INDIVIDUAL HMO SUBSCRIBER AGREEMENT
(Approved Service Area)

Guaranteed Renewable

Issued by

KEYSTONE HEALTH PLAN CENTRAL, INC.*
("Keystone" or "the HMO")

* Independent corporation operating under a license from the BlueCross BlueShield Association.

A Pennsylvania corporation
Located at:
PO Box 779519
Harrisburg, PA 17177-9519

DESCRIPTION OF COVERAGE: Product Name marketed as Healthy Benefits HMO 3500.0

This HMO Subscriber Agreement sets forth a comprehensive program of Inpatient and outpatient health care benefits for Subscribers and their eligible Dependents who reside and obtain Covered Services from Participating Providers within Keystone's Approved Service Area, which is a geographical area consisting of the following twenty-one (21) Pennsylvania counties: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union and York. In most cases, Members must obtain Referrals for Covered Services, and benefits are provided only for services performed by a Participating Provider. Preauthorization by Keystone is required for any services requiring a Referral to a Provider who is not a Participating Provider. Certain benefits are subject to cost-sharing provisions such as Deductible, Copayments and Coinsurance.

Vision – Pediatric Vision coverage under this HMO Subscriber Agreement is provided under a separate policy which is incorporated into this HMO Subscriber Agreement. For specific benefit limits and details relating to vision coverage, including limitations and exclusions, refer to the Capital Advantage Assurance Company Individual Pediatric Vision Policy attached to this HMO Subscriber Agreement. This HMO Subscriber Agreement is issued with a Vision Rider and underwritten by the company listed therein.

NOTICE OF SUBSCRIBER's RIGHT TO EXAMINE AGREEMENT: The Subscriber shall have the right to return the Subscriber Agreement within ten (10) days of its delivery and to have the Premium refunded if, after examination of the Subscriber Agreement, the Subscriber is not satisfied for any reason. This Agreement may be returned to Keystone. If the Agreement is returned, it will be null and void from the beginning and no benefits will be payable under its terms.

This Agreement is nonparticipating in any divisible surplus of premium.

GUARANTEED RENEWABLE: Upon the payment of the applicable rate, the HMO agrees to make payment for those services as set forth in this Subscriber Agreement. Subject to the right of the HMO to terminate coverage in accordance with Section EL - Eligibility, Change And Termination Rules Under The Plan. This Agreement is guaranteed renewable and may be renewed by payment of renewal Premiums within thirty (30) days after the first day of the month for which payment must be made. Coverage continues for one month from the effective date of the Agreement and from month to month thereafter until terminated as

provided in Section EL - Eligibility, Change And Termination Rules Under The Plan. Non-renewal shall not be based on the deterioration of mental or physical health of any individual covered under this Agreement. Subject to the approval of the Pennsylvania Insurance Department, the HMO may adjust Premium rates. Any change in the Premium rate shall become applicable for Subscribers upon the expiration of the period covered by the Subscriber's current payment at the time of such change.

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WELCOME

Thank you for joining Keystone. Our goal is to provide our Members with access to quality health care coverage. This Subscriber Agreement ("Agreement") describes Member benefits and the procedures required in order to receive the benefits and services to which Members are entitled. Member specific benefits covered by the HMO are described in Section CS - Description Of Covered Services of this Agreement. If changes are made to this Agreement, Members will be notified by the HMO. Changes to the Agreement will apply to benefits for services received after the effective date of change.

Please read this Agreement thoroughly and keep it handy. It will answer most Member questions regarding the HMO's procedures and services. Keystone is committed to providing excellent service to our Members. The following pages outline various ways that Members can contact Keystone. Members may contact us if they have any questions or encounter difficulties using their coverage with Keystone.

Members may also access information on standard benefits, wellness programs and information regarding when a referral/authorization is needed at Keystone's website at capbluecross.com

Any rights of a Member to receive Benefits under this Subscriber Agreement are personal to the Member and may not be assigned in whole or in part to any person, Provider or entity, nor may benefits of this Agreement be transferred, either before or after Covered Services are rendered. However, a Member can assign benefit payments to the custodial parent of a Dependent covered under this Subscriber Agreement, as required by law.

HOW TO CONTACT US

Telephone

Monday through Friday, 8:00 a.m. to 6:00 p.m., Members can call the following telephone numbers and speak with a Customer Service Representative.

Members can call the telephone number on their Identification Card or call:

Telephone: 1-800-730-7219

Telephone (TTY): 711

Physical Disabilities

Keystone and it's providers accommodate Members with physical disabilities or other special needs. If Members have any questions regarding access to providers with these accommodations, they should contact Keystone's Customer Service Department.

Preauthorization or Other Clinical Management Programs

Members can call the telephone number on their ID card or call Keystone's Customer Service at 1-800-730-7219 with questions on Preauthorization. Members should refer to the **Medical Care Preauthorization Schedule** attachment to this Agreement for more information.

Internet and Electronic Mail (E-Mail)

The website, capbluecross.com, contains information about Keystone's products and how to utilize benefits and access services. Members may access material on standard benefits, wellness programs and search the online provider directory to locate area physicians, Hospitals, and ancillary providers.

Members may also access and update personal information through the Secure Services feature on the website. By using this feature Members may verify eligibility, check claims status, change primary care physicians, update their name and address, and request an ID card.

Members can e-mail us at CustomerService@khpc.com. E-mail inquiries are reviewed Monday through Friday, 8:00 a.m. to 4:30 p.m. A Customer Service Representative will respond within 24 hours or one business day of receiving the Member's inquiry.

Mail

Members can contact Keystone through the United States mail. When writing to Keystone, Members should include their name, the identification number from their Keystone ID card, and explain their concern or question. Inquiries should be sent to:

Keystone Health Plan Central
PO Box 779519
Harrisburg, PA 17177-9519
Fax: 717-703-8494

In Person

Members can meet with a Customer Service Representative at our offices at:

2500 Elmerton Avenue Harrisburg, PA 17177	or	1221 W. Hamilton Street Allentown, PA 18102	or	Capital Blue The Promenade Shops at Saucon Valley 2845 Center Valley Parkway Center Valley, PA 18034

Staff is available to assist Members Monday through Friday from 8:00 a.m. to 4:30 p.m.

Language Assistance

Keystone offers language assistance for non-English speaking Members. Language assistance includes interpreting services provided directly in the Member's preferred language and document translation services available upon request. Language assistance is also available to disabled Members. Information in Braille, large print or other alternate formats are available upon request.

To access these services, Members can simply call Keystone's Customer Service Department at the telephone numbers listed above.

MEMBER IDENTIFICATION (ID) CARD

The member's identification card is the key to accessing the benefits provided under this coverage with Keystone. Members should show their card and any other identification cards they may have evidencing other coverage **each time they seek medical services**. ID cards assist providers in submitting claims to the proper location for processing and payment.

The following is important information about the ID card:

Suitcase Symbol: Keystone provides coverage for benefits through BlueCross and BlueShield affiliated providers when Members are traveling outside Keystone Health Plan Central's Approved Service Area. This program is called the national BlueCard® Program. Because Keystone participates in this program, the suitcase symbol is on the front of the Keystone ID card. The suitcase symbol means that Keystone Members have access to a national network of providers for urgent care services whenever they travel outside of the Keystone's Approved Service Area. It also gives providers a better understanding of how to submit urgent

care claims. Keystone's participation in the BlueCard Program should result in more timely payment of out-of-area claims. A provider locator telephone number is on the back of the ID card.

Laboratory Services: Keystone uses several outpatient laboratories. The Member's ID card includes a field titled "lab" that designates which laboratory is aligned with the Member's PCP. Members should give this lab indicator information to all providers to assist them in correctly routing laboratory services.

Copayments: Providers will use this information to determine the copayment they may collect from Members at the time a service is rendered. Members should use the following list as a reference:

- PCP $$ -- PCP office visit copayment
- SPC $$ -- specialist office visit copayment
- ER $$ -- emergency room visit copayment
- UC $$ -- urgent care visit copayment
  AH $$ -- after hours PCP office visit copayment (This copayment is in addition to the PCP office visit copayment)

The Member's ID card may also contain information regarding coverage for dental, vision, and prescription drug benefits.

Preauthorization: The term preauthorization alerts providers that this element of a Member's coverage is present. Members should refer to the **Preauthorization Program** attachment to this Agreement for more information.

On the back of the ID card, members can find important additional information on:

- Preauthorization instructions and toll-free telephone number.
- General instructions for filing claims.

Members should remember to destroy old ID cards and use only their latest ID card. Members should also contact Keystone's Customer Service if any information on their ID card is incorrect or if they have questions.

Listed below are some important things to do and to remember about a Member ID Card:

- **Check** the information on the ID Card for completeness and accuracy.
- **Check** that one ID Card is received for each enrolled family Member.
- **Check** that the name of the Primary Care Physician (or office) that was selected is shown on the ID Card. Also, please check the ID Card for each family Member to be sure the information on it is accurate.
- **Call** Keystone's Customer Service Department if the ID Card is lost or there is an error on the card.
- **Carry** the ID Card at all times. Members must present an ID Card whenever they receive Medical Care.

On the reverse side of the ID Card, Members will find information about medical services. There is even a toll-free number for use by Hospitals if they have questions about a Member's coverage.

SECTION DE - DEFINITIONS

For the purposes of this Agreement, the terms below have the following meaning:

ADVERSE BENEFIT DETERMINATION – any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Investigational or not Medically Necessary.

AGREEMENT RENEWAL DATE – January 1st of each calendar year.

AGREEMENT YEAR – the twelve (12) month period beginning on January 1st of each calendar year.

ALLOWABLE AMOUNT – the payment level that Keystone reimburses for benefits provided to a Member under the Member's coverage. For Participating Providers, the allowable amount is the amount provided for in the contract between the Provider and Keystone, unless otherwise specified in this Agreement.

AMBULATORY SURGICAL FACILITY – A facility provider licensed and approved by the state in which it provides covered health care services or as otherwise approved by Keystone Health Plan Central and which:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
- provides treatment by or under the supervision of physicians whenever the patient is in the facility;
- does not provide inpatient accommodations; and
- is not, other than incidentally, a facility used as an office or clinic for the private practice of a physician.

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

ANNUAL ENROLLMENT PERIOD – Annual enrollment means the period each year during which an Individual may enroll or change coverage.

APPLICATION – the written request of the Applicant for coverage, set forth in a format approved by the HMO.

APPLICATION/CHANGE FORM – the properly completed written request for enrollment for HMO Membership submitted in a format provided by the HMO, together with any amendments or modifications thereof.

APPROVED CLINICAL TRIAL – A phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to prevention, detection, or treatment of cancer or other life threatening disease or condition and is described below:

A. 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. Centers for Disease Control and Prevention (CDC)

3. Agency for Healthcare Research and Quality (AHRQ)

4. Centers for Medicare and Medicaid Services (CMS)

5. Cooperative group or center of any of the entities described in 1 through 4 or the Department of Defense (DOD) or the Department of Veterans Affairs (VA).

6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of health for center support grants.

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

C. The study or investigation is a drug that is exempt from having such an investigational new drug application.

In the absence of meeting the criteria listed in above, the Clinical Trial must be approved by the HMO as a qualifying Clinical Trial.

AWAY FROM HOME CARE COORDINATOR – the staff whose functions include assisting Members with registering as a Guest Member for Guest Membership Benefits under the Away From Home Care Program.

AWAY FROM HOME CARE PROGRAM – a program, made available to independent licensees of the BlueCross BlueShield Association, that provides Guest Membership Benefits to Members registered for the Program while traveling outside of Keystone's Approved Service Area for an extended period of time. The Away From Home Care Program offers portable HMO coverage to Members traveling in a Host HMO Service Area. Registration for Guest Membership Benefits under the Away From Home Care Program is coordinated by the Away From Home Care Coordinator.

BENEFITS – see **COVERED SERVICE**.

BIRTH DEFECT – also known as congenital anomalies, congenital disorders or congenital malformations, can be defined as structural or functional abnormalities, including metabolic disorders, which are present from birth (whether evident at birth or become manifest later in life) and can be caused by single gene defects, chromosomal disorders, multifactorial inheritance, environmental teratogens or micronutrient deficiencies.

BIRTH FACILITY – a Facility Provider licensed and approved by the appropriate governmental agency, which is primarily organized and staffed to provide maternity care by a licensed certified nurse midwife.

BLUECARD PROGRAM – a program that enables Members obtaining health care services while traveling outside Keystone's Approved Service Area to receive all the same benefits of their Plan and access to BlueCard Traditional Providers and savings. The program links participating health care Providers and the independent Blue Cross and Blue Shield Licensees across the country and also to some international locations through a single electronic network for claims processing and reimbursement.

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

CLINICAL MANAGEMENT – Programs used to approve, review, and facilitate health care services.

COINSURANCE – The percentage of the Allowable Amount that will be paid by the Member. Coinsurance percentages, if any, are identified in Section SC - Schedule Of Cost Sharing.

COPAYMENT – a specified dollar amount applied to a specific Covered Service for which the Member is responsible per Covered Service. Copayments, if any, are identified in Section SC - Schedule Of Cost Sharing.

COST SHARING AMOUNT – The amount subtracted from the Allowable Amount which the Member is obligated to pay before Keystone makes payment for benefits. Cost Sharing Amounts include: Copayments, Deductibles, Coinsurance, and Out-of-Pocket Maximums.

COVERED SERVICE – a service or supply specified in the Agreement and summarized in Section CS - Description Of Covered Services for which benefits will be provided.

CUSTODIAL CARE (DOMICILIARY CARE) – care provided primarily for maintenance of the patient or care which is designed essentially to assist the patient in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision of self-administration of medications which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

DEDUCTIBLE – The amount of the Allowable Amount that must be incurred by a Member each Agreement Year before benefits are covered under this Subscriber Agreement. Deductibles, if any, are identified in Section SC - Schedule Of Cost Sharing.

DEPENDENT –

A. The legal spouse of the Subscriber;

B. A child (natural, legally adopted or placed for adoption, or stepchild) of either the Subscriber or the Subscriber's spouse, or a child for whom the Subscriber or the Subscriber's spouse is a court appointed legal guardian.

C. A child who is past the Limiting Age for Dependents and who: (1) is eligible for coverage under this Agreement; and (2) prior to attaining the Limiting Age for Dependents and while a full-time student was (a) a Member of the Pennsylvania National guard or any reserve component of the U.S. armed forces and who was called or ordered to active duty, other than active duty for training for a period of 30 or more consecutive days; or (b) a Member of the Pennsylvania National Guard who is ordered to active state duty, including duty under Pa. C.S. Ch. 76 (relates to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

   Eligibility for these Dependents will be extended for a period equal to the duration of the Dependent's service on duty or active state duty or until the individual is no longer a full-time student regardless of the age of the Dependent when the educational program at the Accredited Educational Institution was interrupted due to military duty.

   As proof of eligibility, the Subscriber must submit a form to the HMO approved by the Department of Military & Veterans Affairs (DMV A): (1) notifying the HMO that the Dependent has been placed on active duty; (2) notifying the HMO that the Dependent is no longer on active duty; and (3) showing that the Dependent has re-enrolled as a full-time student in an Accredited Educational Institution for the first term or semester starting 60 or more days after his release from active duty; or

   A Dependent child must be within the Limiting Age for Dependents and meet the applicable eligibility requirements set forth in Section EL-Eligibility, Change And Termination Rules Under The Plan of this Agreement. The Dependent must be enrolled hereunder through submission of an

Application Change Form, and have had the appropriate payment submitted on their behalf and received by the HMO.

When used throughout this Agreement, the following terms, when applied to Dependents, will have these meanings:

- The term "acquired" will refer to those Dependents who are eligible for enrollment after the Effective Date of Coverage, and may include a new spouse, stepchild, or child covered as required by a court order.
- The term "placement" will refer to a Dependent adopted child and the process or act of being placed for adoption.

DIABETIC SUPPLIES – Shall mean medication and supplies used to treat diabetes, including insulin, needles and syringes, and other diabetic supplies. Diabetic Supplies do not include batteries, alcohol swabs, preps and gauze.

DURABLE MEDICAL EQUIPMENT (DME) – Durable medical equipment consists of items that are: primarily and customarily used to serve a medical purpose; not useful to a person in the absence of illness or injury; ordered by a Physician; appropriate for use in the home; reusable; and can withstand repeated use.

EFFECTIVE DATE OF COVERAGE – the date coverage begins for a Member. All coverage begins at 12:01 a.m. on the date reflected on the records of the HMO.

EMERGENCY SERVICES – any health care services provided to a Member after the sudden onset of a medical condition. The condition manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Member or with respect to a pregnant Member, the health of the pregnant Member or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- Other serious medical consequence.

Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an Emergency Service.

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

- Ambulance Service Provider
- Ambulatory Surgical Facility
- Birth Facility
- Durable Medical Equipment Supplier
- Freestanding Outpatient /Diagnostic Facility
- Freestanding Dialysis Facility
- Freestanding Ambulatory Care Facility
- Home Health Care Agency
- Hospice
- Hospital
- Hospital Laboratories
- Infusion Therapy Provider
- Orthotics Supplier
- Pharmacy Medical Supplier
- Prosthetics Supplier
- Psychiatric Hospital
- Rehabilitation Hospital
- Skilled Nursing Facility
- Substance Abuse Treatment Facility
- Urgent Care Center

FINAL INTERNAL ADVERSE BENEFIT DETERMINATION – an Adverse Benefit Determination that has been upheld by the HMO at the completion of the internal appeals process.

FREESTANDING DIALYSIS TREATMENT FACILITY – a Facility Provider, licensed or approved by the appropriate governmental agency and approved by the HMO, which is primarily engaged in providing Dialysis treatment, Maintenance or training to patients on an Outpatient or home care basis.

GUEST MEMBER – a Member who has a pre-authorized Guest Member registration in a Host HMO Service Area for a defined period of time. After that period of time has expired, the Member must again meet the eligibility requirements for Guest Membership Benefits under the Away From Home Care Program and re-enroll as a Guest Member to be covered for those benefits.

A Subscriber's eligible Dependent may register as a 'student Guest Member'. The Dependent must be a student residing outside Keystone's Approved Service Area and inside a Host HMO Service Area. The Dependent student must not be residing with the Subscriber and must be residing in a Host HMO Service Area.

GUEST MEMBERSHIP (GUEST MEMBERSHIP PROGRAM) – a program that provides Guest Membership Benefits to Members while outside of Keystone's Approved Service Area for a period of at least ninety (90) consecutive days. Guest Membership Benefits provide coverage for a wide range of health care services. The Guest Membership Program offers portable Keystone coverage to Members. Services provided under the Guest Membership Program are coordinated by the Guest Membership Coordinator. Guest Membership is available for a limited period of time. The Guest Membership Coordinator will confirm the period for which a Member is registered as a Guest Member.

GUEST MEMBERSHIP BENEFITS – benefits available to Members while traveling outside of Keystone's Approved Service Area for a period of at least ninety (90) consecutive days. Guest Membership Benefits provide coverage for a wide range of health care services. Members can register for Guest Membership Benefits available under the Away From Home Care Program by contacting the Away From Home Care Coordinator. The Away From Home Care Coordinator will also confirm the period for which the Member is registered as a Guest Member since Guest Membership Benefits are available for a limited period of time.

GUEST MEMBERSHIP COORDINATOR – the staff that assists Members with registration for Guest Membership and provides other assistance to Members while Guest Members.

HEARING AID – Any device that does not produce as its output an electrical signal that directly stimulates the auditory nerve. Examples of hearing aids are devices that produce air-conducted sound into the external auditory canal, devices that produce sound by mechanically vibrating bone, or devices that produce sound by vibrating the cochlear fluid through stimulation of the round window. Devices such as cochlear implants, which produce as their output an electrical signal that directly stimulates the auditory nerve, are not considered to be hearing aids.

HOME HEALTH CARE PROVIDER – a licensed Provider that has entered into an agreement with the HMO to provide home health care Covered Services to Members on an intermittent basis in the Members home in accordance with an approved home health care Plan of Treatment.

HOSPICE – a Facility Provider that is engaged in providing palliative care rather than curative care to terminally ill individuals. The Hospice must be (1) certified by Medicare to provide Hospice services, or accredited as a Hospice by the appropriate regulatory agency; and (2) appropriately licensed in the state where it is located.

HOSPITAL – a short-term, acute care, general Hospital which has been approved by the Joint Commission on Accreditation of Healthcare Organizations and/or by the American Osteopathic Hospital Association or by the HMO and which:

A. Is a duly licensed institution;

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

C. Has organized departments of medicine;

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

E. Is not, other than incidentally, a: Skilled Nursing Facility; nursing home; Custodial Care home; health resort, spa or sanitarium; place for rest; place for aged; place for provision of rehabilitation care; place for treatment of pulmonary tuberculosis; place for provision of Hospice care.

HOST BLUE – A local BlueCross and/or BlueShield Licensee serving a geographic area other than Keystone Health Plan Central's service area that has contractual agreements with providers in that geographic area, which participate in the Bluecard Program, regarding claim filing or payment for covered health care services rendered to Members when traveling outside Keystone's Approved Service area.

IDENTIFICATION CARD (ID CARD) – the currently effective card issued to the Member by the HMO which must be presented when a Covered Service is requested.

IMMEDIATE FAMILY: the Subscriber's or Member's spouse, parent, step-parent, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law, child, step-child, grandparent, or grandchild

INDEPENDENT REVIEW ORGANIZATION (IRO) – means an entity that conducts independent external reviews of adverse benefit determinations and final internal adverse benefit determinations.

INITIAL ENROLLMENT PERIOD – The period October 1, 2013 and March 31, 2014.

INPATIENT – the actual entry into a Hospital, extended care facility or Facility Provider of a Member who is to receive Inpatient services as a registered bed patient in such Hospital, extended care facility or Facility Provider and for whom a room and board charge is made. The Inpatient Admission shall continue until such time as the Member is actually discharged from the facility.

INVESTIGATIONAL – For the purposes of the Agreement, a drug, treatment, device, or procedure is investigational if:

- it cannot be lawfully marketed without the approval of the Food and Drug Administration ("FDA") and final approval has not been granted at the time of its use or proposed use;
- it is the subject of a current Investigational new drug or new device application on file with the FDA;
- the predominant opinion among experts as expressed in medical literature is that usage should be substantially confined to research settings;
- the predominant opinion among experts as expressed in medical literature is that further research is needed in order to define safety, toxicity, effectiveness or effectiveness compared with other approved alternatives; or
- it is not investigational in itself, but would not be Medically Necessary except for its use with a drug, device, treatment, or procedure that is investigational.

In determining whether a drug, treatment, device or procedure is investigational, the following information may be considered:

- the Member's medical records;
- the protocol(s) pursuant to which the treatment or procedure is to be delivered;
- any consent document the patient has signed or will be asked to sign, in order to undergo the treatment or procedure;

- the referred medical or scientific literature regarding the treatment or procedure at issue as applied to the injury or illness at issue;
- regulations and other official actions and publications issued by the federal government; and
- the opinion of a third party medical expert in the field, obtained by Keystone, with respect to whether a treatment or procedure is investigational.

KEYSTONE HEALTH PLAN CENTRAL ("**KEYSTONE**" or "**the HMO**") – a health maintenance organization providing access to comprehensive health care to Members.

KEYSTONE'S APPROVED SERVICE AREA – the geographical area consisting of the following twenty-one (21) Pennsylvania counties within which Keystone is approved to operate as an HMO: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union and York.

LIMITING AGE FOR DEPENDENTS – the end of the month in which a child reaches age 26.

MARKETPLACE – Shall mean a Marketplace established and operated within Pennsylvania by the United States Secretary of Health and Human Services under section 1321(c)(1) of PPACA or operated by the Commonwealth of Pennsylvania in accordance with PPACA's provisions. Also called an "Exchange."

MEDICALLY NECESSARY (MEDICAL NECESSITY) – Shall mean:

- Services or supplies that a physician exercising prudent clinical judgment would provide to a Member for the diagnosis and/or direct care and treatment of the Member's medical condition, disease, "illness, or injury that are necessary;
- In accordance with generally accepted standards of good medical practice;
- Clinically appropriate for the Member's condition, disease, illness or injury;
- Not primarily for the convenience of the Member and/or Member's family, physician, or other health care provider; and
- Not more costly than alternative services or supplies at least as likely to produce equivalent results for the Plan Member's condition, disease, illness or injury.

For purposes of this definition, "generally accepted standards of good medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other clinically relevant factors. The fact that a provider may prescribe, recommend, order, or approve a service or supply does not of itself determine medical necessity or make such a service or supply a covered benefit.

MEDICARE – Hospital or medical insurance Benefits provided by the United States Government under Title XVIII of the Social Security Act of 1965, as amended.

MEMBER – a Subscriber or Dependent who meets the eligibility requirements for enrollment and is contractually entitled to receive Covered Services pursuant to this Subscriber Agreement. This would include a newborn for the first thirty-one (31) days after birth or placement of adoption.

MENTAL ILLNESS/DISORDER – a health condition that is characterized by alterations in thinking, mood, or behavior (or some combination thereof), that are all mediated by the brain and associated with distress and/or impaired functioning.

NON-PARTICIPATING PROVIDER – a Facility Provider, Professional Provider, Ancillary Service Provider that is not a Member of the network of Providers for Keystone's Approved Service Area.

OUT -OF-AREA SERVICES – services provided outside the Keystone's Approved Service Area. When receiving services outside of Keystone's Approved Service, covered services are limited to (i) Emergency

Services, (ii) Urgent Care and Follow-Up Care, (iii) services arranged or Referred by a Member's PCP, and (iv) Services provided to a Member registered as a Guest Member under the Away From Home Care Program.

OUT-OF-POCKET MAXIMUM – The amount of the Allowable Amount that a Member is required to pay during an Agreement Year. After this amount has been paid, the Member is no longer required to pay any portion of the Allowable Amount for benefits during the remainder of that Agreement Year. The amount of the Out-of-Pocket Maximum is identified in Section SC - Schedule Of Cost Sharing.

OUTPATIENT CARE – medical, nursing, counseling or therapeutic treatment provided to a Member who does not require an overnight stay in a Hospital or other Inpatient facility.

PARTICIPATING PROVIDER – a Facility Provider, Professional Provider or Ancillary Services Provider with whom the HMO has contracted directly or indirectly for Keystone's Approved Service Area and, where applicable, is Medicare certified to render Covered Services. This includes, but is not limited to:

A. **Primary Care Physician (PCP)** – a Professional Provider selected by a Member who is responsible for providing all primary care Covered Services and for authorizing and coordinating all covered Medical Care, including Referrals for Specialist Services.

B. **Participating Specialist** – a Professional Provider who provides Specialist Services with a Referral or, for direct access care, without a Referral. A Participating Specialist is in one of the following categories:

    1. **Referred Specialist** – a Professional Provider who provides Covered Specialist Services within his or her specialty upon Referral from a Primary Care Physician. In the event there is no Participating Provider to provide these services, Referral to a Non-Participating Provider will be arranged by a Member's Primary Care Physician with Preauthorization by the HMO. See Section ACC - Access to Primary, Specialist and Hospital Care Network for procedures for obtaining Preauthorization for use of a Non-Participating Provider.

        For the following outpatient services, the Referred Specialist is the Member's Primary Care Physician's Designated Provider: (a) certain rehabilitation Therapy Services (other than Speech Therapy); (b) podiatry services, if the Member is age nineteen (19) or older; and (c) certain diagnostic radiology services, if the Member is age five (5) or older. A Member's Primary Care Physician will provide a Referral to the Designated Provider for these services.

    2. **Participating Obstetricians and Gynecologists** – a Participating Provider selected by a female Member who provides Covered Services without a Referral. All non-facility obstetrical and gynecological Covered Services are subject to the same Copayment that applies to Office Visits to a Member's PCP.

        Participating obstetricians and gynecologists have the same responsibilities as Referred Specialists. For example, seeking Preauthorization for-certain services.

    3. **Dialysis Specialist** – A Professional Provider who provides services related to dialysis without a Referral.

C. **Participating Hospital** – a Hospital that has contracted with the HMO to provide Covered Services to Members.

D. **Durable Medical Equipment (DME) Provider** – a Participating Provider of Durable Medical Equipment that has contracted with the HMO to provide Covered Supplies to Members.

E. **Hospice Provider** – a licensed Participating Provider that is primarily engaged in providing pain relief, symptom management, and supportive services to a terminally ill Member with a medical prognosis of six (6) months or less.

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

PLAN OF TREATMENT – a plan of care which is developed or approved by a Member's Primary Care Physician for the treatment of an injury or illness. The Plan of Treatment should be limited in scope and extent to that care which is Medically Necessary for the Member's diagnosis and condition.

PREAUTHORIZATION – An authorization (or approval) from Keystone Health Plan Central or its designee which results from a process utilized to determine member eligibility at the time of request, benefit coverage and medical necessity of proposed medical services prior to delivery of services. Preauthorization is required for the procedures identified in the **Preauthorization Program** attachment to this Agreement.

PREMIUM – The payment due for coverage under this Agreement.

PROFESSIONAL PROVIDER – a person or practitioner who is certified, registered or who is licensed and performing services within the scope of such licensure. The Professional Providers are:

- Audiologist
- Certified Registered Nurse Anesthetist
- Certified Registered Nurse Midwife
- Certified Nurse Practitioner
- Chiropractor
- Clinical or Physician Laboratory
- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Licensed Dietitian-Nutritionist
- Licensed Social Worker
- Occupational Therapist
- Oral Surgeon
- Physical Therapist
- Physician Assistant
- Podiatrist
- Psychologist
- Respiratory Therapist
- Social worker/Other Masters Prepared Therapists
- Speech Language Pathologist

PROVIDER – A hospital, physician, person or practitioner licensed (where required) and performing services within the scope of such licensure and as identified in this Agreement. Providers include participating providers and non-participating providers.

RECONSTRUCTIVE SURGERY – Shall mean a procedure performed to improve or correct a Functional Impairment, restore a bodily function or correct deformity resulting from an otherwise covered sickness, Birth Defect or accidental injury. The fact that a Member might suffer psychological consequences from a deformity does not, in the absence of bodily Functional Impairment, qualify Surgery as being Reconstructive Surgery.

REFERRAL – The process by which a primary care physician coordinates a member's care with another provider for benefits which the primary care physician does not provide. Referrals must be properly documented and are valid only for benefits as defined in this Agreement.

REHABILITATION HOSPITAL – a Facility Provider, approved by the HMO, which is primarily engaged in providing rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

ROUTINE COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS – Routine costs include all the following:

A. Covered Services under this Subscriber Agreement that would typically be provided absent a Qualifying Clinical Trial.

B. Services and supplies required solely for the provision of the Experimental/Investigational drug, biological product, device, medical treatment or procedure.

C. The clinically appropriate monitoring of the effects of the drug, biological product, device, medical treatment or procedure required for the prevention of complications.

D. The services and supplies required for the diagnosis or treatment of complications.

SERIOUS MENTAL ILLNESS – the following biologically based Mental Illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual:

- Schizophrenia;
- Bipolar disorder;
- Obsessive-compulsive disorder;
- Major depressive disorder
- Panic disorder;
- Anorexia nervosa;
- Bulimia nervosa;
- Schizo affective disorder;
- Delusional disorder; and
- Any other Mental Illness that is considered to be a Serious Mental Illness by law.

SKILLED NURSING FACILITY – an institution or a distinct part of an institution, other than one which is primarily for the care and treatment of Mental Illness, tuberculosis, or Substance Abuse and has contracted with the HMO to provide Covered Services to Members, which:

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

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

C. Is otherwise acceptable to the HMO.

SPECIAL ENROLLMENT PERIOD – a period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through the HMO outside of the initial and Annual Enrollment Period.

STANDING REFERRAL – documentation from the HMO that authorizes Covered Services for a life-threatening, degenerative or disabling disease or condition. The Covered Services will be rendered by the Referred Specialist named on the Standing Referral form. The Referred Specialist will have clinical expertise in treating the disease or condition.

A Standing Referral must be issued to the Member prior to receiving Covered Services. The Member, the Primary Care Physician and the Referred Specialist will be notified in writing of the length of time that the Standing Referral is valid. Standing Referred Care includes all primary and Specialist Services provided by that Referred Specialist.

SUBSCRIBER – a person who meets all applicable eligibility requirements as described under Section EL - Eligibility, Change And Termination Rules Under The Plan, is enrolled for coverage under this Agreement, is

subject to Premium requirements as described in the Premium Rates subsections of Section GP - General Provisions, and has been accepted for coverage by the HMO.

SUBSCRIBER AGREEMENT (**AGREEMENT**) – this agreement between the HMO and the Subscriber, including the Application/Change Form, schedules, Riders and/or amendments if any.

SUBSTANCE ABUSE – any use of alcohol or other drugs which produces a pattern of pathological use causing impairment in social or occupational functions or which produces physiological dependency evidenced by physical tolerance or withdrawal.

SURGERY – the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures. Payment for Surgery includes an allowance for related Inpatient preoperative and postoperative care. Treatment of burns, fractures and dislocations are also considered Surgery.

TOTALLY DISABLED (**TOTAL DISABILITY**) – Shall mean the continuous inability of the Member to perform all of the substantial and material duties of his or her regular occupation resulting from an illness or injury. After 24 months of continuous disability, "total disability" means the inability of the Member to perform all of the substantial and material duties of any occupation for which the Member is reasonably suited by education, training or experience. During the entire period of total disability, the Member may not be engaged in any activity whatsoever for wage or profit and must be under the regular care and attendance of a Physician, other than the Member or a member of the Member's immediate family.

URGENT CARE - Medically Necessary Covered Services provided in order to treat an unexpected illness or Accidental Injury that is not life-or limb-threatening. Such Covered Services must be required in order to prevent a serious deterioration in the Member's health if treatment were delayed.

SECTION MC - USING THE HMO SYSTEM

The HMO program is different from traditional health insurance coverage. In addition to covering health care services, the HMO actually provides access to a Member's medical care through a Primary Care Physician (PCP). Members have the right to designate any PCP who participates in the network for Keystone's Approved Service Area and who is available to accept new patients. For children, a pediatrician may be designated as the PCP. For information on how to select a PCP, and for a list of the participating PCPs, contact Keystone Customer Service.

All medical treatment begins with the Member's Primary Care Physician. Under certain circumstances, continuing care by a Non-Participating Provider will be treated in the same way as if the Provider were a Participating Provider (See Continuity of Care appearing later Section ACC in this Subscriber Agreement.)

Because a Member's Primary Care Physician is the key to using the HMO program, it is important to remember the following:

- **A Member's Primary Care Physician should always be called first** before receiving Medical Care (except for conditions requiring Emergency Services). Please schedule routine visits well in advance.

- **When Specialist Services** are needed, a Member's Primary Care Physician will send an electronic Referral for specific care or will obtain a Preauthorization from the HMO when required. A Standing Referral may be available if a Member's condition is life-threatening, degenerative or disabling disease or condition.

