowable Payment for Facilities. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount is determined by
reimbursing fifty percent (50%) of the Facility Provider’s charges for Covered Services.

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

i. For Covered Services by a Preferred Professional Provider or Blue Card PPO Provider, “Covered Expense” means the rate of reimbursement for Covered Services that the Professional Provider has agreed to accept as set forth by contract with the Carrier, or the Blue Card PPO Provider;

ii. For a Participating Professional Provider, “Covered Expense” means the rate of reimbursement for Covered Services will be made in accordance with the Supplemental Medical-Surgical Health Care Contract for Out-of-Network Services.

iii. For a Non-Preferred Professional Provider, “Covered Expense” means the lesser of the Medicare professional allowable payment or the Provider’s charges for Covered Services. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Carrier’s applicable proprietary fee schedule or the Provider’s charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Carrier’s applicable proprietary fee schedule, the amount is determined by reimbursing fifty percent (50%) of the Professional Provider’s charges for Covered Services.

C. For Covered Services provided by an Ancillary Provider, “Covered Expense” means the following:

i. For Covered Services provided by a Preferred Ancillary Provider or Blue Card PPO Provider “Covered Expense” means the amount payable to the Provider under the contractual arrangement in effect with the Carrier or Blue Card PPO Provider.

ii. For Covered Services provided by a Non-Preferred Ancillary Provider, “Covered Expense” means the lesser of the Medicare Ancillary Allowable Payment or the Provider’s charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Carrier’s applicable proprietary fee schedule or the Provider’s charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Carrier’s applicable proprietary fee schedule, the amount is determined by reimbursing fifty percent (50%) of the Non-Preferred Ancillary Provider’s charges for Covered Services.

D. Nothing in this section shall be construed to mean that the Carrier would provide coverage for services other than Covered Services.
COVERED STUDENT — A student attending the Educational Institution covered under this Contract who is considered a student on a full time basis by the registrar of the Educational Institution. The Carrier considers full-time enrollment to be twelve (12) credits per semester for undergraduate students. If any disputes arise regarding full-time status, the Carrier reserves the right to contact the school’s registrar.

CUSTODIAL CARE — Care that is primarily provided to assist the patient in meeting his activities of daily living. Such care is not primarily provided for its restorative or therapeutic value in the treatment of an Illness, injury, disease or condition.

DEPENDENT — The Covered Student’s: (1) spouse; or (2) natural born or legally adopted child (including a child for whom adoption proceedings have been initiated), including a stepchild; or (3) unmarried child age 26 or older who is unable to earn his own living due to a physical or Mental Illness or handicap (subject to Eligibility —Continuation of Eligibility).

DOCTOR — A practitioner, other than a Subscriber, who is acting within the scope of his license as a Doctor of medicine; osteopathy; podiatry; dentistry; optometry; chiropractic; licensed speech pathologist; licensed audiologist; licensed teacher of the hearing impaired; or any other practitioner that the Carrier must by law recognize as a Doctor legally entitled to render treatment.

DURABLE MEDICAL EQUIPMENT — Charges for: (a) non-disposable equipment that is primarily medical in nature, such as wheelchairs and hospital beds; and (b) orthotics or medical devices which are applied to or around the body for care or treatment of an injury or Illness; and (c) assorted medical items necessary for the treatment of respiratory diseases, such as oxygen tanks, oxygen contents, and oxygen masks.

EDUCATIONAL INSTITUTION — Swarthmore College.

EMERGENCY ACCIDENT TREATMENT — Provider expenses charged for the initial treatment of an Accidental Injury. Such treatment must begin within 72 hours of the injury that is being treated and excludes Ambulance services.

EMERGENCY MEDICAL TREATMENT — Provider expenses charged for the initial treatment of a condition with acute symptoms that is life threatening or that could cause serious damage to a bodily function. Such treatment must begin within 72 hours of the onset of the condition that is being treated and excludes Ambulance services.

EXPERIMENTAL/INVESTIGATIVE SERVICES AND SUPPLIES — A drug, biological product, device, medical treatment or procedure which meets any of the following criteria:

A. Is the subject of ongoing clinical trials;
B. Is the research, experimental, study or investigational arm of an on-going clinical trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;

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

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

E. Is generally recognized, based on Reliable Evidence, by the medical community as a diagnostic or treatment intervention for which additional study regarding its safety and efficacy for the diagnosis or treatment of the Subscriber’s particular condition, is recommended.