  Members do not need Preauthorization from Keystone or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a health care professional in the network for Keystone's Approved Service Area who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Preauthorization for certain services following a pre-approved treatment plan, or procedures for making Referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Keystone's Customer. Primary Care Physicians must obtain a Preauthorization for Specialist Services provided by Non-Participating Providers.

  It is important to note that all laboratory services must be obtained using the PCP's laboratory arrangement listed on the Member's ID Card.

- **After Hours Services –** Members who need medical services after normal hours should contact their PCP. The PCP's answering service may take the Member's call. If so, the answering service will contact the Member's physician or the physician on call, who will contact the Member as soon as possible. After hours calls should be limited to medical problems requiring immediate attention. However, Members should not postpone calling their PCP's office if they believe they need medical attention.

- **All continuing care** as a result of Emergency Services must be provided or Referred by a Member's Primary Care Physician or coordinated through Keystone's Customer Service Department.

- **Some services must be Preauthorized by the HMO**. Your Primary Care Physician or Participating Specialist works with the HMO's Care Management and Coordination team during the Preauthorization process. Services in this category include, but are not limited to: hospitalization; certain outpatient services; Skilled Nursing Facility services; and home health care. Services that require Preauthorization are noted in the attached Medical Care Preauthorization Schedule included with this Agreement. You have the right to appeal any decisions through the Member Complaint Appeal and Grievance Appeal Process. Instructions for the appeal will be described in the denial notifications.

- **All services must be received from Participating Providers within Keystone's Approved Service Area unless Preauthorized by Keystone, or except in cases requiring (1) Emergency Service, Urgent Care and follow-up care under the BlueCard Program while outside Keystone's Approved Service Area; or (2) Guest Membership Benefits under the Away From Home Care Program while outside Keystone's Approved Service Area.** See Sections ER – Emergency, Urgent, Follow-up Care and GM – Away From Home Care Program Guest Membership Benefits. See also Section ACC - Access to Primary, Specialist and Hospital Care Network for procedures for obtaining Preauthorization for use of a Non-Participating Provider. Keystone Members may submit a written request for a written list of Participating Providers affiliated with participating Hospitals. Use your Provider Directory to find out more about the individual Providers and their qualifications, including Hospitals and Primary Care Physicians and Participating Specialists and their affiliated Hospitals. The directory also lists whether the Provider is accepting new patients.

- **To change Primary Care Physician**, call Keystone's Customer Service Department at the telephone number shown on the ID Card or go to Keystone's website at capbluecross.com.

- **Services Coordinated By The Contracted Behavioral Health Management Company**. Members seeking mental health care and substance abuse services may obtain preauthorization for such services from the contracted behavioral health management company.

  The contracted behavioral health management company may refer members to participating providers for mental health care and substance abuse services and may also coordinate emergency care for such services. Members may contact the contracted behavioral health management company by calling 1-800-216-9748 (TTY number: 1-877-342-6815).

  Any such services which are not coordinated, or which exceed the services authorized by the member's PCP or the contracted behavioral health management company, are not covered.

  For outpatient non-emergency services to be covered, the services must be received from a Participating Provider and must have a prior notification by the contracted behavioral health management company. If a need for inpatient care or partial hospitalization is identified, the inpatient stay or partial hospitalization must be preauthorized by the contracted behavioral health management company.

SECTION CM – CLINICAL MANAGEMENT

A wide range of Clinical Management Programs are available under this coverage with Keystone.

These Clinical Management Programs are intended to provide a personal touch to the administration of the benefits available under this coverage. Program goals are focused on providing members with the skills necessary to become more involved in the prevention, treatment and recovery processes related to their specific illness or injury.

- Clinical Management Programs include:
- Utilization Management (Preauthorization, Medical Claims Review);
- Care Management (Concurrent Review, SmartSurgery[sm] Program, Discharge Outreach Call Program, Case Management);
- Disease Management;
- Maternity Management;
- Quality Management; and
- Health Education and Wellness (including 24-Hour Nurse Line and Nicotine Cessation Program).

UTILIZATION MANAGEMENT

The Utilization Management Program is a primary resource for the identification of Members for timely and meaningful referral to other Clinical Management Programs and includes Preauthorization and Medical Claims Review. Both Preauthorization and Medical Claims Review use a Medical Necessity and/or Investigational review to determine whether services are covered benefits. Members who have questions regarding a utilization review can contact Customer Service Monday through Friday, 8:00 a.m. to 6:00 p.m. by calling the toll-free number on their ID card. If the question is about a specific utilization case or decision that cannot be answered by Customer Service, the Member's call will be forwarded to the Utilization Management Department. After normal business hours, Members can still call this telephone number to leave a message. A Keystone Customer Service Representative will return their call the next business day.

Medical Necessity Review

This coverage with Keystone provides benefits only for services Keystone or its designee determines to be Medically Necessary as defined in Section DE - Definitions, except in limited circumstances as required by law.

When Preauthorization is required, Medical Necessity of benefits is determined by Keystone or its designee prior to the service being rendered. However, when Preauthorization is not required, services still undergo a Medical Necessity review and must still be considered Medically Necessary to be eligible for Coverage as a benefit.

A Participating Provider will accept Keystone's determination of Medical Necessity. The Member will not be billed by a Participating Provider for services that Keystone determines are not Medically Necessary.

A Participating Provider is required to obtain Preauthorization for those services requiring Preauthorization.

Not all treatment and services recommended by a provider will meet Keystone's definition of Medically Necessary as defined in this Agreement.

The Member or the provider may contact Keystone's Clinical Management Department to determine whether a service is Medically Necessary.

Keystone does not reward individuals or practitioners for issuing denials of coverage or provide financial incentives of any kind to individuals to encourage decisions that result in underutilization.

Investigational Treatment Review

This coverage with Keystone does not include services Keystone determines to be Investigational Services as defined in Section DE - Definitions of this Agreement.

However, Keystone recognizes that situations occur when a Member elects to pursue Investigational Services at the Member's own expense. If the Member receives a service Keystone considers to be Investigational Services, the Member is solely responsible for payment of these services and the non-covered amount will not be applied to the Out-of-Pocket Maximum or Deductible, if applicable.

A Member or a provider may contact Keystone to determine whether Keystone considers a service to be Investigational Services.

Preauthorization

Preauthorization is a process for evaluating requests for coverage of services prior to the delivery of care. The general purpose of the Preauthorization program is to facilitate the receipt by Members of:

- Medically appropriate treatment to meet individual needs;
- Care provided by Participating Providers delivered in an efficient and effective manner; and
- Maximum available benefits, resources, and coverage.

Participating Providers are responsible for obtaining required Preauthorizations.

Members should refer to the Medical Care Preauthorization Schedule attachment to this Agreement for information on this program. Members should carefully review this attachment to determine whether services they wish to receive must be preauthorized by Keystone. This listing may be updated periodically.

A Preauthorization decision is generally issued within two (2) business days of receiving all necessary information for non-urgent requests.

Medical Claims Review

Keystone's clinicians conduct Medical Claims Review retrospectively through the review of medical records to determine whether the care and services provided and submitted for payment were medically necessary. Retrospective review is performed when Keystone receives a claim for payment for services that have already been provided. Claims that require retrospective review include, but are not limited to, claims incurred:

- under coverage that does not include the preauthorization program;
- in situations such as an emergency when securing an authorization within required time frames is not practical or possible;
- for services that are potentially investigational or cosmetic in nature; or
- for services that have not complied with preauthorization requirements.

A retrospective review decision is generally issued within thirty (30) calendar days of receiving all necessary information.

If a retrospective review finds a procedure to not be medically necessary, the Member may be liable for payment to the provider.

CARE MANAGEMENT

The Care Management Program is a proactive Clinical Management Program designed for members with acute or complex medical needs who could benefit from additional support with coordinating their care. The Care Management Program includes:

- Concurrent Review Program (including Discharge Planning);
- SmartSurgery Program;
- Discharge Outreach Call Program; and
- Case Management Program.

Concurrent Review Program

The Concurrent Review Program includes Concurrent Review and Discharge Planning

Concurrent Review

Concurrent review is conducted by experienced Keystone Health Plan Central registered nurses and board-certified Physicians to evaluate and monitor the quality and appropriateness of initial and ongoing medical care provided in Inpatient settings (Acute Care Hospitals, Skilled Nursing Facilities, Inpatient Rehabilitation Hospitals, and Long-Term Acute Care Hospitals). In addition, the program is designed to facilitate identification and referral of Members to other Clinical Management Programs, such as Case Management and Disease Management; to identify potential quality of care issues; and to facilitate timely and appropriate discharge planning.

A Concurrent Review decision is generally issued within one (1) day of receiving all necessary information.

Discharge Planning

Discharge planning is performed by Concurrent Review nurses who communicate with hospital staff, either in person or by telephone, to facilitate the delivery of post-discharge care at the level most appropriate to the patient's condition. Discharge planning is also intended to promote the use of appropriate outpatient follow-up services to prevent avoidable complications and/or readmissions following inpatient confinement.

SmartSurgery Program

The SmartSurgery Program is for members scheduled to undergo selected elective surgical procedures. Prior to admission, a Keystone nurse may contact a member by telephone to discuss expectations regarding the upcoming Hospital stay, answer questions about scheduled procedures and address any other concerns regarding post-discharge care. The goal of the program is to promote a successful inpatient stay and facilitate a smooth recovery by encouraging preoperative education, proper coordination of care, and early discharge planning.

Discharge Outreach Call Program

The Discharge Outreach Call Program assists members in understanding their post-discharge treatment plan and thereby helps prevent avoidable complications and readmissions. Within two (2) days of discharge from a Hospital, a Keystone nurse may contact a member by telephone to discuss any discharge concerns; to assess the member's understanding of and adherence to the provider's discharge instructions, including the timing of any follow-up appointments; to determine the member's understandings about any medications prescribed; and to make sure any necessary arrangements for services, such as home health care, are proceeding appropriately.

Case Management Program

The Case Management Program is a service for members with complex medical needs or who may be at risk for future adverse health events due to an existing medical condition or who may require a wide variety of resources, information, and specialized assistance to help them manage their health and improve their quality of life. The program assigns an experienced Keystone Case Management nurse or coordinator to a member or family caretaker to help make arrangements for needed care or to provide assistance in locating available community resources.

Case Management services provided to members are numerous and are always tailored to the individual needs of a member. Participation in Keystone's Case Management Program is voluntary and involves no additional cost to our members. Services often include, but are not limited to:

- Assistance with coordination of care;
- Discussion of disease processes;
- Facilitating arrangements for complex surgical procedures, including organ and tissue transplants;
- Facilitating arrangements for home services and supplies, such as durable medical equipment and home nursing care; or
- Identification and referral to available community resources, programs; or organizations.

DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA

Utilization Review and Criteria for Behavioral Health Services

Utilization Review activities for behavioral health services (Mental Health and Substance Abuse services) have been delegated by the HMO to its contracted behavioral health management company which administers the behavioral health Benefits for the majority of the HMO's Members. Members seeking Mental Health care and Substance Abuse services may obtain Preauthorization for such services from the contracted behavioral health management company.

DISEASE MANAGEMENT PROGRAMS

The Disease Management Program is a collaborative program that assesses the health needs of Members with a chronic condition and provides education, counseling, and information designed to increase the Member's self-management of this condition.

The goals of Keystone Health Plan Central's Disease Management Program are to maintain and improve the overall health status of Members with specific diseases through the provision of comprehensive education, monitoring and support for healthy self-management techniques. The Disease Management Program is especially beneficial for Members who have complex health care needs or who require additional assistance and support. Participation in Keystone Health Plan Central's Disease Management Program is voluntary and involves no additional cost to our Members.

MATERNITY MANAGEMENT PROGRAM

Precious Baby Prints® is a voluntary Maternity Management Program designed to support expectant mothers who experience both complicated and uncomplicated pregnancies. Program participation extends throughout pregnancy, delivery and postpartum care. The program provides educational information, teaching, and personalized support to pregnant members.

The assessment phase of the program includes a questionnaire that helps to identify members who may be at risk for pregnancy-related complications or who may be experiencing complications. Members identified as being potentially at high risk for complications are assigned a Maternity Case Manager (R.N.) for more intensive personalized services.

Program activities for low risk members are designed to supplement the advice and treatment provided by the member's Obstetric provider and physicians. The program is tailored to each member's individual health and educational needs and provides credible educational materials related to pregnancy, general health issues, childcare and parenting skills.

QUALITY MANAGEMENT PROGRAM

The Quality Management Program is designed to facilitate the receipt of quality care and services by Keystone members. The program is multidisciplinary, involving all departments within Keystone that have a

direct impact on quality of care, services and accessibility. The program provides for the monitoring, evaluation, measurement, and reporting of the quality of medical care, the quality of service, and the safety of program services.

Responsibilities of the Quality Management Program include but are not limited to:

- Clinical appeals and Grievances;
- Identification, evaluation and corrective action (as necessary) for all potential quality issues;
- Analysis of member satisfaction surveys;
- Monitoring of provider practice patterns; and
- Compliance with all regulatory and accrediting standards.

HEALTH EDUCATION AND WELLNESS PROGRAMS

Keystone's Health Education and Wellness Programs are provided through a special unit within the Clinical Management Department. Keystone believes that motivating individuals to adopt healthier lifestyles results in better outcomes when individuals have access to comprehensive and accurate health and wellness information. In addition, the Health Education and Wellness Programs include a 24-Hour Nurse Line service that is available to all of our members free of charge and a Nicotine Cessation Program. Multiple areas on the Capital BlueCross website are dedicated to providing health and wellness education for our members. For more information, visit capbluecross.com and healthforums.com.

24-Hour Nurse Line

The Keystone 24-Hour Nurse Line staff of registered nurses are available to answer questions on health-related issues 24 hours a day, every day of the year. The service is designed to offer health and medical information, education and support. The service also offers assessment and advice, and suggests appropriate levels of care for symptomatic callers in the event members are unable to reach their physician. Members are encouraged to call **1-800-452-BLUE** when they have the need for health information/education, or want assistance in determining how to best handle specific medical symptoms. Nurses are prepared to provide the following services:

- Answers to a member's questions on a health-related topic;
- Send information/educational materials as appropriate to the member's home; or
- Refer a member to an Audio Library for comprehensive information on a specific topic, disease or procedure.
- If the call is for symptomatic reasons, the nurses will:
  - Conduct an assessment of the member's symptoms;
  - Direct the member to dial 911 in the event the symptoms described warrant it;
  - Suggest the appropriate level of care in the event the member's physician is not available.

Nicotine Cessation Program

Keystone's Nicotine Cessation Program is designed to assist members who are interested in breaking their habit of tobacco product use. Members may access information via our website, including contact information for the PA Quit Line, Pennsylvania's nicotine cessation counseling services. Additional resources available via the capbluecross.com website include:

- Nurse Line - access 24 hours a day to a live nurse who can assist members with questions and resources focused on nicotine cessation;
- Discount Health Network - a network of local and regional community organizations who offer discounts on health-related services;
- Website links to credible organizations and programs focused on nicotine cessation; and
- References to available community programs.

Members also have access to counseling services provided by trained nicotine cessation counselors from the American Cancer Society. This counseling is provided in combination with nicotine replacement therapy (e.g. gum, patches) provided by Keystone's vendor, subject to any applicable cost-sharing amount required of the member. No additional costs for the counseling services are incurred by the member.

HOW WE EVALUATE NEW TECHNOLOGY

Changes in medical procedures, behavioral health procedures, drugs, and devices occur at a rapid rate. Keystone strives to remain knowledgeable about recent medical developments and best practice standards to facilitate processes that keep our medical policies up-to-date. A committee of local practicing physicians representing various specialties evaluates the use of new medical technologies and new applications of existing technologies. This committee is known as the Clinical Advisory Committee. The physicians on this Committee provide clinical input to Keystone concerning our medical policies, with an emphasis on community practice standards. The Committee, along with Keystone's Medical Directors and Medical Policy Staff, look at issues such as the effectiveness and safety of the new technology in treating various conditions, as well as the associated risks.

The Clinical Advisory Committee meets regularly to review information from a variety of sources, including technology evaluation bodies, current medical literature, national medical associations, specialists and professionals with expertise in the technology, and government agencies such as the Food and Drug Administration, the National Institutes of Health, and the Centers for Disease Control and Prevention. The five (5) key criteria used by the Committee to evaluate new technology are listed below:

- The technology must have final approval from the appropriate governmental regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and
- The improvement must be attainable outside the Investigational setting.

After reviewing and discussing all of the available information and evaluating the new technology based on the criteria listed above, the Committee provides a recommendation to Keystone's Corporate Policy Committee regarding the new technology and any necessary changes to medical policy. The Corporate Policy Committee makes final determinations concerning medical policy after assessing provider and Member impacts of recommended policies.

Keystone's medical policies are developed to assist us in administering benefits and do not constitute medical advice. Although the medical policies may assist Members and their provider in making informed health care decisions, Members and their treating providers are solely responsible for treatment decisions. Benefits for all services are subject to the terms of this coverage.

ALTERNATIVE TREATMENT PLANS

Notwithstanding anything under this coverage to the contrary, Keystone, in its sole discretion, may elect to provide benefits pursuant to an approved alternative treatment plan for services that would otherwise not be covered. Such services require Preauthorization from Keystone. All decisions regarding the treatment to be provided to a member remain the responsibility of the treating physician and the member.

If Keystone elects to provide alternative benefits for a Member in one instance, it does not obligate Keystone to provide the same or similar benefits for any member in any other instance, nor can it be construed as a waiver of Keystone's right to administer this coverage thereafter in strict accordance with its express terms.

SECTION ACC - ACCESS TO PRIMARY CARE, SPECIALIST AND HOSPITAL CARE NETWORK

DIRECT ACCESS TO CERTAIN CARE

A Member does not need a Referral from his/her Primary Care Physician for the following Covered Services obtained from a Participating Provider in the network for Keystone's Approved Service Area:

- Emergency Services
- Care from a participating obstetrical/gynecological Specialist
- Mammograms
- Inpatient Hospital Services that require Preauthorization.
- Dialysis services performed in a Participating Facility Provider or by a Participating Professional Provider

SELECTION OF A PRIMARY CARE PHYSICIAN

Prior to the time a Member's coverage becomes effective in accordance with the provisions of this Agreement, the Member must choose a Participating Primary Care Physician (PCP) in the network for Keystone's Approved Service Area from whom the Member wishes to receive Covered Services under this Agreement. If the Member is a minor or otherwise incapable of selecting a PCP, the Subscriber or legal guardian should select a PCP on the Member's behalf. A Member may designate any Participating Primary Care Physician who is available to accept Members as the Member's Primary Care Physician. If the Member is a minor, the Subscriber or legal guardian may select a pediatrician as the Member's PCP.

At the new Member's option and subject to the Non-Participating Provider's agreement to certain terms and conditions, the Member may continue an ongoing course of treatment with a Non- Participating Provider for a period of up to ninety (90) days from the Member's Effective Date of Coverage (See Continuity of Care provision below).

If a Member fails either to select a Primary Care Physician or complete a Continuity of Care form within thirty (30) days of Membership, the HMO reserves the right to assign a Member to a Primary Care Physician subject to the Member's right to change Primary Care Physicians as described below.

HOW TO OBTAIN A SPECIALIST REFERRAL

Members should always consult their Primary Care Physician first when they need Medical Care.

If the PCP determines that the Member needs specialized services, the PCP will refer the Member to the appropriate Participating Provider. Some services will also require Preauthorization form Keystone. Referrals are valid only for the provider to whom the Member was originally referred. Members who wish to change the specialist to whom they have been referred should contact their PCP.

When the PCP refers the Member for Medically Necessary care, the PCP will issue a referral. The referral notification will indicate the services to be performed by the specialist or facility and any specific time frame for which the referral is valid. The specialist or facility must contact the PCP before providing additional services not originally referred.

It is important to note that all laboratory services must be obtained using the PCP's laboratory arrangement listed on the Member's ID card.

Certain services require Preauthorization by Keystone. Members should consult the enclosed listing for services that require Preauthorization. To avoid delays in claims payment, Members should consult with their Provider prior to having services rendered to ensure that the proper Preauthorization has been obtained from Keystone for the listed services.

Members must be enrolled at the time they receive services from a Referred Specialist or Non- Participating Provider in order for services to be covered.

See the Preauthorization for Non-Participating Providers section of this Subscriber Agreement for information regarding services provided by Non-Participating Providers. Services by Non-Participating Providers require Preauthorization by the HMO in addition to the electronic Referral from your Primary Care Physician.

HOW TO OBTAIN A STANDING REFERRAL

For Members who are afflicted with life-threatening, degenerative or disabling diseases or conditions, a Standing Referral may be given to a specialist with clinical expertise in treating the disease or condition. In certain cases, a specialist may be designated to provide and coordinate the Member's primary and specialty care. This Standing Referral must be obtained from the Member's PCP. The referral provides the specialist with the ability to perform the treatment required for a specific episode of illness, and is valid for 365 days or until the end of the Agreement Year, whichever occurs first. The specialist may refer the patient for additional medical services such as durable medical equipment, education/training, and outpatient surgeries. Laboratory services must follow the PCP's laboratory arrangement as indicated on the Member's ID card. Please note that all Preauthorization guidelines will still apply.

Designations of specialists to provide and coordinate the Member's primary and specialty care must be requested in writing and shall be approved pursuant to a treatment plan approved by Keystone in consultation with the Member, the Member's PCP and, as appropriate, the specialist.

DESIGNATING A REFERRED SPECIALIST AS A PRIMARY CARE PHYSICIAN

If a Member has a life-threatening, degenerative or disabling disease or condition, they may have a Referred Specialist named to provide and coordinate both primary and specialty care. The Referred Specialist will be a Physician with clinical expertise in treating the Member's disease or condition. It is required that the Referred Specialist agree to meet the HMO's requirements to function as a Primary Care Physician.

Follow these steps to initiate a request for a Referred Specialist to be a Member's Primary Care Physician.

1. Call Keystone's Customer Service Department at the telephone number shown on the Member's ID Card. (Or, the Member's Primary Care Physician may call Provider Services or Care Management and Coordination to initiate the request.)

2. A "Request for Specialist to Coordinate All Care" form will be mailed or faxed to the requestor.

3. A Member must complete a part of the form and the Primary Care Physician will complete the clinical part. The Primary Care Physician will then send the form to Care Management and Coordination.

4. The Medical Director will speak directly with the Primary Care Physician and the selected Referred Specialist to apprise all parties of the primary services that the Referred Specialist must be able to provide in order to be designated as a Member's Primary Care Physician. If Care Management and Coordination approves the request, it will be sent to the Provider service area. That area will confirm that the Referred Specialist meets the same credentialing standards that apply to Primary Care Physicians. (At the same time, the Member will be given a Standing Referral to see the Referred Specialist.)

If the Referred Specialist as Primary Care Physician Request is Approved

If the request for the Referred Specialist to be the Primary Care Physician is approved, the Referred Specialist, the Primary Care Physician and the Member will be informed in writing by Care Management and Coordination.

If the Referred Specialist as Primary Care Physician Request is Denied

If the request to have a Referred Specialist designated to provide and coordinate a Member's primary and specialty care is denied, the Member and their Primary Care Physician will be informed in writing. The Member will be given information on how to file a formal Complaint, if they so desire.

CHANGING YOUR PRIMARY CARE PHYSICIAN

If a Member wishes to transfer to a different Primary Care Physician, a request must be submitted in writing or by telephone to Keystone's Customer Service Department. The change will become effective the first day of the month after the month in which the request is received.

A Primary Care Physician may request in writing to the HMO, that care for a Member be transferred to another Primary Care Physician. However, a Primary Care Physician shall not seek to have a Member transferred because of the amount of Covered Services required by the Member or because of the physical condition of the Member.

Any additional Medically Necessary treatment recommended by the Referred Specialist will require another electronic Referral from a Member's Primary Care Physician. If the care is part of either the specialty cardiac or gastroenterology care programs designed by the HMO, a single Referral from a Member's Primary Care Physician will apply for most Inpatient and outpatient services for ninety (90) days from the date of the Referral. Members do not need to return to their Primary Care Physician for Referrals for cardiac or gastroenterology care services by either Referred Specialist during that ninety (90) day period of time.

CHANGING YOUR REFERRED SPECIALIST

The Member may change the Referred Specialist to whom the Member has been Referred by a Primary Care Physician or for whom the Member has a Standing Referral. To do so, the Member should ask the Primary Care Physician to recommend another Referred Specialist before services are performed. Or, the Member may call Keystone's Customer Service Department at the telephone number shown on the ID Card. Only services authorized on the Referral form will be covered.

PROVIDER DIRECTORY

A Provider Directory is made available to Members via our website at capbluecross.com. A printed provider directory is available upon request. It includes a listing of Hospitals and Primary Care Physicians and Referred Specialists by location, telephone numbers and Hospital affiliation. The Directory also will indicate whether the Physician is accepting new patients.

CONTINUITY OF CARE

New Members may continue an on-going course of treatment with a Non-Participating Provider for a transitional period of up to ninety (90) days from the effective date of their Keystone coverage when approved by Keystone in advance of receiving services. Keystone, in consultation with the Member and the health care Provider, may extend this transitional period if determined to be clinically appropriate. If the new Member is in the second or third trimester of pregnancy, the transitional period will be extended to postpartum care related to the delivery. Members wishing to receive continuing care from a Non-Participating Provider for a transitional period must obtain Preauthorization for the requested services from Keystone. All terms and conditions of this Agreement, including Preauthorization requirements, will apply during any transitional period. Additionally, the Non-Participating Provider must agree to accept Keystone's reimbursement as payment in full.

Except in the case where a Participating Provider has been terminated for cause, if Keystone initiates termination of the contract with the Provider or a Participating Provider initiates termination with Keystone, the Member may continue an ongoing course of treatment with the Provider, at the Member's option, for a

transitional period of up to ninety (90) days from the date of the Participating Provider's termination. Keystone, in consultation with the Member and the health care Provider, may extend the transitional period if determined to be clinically appropriate. In the case of a Member in the second or third trimester of pregnancy on the effective date of enrollment, the transitional period shall extend through the postpartum care related to the delivery. All terms and conditions of this Agreement, including Preauthorization requirements, will apply during any transitional period. Any health care service provided by a Non-Participating Provider under this section shall be covered by Keystone under the same terms and conditions as applicable for Participating Providers.

If Keystone terminates the contract of a PCP, Keystone will notify every Member served by that provider of the termination of the contract and will request the Member to select another PCP. Keystone will assist the Member in the selection of another PCP. If the Member does not select another PCP, Keystone may assign the Member to a new PCP.

If Keystone terminates the contract of a PCP for cause, including breach of contract, fraud, criminal activity or posing a danger to a Member or the health, safety or welfare of the public as determined by Keystone, the Member will be notified by Keystone and must select another PCP. Keystone will assist the Member in the selection of another PCP. If the Member does not select another PCP, Keystone may assign the Member to a new PCP. Keystone shall not be responsible for coverage of the health care services provided to the Members by such formerly Participating Provider following the date of termination, and no Member shall have a right to continue with such former Participating Provider.

PREAUTHORIZATION FOR NON-PARTICIPATING PROVIDERS

The HMO may approve payment for Covered Services provided by a Non-Participating Provider if a Member has:

- First sought and received care from a Participating Provider in the same American Board of Medical Specialties (ABMS) recognized specialty as the Non-Participating Provider that you have requested. (A Member's Primary Care Physician is required to obtain Preauthorization from the HMO for services provided by a Non-Participating Provider.)
- Been advised by the Participating Provider that there are no Participating Providers that can provide the requested Covered Services; and
- Obtained authorization from the HMO prior to receiving care. The HMO reserves the right to make the final determination whether there is a Participating Provider that can provide the Covered Services.

If the HMO approves the use of a Non-Participating Provider, a Member will not be responsible for the difference between the provider's billed charges and the HMO's payment to the Provider but a Member will be responsible for applicable Copayments, Coinsurance and/or Deductibles. Applicable program terms including Medical Necessity, Referrals and Preauthorization by the HMO, when required, will apply.

HOSPITAL ADMISSIONS

If a Member needs hospitalization or outpatient Surgery, their Primary Care Physician or Participating Specialist will arrange admission to the Hospital or outpatient surgical facility on their behalf.

To be eligible for coverage for benefits, all non-emergency Hospital admissions must be preauthorized by Keystone's Clinical Management Department. A Member's Primary Care Physician or Participating Specialist will coordinate the Preauthorization for outpatient Surgery or Inpatient admission with the HMO, and the HMO will assign a Preauthorization number. Preauthorization is not required for a maternity Inpatient Stay.

Members do not need to receive an electronic Referral from your Primary Care Physician for Inpatient Hospital services that require Preauthorization.

Upon receipt of information from a Member's Primary Care Physician or Participating Specialist, Care Management and Coordination will evaluate the request for hospitalization or outpatient Surgery based on clinical criteria guidelines. Should the request be denied after review by the HMO's Medical Director, the Member, their Primary Care Physician or Participating Specialist have a right to appeal this decision through the Grievance Process.

During an Inpatient hospitalization, Care Management and Coordination is monitoring a Member's Hospital stay to assure that a plan for their discharge is in place. This is to make sure that Members have a smooth transition from the Hospital to home, or to another setting such as a Skilled Nursing or Rehabilitation Facility. An HMO Case Manager will work closely with a Member's Primary Care Physician or Participating Specialist to help with their discharge and if necessary, arrange for other medical services.

Should a Member's Primary Care Physician or Participating Specialist agree with the HMO that Inpatient hospitalization services are no longer required, the Member will be notified in writing of this decision. Should the Member decide to remain hospitalized after this notification, the Hospital has the right to bill the Member after the date of the notification. The Member may appeal this decision through the Grievance Process.

RECOMMENDED PLAN OF TREATMENT

Members agree, when joining the HMO, to receive care according to the recommendations of the Member's Primary Care Physician. Members have the right to give their informed consent before the start of any procedure or treatment. Members also have the right to refuse any drugs, treatment or other procedure offered to them by the HMO Providers, and to be informed by their Physician of the medical consequences of their refusal of any drugs, treatment, or procedure. The HMO and their Primary Care Physician will make every effort to arrange a professionally acceptable alternative treatment. The HMO will not be responsible for the costs of any alternative treatment that is not a Covered Service or determined to be not Medically Necessary for that condition. Members may use the Grievance Procedure to have any denial of benefits reviewed, if they so desire.

Special Circumstances, as recognized in the community and by the HMO and appropriate regulatory authority, are extraordinary circumstances not within the control of the HMO, including but not limited to:

- a major disaster;
- an epidemic;
- a pandemic;
- the complete or partial destruction of facilities;
- riot;
- civil insurrection; or
- similar causes.

MEMBER LIABILITY

Except when certain Copayments or other Limitations are specified in Subscriber Agreement or the Schedule of Cost Sharing, Members are not liable for any charges for Covered Services when these services have been provided or Referred by their Primary Care Physician and the Member is eligible for such benefits on the date of service.

LIMITATION OF THE HMO'S LIABILITY

The HMO shall not be liable for injuries or damage resulting from acts or omissions of any officer or employee of any Provider or other person providing services or supplies to the Member; nor shall the HMO be liable for injuries or damage resulting from the dissemination of information for the purpose of claims processing or facilitating patient care.

RIGHT TO RECOVER PAYMENTS MADE IN ERROR

If the HMO should pay for any contractually excluded services through inadvertence or error, the HMO maintains the right to seek recovery of such payment from the Provider or Member to whom such payment was made.

SECTION ER - EMERGENCY, URGENT CARE, FOLLOW-UP CARE

WHAT ARE EMERGENCY SERVICES

"Emergency Services" are any health care services provided to a Member after the sudden onset of a medical condition. The condition manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the Member or with respect to a pregnant Member, the health of the Member or her unborn child, in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.
- Other serious medical consequences

Emergency transportation and related Emergency Service provided by a licensed ambulance service shall constitute an Emergency Service.

In a true emergency, the first concern is to obtain necessary medical treatment; so Members should seek care from the nearest appropriate Facility Provider.

Emergency Services do not require a Referral for treatment from the Primary Care Physician.

Emergency Services Inside and Outside Keystone's Approved Service Area

Emergency Services are covered whether they are provided inside or outside Keystone's Approved Service Area. Emergency Services do not require a Referral for treatment from the Member's Primary Care Physician. A Member must notify their Primary Care Physician to coordinate all continuing care. Medically Necessary Care by any provider other than the Member's Primary Care Physician will be covered until the Member can, without medically harmful consequences, be transferred to the care of their Primary Care Physician, a Referred Specialist designated by their Primary Care Physician, an Obstetrician or Gynecologist, or a Dialysis Specialist.

When Emergency Services are provided by Non-Participating Providers, Benefits will be provided at the in-network benefit level. Members will be responsible for any applicable Cost-Sharing Amounts such as Deductibles, Coinsurance, and Copayments. In situations where emergency services cannot reasonably be attended to by a preferred provider, the Member is not liable for a greater out-of-pocket expense than if they had been attended to by a preferred provider.

Examples of conditions requiring Emergency Services are: excessive bleeding; broken bones; serious burns; sudden onset of severe chest pain; sudden onset of acute abdominal pains; poisoning; unconsciousness; convulsions; and choking. In these circumstances, 911 services are appropriate and do not requires Preauthorization.

Ongoing Emergency Services Care From Non-Participating Providers

Inpatient admissions at a Non-Participating Provider incidental to Emergency Services which are the result of an emergency room visit are subject to Preauthorization guidelines. If it is impractical to obtain Preauthorization for an Inpatient admission, the Member or the Member's designee must contact Keystone within forty-eight (48) hours of admission, or as soon as possible thereafter. Services received after the date upon which the Member can be safely transferred to a Participating Provider shall not be covered.

WHAT IS URGENT CARE?

Urgent Care is medical care for an unexpected illness or injury that does not require Emergency Services but which may need prompt medical attention to minimize severity and prevent complications.

In the event of an urgent situation, Members should first call their PCP to determine appropriate medical care for the situation. In most circumstances, the Member will NOT be directed to an emergency room of a Hospital for Urgent Care. In the event that Members are unable to obtain a PCP Referral for Medically Necessary care in advance of receipt of the Urgent Care services, they should notify their PCP by the next business day.

OUT-OF-AREA SERVICES

When Members travel outside of Keystone's Approved Service Area and need health care services, several guidelines apply.

EMERGENCY SERVICES, URGENT CARE AND FOLLOW-UP CARE OUTSIDE KEYSTONE'S APPROVED SERVICE AREA – THE BLUECARD PROGRAM'S URGENT AND FOLLOW-UP CARE BENEFITS

Members have access to health care services when traveling outside of Keystone's Approved Service Area. These services are available through the BlueCross BlueShield Association's BlueCard Program. The length of time that the Member is outside Keystone's Approved Service Area may affect: (1) the benefits the Member receives; (2) the Member's portion of cost-sharing; and (3) the procedures to be followed to obtain care covered under the Plan.

Through the BlueCard Program, Members have access to Medically Necessary Emergency Services and Urgent Care needed while outside Keystone's Approved Service Area during a temporary absence (less than ninety (90) consecutive days). Covered Services will be provided by a contracting Blue Cross and Blue Shield Association traditional participating Provider ("BlueCard Traditional Provider"). The Agreement describes the steps to follow to obtain the needed Urgent Care.

Out of pocket costs are limited to applicable Copayments. A claim form is not required to be submitted in order for a Member to receive benefits, provided the Member meets the requirements identified below.

Emergency Services Benefits When Traveling Outside Keystone's Approved Service Area

Subscribers and their eligible Dependents may receive Emergency Services while traveling outside of Keystone's Approved Service Area.

When Emergency Services are provided by Non-Participating Providers, Benefits will be provided at the in-network benefit level. Members will be responsible for any applicable Cost-Sharing Amounts such as Deductibles, Coinsurance, and Copayments. In situations where emergency services cannot reasonably be attended to by a preferred provider, the Member is not liable for a greater out-of-pocket expense than if they had been attended to by a preferred provider.

Urgent Care Benefits When Traveling Outside Keystone's Approved Service Area

Urgent Care Benefits cover Medically Necessary treatment for any unforeseen illness or injury that requires treatment prior to when the Member returns to Keystone's Approved Service Area. Covered Services for Urgent Care are provided by a contracting Blue Cross and Blue Shield Association traditional participating provider ("BlueCard Traditional Provider"). Coverage is for Medically Necessary services required to prevent serious deterioration of the Member's health while traveling outside Keystone's Approved Service Area during a temporary absence (less than ninety (90) consecutive days). After that time, the Member must return

to Keystone's Approved Service Area or be disenrolled automatically from the Plan, unless the Member is enrolled as a Guest Member under the Guest Membership Program (see below).

Urgent Care required during a temporary absence (less than ninety (90) consecutive days) from the Keystone's Approved Service Area will be covered when:

- The Member calls 1-800-810-BLUE. This number is available twenty-four (24) hours a day, seven (7) days a week. The Member will be given the names, addresses and phone numbers of three BlueCard Traditional Providers. The BlueCard Program has some international locations. When the Member calls, they will be asked whether they are inside or outside of the United States.
- The Member decides which provider he or she will visit.
- The Member must call 1-800-810-BLUE to get prior authorization for the service from the HMO.
- With the HMO's approval, the Member calls the provider to schedule an appointment.
- The BlueCard Traditional Provider confirms Member eligibility.
- The Member shows his or her ID Card when seeking services from the BlueCard Traditional Provider.
- The Member pays the Copayment at the time of his or her visit.

Follow-Up Care Benefits When Traveling Outside Keystone's Approved Service Area

Follow-Up Care Benefits under the BlueCard Program cover Medically Necessary Follow-Up Care required while the Member is traveling outside of Keystone's Approved Service Area. The care must be needed for urgent ongoing treatment of an injury, illness, or condition that occurred while the Member was in Keystone's Approved Service Area. Follow-Up Care must be pre-arranged and Preauthorized by the Member's Primary Care Physician in Keystone's Approved Service Area prior to leaving Keystone's Approved Service Area. Under the BlueCard Program, coverage is provided only for those specified, Preauthorized service(s) authorized by the Member's Primary Care Physician in Keystone's Approved Service Area and the HMO's Care Management and Coordination Department. Follow-Up Care Benefits under the BlueCard Program are available during the Member's temporary absence (less than ninety (90) consecutive days) from the Keystone's Approved Service Area.

Follow-Up Care required during a temporary absence (less than ninety (90) consecutive days) from the Keystone's Approved Service Area will be covered when these steps are followed:

- The Member is currently receiving urgent ongoing treatment for a condition.
- The Member plans to go out of Keystone's Approved Service Area temporarily, and his or her Primary Care.
- Physician recommends that the Member continue treatment.
- The Primary Care Physician calls Keystone to get prior authorization for the service. If a BlueCard Traditional Provider has not been pre-selected for the Follow-Up Care, the Primary Care Physician or Member will be told to call 1-800-810-BLUE.
- The Primary Care Physician or Member will be given the names, addresses and phone numbers of three BlueCard Traditional Providers.
- Upon deciding which BlueCard Traditional Provider will be visited, the Primary Care Physician or Member must inform the HMO by calling the number on the ID Card.
- The Member calls the BlueCard Traditional Provider to schedule an appointment.
- The BlueCard Traditional Provider confirms Member eligibility.
- The Member shows his or her ID Card when seeking services from the BlueCard Traditional Provider.
- The Member pays the Copayment at the time of his or her visit.

Out-of-Country Services

BlueCard Worldwide provides Members with access to medical assistance services around the world. Members traveling or residing outside of the United States have access to doctors and Hospitals in more than 200 countries and territories.

Members who are traveling outside the United States should remember to always carry their Keystone identification card. If Urgent Care is needed, Members can call 1-800-810-BLUE. An assistance coordinator, in conjunction with a medical professional, will assist Members in locating appropriate care. The BlueCard Worldwide Service Center is staffed with multilingual representatives and is available 24 hours a day, 7 days a week. As soon as reasonably possible after services are rendered, Members should contact their PCP to advise the PCP of the care they received and/or to authorize follow-up services if needed. The PCP must notify Keystone and obtain authorization for these services. The PCP's telephone number is listed on the front of the Member's ID card.

Members who need emergency care should go to the nearest Hospital. If admitted, Members should call the BlueCard Worldwide Service Center at 1-800-810-BLUE or call collect (1-804-673-1177).

To locate BlueCard Worldwide providers outside the United States, Members can call BlueCard Worldwide Service Center 1-800-810-BLUE 24 hours a day, 7 days a week, or visit bcbs.com.

Keystone does not pay for routine care (e.g., physicals) or other non-Urgent Care provided outside of Keystone's Approved Service Area. Members should schedule such care while in Keystone's Approved Service Area through regular appointments with their PCP. Members who are going out of the country for vacation or a business trip, for example, should contact their PCP and schedule routine care before they leave.

CONTINUING CARE

Medically Necessary care provided by any Provider other than a Member's Primary Care Physician will be covered, subject to the Section CS - Description of Covered Services, Section EX - Exclusions, Section SC - Schedule of Cost Sharing sections, and the Medical Care Preauthorization Schedule only until they can, without medically harmful consequences, be transferred to the care of their Primary Care Physician or a Referred Specialist designated by their Primary Care Physician.

All continuing care must be provided or Referred by a Member's Primary Care Physician or coordinated through Keystone's Customer Service Department.

SECTION GM - AWAY FROM HOME CARE PROGRAM® GUEST MEMBERSHIP BENEFITS

Members who will be out of Keystone's Approved Service Area for an extended period of time may wish to enroll in Keystone's Away From Home Care Guest Membership Program. This program gives Members coverage, similar to that provided by Keystone, and the Blue Cross and/or Blue Shield HMO in that particular geographic area. Members will have a PCP both at the guest HMO and in Keystone's Approved Service Area. Essentially, the Member is covered under two (2) plans at the same time at no additional cost.

Members who take extended business trips (three to six months), students at college, or families living apart may all take advantage of the benefit of a Guest Membership.

Not all geographic areas within the United States participate in the Guest Membership Program. Members should contact Keystone's Customer Service Department by calling the telephone number on their ID card or as outlined in this Agreement to find out if the geographic area where they will be staying participates in the Guest Membership Program and to find out if they are eligible.

Subscribers who will be out of Keystone's Approved Service Area for greater than six (6) months or who change their permanent residence to an address outside of Keystone's Approved Service Area, are not eligible for the Guest Membership Program.

SECTION MR - MEMBERSHIP RIGHTS AND RESPONSIBILITIES

If a Member has questions, suggestions, problems, or concerns regarding benefits or services rendered, the HMO is ready to assist. Members should call Keystone's Customer Service Department at the telephone number shown on their ID Card. A Keystone Representative will respond to any inquiry promptly.

MEMBER RIGHTS

Members have a right:

- To be treated with respect and recognition of their dignity and right to privacy at all times, to receive considerate and respectful care regardless of religion, race, national origin, age, gender, or financial status.
- To receive information about Keystone, its services, its contracted practitioners and providers (including information regarding a provider's qualifications, such as medical school attended, residency completed, or board certification status), and Member rights and responsibilities. Members can call Customer Service to obtain this information.
- To make recommendations to the list of Member rights and responsibilities.
- To have Keystone Member literature and material for the Member's use, written in a manner which truthfully and accurately provides relevant information that is easily understood.
- To know the name, professional status, and function of those involved in their care.
- To obtain from their physician complete current information concerning their diagnosis, treatment, and prognosis in terms they can reasonably understand, unless it is not medically advisable to provide such information.
- To candid discussion of appropriate or Medically Necessary treatment options for their condition, regardless of cost or benefit coverage.
- To participate with practitioners in decision making regarding their health care.
- To know what procedure and treatment will be used so that when they give consent to treatment, it is truly informed consent. Members should be informed of any side effects or complications that may arise from proposed procedures and treatment in addition to possible alternative procedures. Their physician is responsible for providing them with information they can understand.
- To be advised if any experimentation or research program is proposed in their case and of their right to refuse participation.
- To refuse any drugs, treatment, or other procedure offered to them to the extent permitted by law and to be informed by their physician of the medical consequences of such refusal.
- To all information contained in their medical record unless access is specifically restricted by the attending physician for medical reasons.
- To expect that all records pertaining to their medical care are treated as confidential unless disclosure is necessary for treatment, payment and operations.
- To be afforded the opportunity to approve or refuse release of identifiable personal information except when such release is allowed or required by law.

- To file Complaints or Grievances about Keystone, services requested, or the care rendered by their provider.

MEMBER RESPONSIBILITY

Members have a responsibility:

- To follow the rules of Membership and to read all materials carefully.
- To carry their Keystone ID card with them and present it when seeking health care services.
- To provide Keystone with relevant information concerning any additional health insurance coverage which they or any of their dependents may have.
- To timely notify Keystone and their employer of any changes in their Membership, such as change of address, marital status, etc.
- To seek and obtain services from the PCP they have chosen as well as direct access to obstetrical/gynecological care and in emergencies or when their chosen physician has referred them to other Participating Providers and/or Keystone has preauthorized them to do so.
- To communicate openly with the physician they choose by developing a physician-patient relationship based on trust and cooperation.
- To follow the plans and instructions for care that they have agreed upon with their practitioner.
- To ask questions to make certain they understand the explanations and instructions they are given.
- To understand their health problems and participate, to the degree possible, in developing mutually agreed upon treatment goals.
- To understand the potential consequences if they refuse to comply with treatment plans or recommendations.
- To keep scheduled appointments or give adequate notice of delay or cancellation.
- To pay appropriate Copayments and Coinsurance to Providers when services are received.
- To keep Keystone informed of any concerns regarding the medical care they receive.
- To provide information, to the extent possible, that Keystone needs to administer coverage and that practitioners need to provide care.
- To treat others with respect and recognition of dignity, and to provide considerate and respectful interaction with others regardless of their religion, race, national origin, age, or gender.

SECTION APP - MEMBER APPEAL PROCEDURES (Non Multi-State)

GENERAL INFORMATION

There are two types of appeals for Members who are dissatisfied and wish to appeal denials of coverage or other issues related to their health plan; a Complaint process and an appeal of an Adverse Benefit Determination process[1]. Complaints and appeals of Adverse Benefit Determinations address different issues and have different appeal processes as explained more fully below.

A Complaint is a dispute or objection regarding coverage, including exclusions and non-Covered Services under the plan, Participating or Non-Participating Providers' status or the operations or management policies of the HMO. Examples of Complaints are disputes relating to contract exclusions, co-payments, changes made to the HMO's formulary and services beyond contractual limitations.

The Member may also appeal an Adverse Benefit Determination of the HMO concerning the Medical Necessity or appropriateness of a health care service (Adverse Benefit Determination). Examples of these Adverse Benefit Determinations that involve medical judgment include decisions based on the HMO's requirements for Medical Necessity and appropriateness, health care setting, level of care or effectiveness of a covered benefit as well as the HMO's determination that a treatment is experimental/investigational or cosmetic.

MEMBER CLASSIFICATION OF APPEAL AS A COMPLAINT OR APPEAL OF AN ADVERSE BENEFIT DETERMINATION PERTAINING TO MEDICAL NECESSITY

The HMO will acknowledge an appeal by sending the Member a letter which will explain that the HMO classifies the appeal as either a Complaint or an appeal of an Adverse Benefit Determination and describe the specific appeal process. If a Member disagrees with the HMO's classification of a dispute as a Complaint or appeal of an Adverse Benefit Determination, the Member has the right to question the classification by contacting the Customer Service number on their Identification Card or the Pennsylvania Department of Health or Pennsylvania Insurance Department as set forth below:

Bureau of Consumer Services Pennsylvania Insurance Department 1209 Strawberry Square Harrisburg, PA 17120	OR	Bureau of Managed Care Pennsylvania Department of Health Health and Welfare Building, Room 912 625 Forster Street Harrisburg, PA 17120
1-717-787-2317; Toll Free: 1-877-881-6388		1-717-787-5193; Toll Free: 1-888-466-2787

Appeals of an Adverse Benefit Determination are also classified as pre or post-service. This classification will affect the time available to HMO to conduct the appeal review.

[1] An appeal of an Adverse Benefit Determination is also known as a grievance.

A pre-service appeal of an Adverse Benefit Determination is where the Member received a denial before services are received, for example where a Preauthorization has been requested and the HMO's decision is not to authorize the services. A maximum of thirty (30) days is available to the HMO to issue a decision in a standard pre-service appeal.

A post-service appeal of an Adverse Benefit Determination is an appeal of a denial of coverage for medical care or services that a Member has already received. A maximum of sixty (60) days is available to the HMO to issue a decision in a standard post-service appeal.

Expedited Appeal Process for Claims Involving Urgent Care

There are standard and expedited Adverse Benefit Determination appeal processes. The expedited process is more fully discussed in the following sections.

Authorizing Someone to Represent the Member

At any time during the Complaint appeal or appeal of an Adverse Benefit Determination process, a Member may choose to designate a representative such as a Provider, lawyer, relative or another individual to act on their behalf. A Member's authorized representative may make all decisions regarding the Member's appeal including providing and obtaining documents and correspondence, and may authorize the release of medical records. To designate an individual to serve as an Authorized Representative for the appeal Members must complete an Authorized Representative Designation Form. Members may request this form by calling the Customer Service number on their ID card or by downloading it from our website at capbluecross.com. Except in the case of an Expedited appeal (see discussion on Expedited Appeals section herein), where the Member wishes to designate a representative for the appeal, HMO must receive a completed authorization form *before* the appeal can be processed. The Member is able to withdraw or rescind authorization of an appeal representative at any time during the process.

How to File a Complaint or an Appeal of an Adverse Benefit Determination and Obtain Assistance

Appeals may be filed either verbally or in writing by the Member or the Member's Authorized Representative with the Authorized Representative Designation Form by following the steps discussed below in the descriptions of Member Complaint Appeal Process and Adverse Benefit Determination Appeal Process. At any time during the appeal process, the Member may request the assistance of an HMO employee, at no charge, in preparing their appeal.

MEMBER COMPLAINT PROCESS

Filing a Complaint

Problems or concerns regarding Participating Providers, coverage issues (including certain exclusions and services beyond a contractual limit), or the HMO's operations or policies can often resolved by calling the HMO at the Customer Service number on the back of the Member's Identification Card. If the HMO is not able to readily resolve the Member's issue, the Member may file a formal Complaint.

A Member must file a Complaint with the HMO within one hundred eighty (180) days of the circumstances giving rise to the Complaint. Complaints may be filed by contacting the HMO's Customer Service at the following address or fax number:

HMO First Level Complaints
P.O. 779518
Harrisburg, PA 17177-9518

Fax: 717-703-8494

If the Member needs assistance in filing the Complaint, he or she may call Customer service at the following telephone numbers:

Toll-free: 1-800-730-7219 TTY: 711

The HMO will acknowledge receipt of the Complaint in writing and will describe the Complaint process and the Member's rights. Members may, but are not required to, appoint a representative to act on their behalf at any time during the Complaint process. (See **Authorizing Someone to Represent the Member** above).

INTERNAL COMPLAINT REVIEW

The HMO Complaint Committee will complete its review of the Member's standard Complaint and send its decision to the Member within thirty (30) days and will notify the Member and the Member's representative if applicable of the decision in writing within five business days.

First Level Internal Complaint Review

The First Level Complaint Committee is composed of one (1) or more of the HMO's employees who have had no previous involvement with the Member's case and who are not subordinates of any person who made the initial determination. If the Complaint is denied, the decision letter will include the specific reason for the decision; the plan provision on which the decision is made and instructions on how to access the provision and how the Member can appeal to the next level if unsatisfied.

Second Level Internal Complaint Review

A Member has sixty (60) days from receipt of the First Level Internal Complaint Review decision to file a second level internal Complaint review. A Member may request a second level internal Complaint review by contacting the HMO's Customer Service Department at the following address, fax and telephone numbers:

HMO Second Level Complaints
P.O. Box 779518
Harrisburg, PA 17177-9518

Fax: 717-703-8494

Toll-free: 1-800-730-7219 TTY: 711

The HMO will acknowledge receipt of the request for a second level internal Complaint appeal with a letter explaining the procedure to be followed during the second level internal Complaint Review. The Member will receive notice of the date and time scheduled for the second level internal Complaint review. When possible, the Member will receive fifteen (15) days advance written notice of the date and time scheduled for the review. The Member and/or the Member's representative may participate in second level internal Complaint Review in person or by conference call. The Member or the Member's representative may request the aid, at no charge, of an HMO employee in preparing the Complaint. The Member will have an opportunity to present their case and to submit any additional documentation they would like the Committee to review.

The second level internal Complaint Review Committee, consisting of three (3) or more individuals who did not participate in the first level Complaint review and are not directly supervised by any previous decision makers, will review the Complaint. At least one-third of the second level internal Complaint Review Committee will be individuals who are not employed by the HMO or a related subsidiary or affiliate.

The second level internal Complaint Review Committee will review the Complaint and reach a decision within thirty (30) days and will notify the Member and the Member's representative if applicable of the decision in writing within five business days. The notice will include the basis for the decision and the procedures to file an external appeal of the decision if the Member is dissatisfied.

EXTERNAL COMPLAINT REVIEW

If a Member is not satisfied with the decision of the second level internal review committee, he or she has fifteen (15) days of their receipt of the decision to request an external appeal of the Complaint to either the Pennsylvania Insurance Department or the Pennsylvania Department of Health. The Member's appeal must be in writing to one of the agencies at the address noted below[2]:

Bureau of Consumer Services
Pennsylvania Insurance Department
1209 Strawberry Square
Harrisburg, PA 17120

1-717-787-2317
Toll Free: 1-877-881-6388
Fax: 1-717-787-8585

OR

Bureau of Managed Care
Pennsylvania Department of Health
Health and Welfare Building, Room 912
625 Forster Street
Harrisburg, PA 17120

1-717-787-5193
Toll Free: 1-888-466-2787
Fax: 1-717-705-0947

Pennsylvania AT&T Relay Services: **1-800-654-5984**

The Member's request for external review of a Complaint should include the Member's name, address, daytime telephone number, identification of the HMO, the Member's HMO identification number and a brief description of the issue being appealed. The HMO will be notified of the appeal by the receiving agency and will transmit records from the first and second level Complaint reviews to the appropriate agency.

Expedited Review Process for Complaints Involving Urgent Care

There is one level of internal appeal in an expedited Complaint appeal. The HMO will follow a second-level Complaint process and issue its decision in the case of an expedited Complaint within forty-eight (48) hours of the qualifying request.

PROCESS FOR MEMBER APPEAL OF AN ADVERSE BENEFIT DETERMINATION

Filing an Appeal of an Adverse Benefit Determination

A Member or a Member's authorized representative or a health care provider with the Member's written consent can dispute an Adverse Benefit Determination that a service or care was not Medically Necessary by filing an appeal. A Member must file an appeal of an Adverse Benefit Determination with the HMO within one hundred eighty (180) days of the circumstances giving rise to the appeal. An appeal of an Adverse Benefit Determination may be filed by contacting the HMO's Customer Service at the following address or fax number:

[2] The external appeal may be filed with either agency. The receiving agency will review the appeal and may transfer it to the other agency if appropriate.

HMO Internal Adverse Benefit Determination Review
P.O. 779518
Harrisburg, PA 17177-9518
Fax: 717-703-8494

If the Member needs assistance in filing the Appeal, he or she may call Customer service at the following telephone numbers:

Toll-free: 1-800-730-7219 TTY: 711

Spanish: Para obtener asistencia en Espanol, llame al 1-800-962-2242.
Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-962-2242
Chinese: 如果需要中文的帮助，请拨打这个号码 1-800-962-2242
Navajo: Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-962-2242

Review of Information and Submission of Additional Documentation

The Member or the Member's representative may review information related to the Adverse Benefit Determination including any internal policy, rule, guideline, criteria or protocol which the HMO relied upon in making the decision being appealed. The HMO will provide copies of this information without charge upon request. The Member may supply additional information including written comments, correspondence, medical records and other information for consideration on appeal by writing to the HMO at the above address. Members may request copies of all documents relevant to the appeal (free of charge) including treatment and diagnosis codes by calling the Customer Service number located on the back of their Identification Card or by writing to us at:

Keystone Health Plan Central
PO Box 779519
Harrisburg, PA 17177-9519

INTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION

There is one level of internal review for appeal of an Adverse Benefit Determination. The HMO will complete its review of the Member's standard appeal and send its decision to the Member within thirty (30) days for a pre-service Adverse Benefit Determination appeal and within sixty (60) days for a post-service Adverse Benefit Determination appeal. At any time during the appeal process, the Member may request the assistance of an HMO employee, at no charge, in preparing their Adverse Benefit Determination appeal.

A plan Medical Director is the decision-maker for review of an Adverse Benefit Determination. The decision-maker is either a matched specialist or will receive input from a matched specialist when necessary. A matched specialist is the same or similar physician or psychologist who typically consults on the service under review.

Prior to issuing a decision called a Final Internal Adverse Benefit Determination, the HMO will supply the Member free of charge with any new or additional evidence it considered, relied upon or generated in connection with the claim for benefits including a copy of a matched specialist report, if any. The Member may respond to such evidence. Also prior to issuing a Final Internal Adverse Benefit Determination with a different rationale than the initial Adverse Benefit Determination appealed from, HMO will advise the Member of this different rationale so that the Member may respond if he or she chooses to do so before the decision is made final.

EXTERNAL REVIEW OF A FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

If a Member is not satisfied upon receiving the Final Internal Adverse Benefit Determination, he or she has four (4) months from receipt to request an external appeal through an Independent Review Organization

(IRO). External review is available for appeals from an Adverse Benefit Determination or Final Adverse Benefit Determination that involves medical judgment (including, decisions based on the HMO's requirements for Medical Necessity and appropriateness, heath care setting, level of care or effectiveness of a covered benefit as well as the HMO's treatment is experimental /investigational or cosmetic. In order to request an external appeal, the Member must contact the HMO at the following address, fax and telephone numbers:

HMO
External Grievance Review
P.O. Box 779518
Harrisburg, PA 17177-9518

Fax: 717-703-8494

Toll-free: 1-800-730-7219 TTY: 711

Within five (5) business days of receipt of the Member's request, the HMO will forward the Member's request to a randomly assigned IRO. The HMO will forward the documentation pertaining to the denial to the IRO assigned and will simultaneously forward a list of the documents to the Member. The Member may submit additional information to the IRO for consideration in the external appeal.

The IRO will notify the Member of its decision in writing within forty-five (45) days from the date of the IRO's receipt of the request for external review.

External appeals are for appeals involving Medical Necessity issues.

EXPEDITED REVIEW PROCESS FOR APPEALS OF AN ADVERSE BENEFIT DETERMINATION OR FINAL INTERNAL ADVERSE BENEFIT DETERMINATION INVOLVING URGENT CARE

Requests for expedited review may be made at any time in the appeals process. To request an expedited review of an Adverse Benefit Determination or Final Adverse Benefit Determination the Member may call Customer Services at **1-800-730-7219** (TTY: **711)**. Requests for expedited review should be made by telephone in order to avoid any mail delays. The HMO will promptly inform the Member and the Member's provider if the request qualifies for expedited review.

Internal Expedited Review Process

A Member is entitled to request an expedited review process at the time her or she receives an Adverse Benefit Determination which involves a medical condition for which the timeframe for completion of a standard internal review would seriously jeopardize the Member's life or health or would jeopardize the Member's ability to regain maximum function.

A Member is also entitled to an expedited review process if in the opinion of a physician with knowledge of the Member's condition, the delay from a standard pre-service review would subject the Member to severe pain that cannot adequately be managed without the care or treatment for which coverage is being sought.

The HMO will conduct an expedited internal review and issue its Final Internal Adverse Benefit Determination within (72) hours of receipt of the request which qualifies for an expedited review. The Member will be notified by telephone of the expedited determination. If the Member is not satisfied with the result of the expedited review, they may seek an expedited external review of the Final Internal Adverse Benefit Determination. The Member also has the right to request expedited external review simultaneously with the expedited internal review.

Expedited External Review of a Final Internal Adverse Benefit Determination

The Member may request an expedited external review of an Adverse Benefit Determination as well as from a Final Internal Adverse Benefit Determination if the Member's condition involves a medical condition for which the timeframe for completion of a standard review would seriously jeopardize the Member's life or health or would jeopardize the Member's ability to regain maximum function.

Further a Member is entitled to an expedited review if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay or health care service for which the Member received Emergency Services but has not been discharged from a facility.

Upon receipt of a request for a qualified expedited external review, the HMO will assign an IRO and will transmit the file to the assigned IRO to review the appeal. The IRO will issue a decision as expeditiously as possible, but in no event later than seventy-two (72) hours of receipt of the request.

SECTION PR - ADDITIONAL INFORMATION ABOUT HOW WE REIMBURSE PROVIDERS

Our HMO reimbursement programs for health care Providers are intended to encourage the provision of quality, cost-effective care for our Members. Set forth below is a general description of our HMO reimbursement programs. 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 after reading this material you have any questions about how your health care provider is compensated, please contact Keystone at the telephone number provided on your ID card.

PROFESSIONAL PROVIDERS

Primary Care Physicians

Most Primary Care Providers (PCPs) are paid in advance for their services, receiving a set dollar amount per Member, per month for each Member selecting that PCP. This is called a capitation payment and it covers most of the care delivered by the PCP. Covered Services not included under capitation are paid fee-for-service according to the current HMO fee schedule. Capitated PCPs, are also eligible to receive additional payments for meeting certain medical quality, patient service and other performance standards.

Referred Specialists

Most Referred Specialists are paid on a fee-for-service basis, meaning that payment is made according to our current HMO fee schedule for the specific medical services that the Referred Specialist performs. Obstetricians are paid global fees that cover most of their professional services for prenatal care and for delivery. PCP referrals to Referred Specialists are generally valid for ninety (90) days and apply to all Covered Services provided by a Referred Specialist in his/her office.

Accountable Care Program Arrangements

The HMO and some primary care physician or specialty physician groups participate in an Accountable Care Program arrangement (ACP). The ACP is a collaboration between a physician group and the HMO designed to incent high quality patient care, increased physician patient satisfaction, and more efficient and cost effective services. Under an ACP arrangement, the HMO may pay the physicians an incentive payment to focus on spending more time with their patients or on coordinating treatment plans for their more chronically ill patients, along with support services provided by the HMO to the physician. Although a Member whose physician participates in an ACP arrangement experiences no change in their benefit levels, the expectation is that such Members' physicians coordinate their referrals and management of their patients in a high-quality, cost efficient manner.

INSTITUTIONAL PROVIDERS

Hospitals

For most Inpatient medical and surgical Covered Services, Hospitals are paid per diem rates, which are specific amounts paid for each day a Member is in the Hospital. These rates usually vary according to the intensity of services provided and do not typically include any payment for professional (e.g., physician/surgeon) charges or expenses. 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 Covered Services and procedures, most Hospitals are paid specific rates based on the type of service performed. Hospitals may also be paid a global rate for certain outpatient Covered Services (e.g., lab and radiology) that includes both the Facility (or a technical charge) and Physician payment. For a few Covered Services, Hospitals are paid based on a percentage of their billed charges. Most Hospitals are paid through some combination of the above payment mechanisms for various Covered Services.

Some Hospitals participate in a quality incentive program. The program provides increased reimbursement to these Hospitals when they meet specific quality and other criteria, including "Patient Safety Measures". Such patient safety measures may include and are consistent with recommendations by CMS, The Leap Frog Group, Joint Commission on Accreditation of Health care Organizations (JCAHO), and the Agency for Health Care Research and Quality (AHRQ). The quality criteria are designed to help reduce medical and medication errors. Other criteria are directed at improved patient outcomes and electronic claim and record submissions. Use of these types of incentives is expected to evolve over time.

Skilled Nursing Homes, Rehabilitation Hospitals, and other care facilities

Most Skilled Nursing Facilities and other special care facilities are paid per diem rates, which are specific amounts paid for each day a Member is in the facility and do not typically include any payment to the facility for professional (e.g., physician) charges or expenses. These amounts may vary according to the intensity of services provided.

Ambulatory Surgical Centers (ASCs)

Most ASCs are paid specific rates based on the type of service performed. For a few Covered Services, some ASCs are paid based on a percentage of its billed charges.

Ancillary Service Providers

Some ancillary service providers, such as Durable Medical Equipment and Home Health Care Providers, are paid fee-for-service payments according to our HMO fee schedule for the specific medical services performed. Other ancillary service providers, such as those providing laboratory, dental and vision Covered Services, may be paid per Member per month amount for each Member or may be paid on a fee-for-service basis. Capitated ancillary service vendors are responsible for paying their contracted providers and do so on a fee-for-service basis.

Behavioral Health Services

Keystone contracts with a behavioral health management company which provides a network of participating behavioral health providers and is paid on a per Member per month amount (capitation) for each Member. This company pays its affiliated providers on a fee-for-service basis.

SECTION CL - CLAIM PROCEDURES

CLAIMS AND HOW THEY WORK

In order to receive payment for benefits under this coverage, a claim for benefits must be submitted to Keystone. The claim is based upon the itemized statement of charges for health care services and/or supplies provided by a Provider. After receiving the claim, Keystone will process the request and determine if the services and/or supplies provided under this coverage with Keystone are benefits provided by the Member's coverage, and if applicable, make payment on the claim. The method by which Keystone receives a claim for benefits is dependent upon the type of Provider from which the Member receives services. Providers that are excluded or debarred from governmental plans are not eligible for payment by Keystone.

When Members receive services from a Participating Provider, they should show their Keystone Identification Card to the Provider. The Participating Provider will submit a claim for benefits directly to Keystone. Members will not need to submit a claim. Payment for benefits – after applicable Cost-Sharing Amounts, if any - is made directly to the Participating Provider.

Out-of-Area Providers - Emergency Services and Urgent Care

If Members receive Emergency Services or Urgent Care from a Provider outside of Keystone's Approved Service Area, and the Provider is a Member of the local Blue Plan, Members should show their ID card to the Provider. The Provider will file a claim with the local Blue Plan that will in turn electronically route the claim to Keystone for processing. Keystone applies the applicable benefits and Cost-Sharing Amounts to the claim. This information is then sent back to the local Blue Plan that will in turn make payment directly to the Participating Provider – after applicable Cost-Sharing Amounts, if any, have been applied.

ALLOWABLE AMOUNT

For Professional Providers and Facility Providers, the benefit payment amount is based on the Allowable Amount on the date the service is rendered.

Benefit payments to Hospitals or other Facility Providers may be adjusted from time to time based on settlements with such Providers. Such adjustments will not affect the Member's Cost-Sharing Amount obligations.

FILING A CLAIM

If it is necessary for Members to submit a claim to Keystone, they should be sure to request an itemized bill from their health care Provider. The itemized bill should be submitted to Keystone with a completed Keystone Health Plan Central Claim Form.

Members can obtain a copy of the Keystone Health Plan Central Claim Form by contacting Customer Service or visiting the Member link on Keystone's website at capbluecross.com. The Member's claim will be processed more quickly when the Keystone Health Plan Central Claim Form is used. A separate claim form must be completed for each Member who received medical services.

Members should include **all** of the following information with their claim:

1. Identification Number – Subscriber's nine-digit identification number, preceded by three-letter alpha prefix.
2. Name of Subscriber – full name of the person enrolled for coverage through the Agreement.
3. Address – full address of the Subscriber including: number and street, city, state, country, and ZIP code.

4. Patient's Name – last and first name of the patient who received the service.

5. Patient's Gender – indicate male or female.

6. Patient's Date of Birth – patient's date of birth by month, day, and year.

7. Patient's Relationship to Subscriber – relationship of the patient to the Subscriber.

8. Provider Name – full name, address, city, state, country, and ZIP code of the facility, Physician, or supplier rendering the services.

9. Procedure Code – procedure code or description of each service rendered.

10. Type of Admission/Surgery – Type of service such as Inpatient or outpatient and what was done, if applicable.

11. Date(s) of Service – dates on which patient received services, including initial admission date and final discharge date if applicable.

12. Diagnosis, Illness, or Injury – complete diagnosis or injury for particular admission.

13. Receipts from Provider – receipts from Provider showing patient name, type of service, date of each service, and amount charged for each service.

Members must also provide the following information, if applicable:

1. Other insurance payment and/or rejection notices including a Medicare Summary Notice if applicable.

2. Accident information (i.e., date of accident, type of accident, payment or rejection notice, letter of benefit exhaustion, itemized statement).

3. Workers' compensation payment and/or rejection notice.

4. Student information.

5. Medical records which may include Physician notes and/or treatment plans (see special note regarding medical records).

6. Ambulance information – point of origin and destination (example: from home to Hospital).

7. Anesthesia – the length of time patient was under anesthesia and specific Surgery for which anesthesia was given.

8. Blood – number of units received, charge for each unit, and number of units replaced by donor(s).

9. Chemotherapy – name of drug, dosage of drug, charge for each drug, and the method of administration (oral, intra-muscular injections, intravenous, etc.)

10. Durable medical equipment certification from the doctor concerning the Medical Necessity and expected length of time equipment will be needed. If renting equipment, Members should have the durable medical supplier provide the equipment purchase price.

A Special Note About Medical Records

In order to determine if the services are benefits covered under this coverage, the Member (or the Provider on behalf of the Member) may need to submit medical records, Physician notes, or treatment plans. Keystone

will contact the Member and/or the Provider if additional information is needed to determine if the services and/or supplies received are Medically Necessary.