A drug will not be considered Experimental/Investigative if it has received final approval by the U.S. Food and Drug Administration (FDA) to market with a specific indication for the particular diagnosis or condition present. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational New Drug Exemption (as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the established referenced Compendia identified in the Company's policies recognize the usage as appropriate medical treatment.

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

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

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

C. Reliable Evidence clearly demonstrates that the biological product, device, medical treatment or procedure is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.

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

E. Reliable Evidence shows that the prevailing opinion among experts regarding the biological product, device, medical treatment or procedure is that studies or clinical trials have determined its maximum tolerated dose, its
toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.

**FACILITY** — An institution or entity licensed, where required, to provide care. Such Facilities include:

- Alcoholism Treatment Facility
- Ambulatory Surgical Center
- Birthing Center
- Freestanding Dialysis Facility
- Freestanding Outpatient Facility
- Home Health Care Agency
- Hospital
- Psychiatric Hospital
- Rehabilitation Hospital
- Skilled Nursing Facility
- Substance Abuse Treatment Facility

**FAMILY UNIT** — A Covered Student and his or her covered Dependents.

**HOME HEALTH AGENCY** — An agency, association or part of a Hospital that: (a) provides Skilled Nursing Care in the patient’s home for the treatment of a physical illness or injury that requires medical supervision and treatment; and (b) provides such care by or under the supervision of a Registered Nurse acting under the direction of a Doctor; and (c) is approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare.

**HOSPICE** — A Facility that: (a) is primarily engaged in providing palliative care to terminally ill individuals; and (b) is licensed and operated according to the laws of the state in which it is located and approved by the Carrier.

**HOSPITAL** — A short-term, acute care Facility that: (a) is a duly licensed institution; and (b) is primarily engaged in providing Inpatient diagnostic and medical services for the care or treatment of sick and injured persons; and (c) provides such care by or under the supervision of a staff of organized Doctors; and (d) has organized departments of medicine; and (e) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (f) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by the Carrier. A Hospital is not, other than incidentally, a:

- Nursing Home
- Place for Rest
- Place for the Aged
- Place for the Provision of Hospice Care
- Place for the Provision of Rehabilitation Care
- Place for the Treatment of Alcoholism or other Drug Abuse
- Place for the Treatment of Mental Illness
- Skilled Nursing Facility
- Spa or Sanitarium

**HOSPITAL-BASED PROVIDER** — A physician who provides Medically Necessary services in a Hospital or Preferred Facility Provider supplemental to the primary care being provided in the Hospital or Preferred Facility Provider, for which
the Subscriber has limited or no control of the selection of such physician. Hospital-based providers include physicians in the specialties of radiology, anesthesiology and pathology and/or other specialties as determined by the Carrier. When these physicians provide services other than in the Hospital or Preferred Facility, they are not considered Hospital-Based Providers.

ILLNESS — A condition marked by pronounced deviation from the normal, healthy state.


INCURED — A charge is deemed Incurred as of the date of the service or purchase giving rise to the charge.

INPATIENT — A person who is treated as a registered overnight bed patient in a Facility.

LICENSED PRACTICAL OR VOCATIONAL NURSE (L.P.N. OR L.V.N.) — A nurse who has graduated from a formal practical or vocational nursing education program and is licensed by the appropriate state authority.

LIFE-THREATENING DISEASE OR CONDITION (for Qualifying Clinical Trials) — Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

MAINTENANCE CARE — Care provided to maintain the patient’s current level of functioning or to prevent deterioration. Such care is not primarily provided for its therapeutic value in the treatment of an Illness, disease, injury or condition and does not require participation or administration by professional medical personnel.

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

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

A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.
B. It is the most appropriate Supply or level of service, considering the potential benefit and harm to the Subscriber.

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

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

   “Scientific Evidence” consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used.

   Partially controlled observational studies and uncontrolled clinical series may be suggestive. These do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by (a) the natural history of the medical condition, or (b) potential experimental biases.

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

ii. **Existing interventions**: Effectiveness is determined first by Scientific Evidence, then by professional standards, then by expert opinion. For existing interventions, Scientific Evidence should be considered first and, to the greatest extent possible, be the basis for a determination of Medical Necessity. If no Scientific Evidence is available, professional standards of care should be considered. If professional standards of care do not exist, are outdated, or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to Scientific Evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive Scientific Evidence.