Where to Submit Medical Claims

Members can submit their claims, which include a completed Keystone Health Plan Central Claim Form, an itemized bill, and all required information listed above, to the following address:

Keystone Health Plan Central
PO Box 779519
Harrisburg, PA 17177-9519

Members who need help submitting a medical claim can contact Customer Service at **1-800-730-7219** (TTY: **711**).

OUT-OF-COUNTRY CLAIMS

There are special claim filing requirements for Emergency Services and Urgent Care received outside of the United States.

Inpatient Hospital Claims

Claims for Inpatient Hospital services arranged through the BlueCard Worldwide Service Center require Members to pay only the usual Cost-Sharing Amounts. The Hospital files the claim for the Member. Members who receive Inpatient Hospital care from a Non-Participating Hospital or services that were not coordinated through the BlueCard Worldwide Service Center may have to pay the Hospital and submit the claim to the BlueCard Worldwide Service Center at P.O. Box 261630, Miami, FL 33126.

Professional Provider Claims

For all outpatient and professional medical care, the Member pays the Provider and then submits the claim to the BlueCard Worldwide Service Center at P.O. Box 261630, Miami, FL 33126. The claim should be submitted showing the currency used to pay for the services.

International Claim Form

There is a specific claim form that must be used to submit international claims. Itemized bills must be submitted with the claim form. The international claim form can be accessed at capbluecross.com.

CLAIM FILING AND PROCESSING TIME FRAMES

Time Frames for Submitting Claims

All claims must be submitted within twelve (12) months from the date of service with the exception of claims from certain State and Federal agencies.

Time Frames Applicable to Medical Claims

If the Member's claim involves a medical service or supply that was already received, Keystone will process the claim within thirty (30) days of receiving the claim. Keystone may extend the thirty (30)-day time period one (1) time for up to fifteen (15) days for circumstances beyond Keystone's control. Keystone will notify the Member prior to the expiration of the original time period if an extension is needed. The Member and Keystone may also agree to an extension if the Member or Keystone requires additional time to obtain information needed to process the claim.

Special Time Frames Applicable to "Concurrent Care" Claims

Medical circumstances may arise under which Keystone approves an ongoing course of treatment to be provided to the Member over a period of time or number of treatments. If the Member or the Member's Provider believes that the period of time or number of treatments should be extended, the Member should follow the steps described below.

If it is believed that any delay in extending the period of time or number of treatments would jeopardize the Member's life, health, or ability to regain maximum function, the Member must request an extension at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. The Member must make a request for an extension by calling Keystone's Customer Service Department, toll-free, at **1-800- 730-7219**. Keystone will review the Member's request and will notify the Member of Keystone's decision within twenty-four (24) hours after receipt of the request.

Members who are dissatisfied with the outcome of their request may submit an appeal. Section APP - Member Complaint and Grievances Procedures of this Agreement contains instructions for submission of an appeal. For all other requests to extend the period of time or number of treatments for a prescribed course of treatment, Members should contact Keystone's Customer Service Department.

COORDINATION OF BENEFITS (COB)

The coordination of benefits provision of this policy applies when a person has health care coverage under more than one Plan as defined below.

The order of benefit determination rules govern the order in which each Plan pays a claim for benefits.

- The Plan that pays first is the "Primary Plan". The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- The Plan that pays after the Primary Plan is the "Secondary Plan." The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

The HMO will provide access to Covered Services first and determine liability later.

Definitions Unique to Coordination of Benefits

In addition to the defined terms in the **Definitions** section of this policy, the following definitions apply to this provision:

Plan: Plan means This Coverage and/or Other Plan.

Other Plan: Other Plan means any individual coverage or group arrangement providing health care benefits or services through:

1. individual, group, blanket or franchise insurance coverage except that it shall not mean any blanket student accident coverage or Hospital indemnity plan of one hundred ($100) dollars or less;

2. Blue Cross, Blue Shield, group practice, individual practice, and other prepayment coverage;

3. coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and

4. coverage under any tax-supported or any government program to the extent permitted by law.

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

This Coverage: This Coverage means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Coverage. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rule: The order of benefit determination rules determine whether This Coverage is a Primary Plan or Secondary Plan when the Member has health care coverage under more than one Plan.

Primary Plan: The Plan that typically determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits.

Secondary Plan: The Plan that typically determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense deemed customary and reasonable by Keystone.

Covered Service: A service or supply specified in This Coverage for which benefits will be provided when rendered by a Provider to the extent that such item is not covered completely under the Other Plan. When benefits are provided in the form of services, the reasonable cash value of each service shall be deemed the benefit.

Keystone will not be required to determine the existence of any Other Plan, or amount of benefits payable under any Other Plan, except This Coverage.

The payment of benefits under This Coverage shall be affected by the benefits that would be payable under Other Plans only to the extent that Keystone is furnished with information regarding Other Plans by the Member or Subscriber or any other organization or person.

Allowable Expense: Allowable expense is a health care expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any Plan covering the Member. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the Member is not an Allowable Expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable Expense.

Examples of expenses that are not Allowable Expenses include, but are not limited to:

- The difference between the cost of a semi-private Hospital room and a private Hospital room, unless one of the Plans provides coverage for private Hospital room expenses.
- Any amount in excess of the highest reimbursement amount for a specific benefit when two (2) or more Plans that calculate benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology cover the Member.
- Any amount in excess of the highest of the negotiated fees when two (2) or more Plans that provide benefits or services on the basis of negotiated fees cover the Member.
- If the Member is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology covers a person and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit

or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

- The amount of any benefits reduction by the Primary Plan because the Member has failed to comply with the Plan provisions. Examples of these types of Plan provisions include second surgical opinions, Preauthorization, and preferred provider arrangements.

Closed Panel: Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel Member. An HMO is an example of a closed panel plan.

Custodial Parent: Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Dependent: A dependent means, for any Other Plan, any person who qualifies as a dependent under that plan.

Order of Benefit Determination Rules

When a Member is covered by two (2) or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

2. A Plan that does not have a coordination of benefits provision as described in this section is always the Primary Plan unless both Plans state that the Plan with a coordination of benefits provision is primary.

3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

4. Each Plan determines its order of benefits using the first of the following rules that apply:

   A. Non-Dependent or Dependent.

   The Plan that covers the Member as an employee, policyholder, Subscriber or retiree is the Primary Plan. The Plan that covers the Member as a Dependent is the Secondary Plan.

   B. Child Covered Under More Than One Plan.

   Unless there is a court decree stating otherwise, when a child is covered by more than one Plan, the order of benefits is determined as follows:

   (i) For a child whose parents are married or are living together, whether or not they have ever been married:

   - The Plan of the parent whose birthday falls earlier in the calendar year is the primary Plan. This is known as the Birthday Rule; or
   - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan; or
   - If one of the Plans does not follow the Birthday Rule, then the Plan of the child's father is the Primary Plan. This is known as the Gender Rule.

(ii) For a child whose parents are divorced, separated or not living together, whether or not they have ever been married:

- If a court decree states that one of the parents is responsible for the child's health care expenses or coverage and the Plan of that parent has actual knowledge of this decree, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
- If a court decree states that both parents are responsible for the child's health care expenses or coverage, the provisions of subparagraph (i) determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the child, the provisions of subparagraph (i) determine the order of benefits; or
- If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits for the child is as follows:
  - The Plan covering the Custodial Parent;
  - The Plan covering the spouse of the Custodial Parent;
  - The Plan covering the non-custodial parent; and then
  - The Plan covering the spouse of the non-custodial parent.

(iii) For a child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (i) or (ii) above shall determine the order of benefits as if those individuals were the parents of the child.

C. Active Employee or Retired or Laid-off Employee.

The Plan that covers the Member as an active employee is the Primary Plan. The Plan covering that same Member as a retired or laid-off employee is the Secondary Plan. The same would hold true if the Member is a Dependent of an employee covered by the active, retired or laid-off employee.

If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Non-Dependent or Dependent "rule can determine the order of benefits.

D. COBRA or State Continuation Coverage.

If a Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Member as an employee, Subscriber or retiree or covering the Member as a Dependent of an employee, Subscriber or retiree is the Primary Plan. The COBRA or state or other federal continuation coverage is the Secondary Plan.

If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Non-Dependent or Dependent" rule can determine the order of benefits.

E. Longer or Shorter Length of Coverage.

The Plan that covered the Member as an employee, policyholder, Subscriber or retiree longer (as measured by the effective date of coverage) is the Primary Plan and the Plan that covered the Member the shorter period of time is the Secondary Plan. The status of the Member must be the same for all Plans for this provision to apply. The same primacy would be true if the Member is a dependent of an employee covered by the Longer or Shorter length of coverage.

If the preceding rules do not determine the order of benefits, the Allowable Expense is shared equally between the Plans. In addition, This Coverage will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Coverage

When This Coverage is secondary, it may reduce benefits so that the total paid or provided by all Plans for a service are not more than the total Allowable Expenses.

In determining the amount to be paid, the Secondary Plan calculates the benefits it would have paid in the absence of other health care coverage. That amount is compared to any Allowable Expense unpaid by the Primary Plan. The Secondary Plan may then reduce its payment so that the unpaid Allowable Expense is the considered balance. When combined with the amount paid by the Primary Plan, the total benefits paid by all Plans may not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan credits to its Deductible any amounts it would have otherwise credited to the Deductible.

If a Member is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Coverage and other Plans. Keystone may obtain and use the facts it needs to apply these rules and determine benefits payable under This Coverage and other Plans covering the Member claiming benefits. Keystone need not tell, or get the consent of, the Member or any other person to coordinate benefits. Each Member claiming benefits under This Coverage must give Keystone any facts needed to apply those rules and determine benefits payable.

Failure to complete any forms required by Keystone may result in claims being denied.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Coverage. If it does, Keystone may pay that amount to the organization that made the payment. That amount is treated as though it is a benefit paid under This Coverage. Keystone will not pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Keystone is more than the amount that should have been paid under this COB provision, Keystone may recover the excess amount. The excess amount may be recovered from one or more of the persons or organizations paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

THIRD PARTY LIABILITY/SUBROGATION

Subrogation is the right of Keystone to recover the amount it has paid on behalf of a Member from the party responsible for the Member's injury or illness. To the extent permitted by law, a Member who receives benefits related to injuries caused by an act or omission of a third party or who receives benefits and/or compensation from a third party for any care or treatment(s) regardless of any act or omission, shall be required to reimburse Keystone for the cost of such benefits when the Member receives any amount recovered

by suit, settlement, or otherwise for his/her injury, care or treatment(s) from any person or organization. The Member shall not be required to pay Keystone more than any amount recovered from the third party.

In lieu of payment above, and to the extent permitted by law, Keystone may choose to be subrogated to the Member's rights to receive compensation including, but not limited to, the right to bring suit in the Member's name. Such subrogation shall be limited to the extent of the benefits received under the Agreement. The Member shall cooperate with Keystone should Keystone exercise its right of subrogation. The Member shall not take any action or refuse to take any action that would prejudice the rights of Keystone under this **Third Party Liability/Subrogation** section.

The right of subrogation is not enforceable where prohibited by statute or regulation.

There are three basic categories of medical claims that are included in Keystone's subrogation process: third party liability, workers' compensation insurance, and automobile insurance.

Third Party Liability

Third party liability can arise when a third party causes an injury or illness to a Member. A third party includes, but is not limited to, another person, an organization, or the other party's insurance carrier.

When a Member receives any amount recovered by suit, settlement or otherwise from a third party for the injury or illness, subrogation entitles Keystone to recover the amounts already paid by Keystone for claims related to the injury or illness. Keystone does not require reimbursement from the Member for more than any amount recovered.

Workers' Compensation Insurance

Employers are liable for injuries, illness, or conditions resulting from an on-the-job accident or illness. Workers' compensation insurance is the only insurance available for such occurrences. Keystone denies coverage for claims where workers' compensation insurance is required.

If the workers' compensation insurance carrier rejects a claim because the injury was not work-related, Keystone may consider the charges in accordance with the coverage available under the Agreement. Benefits are not available if the workers' compensation carrier rejects a claim for any of the following reasons:

- The employee did not use the Provider specified by the employer or the workers' compensation carrier;
- The workers' compensation timely filing requirement was not met;
- The employee has entered into a settlement with the employer or workers' compensation carrier to cover future medical expenses; or
- For any other reason, as determined by Keystone.

Motor Vehicle Insurance

To the extent benefits are payable under any medical expense payment provision (by whatever terminology used, including such benefits mandated by law) of any motor vehicle insurance policy, such benefits paid by Keystone and provided as a result of an accidental bodily injury arising out of a motor vehicle accident are subject to coordination of benefit rules and subrogation as described in the **Coordination of Benefits (COB)** and **Subrogation** sections of this Agreement.

ASSIGNMENT OF BENEFITS

Except as otherwise required by applicable law, Members are not permitted to assign any right, benefits or payments for benefits under the Agreement to other Members or to Providers or to any other individual or entity. Further, except as required by applicable law, Members are not permitted to assign their rights to

receive payment or to bring an action to enforce the Agreement, including, but not limited to, an action based upon a denial of benefits.

PAYMENTS MADE IN ERROR

Keystone reserves the right to recoup from the Member or Provider, any payments made in error, whether for a benefit or otherwise.

PRE-EXISTING CONDITIONS

Coverage is not subject to any pre-existing condition limitations.

SECTION EL - ELIGIBILITY, CHANGE AND TERMINATION RULES UNDER THE PLAN

It shall be the responsibility of the Subscriber to notify the HMO within thirty (30) days of any changes which affect the eligibility of a Member for Benefits under this Agreement. The HMO will provide coverage, and terminate coverage, in reliance on the timely notification of the eligibility of a Member. If a Subscriber fails to notify the HMO in a timely manner of the eligibility status of a particular Member, the HMO will provide and terminate coverage in accordance with any HMO administrative processes.

ANNUAL AND SPECIAL ENROLLMENT PERIODS AND EFFECTIVE DATES OF COVERAGE

An individual may enroll for coverage during the following enrollment periods:

Annual Enrollment Period

Individuals may enroll during an Annual Enrollment period as required by applicable law.

Special Enrollment Periods and Effective Dates of Coverage

An Individual may enroll during a Special Enrollment Period consisting of sixty (60) days following the occurrence of certain triggering events.

Events that trigger a Special Enrollment Period include the following:

1. A Subscriber gains a dependent through birth, adoption or placement for adoption. The coverage will be effective on the date of birth, adoption or placement for adoption.

2. A Subscriber gains a spouse through marriage. Coverage will be effective on the first day of the following month.

3. An individual loses other minimum essential coverage, including a loss due to termination of employment or reduction in hours, divorce or legal separation, relocation outside Keystone's Approved Service Area, or a child ceasing to be eligible for coverage under the HMO. Coverage will be effective on the first day of the month following enrollment.

4. An individual's previous enrollment or non-enrollment in QHP coverage through the Marketplace was unintentional, inadvertent or erroneous, and resulted from an error, misrepresentation or inaction of an officer, employee or agent of the Marketplace.

5. An enrollee in a QHP demonstrates that the QHP substantially violated a material provision of its contract in relation to the enrollee.

6. An individual is found to be newly eligible or ineligible for advance payments of the Premium tax credit, or has a change in eligibility for cost sharing reductions.

7. An individual gains access to new coverage as a result of a permanent move.

8. An Individual loses eligibility due to death of a covered employee, termination or reduction of hours of covered employee's employment, divorce or legal separation of the covered individual from the employee's spouse, becoming entitled to Medicare, a dependent child ceasing to be a dependent child, a proceeding commences under Chapter 11 with respect to the employer from whose employment the covered employee retires at any time. Coverage will be effective as of the first day of the month following enrollment.

9. A child who is conceived on or after the Effective Date of this Agreement and born to or adopted by a Member (Newborn Child) is automatically covered under this Agreement for the treatment of sickness or injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and routine

nursery care, for the first thirty-one (31) days from the date of birth or, for an adopted child, the Date of Placement with the Member. If such Newborn Child qualifies as a Dependent under this Agreement after the first thirty-one (31) days, in order to continue coverage for the Newborn Child beyond the first thirty-one (31) days, application must be made to add the Newborn Child as a Dependent within thirty-one (31) days from the date of birth or, for an adopted child, the Date of Placement. If such Newborn Child does not qualify as a Dependent under the Agreement, coverage providing substantially similar benefits is available under another individual health insurance product offered by Keystone.

Except as set forth above, for elections made between the first and fifteenth day of any given month, the coverage will be effective as of the first day of the following month. For elections made between the sixteenth and last day of any given month, the coverage will be effective as of the first day of the second following month.

ELIGIBILITY

Eligible Subscriber

An eligible Subscriber is an individual who:

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

b. Is not incarcerated;

c. Is, at the time of initial enrollment, not entitled to benefits under Medicare Part A or enrolled in Medicare Part B or Medicare Premium Part A; and

d. Is a resident of the Service Area.

Eligible Dependents

An eligible Dependent is an individual who is listed on the Enrollment Application completed by the Subscriber and has been accepted for coverage by the HMO; who resides in the Keystone Approved Service Area, unless otherwise provided in this section; and who is:

a. the lawful spouse of the Subscriber; or

b. a child under age twenty-six (26) who is:

   i. the birth child of the Subscriber or the Subscriber's spouse; or

   ii. legally adopted by or placed for adoption with the Subscriber or the Subscriber's spouse; or

   iii. for whom the Subscriber or the Subscriber's spouse is required to provide health care coverage pursuant to a Qualified Medical Child Support Order (QMCSO); or

   iv. a Ward of the Subscriber or the Subscriber's spouse; or

c. a child twenty-six (26) or older who:

   i. is either the birth or adopted child or Ward of the Subscriber or the Subscriber's spouse,

   ii. is mentally or physically incapable of earning a living, and

   iii. is chiefly dependent upon the Subscriber or the Subscriber's spouse for support and maintenance, provided that:

      - the onset of such incapacity occurred before age twenty-six (26),

- proof of such incapacity is furnished to Capital by the Subscriber within thirty-one (31) days following the child reaching age twenty-six (26), and
- the Subscriber provides information as otherwise requested by Capital, but not more frequently than annually.

Keystone reserves the right to require that a spouse of a Subscriber provide documentation demonstrating the marriage to the Subscriber, including, but not limited to, marriage certificate, court order or joint statement of common law marriage.

Extension of Eligibility for Students on Military Duty

Eligibility to enroll under this Agreement as a child will be extended, regardless of age, when the child's education program at an accredited educational institution was interrupted due to military duty. In order to be eligible for the extension of eligibility, the child must have been a full-time student eligible for health insurance coverage under their parent's health insurance policy and either:

A member of the Pennsylvania National Guard or any reserve component of the armed forces of the United States who was called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days; or

A member of the Pennsylvania National Guard ordered to active State duty, including duty under 35 Pa.C.S. Ch. 76 (relating to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

The extension of eligibility will apply so long as the child maintains enrollment as a full-time student, and shall be equal to the duration of service on active duty or active State duty.

In order to qualify for this extension of eligibility the child or Subscriber must submit the following forms to Capital:

- The form approved by the Pennsylvania Department of Military and Veterans Affairs which notifies an insurer that the Dependent has been placed on active duty;
- The form approved by the Pennsylvania Department of Military and Veterans Affairs which notifies an insurer that the Dependent is no longer on active duty;
- The form approved by the Pennsylvania Department of Military and Veterans Affairs which shows that the Dependent has reenrolled as a full-time student for the first term or semester starting 60 or more days after the Dependent's release from active duty.

The above forms can be obtained by contacting the Pennsylvania Department of Military and Veterans Affairs or visiting their website.

RECORDS AND CHANGES OF MEMBER ELIGIBILITY

Death of Subscriber

In the event of the death of the Subscriber, that coverage shall terminate at the end of the last period for which payment was accepted by the HMO. The spouse of the deceased Subscriber, if covered under the Agreement, shall become the "Applicant" under the Agreement and eligible Dependents will continue as the Subscriber's Dependents under the Agreement.

Divorce of Dependent Spouse

If a Dependent spouse is divorced from the Subscriber, coverage of such Dependent spouse under this Agreement shall terminate at the end of the last period for which payment was accepted by the HMO. The terminated spouse shall be entitled, by applying within sixty (60) days of such termination, to direct pay coverage of the same type for which the terminated spouse is then qualified at the rate then in effect.

Dependent Child Attainment of Limiting Age for Dependents

The eligibility of a Dependent child will terminate on Limiting Age for Dependents, except if the child is a full-time student as defined under Section EL - Eligibility, Change, and Termination Rules Under The Plan of this Agreement. The coverage for such child will terminate at the end of the last period for which Premium was accepted by the HMO. No Premium shall be accepted under this Agreement on behalf of a child for any period for which such child is not an eligible Dependent. However, in the event the HMO accepts Premium for coverage beyond the date eligibility ends for such child, coverage for the child will be extended until the end of the period for which premium was paid. Such child shall be entitled to direct pay coverage of the same or similar type for which he is then qualified by applying within sixty (60) days of such termination.

Change of Status

It shall be the responsibility of the Subscriber to notify the HMO within thirty (30) days of any changes which affect the eligibility of a Member for Benefits under this Contract. The HMO will provide coverage, and terminate coverage, in reliance on the timely notification of the eligibility of a Member. If a Subscriber fails to notify the HMO in a timely manner of the eligibility status of a particular Member, the HMO will provide and terminate coverage in accordance with any HMO administrative processes.

All of the following are changes require the Subscriber to notify the HMO:

- Name
- Address
- Status or number of dependents
- Marital status
- Eligibility for Medicare

Change of Residence

It shall be the responsibility of the Member to notify the HMO within thirty (30) days of any change of a Member's residence. If the Member moves to an area that is not within Keystone's Approved Service Area, the Member's coverage will be terminated.

You must notify the HMO of any changes in Dependent coverage in order to ensure coverage for all eligible family Members.

TERMINATION OF COVERAGE

Benefits continue for one (1) month from the Effective Date of this Agreement and continue from month-to-month thereafter upon renewal of this Agreement and until discontinued, terminated, or voided as provided in this Agreement.

The Subscriber may terminate this Agreement as follows:

The Subscriber may cancel this Agreement on the last day of any calendar month by giving written notice to Keystone at least thirty-one (31) days in advance.

The HMO may terminate this Agreement as follows:

1. The Subscriber's non-payment of Premiums (subject to a 30-day grace period) in accordance with this Agreement; or

2. Upon thirty (30) days written notice to the Subscriber if a Member participated in fraudulent behavior related to the terms of his or her coverage under this Agreement, including but not limited to:

   a. Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts. This includes, but is not limited to, using an Identification Card to obtain goods or services which are not prescribed or ordered for him/her or to which he/she is otherwise not legally entitled. In this instance coverage for the Subscriber and all Dependents will be terminated; or

   b. Allowing any other person to use an Identification Card to obtain services. If a Dependent allows any other person to use his/her Identification Card to obtain services, the coverage of the Dependent who allowed the misuse of the card will be terminated. If the Subscriber allows any other person to use his/her Identification Card to obtain services, the coverage of the Subscriber will be terminated; or

   c. Knowingly misrepresenting or giving false information on any enrollment application which is material to keystone's acceptance of such application.

   In lieu of terminating coverage for the Subscriber and all Dependents, and at the sole discretion of Keystone, Keystone may allow coverage under this Agreement to continue upon payment by the subscriber of the correct Premium for the risk presented both (a) back to inception of the Agreement and (b) moving forward from the date of notice by Keystone of a correction in the Premium.

3. The Subscriber resides outside of the Keystone Approved Service Area;

4. Keystone ceases to offer this coverage, provided that Keystone provides the Subscriber with ninety (90) days prior notice of the discontinued coverage; provided, however, the Subscriber is offered, on a guaranteed issue basis, the option to purchase any guaranteed issue individual health care product offered by Keystone;

5. Keystone ceases to offer all health insurance coverage in the individual market in Pennsylvania, provided that Keystone provides the Subscriber with 180 days prior notice.

   This Agreement shall terminate at 12:01 a.m. on the date reflected on the records of the HMO.

OBLIGATIONS ON TERMINATION OF THE AGREEMENT

Non-Payment of Premium

This Agreement has a regular grace period of thirty (30) days. This means that if a payment is not made on or before the date it is due, it may be paid during the grace period. During the grace period the Agreement will stay in force, unless prior to the date payment was due, the Subscriber gave timely written notice to the HMO that the Agreement is to be cancelled.

If the Subscriber does not make payment during the grace period, the Agreement will be cancelled effective on the last day of the grace period and the HMO will have no liability for services which are incurred after the grace period. The HMO has the right to collect all outstanding premiums, including the premium for the grace period, from the Subscriber.

Inpatient Provision

When this Agreement is terminated, except for termination for incorrect information or material misrepresentation, and a Member is receiving inpatient services billed by a hospital or skilled nursing facility

on the date of termination, benefits will continue to be provided only up to the date of discharge or up to the expiration of eligible benefit days, whichever occurs first. This provision does not apply to services rendered by a second facility provider if the Member is transferred from one facility provider to another if the first facility provider is able to treat the Member's condition at the appropriate level.

Totally Disabled

If a Member is Totally Disabled at the date of termination of coverage, the Benefits of this Agreement shall be furnished for Benefits directly related to the condition causing such Total Disability and for no other condition, illness, disease or injury.

Benefits under this provision for Total Disability shall be provided:

i. up to a maximum period of twelve (12) consecutive months; or

ii. until the maximum amount of Benefits has been paid; or

iii. until the Total Disability ends; or

iv. until the Member becomes covered, without limitation as to the disabling condition, under any other coverage;

whichever occurs first.

Pregnancy

If Keystone elects to terminate this Agreement and a Member is pregnant at the termination date, benefits for pregnancy care will be provided, as set forth in the Section CS - Description of Covered Services. However, if termination of the Agreement is the result of non-payment of Premiums, the liability of Keystone shall cease as of the date of such termination, and no benefits will be provided for pregnancy care incurred after that date.

CONVERSION

In the event of the death of the Subscriber, coverage for the Subscriber shall terminate at the end of the last period for which Premium was accepted by Keystone. The spouse of the deceased Subscriber, if covered under the Agreement, shall become the new "Subscriber" under the Agreement, eligible Dependents will continue as Members under the Agreement. The Premium for continuation of the Agreement shall be the Premium rate applicable to the attained age of the new Subscriber and, if eligible Dependents are covered as Members, the applicable type of policy.

SECTION CSD – COST SHARING DESCRIPTIONS

This section of the Agreement describes the cost-sharing that may be required under this coverage with Keystone.

Since Cost-Sharing Amounts vary depending on the Member's specific coverage, it is important that the Member refers to the **Schedule of Cost Sharing** section of this Agreement for information on the specific cost-sharing and the applicable Cost-Sharing Amounts that are required under this coverage.

APPLICATION OF COST-SHARING

All payments made by Keystone for benefits are based on the Allowable Amount. The Allowable Amount is the maximum amount that Keystone will pay for benefits under this coverage. Before Keystone makes payment, any applicable Cost-Sharing Amount is subtracted from the Allowable Amount.

Payment for benefits may be subject to any of the following cost-sharing in the following order of application:

1. Copayments
2. Deductibles
3. Coinsurance
4. Out-of-Pocket Maximums

In addition, Members are responsible for payment of any services for which benefits are not provided under the Member's coverage, without regard to the Provider's participation status.

Under certain circumstances, if Keystone pays the healthcare provider amounts that are the Member's responsibility, such as Deductible, Copayments or Coinsurance, Keystone may collect such amounts directly from the Member. The Member agrees that Keystone has the right to collect such amounts from the Member.

COPAYMENT

A Copayment is a fixed dollar amount that a Member must pay directly to the Provider for certain benefits at the time services are rendered. Copayment amounts may vary, depending on the type of service for which benefits are being provided and/or the type of Provider performing the service.

For Example: The charge for a particular service provided by a Participating Provider is set by the Participating Provider's contract with Keystone to pay at an Allowable Amount of $60. If the Member's coverage includes a $10 Copayment, the Participating Provider may collect $10 from the Member at the time services are performed. This Copayment is part of the Allowable Amount for the benefit provided under the Member's coverage. Since the Participating Provider already received $10 from the Member, Keystone will reimburse the Participating Provider a maximum of $50 for the service. The Participating Provider still receives the total Allowable Amount of $60; it is just shared between the Member and Keystone.

In this example, payment for the claim is calculated as follows:

Subtract the Copayment paid by the Member from the Allowable Amount to determine Keystone's payment to the Participating Provider ($60 – $10 = $50).

The Member in this example would be responsible for paying the Participating Provider $10, and Keystone would be responsible for paying the Participating Provider $50. So, in the end, the Participating Provider receives a total of $60 (the Allowable Amount).

Members should refer to the **Schedule of Cost-Sharing** section of this Agreement to determine if any Copayments apply to their coverage.

DEDUCTIBLE

A Deductible is a dollar amount that an individual Member or a Subscriber's entire family must incur before benefits are paid under this coverage. The Allowable Amount that Keystone otherwise would have paid for benefits is the amount applied to the Deductible.

For Example: The charge for a particular service provided by a Participating Provider is set by the Participating Provider's contract with Keystone to pay at an Allowable Amount of $60. If the Member's coverage includes a $500 Deductible for Participating Provider benefits, and assuming a Copayment is not applied, the Member is responsible for this $60. The Participating Provider will collect this amount from the Member. Keystone will then apply this $60 towards the $500 Deductible applicable to the Member's coverage. So, on the Member's $500 Deductible, the remaining Deductible amount which must be met would be $440.

In this example, payment for the claim is calculated as follows:

Subtract the Allowable Amount from the Member's total Deductible amount to determine the remaining Deductible amount the Member must meet ($500 - $60 = $440).

For each Deductible amount that may apply to this coverage, two (2) Deductible amounts may apply: an individual Deductible and a family Deductible. Each Member must satisfy the individual Deductible applicable to this coverage every Agreement Year before benefits are paid. Once the family Deductible has been met, benefits will be paid for a family Member regardless of whether that family Member has met his/her individual Deductible. In calculating the family Deductible, Keystone will apply the amounts satisfied by each Member towards the Member's individual Deductible. However, the amounts paid by each Member that count towards the family Deductible are limited to the amount of each Member's individual Deductible.

Members should refer to the **Schedule of Cost-Sharing** section of this Agreement to determine if any Deductible applies to their coverage.

COINSURANCE

Coinsurance is the percentage of the Allowable Amount payable for a benefit that Members are obligated to pay.

For Example: The charge for a particular service provided by a Participating Provider is set by the Participating Provider's contract with Keystone to pay at an Allowable Amount of $60. Assuming no Copayment is applied, any applicable Deductible has been met, and the Member's coverage includes a 10% Coinsurance for Participating Provider services, the Allowable Amount of $60 will be multiplied by 10%, which equals $6. This $6 will then be subtracted from the Allowable Amount of $60, leaving $54, which Keystone will reimburse the Participating Provider. The Participating Provider will then collect the $6 from the Member.

In this example, payment for the claim is calculated as follows:

1. Multiply the Allowable Amount by the Coinsurance percentage to determine the Member's liability ($60 x 10% = $6).

2. Subtract the Coinsurance amount from the Allowable Amount to determine Keystone's payment to the Participating Provider ($60 – $6 = $54).

The Member in this example would be responsible for paying the Participating Provider $6, and Keystone would be responsible for paying the Participating Provider $54. So, in the end, the Participating Provider receives a total of $60 (the Allowable Amount).

Members should refer to the **Schedule of Cost-Sharing** section of this Agreement to determine if Coinsurance applies to their coverage.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the maximum amount of all Cost Sharing that an individual Member or a Subscriber's entire family must pay during an Agreement Year.

For Example: Expanding on the previous Coinsurance example, the Member owes the Participating Provider $6 after Coinsurance was applied to the Allowable Amount for the benefits provided under this coverage. This $6 is the Member's "out-of-pocket" expense. If the Member's coverage includes an Out-of-Pocket Maximum of $1,000, this $6 is applied to the $1,000. The result is that the Member must pay $994 in additional out-of-pocket expenses during the Agreement Year before the Coinsurance is waived and benefits pay at 100% of the Allowable Amount.

In this example, payment for the claim is calculated as follows:

Subtract the Coinsurance amount from the Member's total Out-of-Pocket Maximum amount to determine the remaining Out-of-Pocket Maximum amount the Member must meet ($1,000 - $6 = $994).

For each Out-of-Pocket Maximum amount that may apply to this coverage, two (2) Out-of-Pocket Maximum amounts may apply: an individual Out-of-Pocket Maximum and a family Out-of-Pocket Maximum. Each Member must satisfy the individual Out-of-Pocket Maximum applicable to this coverage every Agreement Year. Once the family Out-of-Pocket Maximum has been met, benefits will be paid for a family Member regardless of whether that family Member has met his/her individual Out-of-Pocket Maximum. In calculating the family Out-of-Pocket Maximum, Keystone will apply the amounts satisfied by each Member toward the Member's individual Out-of-Pocket Maximum. However, the amounts paid by each Member that count towards the family Out-of-Pocket Maximum are limited to the amount of each Member's individual Out-of-Pocket Maximum.

The out-of-pocket maximum amount can be satisfied with eligible amounts incurred for medical benefits, prescription drug benefits, pediatric dental benefits (if covered by Capital Advantage Assurance Company and included as part of the medical plan), pediatric vision benefits, or a combination of all benefits.

Members should refer to the **Schedule of Cost-Sharing** section of this Agreement to determine if any out-of-pocket maximums apply to their coverage.

SECTION CS - DESCRIPTION OF COVERED SERVICES

Subject to the Exclusions, conditions and limitations specified in this Agreement, a Member shall be entitled to receive the Covered Services listed below. A Member may be required to make a Copayment or there may be limits on services and other cost sharing requirements as specified in the Section SC - Schedule Of Cost Sharing of this Agreement.

Most Covered Services are provided or arranged by a Member's Primary Care Physician. In the event there is no Participating Provider to provide the specialty or subspecialty services that a Member needs, a Referral to a Non- Participating Provider will be arranged by the Member's Primary Care Physician, with approval by the HMO. See Section ACC - Access to Primary, Specialist and Hospital Care Network for procedures for obtaining Preauthorization for use of a Non-Participating Provider.

If a Member should have questions about any information in this Agreement or need assistance at any time, they should contact Keystone by calling the telephone number shown on their ID Card.

Some Covered Services must be Preauthorized before a Member receives the services. The Primary Care Physician or Participating Specialist must seek the HMO's approval and confirm that coverage is provided for certain services. Preauthorization of services is a vital program feature that reviews Medical Necessity of certain procedures and/or admissions. In certain cases, Preauthorization helps determine whether a different treatment may be available that is equally effective yet less traumatic. Preauthorization also helps determine the most appropriate setting for certain services. If a Primary Care Physician or Participating Specialist provides Covered Services or Referrals without obtaining such Preauthorization, the Member will not be responsible for payment. More information on Preauthorization is found in Section MC - Using the HMO System of this Agreement and the Medical Care Preauthorization Schedule attached to this Agreement.

PRIMARY AND PREVENTIVE CARE

Members are entitled to benefits for Primary and Preventive Care Covered Services. These Covered Services are provided or arranged by the Member's Primary Care Physician, as noted. The Primary Care Physician will provide a Referral, when one is required, to a Participating Professional Provider when the Member's condition requires a Specialist's Services.

Services resulting from Referrals to Non-Participating Providers will be covered when the Referral is issued by a Member's Primary Care Physician and Preauthorized by Keystone. The Referral is valid for ninety (90) days from date of issue so long as the Member is still enrolled in this plan. Self-Referrals are excluded, except for Emergency Care. Additional Covered Services recommended by the Referred Specialist will require another Referral from the Member's Primary Care Physician.

"Preventive Care" services generally describe health care services performed to catch the early warning signs of health problems. These services are performed when a Member has no symptoms of disease.

"Primary Care" services generally describe health care services performed to treat an illness or injury.

Keystone periodically reviews the Primary and Preventive Care Covered Services based on recommendations from organizations such as The American Academy of Pediatrics, The American College of Physicians, the U.S. Preventive Services Task Force and The American Cancer Society. Accordingly, the frequency and eligibility of Covered Services are subject to change. Keystone reserves the right to modify coverage for these Covered Services at any time after written notice of the change has been given to the Member.

A. **Office Visits**

Medical Care visits for the exam, diagnosis and treatment of an illness or injury by a Member's Primary Care Physician. This also includes physical exams and routine child care, including well-baby visits.

For the purpose of this benefit, Office Visits include Medical Care visits to a Member's Primary Care Physician's office, during and after regular office hours, Emergency visits and visits to a Member's residence, if within Keystone's Approved Service Area.

B. **Pediatric and Adult Preventive Care**

Benefits for preventive care are highlighted on the Schedule of Preventive Care Services guidelines attached to this Agreement. These guidelines are periodically updated to reflect current recommendations from organizations such as the American Academy of Pediatrics (AAP), U.S. Preventive Service Task Force (USPSTF), and Advisory Committee on Immunization Practices (ACIP). This document is not intended to be a complete list of preventive care services and is subject to change.

Services that need to be performed more frequently than stated in the Schedule of Preventive Care Services guidelines attached to this Agreement due to high-risk situations are covered when the diagnosis and procedure(s) are otherwise covered. Keystone follows guidelines set by the Center for Disease Control in determining high-risk individuals. These services are subject to all applicable Cost Sharing Amounts.

C. **Routine Gynecological Exam, Pap Smear**

Female Members are covered for one (1) routine gynecological exam each calendar year. This includes a pelvic exam and clinical breast exam; and routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists. Female Members have "direct access" to care by an Obstetrician or Gynecologist. This means there is no Primary Care Physician Referral needed.

D. **Mammograms**

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

E. **Nutrition Counseling for Weight Management**

Benefits are provided for nutrition counseling visits/sessions for the purpose of weight management when performed by the Member's PCP or a Registered Dietitian (RO).

This benefit is in addition to any other nutrition counseling Covered Services described in this Agreement.

INPATIENT COVERED SERVICES

Services for Inpatient Care are Covered Services when:

- Medically Necessary;
- Provided or Referred by the Member's Primary Care Physician; and
- Preauthorized by Keystone. Services that must be Preauthorized are in the Medical Care Preauthorization Schedule attached to this Agreement.

Services resulting from Referrals to Non-Participating Providers will be covered when the Referral is issued by your Primary Care Physician and Preauthorized by Keystone. A Member's Referral is valid for ninety (90) days from date of issue. Self-Referrals are excluded, except for Emergency Care. Additional Covered Services recommended by the Referred Specialist will require another electronic Referral from your Primary Care Physician.

A. **Hospital Services**

1. Ancillary Services

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

- Drugs and medicines provided for use while an inpatient;
- Use of operating or treatment rooms and equipment;
- Oxygen and administration of oxygen;
- Administration of whole blood, blood plasma and blood components when medically necessary to include the processing and preparation; and
- Medical and surgical dressings, casts and splints.

2. Room and Board

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

- A semi-private room (two or more beds);
- A bed in a special accommodations unit; or
- A private room, if Medically Necessary or if no semi-private accommodations are available. A private room is not Medically Necessary when used solely for the comfort and/or convenience of the Member. When a private room is selected at the Member's option, the Member is responsible for paying ten percent (10%) of the hospital's private room charge.

B. **Medical Care**

Medical Care rendered by a Participating Professional Provider in charge of the Member's case while an Inpatient in a Participating Facility Provider that is a Hospital, Rehabilitation Hospital or Skilled Nursing Facility for a condition not related to Surgery or pregnancy, or except as specifically provided. Such care includes Inpatient intensive Medical Care rendered to a Member while their condition requires a Referred Specialist's constant attendance and treatment for a prolonged period of time.

1. Concurrent Care

Services rendered to a Member while an Inpatient in a Participating Facility Provider that is a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Referred Specialist 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 Member, standby services, routine preoperative physical exams or Medical Care routinely performed in the pre- or post-operative or pre- or post- natal periods or Medical Care required by the Participating Facility Provider's rules and regulations.

2. Consultations

Consultation services when rendered to a Member during an Inpatient Stay in a Participating Facility Provider that is a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Referred Specialist at the request of the attending Professional Provider. Consultations do not include staff consultations which are required by the Participating Facility Provider's rules and regulations.

C. **Skilled Nursing Care Facility**

Benefits are provided for a Participating Skilled Nursing Care Facility, when Medically Necessary as determined by Keystone.

A Member must require treatment by skilled nursing personnel which can be provided only on an Inpatient basis in a Skilled Nursing Care Facility.

During a Member's admission, members of Keystone's Care Management and Coordination team are monitoring their stay to assure that a plan for the Member's discharge is in place. This is to make sure that a Member has a smooth transition from the facility to home or other setting. A Keystone Case Manager will work closely with the Member's Primary Care Physician or the Participating Specialist to help with the Member's discharge and if necessary, arrange for other medical services.

Should the Member's Primary Care Physician or Participating Specialist agree with Keystone that continued stay in a Skilled Nursing Facility is no longer required, the Member will be notified in writing of this decision. Should the Member decide to remain in the facility after this notification, the facility has the right to bill them after the date of the notification. A Member may appeal this decision through the Grievance Appeal Process.

INPATIENT/OUTPATIENT COVERED SERVICES

Services for Inpatient / Outpatient Care are Covered Services when:

- Medically Necessary;
- Provided or Referred by the Member's Primary Care Physician; and
- Preauthorized by Keystone, where specified.

Services resulting from Referrals to Non-Participating Providers will be covered when the Referral is issued by the Member's Primary Care Physician and Preauthorized by Keystone. A Member's Referral is valid for ninety (90) days from date of issue. Self-Referrals are excluded, except for Emergency Care. Additional Covered Services recommended by the Referred Specialist will require another Referral from the Member's Primary Care Physician.

A. **Hospice Services**

Hospice care involves palliative care to terminally ill Members and their families with such services being centrally coordinated through a multi-disciplinary team directed by a Physician. Most hospice care is provided in the Member's home or facility that the Member has designated as home. (i.e. Assisted Living Facility, Nursing Home, etc.) All eligible hospice services must be billed by the hospice provider.

Benefits for hospice care include the following services provided to a Member by a hospice provider responsible for the Member's overall care:

- Professional services provided by a registered nurse or licensed practical nurse;
- Palliative care by a Physician;
- Medical and surgical supplies and durable medical equipment;
- Prescribed drugs related to the hospice diagnosis (drugs and biologicals);
- Oxygen and its administration;
- Therapies (physical medicine, occupational therapy, speech therapy);
- Medical social service consultations;
- Dietitian services;
- Home health aide services;
- Family counseling services;
- Continuous Home Care provided only during a period of crisis in which a patient requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms; and

- Inpatient services of an acute medical nature arranged through the hospice provider in a hospital or skilled setting to address short-term pain and/or symptom control that cannot be managed in other settings.

The member is not eligible to receive further hospice care benefits if the member or the member's authorized representative elects to institute curative treatment or extraordinary measures to sustain life.

Benefits for Covered Hospice Services are provided until the earlier date of your death or discharge from Hospice Care.

Respite Care

When Hospice Care is provided primarily in the home, such care on a short-term Inpatient basis in a Medicare-certified Skilled Nursing Facility will also be covered when the Hospice considers such care necessary to relieve primary caregivers in the home.

B. **Maternity and Obstetrical Care Services**

1. Maternity/Obstetrical Care

Services rendered in the care and management of a Member's pregnancy are Covered Services under this plan. The Member's Obstetrician or Gynecologist will notify Keystone of their maternity care visit. Covered Services include: (1) facility services provided by a Participating Facility Provider that is a Hospital or Birth Center; and (2) professional services performed by an Obstetrician or Gynecologist that is a Physician or a certified nurse midwife. Benefits are also payable for certain services provided by an Obstetrician or Gynecologist for elective home births.

Under federal law, health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce out-of-pocket costs, Members may be required to obtain Precertification. For information on Precertification, contact the plan administrator.

2. Interruptions of Pregnancy

Benefits are provided for Hospital services and medical/surgical services rendered by a Provider only when abortion is necessary to avert the death of the mother and in cases of rape and/or incest. No other Benefits are provided for interruptions of pregnancy under this Agreement.

3. Newborn Care

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

If a Deductible applies to the Member's coverage, only one facility provider Deductible will be applied when the mother and newborn are discharged from the Hospital. If the newborn remains in the Hospital after the mother is discharged or if the newborn is transferred to another Hospital, another individual Deductible will not need to be met before eligible claims are paid for the newborn.

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

If a Member 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 either the Member's referring provider is a Participating Provider who has concluded the Member's participation in the trial would be appropriate, or the Member furnishes medical and scientific information establishing that his or her participation in the trial would be appropriate, benefits shall be payable for routine patient costs for items and services furnished in connection with the trial. Keystone must be notified in advance of the Member's participation in the qualifying clinical trial.

D. **Surgical Services**

Covered Services for Surgery include services provided by a Participating Provider, professional or facility, for the treatment of disease or injury. Separate payment will not be made for Inpatient preoperative care or all postoperative care normally provided by the surgeon as part of the surgical procedure.

1. Mastectomy Care

Coverage for the following when performed subsequent to mastectomy: Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy. Coverage is also provided for:

a. The surgical procedure performed in connection with the initial and subsequent, insertion or removal of prosthetic devices to replace the removed breast or portions thereof; and

b. The treatment of physical complications at all stages of the mastectomy, including lymphedemas.

2. Routine neonatal circumcisions and any voluntary surgical procedure for sterilization.

3. Hospital Admission for Dental Procedures or Dental Surgery.

Benefits will be payable for a Hospital admission in connection with dental procedures or Surgery only when the Member has an existing non-dental physical disorder or condition and hospitalization is Medically Necessary to ensure your health. Dental procedures or Surgery performed during such a confinement will only be covered for the services described below.

4. Oral Surgery

Benefits for oral surgery include root recovery, surgical exposure of impacted or unerupted teeth, fractures and dislocations of the face or jaw, surgical excisions (e.g., cysts, tori, exostosis), dental implants for the treatment of oral cancer and cancer of the esophagus, and lingual frenulum repairs under certain conditions. Orthognathic surgery is limited to conditions resulting in significant functional impairment, or for the treatment of congenital birth defects in newborns, as required by law.

Anesthesia charges associated with oral surgery are covered for Member's who are seven (7) years of age or younger and Members who are developmentally disabled when determined by Keystone to be Medically Necessary and when a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected under general anesthesia. Anesthesia and all related benefits for Members seven (7) years of age or younger and Members who are developmentally disabled are subject to all applicable cost-sharing amounts.

5. Anesthesia

Administration of Anesthesia in connection with the performance of Covered Services when rendered by or under the direct supervision of a Participating Specialist other than the surgeon, assistant surgeon or attending Participating Specialist.

Hospitalization and all related medical expenses normally incurred as a result of the administration of general anesthesia in a Hospital or Ambulatory Surgical Facility in connection with the performance of non-covered dental procedures or non covered oral surgery are covered for Members who are seven (7) years of age or younger and Members who are developmentally disabled when determined by Keystone to be Medically Necessary and when a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected under general anesthesia.

Anesthesia and all related benefits for Members seven (7) years of age or younger and Members who are developmentally disabled are subject to Preauthorization requirements as set forth on the Medical Care Preauthorization Schedule as well as applicable cost-sharing amounts.

E. **Transplant Services**

Eligibility for Covered Services related to human organ, bone and tissue transplant are as follows. When the Member is the recipient of transplanted human organs, marrow, or tissues, benefits are provided for all Covered Services. Covered Services for Inpatient and Outpatient Care related to the transplant include procedures which are generally accepted as not Experimental/Investigational Services by medical organizations of national reputation. These organizations are recognized by the HMO as having special expertise in the area of medical practice involving transplant procedures. Benefits are also provided for those services which are directly and specifically related to the Member's covered transplant. This includes services for the examination of such transplanted organs, marrow, or tissue and the processing of blood provided to the Member.

The determination of Medical Necessity for transplants will take into account the proposed procedure's suitability for the potential recipient and the availability of an appropriate facility for performing the procedure.

Eligibility for Covered Services related to human organ, bone and tissue transplant are as follows. If a human organ or tissue transplant is provided from a donor to a human transplant recipient:

1. When both the recipient and the donor are Members, each is entitled to the benefits of this plan.

2. When only the recipient is a Member, both the donor and the recipient are entitled to the Benefits of this Agreement. However, donor Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program.

3. When only the donor is a Member, the donor is entitled to the Benefits of this Agreement, subject to following additional limitations:

    a. The Benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this Agreement; and

    b. No Benefits will be provided to the non-Member transplant recipient.

4. If any organ or tissue is sold rather than donated to the Member recipient, no Benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered. Benefits for a covered transplant procedure shall include coverage for the

medical expenses of a live donor to the extent that those medical expenses are not covered by another program.

Covered Services of a donor include:

- Removal of the organ;
- Preparatory pathologic and medical examinations; and
- Post-surgical care.

Blue Distinction Centers for Transplant (BDCT)

Blue Distinction Centers for Transplant are a cooperative effort of the Blue Cross and/or Blue Shield Plans, the BlueCross BlueShield Association and participating medical institutions to provide patients who need transplants with access to leading transplant centers through a coordinated, streamlined program of transplant management.

When a transplant is performed at a BDCT facility designated for that transplant type, certain Benefits are provided for travel, lodging, and meal expenses for the Member and one support companion, subject to the limitations set forth in Section A of this Medical Care Schedule of Benefits. Items that are not covered expenses include, but are not limited to, alcohol, tobacco, car rental, entertainment, expenses for persons other than the Member and the Member's companion, phone calls, and personal care items.

F. **Mental Health Care Services**

Benefits for mental health care services include services for mental illness diagnoses. Substance abuse treatment is defined under a separate benefit.

1. Inpatient Services

Benefits for inpatient mental health care services include bed, board and general inpatient nursing services when provided for the treatment of mental illness. Services provided by a professional provider to a Member who is an inpatient for mental health care are also covered.

2. Partial Hospitalization

Benefits for partial hospitalization mental health care services include the treatment of a mental illness in a planned therapeutic program during the day only or during the night only.

The partial hospitalization program must be approved by Keystone Health Plan Central or its designee. Partial hospitalization mental health care is not covered for halfway houses and residential treatment facilities.

3. Outpatient Services

Benefits for outpatient mental health care services include the outpatient treatment of mental illness by a hospital, a physician or another eligible provider.

Attention deficit/hyperactivity disorder (ADHD) is classified as a mental health condition. Treatments for ADHD are eligible under mental health care benefits including medication checks by a Provider other than the Member's PCP. However, medication checks provided by a Member's PCP are considered medical visits.

G. **Substance Abuse Services**

Substance abuse is the use of alcohol or other drugs at dosages that place a Member's social, economic, psychological, and physical welfare in potential hazard, or endanger public health, safety, or welfare. Benefits for the treatment of substance abuse includes detoxification and rehabilitation.

1. Detoxification - Inpatient

   Benefits for inpatient detoxification include services to assist an alcohol and/or drug intoxicated or dependent member in the elimination of the intoxicating alcohol or drug as well as alcohol or drug dependency factors while minimizing the physiological risk to the member.

   Services must be performed under the supervision of a licensed physician and in a facility licensed by the state in which it is located.

2. Rehabilitation

   Benefits for substance abuse rehabilitation include services to assist Members with a diagnosis of substance abuse in overcoming their addiction. Members must be detoxified before rehabilitation will be covered. A substance abuse treatment program provides rehabilitation care.

   Inpatient — Benefits for inpatient substance abuse rehabilitation include: bed, board and general inpatient nursing services. Substance abuse care provided by a professional provider to a Member who is an inpatient for substance abuse rehabilitation is also covered.

   Residential treatment facilities are not covered, other than sub-acute facilities when medical management services are provided.

   Outpatient — Benefits for outpatient substance abuse rehabilitation include services that would be covered on an inpatient basis but are otherwise provided for outpatient or partial hospitalization.

   To be eligible for coverage, these services must be provided by a physician, psychologist, or other eligible provider employed by a licensed substance abuse treatment facility. Otherwise, professional provider services for substance abuse treatment are not eligible for coverage nor are these services eligible under outpatient mental health care benefits.

OUTPATIENT COVERED SERVICES

Services for Outpatient Care are Covered Services when:

- Medically Necessary;
- Provided or Referred by the Member's Primary Care Physician; and
- Preauthorized by the HMO, where specified.

Services resulting from Referrals to Non-Participating Providers will be covered when the Referral is issued by a Member's Primary Care Physician and Preauthorized by the HMO. The Referral is valid for ninety (90) days from date of issue. Self-Referrals are excluded, except for Emergency Care. Additional Covered Services recommended by the Participating Specialist will require another Referral from your Primary Care Physician.

A. Allergy Testing

Benefits for allergy services include testing, immunotherapy, and allergy serums.

1. Testing – Benefits for tests used in the diagnosis of allergy to a particular substance include direct skin testing (percutaneous, intracutaneous) as well as in vitro techniques (i.e., RAST, MAST, FAST).

2. Immunotherapy – Immunotherapy refers to the treatment of disease by stimulating the body's own immune system and involves injections over a period of time in order to reduce the potential for allergic reactions.

   Benefits for immunotherapy include therapy provided to individuals with a demonstrated hypersensitivity that cannot be managed by avoidance or environmental controls.

   However, certain methods of treatment, which are Investigational, as well as items that are for personal convenience (i.e., pillows, mattress casing, air filter, etc.) are not covered.

3. Allergy Serums – Benefits for allergy serums include the immunizing agent (serum) used in immunotherapy injections as long as the immunotherapy itself is covered.

B. Chemotherapy

Chemotherapy involves the treatment of infections or other diseases with chemical or biological antineoplastic agents approved by and used in accordance with the Food and Drug Administration (FDA) guidelines. Benefits for chemotherapy include chemotherapy drugs (except for outpatient oral chemotherapy drugs) and the administration of these drugs provided in either an inpatient or outpatient setting.

C. Emergency and Urgent Care Services

1. Emergency Services - An Emergency Service is any health care service provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

   - Placing the health of the Member, or with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;
   - Serious impairment to bodily functions;
   - Serious dysfunction of any bodily organ or part; or
   - Other serious medical consequences.

   Benefits for Emergency Services include the initial evaluation, treatment and related services, such as diagnostic procedures provided on the same day as the initial treatment.

   Inpatient Hospital stays as a result of an emergency are reimbursed at the level of payment for Inpatient Benefits. Consultations received in the emergency room are subject to the applicable Outpatient consultation Copayment.

   When Emergency Services are provided by Non-Participating Providers, Benefits will be provided at the in-network benefit level. Members will be responsible for any applicable Cost-Sharing Amounts such as Deductibles, Coinsurance, and Copayments. In situations where emergency services cannot reasonably be attended to by a preferred provider, the Member is not liable for a greater out-of-pocket expense than if they had been attended to by a preferred provider.

   Benefits for emergency dental accident services include treatment required only to stabilize the Member immediately following an accidental injury. Treatment of accidental injuries resulting from chewing or biting is not covered.

If Keystone, upon reviewing the emergency room records, determines that the services provided do not qualify as Emergency Services, those non-emergency services may not be covered or may be reduced according to the limitations of this coverage.

2. Urgent Care Services - Benefits for services performed in an Urgent Care center include those that, in the judgment of the Provider, are non-life threatening and urgent and can be treated on other than an Inpatient hospital basis and are performed at a freestanding Urgent Care center by a duly licensed associated Physician or allied health professional practicing within the scope of his/her licensure and specialty. Urgent Care services are performed in an ambulatory medical clinic that is open to the public for walk-in, unscheduled visits during all open hours offering significant extended hours, which may include evenings, holidays and weekends.

D. Diabetes Services

Unless otherwise covered under a Prescription Drug Rider or Policy, coverage is included for drugs, including insulin, equipment, agents, and Orthotics used for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes when prescribed by a health care professional legally authorized to prescribe such items and are mandated by law.

Equipment, agents, and Orthotics shall include:

1. injectable aids (e.g., syringes)
2. pharmacological agents for controlling blood sugar
3. blood glucose monitors and related supplies
4. injection insulin infusion devices
5. Orthotics

To the extent described in Section SC - Schedule of Cost Sharing, Benefits include participation in a diabetes outpatient self-management training and education program under the supervision of a licensed health care professional with expertise in diabetes. Coverage for self-management education and education relating to diet and prescribed by a licensed Physician shall include:

1. Medically Necessary and Appropriate visits upon the diagnosis of diabetes; and
2. visits when a Physician identifies or diagnoses a significant change in the patient's symptoms or conditions that necessitates changes in a patient's self-management and when a new medication or therapeutic process relating to the patient's treatment and/or management of diabetes has been identified as Medically Necessary and Appropriate by a licensed Physician

E. Diagnostic Services

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

1. Routine Diagnostic Services, including routine radiology (consisting of x-rays, ultrasound and nuclear medicine), routine medical procedures (consisting of Electrocardiogram (ECG), Electroencephalogram (EEG), Nuclear Imaging, and other diagnostic medical procedures approved by Keystone) and allergy testing (consisting of percutaneous, intracutaneous and patch tests);
2. Non-Routine Diagnostic Services, including operative and diagnostic endoscopies, Magnetic Resonance Imaging/Magnetic Resonance Angiography (MRIIMRA), Positron Emission Tomography (PET Scan), and Computed Tomography (CT Scan); and

3. Diagnostic laboratory and pathology tests. Keystone uses several outpatient laboratory arrangements. A Member's ID Card includes a field titled "lab" that designates which laboratory is aligned with the Member's PCP. Members should give this lab indicator information to all providers to assist them in correctly routing laboratory services.

   In certain situations, an additional Cost-Sharing Amount may be associated with a lab service performed by a provider other than a physician's office or an Independent Clinical Lab (ICL). Members should consult with their PCP or Keystone prior to receiving services to determine whether an additional Cost-Sharing Amount applies.

F. Dialysis

Benefits will be provided for Medically Necessary dialysis services and supplies when Referred by the PCP. In the case of home dialysis, services include equipment, training, and medical supplies. The decision to purchase or rent necessary equipment for home dialysis will be made by Keystone.

G. Durable Medical Equipment (DME)

Benefits will be provided for Medically Necessary durable medical equipment when referred by the Keystone PCP, Preauthorized by Keystone (when applicable), and obtained from a participating outpatient durable medical equipment provider. A list of participating outpatient durable medical equipment providers can be found in the Keystone provider directory, as updated, and on Keystone's website at capbluecross.com.

Benefits for DME include reasonable repairs, adjustments and certain supplies that are necessary to utilize and maintain the DME in operating condition. Repair costs cannot exceed the purchase price of the DME. Routine periodic maintenance (e.g.: testing, cleaning, regulating and checking of equipment) for which the owner or vendor is generally responsible is not covered.

DME may be rented or purchased based upon:

- Member's condition at diagnosis;
- Member's prognosis;
- Anticipated time frame for utilization; and
- Total costs.

Reimbursement on a rental DME cannot exceed the lesser of the established fee schedule price, billed amount, usual or customary purchase price of the equipment. When DME is purchased by the Member, previous allowances for rental of the DME will be deducted from the amount allowed for the purchase of the DME.

Except in circumstances of risk of disability or death, there are generally no Benefits for replacement DME when repairs are due to equipment misuse and/or abuse or for replacement of lost or stolen items.

Examples of covered DME are wheelchairs, canes, walkers, and nebulizers when shown to be Medically Necessary. Examples of non-covered DME include but are not limited to iPads, home computers, laptops, and wearable activity or health monitors. Enteral pumps are only a covered DME when the enteral nutrition is considered Medically Necessary.

Medical supplies are medical goods that **support** the provision of therapeutic and diagnostic services but cannot withstand repeated use and are disposable or expendable in nature. Benefits for medical supplies include items such as hoses, tubes and mouthpieces that are medically necessary for proper functioning of covered durable medical equipment.

H. Enteral Nutrition

Enteral nutrition involves the use of special formulas and medical foods that are administered by mouth or through a tube placed in the gastrointestinal tract. Benefits for enteral nutrition include enteral nutrition products (i.e. special formulas and medical foods), as well as Medically Necessary enteral feeding equipment (e.g. pumps, tubing, etc).

Benefits for enteral nutrition products are included when administered by any method for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria. Covered enteral nutrition products for these four conditions are exempt from Deductibles.

Benefits for enteral nutrition products are also included for medical foods, as defined by the U.S. Food and Drug Administration, that are administered orally or through a tube, and that provide fifty (50%) percent or more of total nutritional intake.

Benefits for Medically Necessary enteral feeding equipment for feeding through a tube are included for individuals with functioning gastrointestinal tracts, but for whom oral feeding is impossible or severely limited.

I. Home Health Care

Home health care is Medically Necessary skilled care provided to a homebound patient for the treatment of an acute illness, an acute exacerbation of a chronic illness, or to provide rehabilitative services.

Benefits for home health care services provided to a homebound patient include:

- Professional services provided by a registered nurse or licensed practical nurse;
- Physical medicine, occupational therapy and speech therapy;
- Medical and surgical supplies provided by the home health care agency; and
- Medical social service consultation.

1. Home Health Care Visits Related to Mastectomies

   Benefits for home health care visits related to mastectomies include one (1) home health care visit, as determined by the Member's Physician, received within 48 hours after discharge, if such discharge occurs within 48 hours after an admission for a mastectomy.

2. Home Health Care Visits Related to Maternity

   Benefits for home health care visits related to maternity include one (1) home health care visit within 48 hours after discharge when the discharge occurs prior to 48 hours of inpatient care following a normal vaginal delivery or prior to 96 hours of inpatient care following a cesarean delivery. Home health care visits include, but are not limited to: parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests, and the performance of any necessary maternal and neonatal physical assessments. A licensed health care provider whose scope of practice includes postpartum care must make such home health care visits. At the mother's sole discretion, the home health care visit may occur at the facility of the provider. Home health care visits following an inpatient stay for maternity services are not subject to Copayments, Deductibles, or Coinsurance, if applicable to this coverage.

J. Infusion Therapy

Infusion therapy involves the administration of pharmaceuticals, fluids, and biologicals intravenously or through a gastrostomy tube. Infusion therapy is used for a broad range of therapies such as antibiotic therapy, chemotherapy, pain management, and hydration therapy. A home infusion therapy provider typically provides services in the home, but a patient is not required to be homebound.

Benefits for infusion therapy include the drugs and IV solutions, supplies and equipment used to administer the drugs, and nursing visits to administer the therapy.

K. Injectable Medications

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

Specialty Medical Injectable Pharmaceuticals require Preauthorization. Self-administered injectables may be covered under the Supplemental Drug Rider.

L. Medical Transport

Benefits are provided for ambulance services that are Medically Necessary, as determined by Keystone, for transportation in a specially designed and equipped vehicle used only to transport the sick or injured.

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

1. For Emergency Ambulance transport:

   Benefits for emergency ambulance services include transportation to an acute care hospital when the circumstances leading up to the ambulance services qualify as emergency services and the patient is transported to the nearest acute care hospital with appropriate facilities for treatment of the injury or illness involved.

   When Emergency Ambulance Services are provided by Non-Participating Providers, Benefits will be provided at the in-network benefit level. Members will be responsible for any applicable Cost-Sharing Amounts such as Deductibles, Coinsurance, and Copayments. In situations where emergency ambulance services cannot reasonably be attended to by a preferred provider, the Member is not liable for a greater out-of-pocket expense than if they had been attended to by a preferred provider.

   Emergency ambulance services are exempt from any applicable Deductible.

2. For Non-Emergency Ambulance transport:

   All non-emergency ambulance transports must be Preauthorized by Keystone to determine Medical Necessity which includes specific origin and destination requirements specified in Keystone’s policies.

   Non-emergency ambulance transports are not provided for the convenience of the Member, the family, or the Provider treating the Member.

M. Orthotic Devices

An orthotic device is a rigid or semi-rigid supportive device that restricts or eliminates motion of a weak or diseased body part. Benefits for orthotic devices include the purchase, fitting, necessary adjustment, repairs, and replacement of orthotic devices. Examples of orthotic devices are: diabetic shoes; braces for arms, legs, and back; splints; and trusses.

Diabetic shoes and foot orthotics mandated by Pennsylvania state law are covered. Also, orthopedic shoes and other supportive devices of the feet are covered only when they are an integral part of a leg brace. Otherwise, foot orthotics and other supportive devices for the feet are not covered.

N. Prosthetic Appliances

Prosthetic appliances replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body part that is lost or impaired as a result of disease, injury or congenital deficit regardless of whether they are surgically implanted or worn outside the body. The surgical implantation or attachment of covered prosthetics is considered Medically Necessary, regardless of whether the covered prosthetic is functional (i.e., irrespective of whether the prosthetic improves or restores a bodily function.)

Benefits for prosthetics include the purchase, fitting, necessary adjustment, repairs, and replacements after normal wear and tear of the most cost-effective prosthetic devices and supplies. Repair costs cannot exceed the purchase price of a prosthetic device. Prosthetics are limited to the most cost-effective Medically Necessary device required to restore lost body function.

Wigs are covered prosthetics in certain cases. In addition, the use of initial and subsequent prosthetic devices to replace breast tissue removed due to a mastectomy is covered. Glasses, cataract lenses and scleral shells prescribed after cataract or intra-ocular surgery **without** a lens implant, or used for initial eye replacement (i.e., artificial eye) are also covered.

The replacement of cataract lenses and certain dental appliances are not covered.

O. Radiation Therapy

Benefits will be provided for the treatment of disease by x-ray, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery, including the cost of radioactive materials supplied and billed by the Provider.

P. Rehabilitative Therapy Services

Benefits are provided for the following forms of therapy:

1. Cardiac Rehabilitation Therapy

   Benefits for cardiac rehabilitation therapy include regulated exercise programs that are proven effective in the physiologic rehabilitation of a patient with a cardiac illness.

2. Respiratory Therapy

   Benefits for respiratory therapy include the treatment of acute or chronic lung conditions through the use of intermittent positive breathing (IPPB) treatments, chest percussion, postural drainage and pulmonary exercises.

Q. Rehabilitative and Habilitative Services

Benefits are provided for the following forms of rehabilitative and habilitative therapy:

1. Physical Medicine

   Benefits for physical medicine (which also includes pulmonary therapy, orthoptic therapy, and urinary incontinency therapy) include evaluation and treatment by physical means or modalities, such as: mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises or activities performed to relieve pain and restore a level of function following disease, illness or injury.

2. Occupational Therapy

Benefits for occupational therapy include the evaluation and treatment of a physically disabled person by means of constructive activities designed to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living.

3. Speech Therapy

Benefits for speech therapy include those services necessary for the evaluation, diagnosis, and treatment of certain speech and language disorders as well as services required for the diagnosis and treatment of swallowing disorders.

R. Routine Costs Associated With Qualifying Clinical Trials

Benefits are provided for Routine Costs Associated With Qualifying Clinical Trials.

S. Specialist Office Visit

Benefits will be provided for Specialist Services Medical Care provided in the office by a Participating Specialist. For the purpose of this benefit, "in the office" includes Medical Care visits to the Provider's office, Medical Care Visits by the Provider to your residence, or Medical Care consultations by the Provider on an Outpatient basis.