   Existing interventions can meet the contractual definition of Medical Necessity in the absence of Scientific Evidence if: (a) there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, (b) in the absence of such standards, convincing expert opinion.
D. It is cost-effective for this condition compared to alternative interventions, including no intervention. “Cost effective” does not necessarily mean lowest price. An intervention is considered cost effective if the benefit and harm relative to costs represent an economically, efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

An intervention may be medically indicated yet not be a Covered Service or meet this Medically Appropriate/Medically Necessary definition.

MEDICARE PARTS A AND B — “Hospital Insurance Benefits for the Aged and Disabled” under Title XVIII, Part A and/or Part B respectively, of the Social Security Act, as amended from time to time.

MEDICARE ALLOWABLE PAYMENT FOR FACILITIES — The payment amount, as determined by the Medicare program, for the Covered Service for a Facility Provider.

MEDICARE ANCILLARY ALLOWABLE PAYMENT — The payment amount, as determined by the Medicare program, for the Covered Service for an Ancillary Provider.

MEDICARE PROFESSIONAL ALLOWABLE PAYMENT — The payment amount, as determined by the Medicare program, for the Covered Service based on the Medicare Par Physician Fee Schedule – Pennsylvania Locality 01.

MENTAL ILLNESS — An emotional or mental disorder characterized by an abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional, or behavioral disturbances are the dominating feature.

NON-HOSPITAL FACILITY — A Facility Provider, licensed by the Department of Health for the care or treatment of persons suffering from Alcohol or Drug Abuse or dependency, except for transitional living facilities. Non-Hospital Facilities shall include, but not be limited to, Residential Treatment Facilities and Free Standing Ambulatory Care Facilities for Partial Hospitalization Programs.

NON-HOSPITAL RESIDENTIAL TREATMENT — The provision of medical, nursing, counseling, or therapeutic services to Subscribers suffering from Alcohol or Drug Abuse or dependency in a residential environment, according to individualized treatment plans.

NON-PREFERRED ANCILLARY PROVIDER — An Ancillary Provider that is not a member of the PPO Network or is not a Blue Card PPO Provider.

NON-PREFERRED FACILITY PROVIDER — a Facility Provider that is not a member of the PPO Network or is not a Blue Card PPO Provider.
NON-PREFERRED PROFESSIONAL PROVIDER — a Professional Provider who is not a member of the PPO Network or is not a Blue Card PPO Provider, or who is not a Participating Professional Provider.

NON-PREFERRED PROVIDER — A Facility Provider, Professional Provider or Ancillary Provider that is not a member of the PPO Network or is not a Blue Card PPO Provider, and for Professional Providers, is not a Participating Professional Provider.

NURSE MIDWIFE — A Professional Provider who: (a) is certified to practice as a Nurse Midwife; and (b) is licensed by the appropriate state authority as a Registered Nurse; and (c) has completed a program for the preparation of Nurse Midwife that is approved by the state in which the person is practicing.

OUTPATIENT — A person who receives services or Supplies while not an Inpatient.

PARTIAL HOSPITALIZATION — Medical, nursing, counseling or therapeutic services provided on a planned and regularly scheduled basis in a Hospital or Facility Provider, designed for a patient who would benefit from more intensive services than are offered in Outpatient treatment but who does not require Inpatient confinement.

PARTICIPATING PROFESSIONAL PROVIDER — A professional provider who has agreed to a rate of reimbursement determined by the supplemental medical-surgical health care contract for out-of-network services for the provision of covered services to Subscribers.

PLAN YEAR — The twelve month period beginning with August 17th of each year.

PLAN YEAR DEDUCTIBLE — The amount of eligible expenses the Subscriber is required to pay each Plan Year before the Contract begins to pay benefits.

PPO NETWORK — The network of providers with whom the Carrier has contractual arrangements.

PRECERTIFICATION — Prior assessment by the Carrier’s designated agent that proposed services, such as hospitalization, are medically necessary for a Subscriber. Payment of the services depends on whether the services and the Subscriber are covered under the Contract.

PRIOR AUTHORIZATION — Written approval by the Carrier for medical or surgical treatment given prior to such treatment that outlines the Carrier’s liability for such treatment. Such approval will be given only after the Carrier: (a) reviews the case; and (b) receives the Subscriber’s medical history and an explanation of the condition and treatment to be given (including any Surgical Procedures to be performed) written by his Doctor, and any supporting documentation (e.g. X-rays, photographs, etc.).
PRIVATE ROOM — Accommodations in a room designed as such by the Hospital, Rehabilitation Facility or Skilled Nursing Facility and containing not more than one bed.