T. Spinal Manipulation Services

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

SECTION EX - EXCLUSIONS

The following are excluded from your coverage:

1. Which are not Medically Necessary as determined by Keystone Health Plan Central's Medical Director(s) or his/her designee(s);

2. Which are considered by Keystone Health Plan Central to be Investigational, except where otherwise required by law;

3. For any illness or injury which occurs in the course of employment if Benefits or compensation are available or required, in whole or in part, under a workers' compensation policy and/or any federal, state or local government's workers' compensation law or occupational disease law, including but not limited to, the United States Longshoreman's and Harbor Workers' Compensation Act as amended from time to time. This exclusion applies whether or not the Member makes a claim for the Benefits or compensation under the applicable workers' compensation policy/coverage and/or the applicable law;

4. For any illness or injury suffered after the Member's Effective Date of Coverage which resulted from an act of war, whether declared or undeclared;

5. For services received by veterans and active military personnel at facilities operated by the Veteran's Administration or by the Department of Defense, unless payment is required by law;

6. Which are received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group;

7. For the cost of Hospital, medical, or other Benefits resulting from accidental bodily injury arising out of a motor vehicle accident, to the extent such Benefits are payable under any medical expense payment provision (by whatever terminology used, including such Benefits mandated by law) of any motor vehicle insurance policy;

8. For items or services paid for by Medicare when Medicare is primary consistent with the Medicare Secondary Payer Laws. This exclusion shall not apply when the Contract Holder is obligated by law to offer the Member the Benefits of this Coverage as primary and the Member so elects this Coverage as primary;

9. For care of conditions that federal, state or local law requires to be treated in a public facility;

10. For court ordered services when not Medically Necessary and/or not a covered Benefit;

11. For any services rendered while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services are provided outside of any such custodial or incarcerating facility or building, unless payment is required by law;

12. Which are not billed by and either performed by or under the supervision of an eligible Provider;

13. For services rendered by a Provider who is a member of the Member's Immediate Family;

14. For telephone and electronic consultations between a Provider and a Member, including telemedicine services, except for telemedicine services relating to genetic counseling;

15. For charges for failure to keep a scheduled appointment with a Provider, for completion of a claim or insurance form, for obtaining copies of medical records, or for a Member's decision to cancel a Surgery;

16. For services performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program, including services performed by a resident Physician under the supervision of a Professional Provider;

17. Which exceed the Allowable Amount;

18. Which are Cost-Sharing Amounts required of the Member under this Coverage;

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

20. For services incurred prior to the Member's Effective Date of Coverage;

21. For services incurred after the date of termination of the Member's Coverage except as provided for in this Agreement;

22. For services received by a Member in a country with which United States law prohibits transactions;

23. For Inpatient admissions which are primarily for diagnostic studies or for Inpatient services which could have been safely performed on an Outpatient basis;

24. For prophylactic blood, cord blood or bone marrow storage in the event of an accident or unforeseen Surgery or transplant;

25. For Custodial Care, domiciliary care, residential care, protective and supportive care including educational services, rest cures, convalescent care, or respite care not related to Hospice services;

26. For services related to organ donation where the Member serves as an organ donor to a non-member;

27. For transplant services where human organs were sold rather than donated and for artificial organs;

28. For anesthesia when administered by the assistant to the operating Physician or the attending Physician;

29. For Cosmetic Procedures or services related to Cosmetic Procedures performed primarily to improve the appearance of any portion of the body and from which no significant improvement in the functioning of the bodily part can be expected, except as otherwise required by law. This exclusion does not apply to Cosmetic Procedures or services related to Cosmetic Procedures performed to correct a deformity resulting from an otherwise covered sickness, Birth Defect or accidental injury. For purposes of this exclusion, prior Surgery is not considered an accidental injury;

30. For oral Surgery, including surgical extractions of full or partial bony impactions, except as specifically provided in this Agreement;

31. For maintenance therapy services, except as required by law;

32. For physical medicine for work hardening, vocational and prevocational assessment and training, functional capacity evaluations, as well as its use towards enhancement of athletic skills or activities;

33. For occupational therapy for work hardening, vocational and prevocational assessment and training, functional capacity evaluations, as well as its use towards enhancement of athletic skills or activities;

34. For speech therapy for the following conditions: psychosocial speech delay, behavior problems, intellectual disability (except when disorders such as aphasia or dysarthria are present), attention deficit disorder/attention deficit hyperactivity disorder, auditory conceptual dysfunction or conceptual handicap and severe global delay;

35. For all rehabilitative therapy, except as described in the Agreement, including but not limited to play, music, and recreational therapy;

36. For sports medicine treatment or equipment intended primarily to enhance athletic performance;

37. For services or supplies that are considered by Keystone to be Investigational, except routine costs associated with Approved Clinical Trials that have been preauthorized by Keystone. Routine costs do not include any of the following:

    a. The Investigational drug, biological product, device, medical treatment or procedure itself.

    b. The services and supplies provided solely to satisfy data collection and analysis needs and that are not used in the direct Clinical Management of the patient.

    c. The services and supplies customarily provided by the research sponsors free of charge for any enrollee in the Approved Clinical Trial.

    d. Member travel expenses;

38. For all dental services rendered after stabilization of a Member in an emergency following an accidental injury, including but not limited to, oral Surgery for replacement teeth, oral prosthetic devices, bridges, or orthodontics;

39. For travel expenses incurred in conjunction with Benefits unless specifically identified as a covered service elsewhere in this Agreement;

40. For the following Mental Health Care/Substance Abuse services: educational testing, evaluation testing, hypnosis, marital therapy, methadone maintenance, intellectual disability services, attention deficit disorder testing, other learning disability testing, and long-term care services provided in extended care and state mental health facilities;

41. For neuropsychological testing (NPT) when done through self-testing, self-scored inventories, and projective techniques testing or when done for educational purposes, screening purposes, patients with stable conditions, occupational exposure to toxic substances, or mental health diagnosis, including substance abuse;

42. For back-up or secondary durable medical equipment, including ventilators and prosthetic appliances, and for durable medical equipment requested specifically for travel purposes, recreational or athletic activities, or when the intended use is primarily outside the home;

43. For replacement of lost or stolen durable medical equipment items, including prosthetic appliances, within the expected useful life of the originally purchased durable medical equipment or for continued repair of durable medical equipment after its useful life has exhausted;

44. For replacement of defective or non-functional durable medical equipment when the equipment is covered under the manufacturer's warranty;

45. For upgrade or replacement of durable medical equipment when the existing equipment is functional except when there is a change in the health of the *member* such that the current equipment no longer meets the Member's medical needs;

46. For durable medical equipment intended for use in a facility (Hospital grade equipment);

47. For home delivery, education and set up charges associated with purchase or rental of durable medical equipment, as such charges are not separately reimbursable and are considered part of the rental or purchase price;

48. For prosthetic appliances dispensed to a patient prior to performance of the procedure that will necessitate the use of the device;

49. For personal hygiene, comfort and/or convenience items such as, but not limited to, air conditioners, humidifiers, air purifiers and filters, physical fitness or exercise equipment, including, but not limited to inversion, tilt, or suspension device or table, radio and television, beauty/barber shop services, guest trays, chairlifts, elevators, diapers, deodorants, spa or health club memberships, or any other modification to real or personal property, whether or not recommended by a Provider;

50. For items used as safety devices, and for elastic sleeves (except where otherwise required by law), thermometers, bandages, gauze, dressings, cotton balls, tape, adhesive removers, or alcohol pads.

51. For supportive environmental materials and equipment such as handrails, ramps, telephones, and similar service appliances and devices;

52. For enteral nutrition due to lactose intolerance or other milk allergies;

53. For blenderized baby food, regular shelf food, or special infant formula, except as specified in this Agreement;

54. For all other enteral formulas, nutritional supplements, and other enteral products administered orally or through a tube and provided due to the inability to take adequate calories by regular diet, except where mandated by law and as specifically provided in this Agreement;

55. For immunizations required for travel or employment except as required by law;

56. For routine examination, testing, immunization, treatment and preparation of specialized reports solely for insurance, licensing, or employment including but not limited to pre-marital examinations, physicals for college, camp, sports or travel;

57. For services directly related to the care, filling, removal, or replacement of teeth; orthodontic care; treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth; or for dental implants, except where mandated by law and as specifically provided in this Agreement;

58. For treatment of temporomandibular joint syndrome (TMJ) by any and all means including, but not limited to, Surgery, intra-oral devices, splints, physical medicine, and other therapeutic devices and interventions, except for evaluation to diagnose TMJ and except for treatment of TMJ caused by documented organic disease or physical trauma resulting from an accident; Intra-oral reversible prosthetic devices/appliances are excluded regardless of the cause of TMJ;

59. For Hearing Aids, examinations for the prescription or fitting of Hearing Aids, and all related services;

60. For eyeglasses, refractive lenses (glasses or contact lenses), replacement refractive lenses, and supplies, including but not limited to, refractive lenses prescribed for use with an intra-ocular lens transplant;

61. For vision examinations, except for vision screening related to a medical diagnosis for diagnostic purposes. Vision examinations include, but are not limited to: routine eye exams; prescribing or fitting eyeglasses or contact lenses (except for aphakic patients); and refraction, regardless of whether it results in the prescription of glasses or contact lenses;

62. For surgical procedures performed solely to eliminate the need for or reduce the prescription of corrective vision lenses, including but not limited to corneal Surgery, radial keratotomy and refractive keratoplasty;

63. For Infertility services, except for evaluation to diagnose infertility;

64. For donor services related to assisted fertilization and Infertility;

65. For in vitro fertilization and/or embryo transplants;

66. For procedures to reverse sterilization;

67. For Outpatient oral chemotherapy drugs;

68. For whole blood, blood plasma, or blood components;

69. For routine foot care, unless otherwise mandated by law. Routine foot care involves, but is not limited to, hygiene and preventive maintenance (e.g., cleaning and soaking of feet, use of skin creams to maintain skin tone); treatment of bunions (except capsular or bone Surgery), toe nails (except Surgery for ingrown nails), corns, removal or reduction or warts, calluses, fallen arches, flat feet, weak feet, chronic foot strain, or other foot complaints;

70. For supportive devices of the feet, unless otherwise mandated by law and when not an integral part of a leg brace. Supportive devices of the feet include foot supports, heel supports, shoe inserts, and all foot orthotics, whether custom fabricated or sold as is;

71. For treatment, medicines, devices, or drugs in connection with sexual dysfunction, both male and female;

72. For treatment or procedures leading to or in connection with transsexual Surgery or transgender reassignment Surgery except for sickness or injury resulting from such Surgery or for the surgical treatment of congenital ambiguous genitalia present at birth;

73. For abortions, except when the abortion is necessary to avert the death of the mother and in cases of rape and/or incest;

74. For all prescription and over-the-counter drugs dispensed by a pharmacy or Provider for the Outpatient use of a Member, whether or not billed by a Facility Provider, except for allergy serums and mandated pharmacological agents used for controlling blood sugar and except where otherwise required by law. See your Prescription Drug Rider for a listing of exclusions that apply to your Keystone prescription drug plan;

75. For all prescription and over-the-counter drugs dispensed by a Home Health Care Agency Provider, with the exception of intravenous drugs administered under a treatment plan approved by Keystone Health Plan Central;

76. For surgical operations or treatment of obesity and/or morbid obesity, including but not limited to gastric stapling or balloon procedures;

77. For Inpatient stays to bring about non-surgical weight reduction;

78. For private duty nursing services;

79. For biofeedback;

80. For acupuncture;

81. For newborn deliveries outside the Service Area within twenty-eight (28) days of the expected delivery date.

82. For autopsies or any other services rendered after a Member's demise;

83. For wigs and other items intended to replace hair loss due to male/female pattern baldness;

84. For non-neonatal circumcisions, unless Medically Necessary;

85. For all types of skin tag removal, regardless of symptoms or signs that might be present, except when the condition of diabetes is present;

86. For any services related to or rendered in connection with a non-covered service, including but not limited to anesthesia, diagnostic services, etc.;

87. For services provided at unapproved sites, school settings, or as part of a Member's education;

88. For services received pursuant to an invalid Referral including but not limited to Referrals to Non-Participating Providers or Referrals for other non-covered services and Referrals issued subsequent to the date of services being rendered;

89. For membership dues, subscription fees, charges for service policies, insurance premiums and other payments analogous to premiums which entitle enrollees to services, repairs, or replacement of devices, equipment or parts without charge or at a reduced charge;

90. For at-home genetic testing, including confirmatory testing for abnormalities detected by at-home genetic testing, and genetic testing of a Member done primarily for the clinical management of family members who are not Members and are, therefore, not covered under this Agreement; and

91. For any other service or treatment except as provided in this Agreement.

SECTION PR – PREMIUMS

PREMIUM RATE AND BENEFIT PROVISIONS

The Subscriber agrees to pay the HMO in advance, on a monthly or quarterly basis, unless otherwise agreed, the applicable premium rate as filed with and approved by the Commonwealth of Pennsylvania.

In consideration of these payments to the HMO, the HMO agrees to provide access to medical and Hospital Covered Services and other Benefits as specified in this Subscriber Agreement for eligible persons who enroll hereunder, in accordance with the terms, conditions, Limitations and exclusions of this Subscriber Agreement.

If the Subscriber provides incorrect or missing information which causes the premium to be calculated incorrectly, the HMO may, at its option and as allowed by law, either recoup any additional premium which would have been charged if accurate information had been provided, or terminate this Agreement as provided in Section EL - Eligibility, change, and Termination Rules Under The Plan.

PREMIUM RATE CHANGES

Premium rates may be changed prospectively with the prior approval of the Pennsylvania Insurance Department during any month in which this Agreement remains in effect, provided that prior written notice of such proposed change shall be given to the Subscriber by the HMO.

AGE OF MEMBER

To the extent that premiums are based on the age of a Member, premiums will be based on the age of such Member as of the date of Agreement issuance or on the Agreement Renewal Date.

THIRD PARTY PAYMENTS

Capital does not accept payment of premium from a third party except from a family member or unless otherwise required by law.

SECTION GP - GENERAL PROVISIONS

BENEFIT PROVISIONS

A. In consideration of payments to be paid to the HMO by the Subscriber and, in consideration of the Copayments, if required, to be paid by or on behalf of Members, the HMO agrees to provide access to medical and Hospital Covered Services and other Benefits as specified in this Agreement for eligible persons who enroll hereunder, in accordance with the terms, conditions, Limitations, and exclusions of this Agreement.

B. Except as may be provided under Section CS - Description of Covered Services, Inpatient Services, Organ Transplants, no person other than a Member is entitled to receive Benefits under this Agreement.

C. Benefits for Covered Services specified in this Agreement will be provided only for Covered Services and supplies that are rendered by a Provider as specified in Section CS - Description of Covered Services of this Agreement.

D. If the HMO shall pay for any excluded services or supplies through inadvertence or error, the Member shall reimburse the HMO for such payments.

E. The HMO shall not be liable for any services to which a contributing cause was the Member's commission of or attempt to commit a felony, or to which a contributing cause was the Member's being engaged in an illegal occupation. If services are rendered, the Member will be held responsible for payment.

F. Identification Cards issued by the HMO to Members pursuant to this Agreement are for identification purposes only. Possession of an HMO Identification Card confers no rights to Covered Services or other Benefits under this Agreement.

   To be entitled to such Covered Services or Benefits the holder of the card must, in fact, be a Member on whose behalf all applicable payments under this Agreement have been paid. Any person receiving Covered Services or Benefits to which he or she is not entitled pursuant to the provisions of this Agreement is chargeable therefore at the expense incurred by the HMO. For purposes of identification and specific coverage information, a Member's Identification Card must be presented when a Covered Service is requested.

G. The Covered Services or supplies described in Section CS - Description of Covered Services of this Agreement are covered only when they are Medically Necessary, as determined by a Participating Provider or the HMO. Any services requested by a Member which are not Medically Necessary, except as provided under Section CS - Description of Covered Services of this Agreement, will not be covered.

Except as set forth in this Agreement, the Subscriber is solely responsible for the performance of his or her obligations set forth in this Agreement. The Subscriber cannot assign, delegate, or transfer to any party any rights, duties, or obligations described in this Agreement, any interest in this Agreement, or any claim under this Agreement without the prior express written consent of the HMO.

CONFIDENTIALITY AND DISCLOSURE OF MEDICAL INFORMATION

The HMO's privacy practices, as they apply to Members enrolled in this health benefit program, as well as a description of Members' rights to access their personal health information which may be maintained by the HMO, are set forth in the HMO's HIPAA Notice of Privacy Practices (the "Notice"). The Notice is sent to each new Member upon initial enrollment in the health benefit program, and, subsequently, to all the HMO Members if and when the Notice is revised.

By enrolling in this health benefit program, Members give consent to the HMO to receive, use, maintain, and/or release their medical records, claims-related information, health and related information for the purposes identified in the Notice to the extent permitted by applicable law. However, in certain circumstances, which are more fully described in the Notice, a specific Member Authorization may be required prior to the HMO's use or disclosure of Members' protected health information. Members should consult the Notice for detailed information regarding their privacy rights.

CLERICAL ERROR

Clerical error, whether of the Subscriber or the HMO, in keeping any record pertaining to the coverage hereunder, will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

DISCOUNTS

From time to time, Keystone may make available to its Members access to health and wellness related discount programs offered through third party vendors. These discount programs are not insurance and are not an insurance benefit or promise under this Contract. Member access to these programs is not provided by Keystone separately or independently from this Contract. There is no additional charge to Members under this Agreement for accessing these discount programs. If Keystone receives any funds from the third party vendors in conjunction with making the discount programs available to Members, Keystone will use those funds to offset its costs of providing Member access to the discount programs.

ENTIRE AGREEMENT AND CHANGES

A. The entire Agreement between the HMO and the Subscriber consists of the Application/Change Form(s), this Subscriber Agreement, Riders, including those issued by a company other than the HMO, and amendments to these documents (effective now or in the future), and the appropriate payment.

B. No change in this Agreement will be effective until approved by an authorized officer of the HMO. This approval must be noted on or attached to this Agreement. No agent or representative of the HMO other than an officer of the HMO, may otherwise change this Agreement or waive any of its provisions. All statements made by an individual Member shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense of a claim under this Agreement, unless it is contained in a written application.

C. The HMO may amend this Agreement with respect to any matter, including required payments, by mailing a postage prepaid notice of the amendments to the Subscriber at his address of record with the HMO, at least thirty (30) days, or other period required by law, before the effective date of the amendment. The Subscriber's concurrence with such amendments shall be established by continuation of payment for coverage hereunder after the effective date of the amendment.

D. If the provisions of the Agreement do not conform to the requirements of any state or federal law or regulation that applies to the Agreement, the Agreement provisions are automatically changed to conform with the HMO's interpretation of the requirements of that law or regulation.

GENDER

The use of any gender herein shall be deemed to include the other gender, and, whenever appropriate, the use of the singular herein shall be deemed to include the plural (and vice versa).

HEALTH EDUCATION AND WELLNESS PROGRAMS

Keystone believes that providing health and wellness information assists individuals in adopting healthy lifestyles. From time to time, Keystone may provide on-line health education and wellness programs to its Members. Participation in these programs is optional to each Member. These programs are not insurance and are not an insurance benefit or promise under this Agreement.

INTERPRETATION OF SUBSCRIBER AGREEMENT

The laws of the Commonwealth of Pennsylvania shall be applied to interpretations of this Subscriber Agreement.

LEGAL ACTION

A. No legal action may be commenced against the HMO with respect to the Agreement until at least sixty (60) days after the HMO has received a properly completed claim form, Referral or encounter form. No legal action against the HMO with respect to the Agreement may be filed later than three (3) years after the Covered Services or supplies were performed or provided.

B. In addition, no legal action regarding a Complaint or Grievance may be commenced against the HMO until the Member has exhausted his or her administrative remedies and appeals as detailed in this Agreement.

NON-DISCRIMINATION

The Member shall not be discriminated against in eligibility, continued eligibility or variation in premium amounts by virtue of any of the following:

- The receipt of a federal premium Subsidy, or by virtue of taking any other action to enforce his/her rights under applicable law.
- On the basis of race, color, natural origin, disability, age, sex, gender identity or sexual orientation.
- Health status-related factors pertaining to the member or his or her dependent. Factors include health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability.

NOTICE OF CLAIM

Written notice of claim must be given to Keystone within twenty (20) days after the occurrence of commencement of any loss covered by the Agreement, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Subscriber to:

Keystone Health Plan Central
PO Box 779519
Harrisburg, PA 17177-9519

or to any authorized agent of Keystone, with information sufficient to identify the Subscriber, shall be deemed notice to Keystone.

CLAIM FORM

Keystone, upon receipt of a notice of claim, will furnish to the Subscriber such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the Subscriber shall be deemed to have complied with the requirements of this Agreement as to proof of loss upon submitting, within the time fixed in the agreement for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The claim form to

be used under this clause for medical care claims is the CMS Form-1500, or comparable form, as required by law.

PROOF OF LOSS

Subscribers must submit written proof of loss of their claims within ninety (90) days after completion of the covered services to receive Benefits from Keystone. Keystone will not be liable under this Agreement unless proper and prompt notice is furnished to Keystone that covered services have been rendered to a Member. No payment will be issued until the Deductible has been met, except for those covered services to which the Deductible does not apply as set forth in the Schedule of Cost Sharing of this agreement. The claims must include the data necessary for Keystone to determine benefits. An expense will be considered incurred on the date the service or supply was rendered. Claims should be sent to:

Keystone Health Plan Central
PO Box 779519
Harrisburg, PA 17177-9519

Keystone reserves the right to verify the validity of each claim with the Provider or Pharmacy and to deny payment if the claim is not adequately supported. Failure to furnish proof of loss to Keystone within the time specified will not reduce any Benefit if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event will Keystone be required to accept the proof of loss more than twelve (12) months after Benefits are provided, except if the person lacks legal capacity.

TIME OF PAYMENT OF CLAIMS

Claim payment for Benefits payable under this agreement will be processed immediately upon receipt of proper proof of loss.

PAYMENT OF CLAIMS

Keystone is authorized by the Subscriber to make payments directly to Providers or Pharmacies furnishing services or Prescription Drugs for which Benefits are provided under this Agreement. However, Keystone reserves the right to make the payments directly to the Subscriber. In addition, Keystone is authorized by the Subscriber to make payments directly to a state or federal governmental agency or its designee whenever Keystone is required by law or regulation to make payment to such entity. Once services are rendered by a Provider or Pharmacy, Keystone will not honor Subscriber requests not to pay claims submitted by the Provider or Pharmacy. Keystone will have no liability to any person because of its rejection of the request. Payment of Benefits is specifically conditioned on the Member's compliance with the terms of this agreement.

OUT-OF-AREA BENEFITS WHEN OUTSIDE KEYSTONE'S APPROVED SERVICE AREA – BLUECARD AND GUEST MEMBERSHIP PROGRAMS

Keystone has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever Members obtain healthcare services outside of Keystone's Approved Service Area, the claims for these services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside Keystone's Approved Service Area, Members will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from non-participating healthcare providers. Keystone's payment practices in both instances are described below.

Keystone Health Plan Central covers only limited healthcare services received outside of Keystone's Approved Service Area. As used in this section, "Out-of-Area Covered Healthcare Services" include Emergency Care, Urgent Care and related authorized follow-up services obtained outside the geographic area of Keystone serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements unless authorized by a Member's primary care physician ("PCP").

A. BlueCard® Program

Under the BlueCard Program, when Members obtain Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, Keystone will remain responsible for fulfilling Keystone's contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard Program enables Members to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to the Member, so there are no claim forms for a Member to fill out. The Member will be responsible for any applicable Cost-Sharing Amounts, as outlined in the Schedule of Cost Sharing section of this Agreement.

Emergency Care Services: If a Member experiences a Medical Emergency while traveling outside Keystone's Approved Service Area, medical treatment should be sought from the nearest appropriate Facility Provider.

Whenever Members access covered healthcare services outside Keystone's Approved Service Area and the claim is processed through the BlueCard Program, the amount Members pay for covered healthcare services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for their covered services; or
- The negotiated price that the Host Blue makes available to Keystone.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Member's healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the Member's healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over - or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Keystone uses for Members' claims because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to this calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Keystone would then calculate Member liability for any covered healthcare services according to applicable law.

B. Non-Participating Healthcare Providers Outside Keystone's Approved Service Area

1. Member Liability Calculation

When Out-of-Area Covered Healthcare Services are received from non-participating healthcare providers, the amount Members pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state

law. In these situations, Members may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Keystone will make for the covered services as set forth in this Agreement.

2. Exceptions

In certain situations, Keystone may use other payment bases, such as billed covered charges, the payment Keystone would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Keystone will pay for services rendered by non-participating healthcare providers. In these situations, Members may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Keystone will make for the covered services as set forth in this Agreement.

3. Out-of-Area Claims: Non-Participating Providers Member Liability Calculation – Emergency Care

When a Member needs Emergency Care, Keystone will provide coverage at the highest level that federal regulations allow. The Member will have to pay for any charges that exceed the Allowable Charges as well as for any Deductibles, Coinsurance, Copayments, and amounts that exceed any Benefit Maximums.

C. Areas Served by the BlueCard or Guest Membership Programs

The BlueCard Program's Urgent and Follow-Up Care benefits are available from providers contracting with the Blue Cross and Blue Shield Association as part of its traditional network ("BlueCard Traditional Providers"). Covered Services under the Guest Membership Program are only available from providers contracting with the Blue Cross and Blue Shield Association as part of its HMO Networks. All BlueCard and Guest Membership Covered Services must be provided by a contracting provider, in the respective networks of providers, unless Preauthorized by the HMO or, in the case of Guest Membership services, the Host HMO. Even when the Member is traveling in a geographic area not served by a contracting BlueCard provider, coverage will be provided anywhere in the fifty (50) states for Emergency and Urgent Care. Urgent Care and Follow-Up Care are available in selected geographic locations in all states and the District of Columbia. Guest Membership registration is available in selected geographic areas. To find out if Urgent Care or Follow-Up Care is available in a specific travel destination, the Member should call 1-800-810- BLUE. For availability of Guest Membership, the Member should call the Guest Membership Coordinator.

D. Grievances And Appeals For BlueCard And Guest Membership Services

If the Member has a problem or concern about the services or Benefits received through the BlueCard or Guest Membership Programs the Member has the same right to file a Grievance or to appeal a coverage decision as when in Keystone's Approved Service Area and receiving care from the HMO Providers. The HMO will retain responsibility for Benefits provided through the BlueCard and Guest Membership Programs. Refer to the Grievance and Appeals section for a complete explanation of the process and procedure for filing a Grievance or an appeal. When filing a Grievance or appeal involving BlueCard or Guest Membership Services, the Member should identify that the BlueCard or Guest Membership Program was being used and indicate which of its specific services (Urgent Care, Follow-Up Care, or the Guest Membership) are at issue.

E. Transfer Of Medical Information

The "Transfer of Medical Information" form must be completed prior to accessing Guest Membership Benefits. This form is the primary means by which the Member's medical information is communicated between the HMO and the Host HMO. This form will assist Providers in coordinating the Member's care during the time away from home and upon return. After the Member has completed and signed the "Transfer of Medical Information" form, the form will be completed by the HMO or the Host Primary Care Physician, as appropriate. The form will be processed through the Guest Membership Program. A Guest Membership

Coordinator is responsible for forwarding the form between the HMO and Host HMO. Failure to sign and date the "Transfer of Medical Information" form will result in a denial of Guest Membership Benefits.

PHYSICAL EXAMINATION AND AUTOPSY

Keystone at its own expense shall have the right and opportunity to examine the person of the Member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

POLICIES AND PROCEDURES

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

REINSTATEMENT

Any Member whose Membership shall have been terminated may be reinstated up to thirty (30) days after the last date of the grace period if the Subscriber applies for reinstatement, and the HMO receives payment of the premium required for reinstatement. The HMO and Members have the same rights under the reinstated Agreement as they had under the Agreement immediately before the due date of the defaulted premium. The right of the applicant to have this Agreement reinstated is limited to one (1) reinstatement within a 12-month period, and two reinstatements per lifetime.

After thirty (30) days, the Applicant must re-apply for coverage under this plan by completing a new Application/change Form. Upon acceptance by the HMO, the applicant and eligible Dependents shall be subject to all the terms of the new Agreement.

RELATIONSHIP OF PARTIES

A. The relationship between the HMO and its Participating Providers, and between the HMO and other contracting Providers of health services, is an independent contract relationship. The HMO Participating Providers are not agents or employees of the HMO, nor is any employee of the HMO an employee or agent of the HMO Participating Providers.

B. The HMO shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any HMO Participating Provider or from any Provider to which the Member has been Referred by the Participating Provider or the HMO.

C. The HMO Participating Providers maintain the Physician-patient relationship with Members and are responsible to Members for the delivery of all medical services.

D. Members are free to choose their Primary Care Physician as described in Section ACC – Access To Primary Care, Specialist And Hospital Care Network.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD PLANS

Keystone Health Plan Central is an independent corporation operating under a license from the BlueCross BlueShield Association, a national association of independent Blue Cross and Blue Shield Plans (the "Association"). Although all of these independent Blue Cross and Blue Shield Plans operate from a license with the Association, each of them is a separate and distinct corporation. The Association allows Keystone Health Plan Central to use the Blue Cross words and symbols. Keystone Health Plan Central, which is entering into this Agreement, is not contracting as an agent of the Association. Only Keystone Health Plan Central shall be liable for any of the obligations under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Keystone Health Plan Central other than those obligations created under other provisions of this Agreement.

REQUIRED DISCLOSURE OF INFORMATION

State law requires that the HMO make the following information available to a Member when they make a request in writing to the HMO.

1. A list of the names, business addresses and official positions of the Membership of the Board of Directors or Officers of the HMO.

2. The procedures adopted to protect the confidentiality of medical records and other enrollee information,

3. A description of the credentialing process for health care Providers.

4. A list of the participating health care Providers affiliated with Participating Hospitals.

5. A description of the procedures followed by the HMO to make decisions about the experimental nature of individual drugs, medical devices or treatments.

6. A summary of the methodologies used by the HMO to reimburse for health care services. (This does not mean that the HMO is required to disclose individual contracts or the specific details of financial arrangements we have with health care Providers).

7. A description of the procedures used in the HMO's quality assurance program.

8. Other information that the Pennsylvania Department of Health or the Insurance Department may require.

STATUS CHANGE

Applications for changes in contract type or additions or deletions of eligible Dependents shall be filed on Application/Change Forms supplied by the HMO and shall become effective and a part of this Subscriber Agreement upon acceptance by the HMO. See Section EL - Eligibility, Change And Termination Rules Under The Plan.

TIME LIMIT ON CERTAIN DEFENSES

After three (3) years from the date of issue of this Agreement, no misstatements, except fraudulent misstatements, made by the Subscriber in application for such Agreement shall be used to void the Agreement or to deny a claim for loss incurred or disability commencing after the date of expiration of such three (3) year period.

SECTION SC – SCHEDULE OF COST SHARING

You are entitled to benefits for the Covered Services described in your Agreement, subject to any Deductible, Coinsurance, Copayment, Out-of-Pocket Maximum or Limitations described below.

If the Participating Provider's usual fee for a Covered Service is less than the Coinsurance or Copayment shown in this Schedule, you are only responsible to pay the Participating Provider's usual fee. The Participating Provider is required to remit any Coinsurance or Copayment overpayment directly to you. If you have any questions, contact Customer Service at the phone number on your ID Card.

Your Primary Care Physician or Referred Specialist must obtain Preauthorization from Keystone to confirm Keystone's coverage for certain Covered Services. If your Primary Care Physician or Referred Specialist provides a Covered Service or Referral without obtaining Keystone's Preauthorization, you are not responsible for payment for that Covered Service. The list of Covered Services that require Preauthorization appear in the Medical Care Preauthorization Schedule attached to your Agreement.

SUMMARY OF COST SHARING	
COPAYMENTS	Copayments (when applicable) vary by service. See below for details.
DEDUCTIBLE	$3,500 per Member $7,000 per family Combined with prescription drug deductible
COINSURANCE	0% Coinsurance
OUT-OF-POCKET MAXIMUM The out-of-pocket maximum is the maximum amount of all Cost Sharing that a Member must pay during an Agreement Year. The following expenses do not apply to the out-of-pocket maximum: charges exceeding the Allowable Amount, and out-of-network non-emergency/non-urgent care. This out-of-pocket maximum amount is combined with, and not in addition to, the out-of-pocket maximum amount reflected in the Summary of Cost-Sharing – Prescription Drug Benefits. This combined out-of-pocket maximum amount can be satisfied with eligible amounts incurred for medical benefits, prescription drug benefits, pediatric dental (if covered by CAAC), pediatric vision benefits, or a combination of all benefits.	$6,350 per Member $12,700 per family
PRIMARY AND PREVENTIVE CARE COVERED SERVICES COPAYMENTS & LIMITATIONS	
PCP OFFICE VISIT	$50 Copayment per visit
PEDIATRIC PREVENTIVE CARE (Includes physical examinations, immunizations and tests)	Paid in full
ADULT PREVENTIVE CARE (Includes physical examinations, immunizations and tests as well as specific women's preventive services as required by law)	Paid in full
ROUTINE GYNECOLOGICAL EXAMINATION	Paid in full
MAMMOGRAMS	Paid in full
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT	Paid in full

PEDIATRIC VISION Vision Coverage for Dependents Under Age 19	Refer to Capital Advantage Assurance Company Individual Pediatric Vision Policy for Specific Benefit Details and Limits.
INPATIENT COVERED SERVICES COPAYMENTS & LIMITATIONS	
HOSPITAL SERVICES	Paid in full after Deductible
MEDICAL CARE	Paid in full after Deductible
SKILLED NURSING CARE FACILITY Maximum of 120 Inpatient days per Agreement Year.	Paid in full after Deductible
INPATIENT/OUTPATIENT COVERED SERVICES COPAYMENTS & LIMITATIONS	
HOSPICE SERVICES	Paid in full after Deductible
MATERNITY/OBSTETRICAL SERVICES	
Professional Service	Paid in full after Deductible
Facility Services	Paid in full after Deductible
SURGICAL SERVICES	
Outpatient Facility Charges	Paid in full after Deductible
Outpatient Anesthesia	Paid in full after Deductible
TRANSPLANT SERVICES $10,000 per episode for Blue Distinction Centers for Transplant (BDCT) travel expenses	Paid in full after Deductible
MENTAL HEALTH CARE SERVICES	
• Inpatient Services	Paid in full after Deductible
• Outpatient Services	$70 Copayment per visit
SUBSTANCE ABUSE SERVICES	
• Inpatient Services	Paid in full after Deductible
• Outpatient Services	$70 Copayment per visit
OUTPATIENT COVERED SERVICES COINSURANCE, COPAYMENTS & LIMITATIONS	
ALLERGY SERVICES	Paid in full after Deductible
CHEMOTHERAPY	Paid in full after Deductible
DIABETES SERVICES	Paid in full after Deductible
DIAGNOSTIC SERVICES	
• Routine Diagnostic Services	Paid in full after Deductible
• Non-Routine Diagnostic Services	Paid in full after Deductible
• Laboratory and Pathology Tests	Paid in full at independent lab; $75 Copayment at hospital-owned lab
DIALYSIS	Paid in full after Deductible
DURABLE MEDICAL EQUIPMENT	Paid in full after Deductible
EMERGENCY CARE	Paid in full after Deductible

ENTERAL NUTRITION	Paid in full after Deductible
HOME HEALTH CARE Maximum of Sixty (60) visits per Agreement Year.	Paid in full after Deductible
INFUSION THERAPY	Paid in full after Deductible
INJECTABLE MEDICATIONS	Paid in full after Deductible
MEDICAL TRANSPORT	
• Emergency Transport	Paid in full after Deductible
• Non-Emergency Transport	Paid in full after Deductible
ORTHOTIC DEVICES	Paid in full after Deductible
PROSTHETIC APPLIANCES Wigs**,** $300 benefit lifetime maximum.	Paid in full after Deductible
RADIATION THERAPY	Paid in full after Deductible
REHABILITATIVE SERVICES	
• Cardiac Rehabilitation Therapy	Paid in full after Deductible
• Respiratory Therapy Twenty (20) visits per Agreement Year	Paid in full after Deductible
REHABILITATIVE AND HABILITATIVE THERAPY SERVICES	
• Physical Medicine and Occupational Therapy Sixty (60) combined Rehabilitative and Habilitative visits per Agreement Year	Paid in full after Deductible
• Speech Therapy Sixty (60) combined Rehabilitative and Habilitative visits per Agreement Year	Paid in full after Deductible
SPECIALIST VISITS	Paid in full after Deductible
SPINAL MANIPULATION THERAPY Twenty (20) visits per Agreement Year	Paid in full after Deductible
URGENT CARE	Paid in full after Deductible

Capital BLUE

Schedule of Preventive Care Services
Child Preventive Health Maintenance Guidelines

This information highlights the preventive care services available under this *coverage*. It is not intended to be a complete list or complete description of available services. Services may be subject to *copayment*, *deductible* and/or *coinsurance*. Additional diagnostic studies may be covered if *medically necessary* for a particular diagnosis or procedure. Members may refer to the benefit contract for specific information on available *benefits or contact Customer Service at the number listed on their ID card.*

SERVICE	RECOMMENDED AGES/FREQUENCY *

Routine History and Physical Examination – Initial/Interval
Exams should include:
• Newborn screening (including gonorrhea prophylactic topical eye medication and hearing loss)
• Head circumference (up to 24 months)
• Height/length and weight
• Body mass index (BMI; beginning at 2 years of age)
• Blood pressure (beginning at 3 years of age)
• Sensory screening for vision and hearing
• Developmental milestones (screening/surveillance)
• Iron supplementation (6 to 12 months) at increased risk for iron deficiency anemia***
• Autism screening (18 + 24 months)
• STD screening (males/females, as appropriate)
• Anticipatory guidance for age-appropriate issues including:
  • Growth and development, breastfeeding/nutrition, obesity prevention, physical activity and psychosocial/behavioral health
  • Safety, unintentional injuries, firearms, poisoning, media access
  • Pregnancy prevention
  • Tobacco products
  • Dental care/fluoride supplementation (≥ 6 months)[3]
  • Fluoride varnish painting of primary teeth (to age 5 years)
  • Sun/UV radiation skin exposure
	Newborn, 3-5 days, by 1 month, 2 months,
	4 months, 6 months, 9 months,
	12 months, 15 months,
	18 months, 24 months, 30 months,
	3 years to 18 years annually

SCREENINGS	**RECOMMENDED AGES/FREQUENCY */****
Newborn screen (including hypothyroidism, sickle cell disease and PKU)	At birth
Lead screening	9-12 months (at risk)[1]
Hemoglobin and Hematocrit	At 12 months: routine one-time testing Assess risk at all other well child visits
Urinalysis	5 years (at risk)
Lipid screening (risk assessment)	Every 2 years, starting at 2 years -- 2, 4, 6, 8 and 10 years Annually, starting at 11 years
Fasting Lipid Profile	Routinely, at 18 years (younger if risk assessed as high)
Tuberculin test	Assess risk at every well child visit
Vision test (objective method)	Beginning at 3 years: annually
Hearing test (objective method)	At birth and at 4, 5, 6, 8 and 10 years
Depression screening (PHQ-2)	Beginning at 11 years: annually
Alcohol and drug use assessment (CRAFFT)	Beginning at 11 years: annually
STI/HIV screening	Beginning at 11 years: annually
Syphilis test (males/females)	18 years and younger (high risk males/females***): suggested testing interval is 1-3 years
HIV test (males/females)	Age 15-18: routine one-time testing Regardless of age: repeat testing of all high risk persons;*** suggested testing interval is 1–5 years
Chlamydia test (females)	18 years and younger (sexually active females as well as other asymptomatic females at increased risk*** for infection): annually
Gonorrhea test (females)	18 years and younger (high risk sexually active females***): suggested testing interval is 1-3 years.
IMMUNIZATIONS	**RECOMMENDED AGES/FREQUENCY */****
Rotavirus (RV)	2 months, 4 months, or 6 months for specific vaccines
Polio (IPV)	2 months, 4 months, 6–18 months, 4–6 years
Diphtheria/Tetanus/Pertussis (DTaP)	2 months, 4 months, 6 months, 15–18 months, 4–6 years
Tetanus/reduced Diphtheria/Pertussis (Tdap)	11–12 years (catch-up through age 18)
Human papillomavirus (HPV2/HPV4 -- females); (HPV4 -- males)	11--12 years (3 doses) (catch-up through age 18)
Measles/Mumps/Rubella (MMR)	12–15 months, 4-6 years (catch-up through age 18)
Hemophilus influenza type b (Hib)	2 months, 4 months, 6 months for specific vaccines & 12-15 months
Varicella/Chickenpox (VAR)	12-15 months, 4-6 years (catch-up through age 18)
Hepatitis A (HepA)	12--23 months (2 doses) (catch-up through age 18)
Influenza	6 months-18 years; annually[2] during flu season
Pneumococcal conjugate (PCV13)	2 months, 4 months, 6 months, 12–15 months
Pneumococcal polysaccharide (PPSV23)	2-18 years (1 or 2 doses) [high risk: see CDC]
Hepatitis B (HepB)	Birth, 1–2 months, 6–18 months (catch-up through age 18)
Meningococcal (MenACWY-D/MenACWY-CRM) [high risk: see CDC]	11--12 years, 16 years (catch-up through age 18)

This preventive schedule is periodically updated to reflect current recommendations from the American Academy of Pediatrics (AAP), U.S. Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control and Prevention (CDC) [www.cdc.gov].