PREFERRED ANCILLARY PROVIDER — An Ancillary Provider that is a member of the PPO Network or is a Blue Card PPO Provider and has agreed to a rate of reimbursement determined by contract for the provision of “in-network” Covered Services and/or supplies to Subscribers.

PREFERRED FACILITY PROVIDER — A Facility Provider that is a member of the PPO Network or is a Blue Card PPO Provider and has agreed to a rate of reimbursement determined by contract for the provision of “in-network” Covered Services to Subscribers.

PREFERRED PROFESSIONAL PROVIDER — A Professional Provider who is a member of the PPO Network or is a Blue Card PPO Provider and has agreed to a rate of reimbursement determined by contract for “in-network” Covered Services rendered to a Subscriber.

PREFERRED PROVIDER — A Facility Provider, Professional Provider or Ancillary Provider that is a member of the PPO Network or is a Blue Card PPO Provider, authorized to perform specific “in-network” Covered Services at the Preferred level of benefits.

PROFESSIONAL PROVIDER — A licensed person or practitioner performing services within the scope of such licensure. The Professional Providers include:

- Autism Service Provider
- Audiologist
- Behavior Specialist
- Certified Registered Nurse
- Chiropractor
- Dentist
- Independent Clinical Laboratory
- Licensed Clinical Social Worker
- Master’s Prepared Therapist
- Nurse Midwife
- Optometrist
- Doctor
- Podiatrist
- Psychologist
- Registered Dietitian
- Speech-language Pathologist
- Teacher of the hearing impaired

PROVIDER — A Facility or Professional Provider, licensed where required.

PSYCHIATRIC HOSPITAL — A Facility that: (a) is primarily engaged in providing Inpatient diagnostic, medical, and psychiatric services for the care or treatment of Mental Illness; and (b) provides such services by or under the supervision of a staff of organized Doctors; and (c) provides continuous 24-hour nursing services by or under the supervision of Registered Nurses; and (d) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by the Carrier.
QUALIFIED INDIVIDUAL (for Clinical Trials) — A Subscriber who meets the following conditions:

A. The Subscriber is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening Disease or Condition; and

B. Either:
   1. The referring health care professional is a health care provider participating in the clinical trial and has concluded that the Subscriber’s participation in such trial would be appropriate based upon the individual meeting the conditions described above; or
   2. The Subscriber provides medical and scientific information establishing that their participation in such trial would be appropriate based upon the Subscriber meeting the conditions described above.

QUALIFYING CLINICAL TRIAL — A phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease Or Condition and is described in any of the following:

A. Federally funded trials: the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
   1. The National Institutes of Health (NIH);
   2. The Centers for Disease Control and Prevention (CDC);
   3. The Agency for Healthcare Research and Quality (AHRQ);
   4. The Centers for Medicare and Medicaid Services (CMS);
   5. Cooperative group or center of any of the entities described in 1-4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
   6. Any of the following, if the Conditions For Departments are met:
      a. The Department of Veterans Affairs (VA);
      b. The Department of Defense (DOD); or
      c. The Department of Energy (DOE).

B. The study of investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or

C. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
In the absence of meeting the criteria listed above, the clinical trial must be approved by the Plan as a Qualifying Clinical Trial.

**REGISTERED NURSE (R.N.)** — A nurse who has graduated from a formal program of nursing education (diploma school, associate degree program, or baccalaureate program) and is licensed by the appropriate state authority.

**REHABILITATION FACILITY** — An institution or part of an institution that: (a) specializes in providing restorative and therapeutic services on an Inpatient and Outpatient basis for the treatment of a physical Illness or injury, Mental Illness, drug addiction and alcoholism; and (b) provides such services by or under the supervision of a staff of Doctors; and (c) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (d) is approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare; and (e) when used for purposes of Alcohol or other drug abuse is also approved by the Pennsylvania Department of Health.

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

**ROUTINE PATIENT COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS** — Routine patient costs include all items and services consistent with the coverage provided under this Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial.

Routine patient costs do not include:

A. The investigational item, device, or service itself;

B. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

C. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

**SCHEDULE OF BENEFITS** — Schedule A of the Contract which describes benefits, maximums, and allowances of the coverage provided under the Contract for each Subscriber.