This schedule includes the services deemed to be mandated under the federal Patient Protection and Affordable Care Act (PPACA). As changes are communicated, Capital BlueCross will adjust the preventive schedule as required.

Sections footnotes:

*Services that need to be performed more frequently than stated due to specific health needs of the Member and that would be considered medically necessary may be eligible for coverage when submitted with the appropriate diagnosis and procedure(s) and are covered under the core medical benefit.

**Capital BlueCross considers Members to be “high risk” or “at risk” in accordance with the guidelines set forth by the Centers for Disease Control and Prevention (CDC).

***Capital BlueCross considers individuals to be “high risk” or “at risk” in accordance with the recommendations set forth by the U.S. Preventive Services Task Force (USPSTF)[www.ahrq.gov/clinic/uspstfix.htm]

Screening/Immunizations footnotes:

[1] Encourage all PA-CHIP Members to undergo blood lead level testing before age 2 years.

[2] Children aged 8 years and younger who are receiving influenza vaccines for the first time should receive 2 separate doses, both of which are covered. Household contacts and out-of-home caregivers of a high risk Member, including a child aged 0-59 months, should be immunized against influenza.

[3] Fluoride supplementation pertains only to children who reside in communities with inadequate water fluoride.

Capital BLUE

Schedule of Preventive Care Services
Adult Preventive Health Maintenance Guidelines

This information highlights the preventive care services available under this *coverage*. It is not intended to be a complete list or complete description of available services. Services may be subject to *copayment*, *deductible* and/or *coinsurance*. Additional diagnostic studies may be covered if *medically necessary* for a particular diagnosis or procedure. *Members* may refer to the benefit contract for specific information on available *benefits* or contact Customer Service at the number listed on their ID card.

SERVICE	RECOMMENDED AGES/FREQUENCY *
Routine History and Physical Examination, including BMI and pertinent patient education *Adult counseling and patient education include:*	WOMEN --19+: at least annually MEN -- 19–29: once 30–49: every 4 years 50+: annually
Women • Folic Acid (childbearing age) • Contraceptive methods/counseling • Mammography screening • HRT (risk vs. benefits) • Breast Cancer chemoprevention (high risk)*** • Breastfeeding support/counseling/supplies	
Men • Prostate Cancer screening	
For Both • Tobacco use • STIs • Seat Belt use • Aspirin prophylaxis (high risk) *** • Physical Activity • Drug and Alcohol use • Unintentional Injuries • Family Planning • Sun/UV skin radiation • Depression • Calcium/vitamin D intake • Fall Prevention • Domestic/Interpersonal Violence	

SCREENINGS	RECOMMENDED AGES/FREQUENCY*/**
Obesity/Healthy diet screening/counseling	Age 19 and older (high risk);*** every year
Pelvic Exam/Pap Smear [USPSTF cytology option][5]	Age 21–29; every 3 years
Pelvic Exam/Pap Smear [USPSTF cytology option][5]	Age 30–65; every 3 years
Pelvic Exam/Pap Smear/HPV DNA [USPSTF co-testing option][5]	Age 30–65; every 5 years
Pelvic Exam/HPV DNA (women) [IOM option][5]	Beginning at 30; every 3 years
Chlamydia Test (women)	Age 19-24: Test all sexually active females; annually Age 25 and older: Test all females at increased risk; *** suggested testing interval is 1–3 years
Gonorrhea Test (women)	Age 19 and older: Test all high risk sexually active females;*** suggested testing interval is 1-3 years.
Syphilis Test (men/women)	Age 19 and older: Test all high risk men/women; *** suggested testing interval is 1–3 years
HIV Test (men/women)	Age 19-65: Routine one-time testing of persons not known to be at increased risk for HIV infection Age 19 and older: Repeat testing all high risk persons; *** suggested testing interval is 1–5 years
Hepatitis C Test	Offer one-time testing of adults born between 1945 and 1965 Periodic testing of persons with *continued high risk*** for HCV infection
Blood Pressure	Age 19 and older: every 2 years (general ≥ 60: < 150/90; general < 60 and all others: < 140/90)
Diabetes Screening Test (type 2)	Beginning at 19; test asymptomatic adults with sustained BP > 135/80 every 3 years
Fasting Lipid Profile	Beginning at 20; every 5 years
Fecal Occult Blood Test[1]	Beginning at 50; annually
Flexible Sigmoidoscopy[2]	Beginning at 50; every 5 years
Colonoscopy[2]	Beginning at 50; every 10 years
Barium Enema X-ray[3]	Beginning at 50; every 5 years
Prostate Specific Antigen	Offer beginning at 50 and annually thereafter
Low-dose CT Scan	Age 55-80 (high risk): *** Annual testing until smoke-free for 15 years.
Abdominal Ultrasound (men)	Age 65–75: one-time screening for abdominal aortic aneurysm in men who have ever smoked
BRCA screening/counseling/testing [as needed]	Beginning at 19 (high risk women); *** reassess screening every 5-10 years
Mammogram	Beginning at 40; every 1-2 years
Bone Mineral Density (BMD) Testing (women)	Age 19–64: testing every 2 years may be appropriate for women at high risk. *** Beginning at 65; every 2 years

IMMUNIZATIONS	RECOMMENDED AGES/FREQUENCY*/**
Tetanus/diphtheria/pertussis (Td/Tdap)	19+; Td every 10 years (substitute one dose of Tdap for Td, regardless of interval since last booster)
Human papillomavirus (HPV2/HPV4 -- women); (HPV4 -- men)	19–26; three doses, if not previously immunized (for men 22-26, see CDC)
Hepatitis A (HepA)	19+; two doses (high risk; see CDC)
Hepatitis B (HepB)	19+; three doses (high risk; see CDC)
Hemophilus influenza type b (Hib)	19+; one or three doses (high risk; see CDC)
Influenza[4]	19+; one dose annually during influenza season
Meningococcal (MCV4/MPSV4)	19+; one or more doses: (college students and others at high risk not previously immunized; see CDC)
Pneumococcal (conjugate) (PCV13)	19+; one dose (high risk; see CDC)
Pneumococcal (polysaccharide) (PPSV23)	19–64; one or two doses (high risk; see CDC) Beginning at 65; one dose (regardless of previous PPSV23 immunization; see CDC)
Measles/Mumps/Rubella (MMR)	19-54; one or two doses, give as necessary based upon past immunization history 55+; one or two doses (high risk; see CDC)
Varicella (Chickenpox)	Beginning at 19; two doses, give as necessary based upon past immunization or medical history
Zoster (Shingles)	Beginning at 50; one dose, regardless of prior zoster episodes (see CDC)

This preventive schedule is periodically updated to reflect current recommendations from the U.S. Preventive Services Task Force (USPSTF); National Institutes of Health (NIH); NIH Consensus Development Conference Statement, March 27–29, 2000; Advisory Committee on Immunization Practices (ACIP); Centers for Disease Control and Prevention (CDC); American Diabetes Association (ADA); American Cancer Society (ACS); Eighth Joint National Committee (JNC 8); Institute of Medicine (IOM); U.S. Food and Drug Administration (FDA).

This schedule includes the services deemed to be mandated under the federal Patient Protection and Affordable Care Act (PPACA). As changes are communicated, Capital BlueCross will adjust the preventive schedule as required.

Sections footnotes:

* Services that need to be performed more frequently than stated due to specific health needs of the member and that would be considered medically necessary may be eligible for coverage when submitted with the appropriate diagnosis and procedure(s) and are covered under the core medical benefit. Occupational, school and other "administrative" exams are not covered.

**Capital BlueCross considers individuals to be "high risk" or "at risk" in accordance with the guidelines set forth by the Centers for Disease Control and Prevention (CDC) [www.cdc.gov]

***Capital BlueCross considers individuals to be "high risk" or "at risk" in accordance with the recommendations set forth by the U.S. Preventive Services Task Force USPSTF) [www.ahrq.gov/clinic/uspstfix.htm]

Screenings/Immunizations footnotes:

[1]For guaiac-based testing, six stool samples are obtained (2 samples on each of 3 consecutive stools, while on appropriate diet, collected at home). For immunoassay testing, specific manufacturer's instructions are followed.

[2]Only one endoscopic procedure is covered at a time, without overlap of the recommended schedules.

[3]Barium enema is listed as an alternative to a flexible sigmoidoscopy, with the same schedule overlap prohibition as found in footnote #2.

[4]Capital BlueCross has extended coverage of influenza immunization to all individuals with the preventive benefit regardless of risk.

[5]Recommendations of both the USPSTF and the IOM are included in order to aid clinicians in counseling their patients about preferred or acceptable preventive strategies. It should be noted that screening for cervical cancer should not be the sole health care concern when conducting ongoing well-woman visits.

Keystone HEALTH PLAN® CENTRAL
A Capital BlueCross Company
Independent Licensees of the BlueCross BlueShield Association

Preauthorization Program

Effective Date: 01/01/2015 HMO

SERVICES REQUIRING PREAUTHORIZATION

A Member's Primary Care Physician or Participating specialist will obtain a Preauthorization from Keystone when required.

Services that require Preauthorization are noted below. All services must be received from Participating Providers within Keystone's Service Area unless Preauthorized by Keystone, or except in cases requiring (1) Emergency Service, Urgent Care and follow-up care under the BlueCard Program while outside the applicable Keystone Service Area; or (2) Guest Membership Benefits under the Away From Home Care Program while outside the applicable Keystone Service Area.

Providers and Members should call our Clinical Management Department toll-free at **1-800-471-2242** to obtain the necessary Preauthorization. Providers/Members should request Preauthorization of non-urgent admissions and services well in advance of the scheduled date of service (15 days).

When Preauthorization is required, Medical Necessity of benefits is determined by Keystone or its designee prior to the service being rendered. However, when Preauthorization is not required, services still undergo a Medical Necessity review and must still be considered Medically Necessary to be eligible for Coverage as a benefit. A Participating Provider will accept Keystone's determination of Medical Necessity. The Member will not be billed by a Participating Provider for services that Keystone determines are not Medically Necessary. A Participating Provider is required to obtain Preauthorization for those services requiring Preauthorization.

Not all treatment and services recommended by a provider will meet Keystone's definition of Medically Necessary as defined in this Agreement. The Member or the provider may contact Keystone's Clinical Management Department to determine whether a service is Medically Necessary. Investigational or experimental procedures are not usually covered benefits. Members should consult their Agreement, Capital BlueCross' Medical Policies, or contact Customer Service at the number listed on the back of their health plan identification card to confirm Coverage. Participating Providers and Members have full access to Keystone's medical policies and may request Preauthorization for experimental or Investigational services/items if there are unique Member circumstances.

You have the right to appeal any decisions through the Member Complaint Appeal and Grievance Appeal Process. Instructions for the appeal will be described in the denial notifications.

The table that follows is a partial listing of the Preauthorization requirements for services and procedures.

Preauthorization Program

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Category	Details	Comments
Inpatient Admissions	Observation care admissions	Emergent/Urgent admissions to observation or inpatient status require notification within two (2) business days. All such services will be reviewed and must meet medical necessity criteria from the first hour of admission. Failure to notify Capital BlueCross of an admission may result in an administrative denial. Non-routine maternity admissions require notification within two (2) business days of the date of admission. Preauthorization requirements do not apply to services provided by a Hospital emergency room Provider. If an inpatient admission or observation admission results from an emergency room visit, notification must occur within two (2) business days of the admission. If the Hospital is a Participating Provider, the hospital is responsible for performing the notification. If the Hospital is a Non-Participating Provider and is not BlueCard, the Member or the Member's responsible party acting on the Member's behalf is responsible for the notification
	Acute care	
	Long-term acute care	
	Non-routine maternity admissions	
	Skilled nursing facilities	
	Rehabilitation hospitals	
	Behavioral Health (mental health care/ substance abuse) includes partial hospitalization & intensive outpatient programs	
Diagnostic Services	Genetic disorder testing **except**: standard chromosomal tests, such as Down Syndrome, Trisomy, and Fragile X, and state mandated newborn genetic testing	Diagnostic services do not require Preauthorization when emergently performed during an emergency room visit, observation stay, or Inpatient admission.
	Cardiac nuclear medicine studies including nuclear cardiac stress tests	
	CT (computerized tomography) scans	
	MRA (magnetic resonance angiography)	
	MRI (magnetic resonance imaging),	
	PET (positron emission tomography) scans	
	SPECT (single proton emission computerized tomography) scans	

Preauthorization Program

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Category	Details	Comments
Durable Medical Equipment (DME), Prosthetic Appliances& Orthotic Devices	Purchases and Repairs greater than or equal to $500	
	Rentals for DME regardless of price per unit	
Office Surgical Procedures When Performed in a Facility*	Aspiration and/or injection of a joint	The items listed are those items or services most frequently requested. This list is not all inclusive. Depending on whether the Provider is participating or non-participating, Members or their Provider must contact Capital to confirm if items or services not listed here require Preauthorization.
	Colposcopy	
	Treatment of warts	
	Excision of a cyst of the eyelid (chalazion)	
	Excision of a nail (partial or complete)	
	Excision of external thrombosed hemorrhoids;	
	Injection of a ligament or tendon;	
	Eye injections (intraocular)	
	Oral Surgery	
	Pain management (including facet joint injections, trigger point injections, stellate ganglion blocks, peripheral nerve blocks, SI joint injections, and intercostals nerve blocks)	
	Proctosigmoidoscopy/flexible Sigmoidoscopy;	
	Removal of partial or complete bony impacted teeth (if a benefit);	
	Repair of lacerations, including suturing (2.5 cm or less);	
	Vasectomy	
	Wound care and dressings (including outpatient burn care)	
Outpatient Surgery for Select Procedures	Weight loss surgery (Bariatric)	The items listed are those items or services most frequently requested. This list is not all inclusive. Depending on whether the Provider is participating or non-participating, Members or their Provider must contact Capital to confirm if items or services not listed here require Preauthorization.
	Implantation electrical nerve stimulator	
	Meniscal transplants, allografts and collagen meniscus implants (knee)	
	Ovarian and Iliac Vein Embolization	
	Photodynamic therapy	
	Radioembolization for primary and metastatic tumors of the liver	
	Radiofrequency ablation of tumors	
	Transcatheter aortic valve replacement	
	Valvuloplasty	

Category	Details	Comments
Therapy Services	Hyperbaric oxygen therapy (non-emergency)	
	Manipulation therapy (chiropractic and osteopathic)	
	Occupational therapy	
	Physical therapy	
	Pulmonary rehabilitation programs	
	Respiratory Therapy	
	Radiation therapy and related treatment planning and procedures performed for planning (such as but not limited to IMRT, proton beam, neutron beam, brachytherapy, 3D conform, SRS, SBRT, Gamma knife, EBRT, IORT, IGRT)	
Reconstructive or Cosmetic Services and Items	Removal of excess fat tissue (Abdominoplasty/Panniculectomy and other removal of fat tissue such as Suction Assisted Lipectomy)	The items listed are those items or services most frequently requested. This list is not all inclusive. Depending on whether the Provider is participating or non-participating, Members or their Provider must contact Capital to confirm if items or services not listed here require Preauthorization.
	Breast Procedures • Breast Enhancement (Augmentation) • Breast Reduction • Mastectomy (Breast removal or reduction) for Gynecomastia • Breast Lift (Mastopexy) • Removal of Breast implants	
	Correction of protruding ears (Otoplasty)	
	Repair of nasal/septal defects (Rhinoplasty/Septoplasty)	
	Skin related procedures • Acne surgery • Dermabrasion • Destruction of premalignant skin cells • Hair removal (Electrolysis/Epilation) • Face Lift (Rhytidectomy) • Removal of excess tissue around the eyes (Blepharoplasty/Brow Ptosis Repair) • Mohs Surgery	
	Treatment of Varicose Veins and Venous Insufficiency	
Transplant Surgeries	Evaluation and services related to transplants	Preauthorization will include referral assistance to the Blue Distinction Centers for Transplant network if appropriate.

Preauthorization Program

Effective Date: 01/01/2015 HMO

Category	Details	Comments
Other Services	Bio-engineered skin or biological wound care products	
	Category IDE trials (Investigational Device Exemption)	
	Clinical trials (including cancer related trials)	
	Enhanced external counterpulsation (EECP)	
	Home health care	
	Home infusion therapy	
	Eye injections (Intravitreal angiogenesis inhibitors)	
	Laser treatment of skin lesions	
	Non-emergency air and ground ambulance transports	
	Radiofrequency ablation for pain management	
	Facility based sleep studies for diagnosis and medical Management of obstructive sleep apnea	
	Specialty medical injectable medications	
	Enteral feeding supplies and services.	
	All care performed by a Non-Participating Provider	

PLEASE NOTE: This listing identifies those services that require Preauthorization only as of the date it was printed. This listing is subject to change. Members should call Keystone at 1-800-962-2242 (TDD number at 711) with questions regarding the Preauthorization of a particular service.

This information highlights the standard Preauthorization Program. Members should refer to their Agreement for the specific terms, conditions, exclusions and limitations relating to their Coverage.

ISSUED BY:
KEYSTONE HEALTH PLAN CENTRAL

Individual HMO Subscriber Agreement

Supplemental Drug Rider

THIS IS IMPORTANT TO YOU – This Supplemental Drug Rider (the "Supplemental Rider") is attached to and made a part of a Member's Keystone Health Plan Central ("Keystone") Individual HMO Subscriber Agreement (the "Agreement").

Coverage under this Supplemental Rider is subject to all terms, conditions, limitations and exclusions set forth in the Agreement to which it is attached except as specifically amended herein. This Supplemental Rider is effective on the Subscriber's Effective Date as set forth in the Agreement.

The Agreement is amended as follows:

PARTICIPATING PHARMACIES: Covered Drugs obtained from Participating Pharmacies are covered under this Supplemental Rider. Members who obtain Covered Drugs through Mail Service Dispensing must use the Mail Service Pharmacy designated by Keystone in order to receive Benefits under this Supplemental Rider. Unless otherwise approved by Keystone, Members who use Specialty Prescription Drugs must use the Specialty Pharmacy designated by Keystone in order to receive Benefits under this Supplemental Rider.

DESCRIPTION OF COVERAGE: COVERED DRUG BENEFITS: Coverage for Covered Drugs under this Supplemental Rider is subject to Deductible, Copayments, and Coinsurance as set forth in Schedule SB – Schedule of Cost-Sharing, Benefits, Limitations & Exclusions.

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Article I - INTRODUCTION

For the purposes of this Supplemental Rider, the term "Keystone" means Keystone Health Plan Central, a wholly owned subsidiary of Capital BlueCross.

The Subscriber and Keystone agree that Keystone shall provide coverage for Benefits in consideration of the Subscriber's timely payment of required Premiums. NO BENEFITS ARE AVAILABLE UNDER THIS SUPPLEMENTAL RIDER IN THE ABSENCE OF CURRENT PAYMENT OF REQUIRED PREMIUMS.

This Supplemental Rider explains your coverage with Keystone. Capitalized words are defined in Article II - Definitions, unless they are the title of a person, a department, or a committee within Keystone. All of the terms and conditions, including, but not limited to, defined terms contained in this Supplemental Rider, are binding on Keystone and the Subscriber.

Benefits shall be covered under this Supplemental Rider as long as they are Medically Necessary and Appropriate.

This Supplemental Rider may not cover all of your Prescription and Over-the-Counter Drugs. Read this Supplemental Rider carefully to determine which services are covered.

Article II - DEFINITIONS

Any capitalized term listed in this Article II shall have the meaning set forth below whenever the capitalized term is used in this Supplemental Rider:

Ancillary Charge(s): Shall mean the difference in cost between a Generic Drug and a Brand Drug, which the Member is obligated to pay. Ancillary Charges do not accrue to the Deductible or Out-of-Pocket Maximum.

Benefits: Shall mean those Medically Necessary and Appropriate Prescription Drugs, Over-the-Counter Drugs, Preventive Coverage, services, Diabetic Supplies, and other supplies covered under, and in accordance with, this Supplemental Rider.

Brand Drug: Shall mean a Prescription Drug sold under its proprietary name(s) by one or more companies. A Brand Drug may or may not have a Generic Drug equivalent available.

Coinsurance: Shall mean the percentage of the Plan Allowance that will be paid by the Member. The Member must pay Coinsurance directly to the Pharmacy at the time services are rendered. Coinsurance percentages, if any, are identified in the **Summary of Cost-Sharing, Benefits, Limitations & Exclusions** section of this Supplemental Rider.

Contracting Rx Entities: Shall mean pharmaceutical manufacturers, PBMs and other third parties with which Keystone may contract for certain Over-the-Counter, Preventive and Prescription products provided to Members.

Copayment: Shall mean the fixed dollar amount that a Member must pay for certain Benefits. The Member must pay Copayments directly to the Pharmacy at the time services are rendered. Copayments, if any, are identified in the **Summary of Cost-Sharing, Benefits, Limitations & Exclusions** section of this Supplemental Rider.

Cost-Sharing Amount: Shall mean the amount subtracted from the Plan Allowance which the Member is obligated to pay before Keystone makes payment for Benefits. Cost-Sharing amounts include: Copayments, Deductibles, Coinsurance, Ancillary Charges, and Out-of-Pocket Maximums.

Covered Drugs: Shall mean, unless specifically excluded, any and all Prescription Drugs, Over-the-Counter and Preventive Drugs mandated by law and diabetic supplies that are, dispensed pursuant to a valid Prescription Order, in each case for the Outpatient use of the Member.

Deductible: Shall mean the amount of the Plan Allowance that must be incurred by a Member each Agreement Year before Benefits are covered under this Supplemental Rider. Deductibles are described in the **Summary of Cost-Sharing, Benefits, Limitations & Exclusions** section of this Supplemental Rider.

Diabetic Supplies: Shall mean medication and supplies used to treat diabetes, including but not limited to: insulin, needles, and syringes. Diabetic Supplies do not include batteries, alcohol swabs, preps and gauze.

Enhanced Prior Authorization (Step Therapy): Shall mean an automated form of Prior Authorization that encourages the use of drugs that should be tried first before coverage is available for other therapies, based on clinical practice guidelines and cost-effectiveness.

Formulary: Shall mean a continually updated list of Prescription Drugs which represents the current clinical judgment of Physicians and other experts in the treatment of disease and preservation of health.

Generic Drug: Shall mean a Prescription Drug, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the FDA as therapeutically equivalent and interchangeable with the Brand Drug having an identical amount of the same active ingredient and identified as such on industry accepted master drug database files (e.g. MediSpan).

Infertility: Shall mean the medically documented diminished ability to conceive, or to conceive and carry to live birth. A couple is considered infertile if conception does not occur after a one-year period of unprotected coital activity without contraceptives, or there is the inability on more than one occasion to carry to live birth.

Investigational: For the purposes of this Supplemental Rider, shall mean a drug, treatment, device, or procedure is Investigational if:

- it cannot be lawfully marketed without the approval of the Food and Drug Administration ("FDA") and final approval has not been granted at the time of its use or proposed use;
- it is the subject of a current Investigational new drug or new device application on file with the FDA;
- the predominant opinion among experts as expressed in medical literature is that usage should be substantially confined to research settings;
- the predominant opinion among experts as expressed in medical literature is that further research is needed in order to define safety, toxicity, effectiveness or effectiveness compared with other approved alternatives; or
- it is not investigational in itself, but would not be Medically Necessary and Appropriate except for its use with a drug, device, treatment, or procedure that is investigational.

In determining whether a drug, treatment, device or procedure is investigational, the following information may be considered:

- the Member's medical records;
- the protocol(s) pursuant to which the treatment or procedure is to be delivered;
- any consent document the patient has signed or will be asked to sign, in order to undergo the treatment or procedure;
- the referred medical or scientific literature regarding the treatment or procedure at issue as applied to the injury or illness at issue;
- regulations and other official actions and publications issued by the federal government; and
- the opinion of a third party medical expert in the field, obtained by Keystone, with respect to whether a treatment or procedure is investigational.

Mail Service Dispensing: Shall mean the dispensing of maintenance Prescription Drugs through the designated Mail Service Pharmacy in quantities up to and not to exceed a ninety (90) day supply per Prescription Order.

Mail Service Pharmacy: Shall mean a duly licensed Mail Service Pharmacy or Pharmacies, designated by Keystone, where Prescription Orders are received through the mail or other means and from which Prescription Drugs are shipped to Members via the United States Postal Service, United Parcel Service, or other delivery service.

Maintenance Choice: Shall mean covered maintenance medications that are available for up to a 90 day supply through mail service or at CVS Pharmacies.

Medically Necessary and Appropriate: Shall mean:

- services or supplies that a Physician exercising prudent clinical judgment would provide to a Member for the diagnosis and/or direct care and treatment of the Member's medical condition, disease, illness, or injury that are necessary;
- in accordance with generally accepted standards of good medical practice;
- clinically appropriate for the Member's condition, disease, illness or injury;
- not primarily for the convenience of the Member and/or the Member's family, Physician, or other health care Provider; and
- not more costly than alternative services or supplies at least as likely to produce equivalent results for the Member's condition, disease, illness or injury.

For these purposes, "generally accepted standards of good medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other clinically relevant factors. The fact that a Provider may prescribe, recommend, order, or approve a service or supply does not of itself determine that it is Medically Necessary and Appropriate or make such a service or supply a covered Benefit.

Non-Participating Pharmacy: Shall mean a Pharmacy who is not under contract with, directly or indirectly, Keystone or the PBM.

Non-Participating Pharmacy Level: Shall mean the level of payment made by Keystone when a Member receives Benefits from a Non-Participating Pharmacy.

Non-Preferred Brand Drug: Shall mean a medication that has been reviewed by the Capital Pharmacy & Therapeutics Committee and found not to have significant therapeutic advantage or overall value over alternative Generic Drugs, Preferred Brand Drugs or Over-the-Counter medications that treat the same condition, factoring in safety, efficacy and cost.

Out-of-Pocket Maximum: Shall mean the amount of the Plan Allowance that a Member is required to pay during an Agreement Year. After this amount has been paid, the Member is no longer required to pay any portion of the Plan Allowance for Benefits during the remainder of that Agreement Year. The amount of the Out-of-Pocket Maximum is described in the **Summary of Cost-Sharing, Benefits, Limitations & Exclusions** section of this Supplemental Rider.

Over-the-Counter Drug: Shall mean Federal Food and Drug Administration drugs that can legally be obtained or dispensed without requiring a prescription from a licensed health care provider.

Participating Pharmacy(ies): Shall mean a Pharmacy or other Prescription Drug provider that is approved by Keystone and, where licensure is required, is licensed in the applicable state and provides covered services and has entered into a Provider agreement with or is otherwise engaged by Keystone or its PBM to provide Benefits to Members. The status of a Pharmacy as a Participating Pharmacy may change from time to time. It is the Member's responsibility to verify the current status of a Pharmacy.

Participating Pharmacy Level: Shall mean the level of payment made by Keystone when a Member receives Benefits from a Participating Pharmacy in accordance with Keystone's policies and procedures.

Pharmaceutical Utilization Management Programs: Shall include, but is not limited to, the following programs:

- Drug Utilization Review;
- Prior Authorization and Enhanced Prior Authorization (Step Therapy); and
- Drug Quantity Management (Quantity Level Limits).

Pharmacy(ies): Shall mean a Pharmacy or other appropriate Prescription Drug Provider that is approved by Keystone and, where licensure is required, is licensed in the state in which it practices or is located and provides covered services and performs services within the scope of such licensure. Pharmacies include Participating Pharmacies and Non-Participating Pharmacies.

Pharmacy Benefit Manager (PBM): Shall mean the Pharmacy Benefit Manager under contract with Keystone to, among other things, assist in the administration of the Benefits under this Supplemental Rider.

Plan Allowance: Shall mean the charge or payment level that Keystone determines is reasonable for benefits provided to a Member:

- The Plan Allowance for Participating Pharmacies is the lesser of the Participating Pharmacy's actual charge or the amount agreed to between Keystone and the PBM.
- The Plan Allowance for Non-Participating Pharmacies is the lesser of the Non-Participating Pharmacy's actual charge or the Participating Pharmacy Level.

Preferred Brand Drug: Shall mean a medication that has been reviewed and approved by the Capital Pharmacy & Therapeutics Committee and found to have a therapeutic advantage or overall value over Non-Preferred Brands that treat the same condition, factoring in safety, efficacy and cost.

Preferred Medication List: Shall mean an abbreviated version of the Formulary, containing the names of some of the most commonly prescribed drugs. A copy of the Preferred Medication List in effect on the date this Supplemental Rider is issued is provided with the Supplemental Rider. The Preferred Medication List is periodically updated and Members are responsible for determining whether a drug is covered prior to filling a Prescription Order. A Member can determine whether a drug is covered and/or request an updated copy of the Preferred Medication List by calling Customer Service at 1-800-962-2242 or accessing the information on the Keystone website capbluecross.com.

Prescriber: Shall mean a person who is licensed and legally entitled to prescribe Prescription Drugs, including but not limited to a Doctor of Medicine (M.D.), a Doctor of Osteopathic Medicine (D.O.), a Certified Registered Nurse Practitioner, or a Certified Physician Assistant (PA-C).

Prescription Drug: Shall mean any FDA-approved medication which, by federal or state law, may not be dispensed without a Prescription Order.

Prescription Order: Shall mean the request for a Covered Drug issued by a Prescriber.

Preventive Coverage: Shall mean certain categories of Over-the-Counter and Prescription Drugs for which coverage is mandated by law as included in preventive care services coverage based on recommendations from the U.S. Preventive Services Task Force as well as the Institute of Medicine.

Prior Authorization: Shall mean an authorization (or approval) from Keystone or its designee which results from a process utilized to determine Benefit coverage and Medical Necessity and appropriateness based on clinical practice guidelines with a requirement that specific criteria are met.

Retail Dispensing: Shall mean the dispensing of Covered Drugs on-site at a Retail Pharmacy in quantities up to a thirty (30) day supply per Prescription Order.

Retail Pharmacy: Shall mean any Pharmacy which is licensed to sell and dispense Prescription Drugs excluding a Mail Service Pharmacy and excluding a Pharmacy that dispenses Prescription Drugs solely via the Internet.

Schedule of Cost-Sharing, Benefits, Limitations & Exclusions: Shall mean the Schedule of Cost-Sharing, Benefits, Limitations & Exclusions set forth in Schedule SB of this Supplemental Rider.