**SECOND SURGICAL OPINION/CONSULTATION** — A written evaluation by another surgeon/specialist, who is not associated in practice with the first surgeon, as to the Medical Necessity of the surgery recommended by the first surgeon.
SERIOUS MENTAL ILLNESS — Means any of the following mental illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizoaffective disorder and delusional disorder.

SEMIPRIVATE ROOM — Accommodations in a room designated as such by the Hospital, Rehabilitation Facility or Skilled Nursing Facility and containing no less than 2 nor more than 4 beds.

SKILLED NURSING CARE — All covered medical expenses charged for services that are primarily restorative and therapeutic in treatment of a physical illness or injury that requires medical supervision of a Registered Nurse acting under the direction of a Doctor.

SKILLED NURSING FACILITY — An institution or part of an institution that: (a) specializes in providing Skilled Nursing Care on an Inpatient basis for the treatment of a physical illness or injury that requires extended medical supervision and treatment; and (b) provides such care by or under the supervision of a staff of Doctors; and (c) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (d) is approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare.

SUBSCRIBER — A Covered Student or his or her eligible Dependents, if any, who have satisfied the specifications of Eligibility.

SUBSTANCE ABUSE — Any use of alcohol or other drug that produces a pattern of pathological use causing impairment in social or occupational functions or that produces physiological dependency evidenced by physical tolerance or withdrawal.

SUBSTANCE ABUSE TREATMENT FACILITY — A Facility that: (a) is primarily engaged in providing detoxification and/or rehabilitation services for alcoholism and/or drug abuse; (b) is approved by the Joint Commission on Accreditation of Healthcare Organizations, appropriate government agency, or by the Carrier; and (c) is also approved by the Pennsylvania Department of Health.

SUPPLIES — Charges made by a Hospital or Doctor for nonprescription, nondurable, disposable medical and surgical items which are necessary for the care or treatment of an Illness or Accidental Injury.

SURGERY/SURGICAL PROCEDURE — Treatment of an Illness, injury or deformity by manual and operative methods.

A. Cosmetic Surgery — A Surgical Procedure for the correction of superficial areas of the body to enhance appearance or to change contour. Such surgeries are performed without the expectation of restoring function to the body area.

B. Elective Surgery — A Surgical Procedure which is of a non-emergency nature and not required to be immediately carried out.
C. **Reconstructive Surgery** — A Surgical Procedure for the correction, restoration, or improvement of bodily functions, or the relief of pain.

**THERAPY SERVICES** — The following services and Supplies when prescribed by a Doctor for the treatment of an Illness or injury to promote the recovery of the Subscriber:

A. **Cardiac Rehabilitation Therapy** — medically supervised rehabilitation program designed to improve a Subscriber’s tolerance for physical activity or exercise.

B. **Chemotherapy** — Treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetics, and other related biotech products.

C. **Dialysis** — Treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body.

D. **Infusion Therapy** — Treatment including, but not limited to infusion or inhalation, parenteral and enteral nutrition, antibiotic therapy, pain management and hydration therapy.

E. **Occupational Therapy** — medically prescribed treatment concerned with improving or restoring neuromusculoskeletal functions which have been impaired by illness or injury, congenital anomaly or prior therapeutic intervention. Occupational Therapy also includes medically prescribed treatment concerned with improving the Subscriber’s ability to perform those tasks required for independent functioning where such function has been permanently lost or reduced by illness or injury, congenital anomaly or prior therapeutic intervention. This does not include services specifically directed towards the improvement of vocational skills and social functioning.

F. **Orthotics / Pleoptic Therapy** — Medically prescribed treatment for the correction of oculomotor dysfunction resulting in the lack of vision depth perception. Such dysfunction results from vision disorder, eye surgery, or injury. Treatment involves a program which includes evaluation and training sessions.

G. **Physical Therapy** — Medically prescribed treatment of physical disabilities or impairments resulting from disease, injury, congenital anomaly, or prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility and the functional activities of daily living.

H. **Pulmonary Rehabilitation Therapy** — Multidisciplinary treatment which combines Physical Therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.
I. **Radiation Therapy** — Treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery.

J. **Speech Therapy** — medically prescribed treatment of speech and language disorders due to disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes that result in communication disabilities and/or swallowing disorders.
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