Selectively Closed Formulary: A formulary system in which coverage for Non-Preferred Brand Drugs is limited to select therapeutic classes and/or drugs.

Specialty Pharmacy: Shall mean a Retail Pharmacy contracted with and designated by Keystone to dispense Specialty Prescription Drugs. A Specialty Pharmacy may receive Prescription Orders through the mail or other means and may ship Specialty Prescription Drugs to Members via the United States Postal Service, United Parcel Service, or other delivery service.

Specialty Pharmacy Preferred: Shall mean for most Specialty Drugs, coverage is available only when dispensed by Keystone's designated Specialty Prescription Drug provider.

Specialty Prescription Drugs: Shall mean biotech and other self-administered Prescription Drugs that are covered under a Prescription Drug benefit typically used in the treatment of complex and potentially life-threatening illnesses. These biopharmaceutical medications typically require special handling and storage.

Article III - PHARMACEUTICAL UTILIZATION MANAGEMENT PROGRAMS

A wide range of Pharmaceutical Utilization Management Programs are available under this coverage with Keystone.

Pharmaceutical Utilization Management Programs include, but are not limited to:

- Drug Utilization Review;
- Prior Authorization and Enhanced Prior Authorization (Step Therapy); and
- Drug Quantity Management.

A. Drug Utilization Review (DUR)

Drug utilization review (DUR) evaluates each Covered Drug dispensed against the Member's prescription profile, which reflects all Covered Drugs acquired from Participating Retail Pharmacies, Participating Specialty Pharmacies, and Participating Mail Service Pharmacies while covered by Keystone. Concurrent DUR alerts the Pharmacist to clinical and plan-specific criteria/edits warranting consideration prior to dispensing. Retrospective DUR alerts the Prescriber to potential issues that may require further assessment.

A Covered Drug obtained through Retail Dispensing from a Participating Pharmacy, Participating Specialty Pharmacy, or from the designated Mail Service Pharmacy will be subject to a drug utilization review at the point-of-sale to identify potential concerns such as adverse drug interactions, duplicate therapies, early refills, and maximum dose.

A Member's prescription profile may be reviewed periodically to monitor appropriate care based on standards of good pharmaceutical practice. The retrospective drug utilization review assists in identifying any potential drug interactions, duplicate drug therapy, drug dosage and duration issues, drug misuse, drug over utilization, less than optimal drug utilization, and drug abuse. If a potential problem is identified, the Prescriber will be notified to further assess and make any necessary changes in therapy or when appropriate and applicable. Interventions may include limiting access to a Prescriber and/or dispensing Pharmacy under appropriate circumstances.

B. Investigational Treatment Review

This coverage with Keystone does not include Prescription Drugs and/or services that Keystone or its designee determines to be Investigational as defined in the **Definitions** section of this Supplemental Rider.

However, Keystone recognizes that situations occur when a Member elects to pursue Investigational treatment at the Member's own expense. If the Member receives a Prescription Drug and/or service which Keystone considers to be Investigational, the Member is solely responsible for payment of this Prescription Drug and/or service; and the non-covered amount will not be applied to the annual Out-of-Pocket Maximum or Deductible, if applicable.

A Member, a Provider, or a Pharmacy may contact Keystone to determine whether Keystone considers a Prescription Drug or service to be Investigational.

C. Prior Authorization

To promote appropriate utilization, selected Prescription Drugs require Prior Authorization before the Prescription Drug is dispensed by the Pharmacy to be eligible as a Covered Drug. These Prescription Drugs are designated in the Formulary. A copy of the Formulary can be requested by calling Customer Service at 1-800-962-2242 or accessed via the Keystone website at capbluecross.com.

Certain Covered Drugs, which are dispensed pursuant to a Prescription Order for the Outpatient use of the Member, are subject to other limits and/or Prior Authorization requirements, as determined by Keystone in its sole discretion from time to time and as thereafter communicated to the Members. For information as to which Covered Drugs are subject to any limits and/or require Prior Authorization, the Member can contact Customer Service at 1-800-962-2242 or access the information on the Keystone website at capbluecross.com.

Members may initiate a Prior Authorization request via the Keystone website at capbluecross.com or by calling Customer Service at 1-800-962-2242. Providers may assist Members in obtaining the required Prior Authorizations. However, the Member is ultimately responsible for ensuring the required Prior Authorization is obtained.

A Prior Authorization decision is generally issued within two (2) business days of receiving all necessary information for non-urgent requests.

D. Enhanced Prior Authorization (Step Therapy)

Certain Covered Drugs that are dispensed pursuant to a Prescription Order for the Outpatient use of the Member are subject to other limits and/or Enhanced Prior Authorization requirements, as determined by Keystone in its sole discretion from time to time and as thereafter communicated to members.

Enhanced Prior Authorization uses clinical practice guidelines to encourage the use of the most cost effective and safest drug as a first-line therapy prior to progressing to more costly second-line therapy, if necessary. Drugs that are designated as second line or higher are automatically authorized at the point-of-sale if the prerequisite steps have been met. Drugs subject to Enhanced Prior Authorization are designated in the Formulary.

For information as to which Covered Drugs are subject to any limits and/or Enhanced Prior Authorization, the Member can contact Customer Service at 1-800-962-2242 or access the information on the Keystone website at capbluecross.com.

E. Drug Quantity Management (Quantity Level Limits)

To facilitate proper utilization and encourage the use of therapeutically indicated drug regimens, some Covered Drugs, which are dispensed pursuant to a Prescription Order for the Outpatient use of the Member, are limited to specific quantities on a per prescription or per day supply basis.

Benefits for such Covered Drugs shall be available based on the quantity which Keystone will determine, in its sole discretion, is a reasonable supply for up to thirty (30) days through Retail Dispensing and Specialty Pharmacy dispensing or up to ninety (90) days through Mail Service Dispensing; or for each Prescription Order.

These Covered Drugs are designated in the Formulary. A copy of the Formulary can be requested by calling Customer Service at 1-800-962-2242 or accessed via the Keystone website at capbluecross.com.

For information as to which Covered Drugs are subject to any limits and/or require Prior Authorization, the Member can contact Customer Service at 1-800-962-2242 or access the information on the Keystone website at capbluecross.com.

F. Mandatory Generic Substitution Program

When a Prescription Order is filled with a Generic Drug, the Member is responsible for the applicable Coinsurance and/or Copayment.

When a Prescription Order is dispensed with a Brand Drug, which has an approved Generic Drug equivalent, the Member is responsible for the applicable Cost Sharing Amount and the difference in cost between such Brand Drug, and the Generic Drug equivalent, even if the Prescriber requires such Brand Drug to be dispensed in place of such Generic Drug equivalent.

G. Alternative Treatment Plans

Notwithstanding anything under this coverage to the contrary, Keystone, in its sole discretion, may elect to provide Benefits, including but not limited to select products which do not legally require a prescription, pursuant to an approved alternative treatment plan for services that would otherwise not be covered. Such services require Prior Authorization from Keystone. All decisions regarding the treatment to be provided to a Member remain the responsibility of the treating Physician and the Member.

If Keystone elects to provide alternative Benefits for a Member in one instance, it does not obligate Keystone to provide the same or similar Benefits for any Member in any other instance, nor can it be construed as a waiver of Keystone's right to administer this coverage thereafter in strict accordance with its express terms.

Article IV - BENEFITS

Subject to the conditions and limitations of this Supplemental Rider and the Schedule of Cost-Sharing, Benefits, Limitations & Exclusions, a Member is entitled to the Benefits described in the Schedule of Cost-Sharing, Benefits, Limitations and Exclusions attached hereto, during the Agreement Year. The Benefits listed on the Schedule of Cost-Sharing, Benefits, Limitations and Exclusions shall be covered under the terms and conditions of this Supplemental Rider when determined to be Medically Necessary and Appropriate and are not otherwise excluded or limited in this Supplemental Rider or the Schedule of Cost-Sharing, Benefits, Limitations & Exclusions. The Benefits, level of payment, and any applicable Cost-Sharing Amounts are set forth in the Schedule of Cost-Sharing, Benefits, Limitations & Exclusions.

Article V - LIMITATIONS AND EXCLUSIONS

Benefits under this coverage are subject to the limitations set forth in this Supplemental Rider and in the Schedule of Cost-Sharing, Benefits, Limitations and Exclusions. Except as specifically provided in this Supplemental Rider, no Benefits are provided under this coverage with Keystone for services, supplies, or Covered Drugs described or otherwise identified in the list of Exclusions set forth in the Schedule of Cost-Sharing, Benefits, Limitations & Exclusions.

Article VI - CLAIMS REIMSURSEMENT

A. Claims and How They Work

In order to receive payment for Benefits under this coverage, a claim for Benefits must be submitted to the PBM. The claim is based upon the itemized statement of charges for Covered Drugs and/or services provided by a Pharmacy. After receiving the claim, the PBM will process the request and determine if the Covered Drugs and/or services provided under this coverage with Keystone are Benefits provided by the Member's coverage, and if applicable, make payment on the claim. The method by which the PBM receives a claim for Benefits is dependent upon the type of Provider from which the Member receives services. Providers that are excluded or debarred from governmental plans are not eligible for payment by Keystone.

1. Participating Pharmacies

When Members receive Covered Drugs or services from a Participating Pharmacy, they should show their Keystone Identification Card to the Pharmacy. The Participating Pharmacy will submit a claim for Benefits directly to the PBM. Members will not need to submit a claim. Payment for Benefits – after applicable Cost-Sharing Amounts, if any - is made directly to that Participating Pharmacy.

2. Non-Participating Pharmacies

If Members receive Covered Drugs or services from a Non-Participating Pharmacy, they will be required to pay for the Covered Drug and/or service at the time the Covered Drug is dispensed or at the time the service is rendered. Non-Participating Pharmacies do not file claims on behalf of Keystone's Members. Therefore, Members need to submit their claim to the PBM for reimbursement.

B. Plan Allowance

The Benefit payment amount is based on the Plan Allowance on the date the Covered Drug is dispensed or the date the service is rendered.

C. Filing A Claim

If it is necessary for Members to submit a claim to the PBM, they should be sure to request an itemized bill from the Pharmacy. The itemized bill should be submitted to the PBM with a completed and signed Prescription Drug Claim Form.

Members can obtain a copy of the Prescription Drug Claim Form by contacting Customer Service or visiting the Member link on Keystone's website at capbluecross.com. A separate claim form must be completed for each Member who received Covered Drugs or services.

1. Where to Submit Covered Drug Claims

Members can submit their claims, which include a completed Prescription Drug Claim Form, an itemized bill, and all required information listed above, to the following address:

CVS Caremark
PO Box 52136
Phoenix, Arizona 85072-2136

Members who need help submitting a Covered Drug claim can contact Customer Service at the telephone number on their ID card.

D. Claim Filing and Processing Time Frames

1. Time Frames for Submitting Claims

All claims must be submitted within ninety (90) days from the date of service with the exception of claims from certain State and Federal agencies.

2. Time Frames Applicable to Covered Drug Claims

Paper claims submitted to the PBM are processed within ten (10) business days, on average, of receiving the properly completed claim. Keystone may extend the filing/processing timeframe period one (1) time for up to fifteen (15) days for circumstances beyond Keystone's control. Keystone will notify the Member prior to the expiration of the original time period if an extension is needed. The Member and Keystone may also agree to an extension if the Member or Keystone requires additional time to obtain information needed to process the claim.

E. Coordination of Benefits (COB)

Coordination of Benefits is not applicable to this coverage.

Article VII - EXCEPTION PROCEDURES

A. Requests for Exceptions to the HMO's Drug Formulary

If the Member is prescribed a drug that is not on the HMO drug formulary (or is Non-Preferred), he or she has two options. The Member may ask the HMO for a list of similar drugs that are on the HMO's formulary and ask their prescribing physician to prescribe a similar formulary drug if appropriate. The Member or the Member's prescribing physician may also ask the HMO to make an exception to cover a drug that is not on the formulary or to waive coverage restrictions or limits on their drug. If the HMO grants a request to cover a non-formulary drug, the Member may not request a higher level of coverage. A request for a formulary exception should be made by calling or writing the HMO's Pharmacy Benefit Manager at:

CVS Caremark
1300 E. Campbell Road
Richardson, TX 75081
Attn: PA Department
Phone: 1-877-432-0116

Generally, the HMO will only approve a request for an exception if the alternative drugs included on the drug formulary, the lower tier drug, or additional utilization restrictions such as quantity limits would not be as effective in treating the Member's condition and/or would cause the Member to have adverse medical effects.

When requesting a formulary or utilization restriction exception, the Member's prescribing physician should submit an oral or written statement supporting the request. Generally, the HMO must make an initial coverage decision within 72 hours of getting the prescribing physician's supporting statement. The Member may request an expedited exception determination if the Member's life or health could be seriously harmed by waiting up to 72 hours for a decision. If the Member's request to expedite the exception process is granted, the HMO must make an initial coverage decision no later than 24 hours after receiving the prescribing physician's supporting statement.

If the HMO denies the exception request the Member may appeal the decision. The appeal must be made within 180 calendar days of the date of the Member's receipt of the initial coverage decision. The Member may appeal either by calling the Customer Service number on the back of the Member's identification card or by faxing or writing the HMO at:

Keystone Health Plan Central
P.O. 779518
Harrisburg, PA 17177-9518

Fax: 1-717-541-6915

The appeal should include the reason(s) the Member disagrees with the HMO's initial coverage decision. The HMO will review the appeal and respond in writing as expeditiously as possible but within 7 days from receipt of the appeal. If the Member's life or health could be seriously harmed by waiting up to 7 days for a decision, the Member may request an expedited appeal and the HMO will make a determination as expeditiously as possible within 72 hours after receiving the expedited appeal.

If the exception request is denied on appeal to the HMO, the Member may request an external review by an Independent Review Entity (IRE). The request for an external review must be made within 60 days after the Member receives the internal appeal denial notice. The Member may request an external review by calling the HMO at the Customer Service number on the back of the Member's identification card or by faxing the HMO at the fax number above or by writing to the HMO's address set forth above. If the Member's prescribing physician did not already provide the HMO with a statement supporting the request for an exception, such a statement should be included along with the external appeal request. The HMO will forward the appeal and all supporting information to the IRE for review. The IRE will make a decision within 72 hours of receipt of the request for an external appeal. If the Member's life or health could be seriously harmed by waiting up to 72 hours for the

external decision on appeal, the Member may ask for an expedited external appeal and the IRE will issue a decision within 24 hours. The IRE will notify the Member and the HMO verbally of the decision and will provide a written determination within 48 hours after the verbal notice has been given.

Article VIII - GENERAL PROVISIONS

A. Assignment/Transferability

No person other than a Member is entitled to receive Covered Drugs or other Benefits to be furnished by Keystone under this Supplemental Rider. Any right to Covered Drugs or services or other Benefits is not transferable.

B. Changes in Law

The parties recognize that this Supplemental Rider at all times is to be subject to applicable federal, state and local law. The parties further recognize that this Supplemental Rider shall be subject to:

- Amendments in such laws and regulations; and
- New legislation.

Any provisions of law that invalidate or otherwise are inconsistent with the terms of this Supplemental Rider or that would cause one or both of the parties to be in violation of the law, shall be deemed to have superseded the terms of this Supplemental Rider; provided, however that the parties shall exercise their best efforts to accommodate the terms and intent of this Supplemental Rider consistent with the requirements of law. In the event that any provision of this Supplemental Rider is rendered invalid or unenforceable by an Act of Congress, or by the Pennsylvania Legislature, or by a regulation duly promulgated by officers of the United States, or of the Commonwealth of Pennsylvania acting in accordance with law, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of this Supplemental Rider shall remain in full force and effect.

C. Choice of Pharmacy

The choice of a Pharmacy is solely the Member's. Keystone does not furnish Benefits but only makes payment for Benefits received by Members. Keystone is not liable for any act or omission of any Pharmacy. Keystone has no responsibility for a Pharmacy's failure or refusal to render Benefits or services to a Member. The use or non-use of an adjective such as participating or non-participating in describing any Pharmacy is not a statement as to the ability, cost or quality of the Pharmacy.

Keystone cannot guarantee continued access during the term of the Member's Keystone enrollment to a particular Pharmacy. If the Member's Participating Pharmacy ceases participation, Keystone, through the PBM, will provide access to other Pharmacies with similar credentials.

D. Discretionary Changes by Keystone

Keystone may change coverage for Benefits, Deductibles, Copayments, Coinsurance and other Cost-Sharing Amounts, or otherwise change coverage upon thirty-one (31) days prior notice at renewal of this Supplemental Rider. Any such change is subject to the prior approval of the Pennsylvania Insurance Department and must be on a uniform basis among all individuals with the same contract form.

E. No Third-Party Beneficiaries

This Supplemental Rider is solely between the Subscriber and Keystone and it is not intended to be and is not enforceable by any third parties.

F. Identification Cards

Keystone will issue Identification Cards to Members.

G. Relationship among Keystone and Providers and Pharmacies

The relationship between Keystone and health care Providers and Pharmacies is that of independent contractors. Health care Providers and Pharmacies are not agents or employees of Keystone, nor is Keystone or any employee of Keystone an employee or agent of health care Providers or Pharmacies.

H. Responsibility for Payment

A Member shall have only those rights and privileges specifically provided in this Supplemental Rider. Subject to the provisions of this Supplemental Rider, a Member is responsible for payment of any amount due to a Provider in excess of the Benefit amount paid by Keystone hereunder.

I. Waiver

The failure of Keystone to enforce any provision of this Supplemental Rider shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, Keystone's failure to enforce any remedy arising from a default under the terms of this Supplemental Rider shall not be deemed or construed to be a waiver of such default. Moreover, payment of a claim does not waive Keystone's right to deny coverage for the reasons specified in this Supplemental Rider.

J. Workers' Compensation

This Supplemental Rider is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance.

Keystone HEALTH PLAN CENTRAL
A Capital BlueCross Company
Independent Licensees of the BlueCross BlueShield Association

Individual HMO Subscriber Agreement

Supplemental Drug Rider

SCHEDULE SB –SCHEDULE OF COST-SHARING, BENEFITS, LIMITATIONS & EXCLUSIONS

SECTION A. SUMMARY OF COST-SHARING & BENEFITS

The Summary of Cost-Sharing & Benefits provides a summary of applicable Cost-Sharing Amounts and the Benefits provided under this coverage with Keystone. The Benefits listed in this Summary are covered in accordance with Keystone's Pharmaceutical Utilization Management policies and procedures.

(Subject to definitions, terms, conditions, exclusions, limitations, Prior Authorization, and other requirements set forth more fully in this Supplemental Rider and this Schedule of Cost-Sharing, Benefits, Limitations & Exclusions.)

SUMMARY OF COST-SHARING			
	Amounts Members Are Responsible For:		
	Retail	**Mail Service**	**Specialty Pharmacy**
	If a retail pharmacy chooses to participate as a mail service pharmacy, then the mail service cost-share applies to all services received from such retail pharmacy.		
Deductible (per Agreement Year)	Per Member Per family Combined with Medical Deductible		
Copayments			
• Generic Drug	Paid in full after Deductible	Paid in full after Deductible	Paid in full after Deductible
• Preferred Brand Drug	Paid in full after Deductible	Paid in full after Deductible	Paid in full after Deductible
• Select Non-Preferred Brand Drug	Paid in full after Deductible	Paid in full after Deductible	Paid in full after Deductible
• Non-Preferred Brand Drug	Not Covered	Not Covered	Not Covered
• Preventive Coverage (excluding Prescription Contraceptives)	No Cost Share	No Cost Share	No Cost Share
Contraceptives (Self Administered)			
• Generic Drug	No Cost Share	No Cost Share	Not Covered

SUMMARY OF COST-SHARING			
	Amounts Members Are Responsible For:		
	Retail	**Mail Service**	**Specialty Pharmacy**
• Select Brand Drug* *For contraceptive therapeutic categories that have no generic option, an available brand drug as determined by Keystone may be purchased at no cost share to the Member	No Cost Share	No Cost Share	Not Covered
• Preferred Brand Drug	Not applicable	Not applicable	Not Covered
• Non-Preferred Brand Drug	Not Covered	Not Covered	Not Covered
Coinsurance	Not applicable	Not applicable	Not applicable
Out-of-Pocket Maximum	$6,350 per Member $12,700 per Family This Out-of-Pocket Maximum amount is combined with, and not in addition to, the Out-of-Pocket Maximum amount reflected in the Schedule of Cost-Sharing – Medical Benefits. This combined Out-of-Pocket Maximum amount can be satisfied with eligible amounts incurred for medical benefits, Covered Drug Benefits, pediatric dental benefits (if covered by Capital), pediatric vision benefits, or a combination of all benefits.		

SUMMARY OF RESTRICTIONS APPLICABLE TO PRESCRIPTION DRUG BENEFITS			
	Retail	**Mail Service**	**Specialty Pharmacy**
Days Supply	Up to 30 days	Up to 90 days	Up to 30 days
Ample Day Supply Limit Percent of the previous supply dispensed that must be used by the Member before a refill will be dispensed. *Retail ample day supply limit is 60% if the retail pharmacy chooses to participate as a mail service pharmacy.	75%*	60%	75%
Drug Quantity Management	Applicable		
Prior Authorization	Applicable		
Enhanced Prior Authorization (Step Therapy)	Applicable		
Specialty Medication Preferred Network	Applicable		
Generic Substitution Policy	**Mandatory Generic Substitution Program** When the Member requests a Prescription Order be dispensed with a Brand Drug, which has an approved Generic Drug equivalent, the Member is responsible for the applicable Brand Drug Coinsurance and/or Copayment in addition to the difference in cost between such Brand Drug and the Generic Drug equivalent, even if the Prescriber requests such Brand Drug to be dispensed in place of an approved Generic Drug equivalent.		
Maintenance Choice	The initial dispensing of maintenance covered drugs plus one refill(s) available through Retail Dispensing. Subsequent refills are covered only through Mail Service or at CVS Pharmacies.		
Specialty Pharmacy	For most Specialty Medications coverage is available only when dispensed by Accredo Health Group, Inc.		

On behalf of Keystone Health Plan Central, CVS/caremark. assists in the administration of Keystone's prescription drug program. CVS/caremark is an independent company.

On behalf of Keystone Health Plan Central, Accredo Health Group, Inc assists in the delivery of specialty medications directly to Members. Accredo Health Group, Inc is an independent company.

SUMMARY OF BENEFITS This list of is intended to be a summary of the most frequently used therapeutic drug classes. It is not a complete list of Covered Drugs.*			
Drug Category	**Retail** (Up to a 30-day supply)	**Mail Service** (Up to a 90-day supply)	**Specialty Pharmacy** (Up to a 30-day supply)
Contraceptives (Self-Administered)	Covered	Covered	Not Covered
Diabetic Supplies	Covered	Covered	Not Covered
Vitamins	Covered	Covered	Not Covered
Topical Retinoid Products	Covered	Covered	Not Covered
Anti-flu therapy	Covered	Not Covered	Not Covered
Specialty Drugs (Self-Administered)	Not Covered	Not Covered	Covered
Prescriptions for Mental Health and Addiction Disorders	Covered	Covered	Covered
Fertility Drugs (Oral)	Covered	Covered	Covered
Sexual Dysfunction Drugs	Not Covered	Not Covered	Not Covered
Weight Loss Drugs (Prescription)	Not Covered	Not Covered	Not Covered
Nicotine Cessation Drugs (Prescription)	Covered	Covered	Not Covered

*Members should refer to the Formulary for the most updated Covered Drug information.

SECTION B. COST-SHARING DESCRIPTIONS

APPLICATION OF COST-SHARING

All payments made by Keystone for Benefits are based on the Plan Allowance. The Plan Allowance is the maximum amount that Keystone will pay for Benefits under this coverage. Before Keystone makes payment, any applicable Cost-Sharing Amount is subtracted from the Plan Allowance.

Payment for Benefits may be subject to any of the following Cost-Sharing Amounts:

1. Deductibles
2. Copayments
3. Coinsurance
4. Out-of-Pocket Maximums

In addition, Members are responsible for payment of any:

Ancillary Charges, as described in the Generic Substitution section of this Supplemental Rider.

Balance billing charges, which Members pay to a Non-Participating Pharmacy and which exceed the Plan Allowance.

Services for which Benefits are not provided under the Member's coverage, without regard to the Pharmacy's participation status.

DEDUCTIBLE

A Deductible is a dollar amount that an individual Member or a Subscriber's entire family must incur before Benefits are paid under this coverage. The Plan Allowance that Keystone otherwise would have paid for Benefits is the amount applied to the Deductible.

> For Example: The Plan Allowance for a particular Covered Drug provided by a Participating Pharmacy is $60. If the Member's coverage includes a $500 Deductible for Participating Pharmacy Benefits, the Member is responsible for this $60. The Participating Pharmacy will collect this amount from the Member at the time the Covered Drug is dispensed. Keystone will then apply this $60 towards the $500 Deductible applicable to the Member's coverage. So, on the Member's $500 Deductible, the remaining Deductible amount which must be met would be $440.
>
> In this example, payment for the claim is calculated as follows: Subtract the Plan Allowance from the Member's total Deductible amount to determine the remaining Deductible amount the Member must meet ($500 - $60 = $440).

For each Deductible amount that may apply to this coverage, two (2) Deductible amounts may apply: an individual Deductible and a family Deductible. Each Member must satisfy the individual Deductible applicable to this coverage every Agreement Year before Benefits are paid. Once the family Deductible has been met, Benefits will be paid for a family Member regardless of whether that family Member has met his/her individual Deductible. In calculating the family Deductible, Keystone will apply the amounts satisfied by each Member towards the Member's individual Deductible. However, the amounts paid by each Member that count towards the family Deductible are limited to the amount of each Member's individual Deductible.

The Deductible amount is combined with, and not in addition to, the Deductible amount reflected in the Schedule of Cost-Sharing – Medical Benefits. This combined Deductible amount can be satisfied with eligible amounts incurred for medical benefits, Covered Drug Benefits, or a combination of the two.

Members should refer to the Summary of Cost-Sharing section of this Schedule of Cost-Sharing, Benefits, Limitations & Exclusions to determine if any Deductibles apply to their coverage.

COPAYMENT

A Copayment is a fixed dollar amount that a Member must pay directly to the Pharmacy for Benefits at the time services are rendered. Copayment amounts may vary, depending on the type of Covered Drug for which Benefits are being provided.

For Example: The Plan Allowance for a particular Covered Drug provided by a Participating Pharmacy is $60. If the Member's coverage includes a $10 Copayment for that particular Covered Drug, the Participating Pharmacy will collect $10 from the Member at the time the Covered Drug is dispensed. This Copayment is part of the Plan Allowance for the Benefit provided under the Member's coverage. Since the Participating Pharmacy already received $10 from the Member, Keystone, through its PBM, will reimburse the Participating Pharmacy a maximum of $50 for the Covered Drug. The Participating Pharmacy still receives the total Plan Allowance of $60; it is just shared between the Member and Keystone.

In this example, payment for the claim is calculated as follows: Subtract the Copayment paid by the Member from the Plan Allowance to determine Keystone's payment to the Participating Pharmacy ($60 – $10 = $50).

The Member in this example would be responsible for paying the Participating Pharmacy $10, and Keystone would be responsible for paying the Participating Pharmacy $50. So, in the end, the Participating Pharmacy receives a total of $60 (the Plan Allowance).

Members should refer to the Summary of Cost-Sharing section of this Schedule of Cost-Sharing, Benefits, Limitations & Exclusions to determine if any Copayments apply to their coverage.

COINSURANCE

Coinsurance is the percentage of the Plan Allowance payable for a Benefit that Members are obligated to pay.

For Example: The Plan Allowance for a particular Covered Drug provided by a Participating Pharmacy is $60. Assuming any applicable Deductible has been met, and the Member's coverage includes a 10% Coinsurance, the Plan Allowance of $60 will be multiplied by 10%, which equals $6. This $6 will then be subtracted from the Plan Allowance of $60, leaving $54, which will be reimbursed to the Participating Pharmacy. The Participating Pharmacy will then collect the $6 from the Member at the time the Covered Drug is dispensed.

In this example, payment for the claim is calculated as follows: Multiply the Plan Allowance by the Coinsurance percentage to determine the member's liability ($60 x 10% = $6). Subtract the Coinsurance amount from the Plan Allowance to determine Keystone's payment to the Participating Pharmacy ($60 – $6 = $54). The Member in this example would be responsible for paying the Participating Pharmacy $6, and Keystone would be responsible for paying the Participating Pharmacy $54. So, in the end, the Participating Pharmacy receives a total of $60 (the Plan Allowance).

A claim for a Non-Participating Pharmacy is calculated differently than a claim for a Participating Pharmacy.

For Example: A Non-Participating Pharmacy's billed charge is $100 for a particular Covered Drug. Assuming the applicable Deductible has been met and the Member's coverage includes a 10% Coinsurance, the Member would pay the $100 charge directly to the Non-Participating Pharmacy. The Member then submits the claim form to the PBM.

In this example, assuming the Plan Allowance is $60, the PBM will calculate payment for the claim as follows: Multiply the Plan Allowance by the Coinsurance percentage to determine the Member's Coinsurance amount ($60 x 10% = $6). Subtract the Coinsurance amount from the Plan Allowance to determine Keystone's payment to the Member ($60 – $6 = $54). So, the Member in this example would be responsible for paying a total of $46.

So, in the end, the Non-Participating Pharmacy has been paid a total of $100, and the Member's cost share is $46.

Members should refer to the Summary Cost-Sharing section of this Schedule of Cost-Sharing, Benefits, Limitations & Exclusions to determine if Coinsurance applies to their coverage.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the maximum amount of Deductible, Copayments, and Coinsurance that an individual Member or a Subscriber's entire family must pay during an Agreement Year.

For Example: Expanding on the previous Coinsurance example for Participating Pharmacies, the Member owes the Participating Pharmacy $6 after Coinsurance was applied to the Plan Allowance for the Benefits provided under this coverage. This $6 is the Member's "out-of-pocket" expense. If the Member's coverage includes an Out-of-Pocket Maximum of $1,000, this $6 is applied to the $1,000. The result is that the Member must pay $994 in additional out-of-pocket expenses during the Agreement Year before the Coinsurance is waived and Benefits pay at 100% of the Plan Allowance.

In this example, payment for the claim is calculated as follows: Subtract the Coinsurance amount from the Member's total Out-of-Pocket Maximum amount to determine the remaining Out-of-Pocket Maximum amount the Member must meet ($1,000 - $6 = $994).

For each Out-of-Pocket Maximum amount that may apply to this coverage, two (2) Out-of-Pocket Maximum amounts may apply: an individual Out-of-Pocket Maximum and a family Out-of-Pocket Maximum. Each Member must satisfy the individual Out-of-Pocket Maximum applicable to this coverage every Agreement Year. Once the family Out-of-Pocket Maximum has been met, Benefits will be paid for a family member regardless of whether that family member has met his/her individual Out-of-Pocket Maximum. In calculating the family Out-of-Pocket Maximum, Keystone will apply the amounts satisfied by each Member toward the Member's individual Out-of-Pocket Maximum. However, the amounts paid by each Member that count towards the family Out-of-Pocket Maximum are limited to the amount of each Member's individual Out-of-Pocket Maximum.

The Out-of-Pocket Maximum amount is combined with, and not in addition to, the Out-of-Pocket Maximum amount reflected in the Schedule of Cost-Sharing – Medical Benefits. This combined Out-of-Pocket Maximum amount can be satisfied with eligible amounts incurred for medical benefits, Covered Drug Benefits, or a combination of the two.

Members should refer to the Summary of Cost-Sharing section of this Schedule of Cost-Sharing, Benefits, Limitations & Exclusions to determine if any Out-of-Pocket Maximums apply to their coverage.

BALANCE BILLING CHARGES

Pharmacies have an amount that they bill for the Covered Drugs and/or services furnished to Members. This amount is called the Pharmacy's billed charge. There may be a difference between the Pharmacy's billed charge and the Plan Allowance.

How the interaction between the Plan Allowance and the Pharmacy's billed charge affects the payment for Benefits and the amount the Member will be responsible to pay a Pharmacy varies depending on whether the Pharmacy is a Participating Pharmacy or a Non-Participating Pharmacy.

- For Participating Pharmacies, the Plan Allowance for a Benefit is set by the Pharmacy's contract. These contracts also include language whereby the Pharmacy agrees to accept the amount paid by Keystone, minus any Cost-Sharing Amount due from the Member, as payment in full.

For Example: The billed charge for a Covered Drug is set by the Pharmacy to be $100. Keystone's Plan Allowance for this Covered Drug is $60. If the Pharmacy is a Participating Pharmacy who has agreed to accept the Plan Allowance, minus any Cost Sharing Amount from the Member, as payment in full, $60 is the maximum dollar amount the Pharmacy will be reimbursed for this Covered Drug; and the Member will not be billed for the additional $40.

- For Non-Participating Pharmacies, the Plan Allowance for a Benefit determines the maximum amount Keystone will pay a Member for Benefits. Since the Non-Participating Pharmacy does not have a contract to provide Covered Drugs or services to Keystone Members, the Pharmacy has not agreed to accept Keystone's payment, minus any Cost-Sharing Amount due from the Member, as payment in full. The Plan Allowance in these situations can be less than the Pharmacy's charge. Therefore, the Member is also responsible for paying the difference between the Pharmacy's charge and the Plan Allowance in addition to any applicable Cost-Sharing Amount. All payment for Covered Drugs and services provided by a Non-Participating Pharmacy will be made to the Member.

For Example: The billed charge for a Covered Drug is set by the Pharmacy to be $100. Keystone's Plan Allowance for this Covered Drug is $60. Since the Non-Participating Pharmacy does not have a contract to provide Covered Drugs or services to Keystone Members, the Member is responsible for paying the full $100 charge. However, the Member can file a claim for reimbursement. The maximum payment Keystone will make to the Member is the Plan Allowance of $60 minus any applicable Cost-Sharing Amounts. Assuming the Member has no other Cost Sharing Amount obligations, the remaining $40 is the Member's expense (in addition to the Member's applicable Copayment or Coinsurance).

SECTION C. BENEFIT DESCRIPTIONS

Subject to the terms, conditions, definitions, Limitations and Exclusions specified in this Supplemental Rider and this Schedule of Cost-Sharing, Benefits, Limitations & Exclusions and subject to the payment by Members of the applicable Cost-Sharing Amounts, if any, Members shall be entitled to receive coverage for the Benefits as described below and listed in the Summary of Benefits. Covered Drugs and services will be covered by Keystone: a) only if they are Medically Necessary and Appropriate; and b) only if they are prior authorized (as applicable) by Keystone and/or its designee; and c) only if the Member is actively enrolled at the time of the service.

It is important to refer to the Summary of Benefits and the Summary of Cost-Sharing sections of this Schedule of Cost-Sharing, Benefits, Limitations & Exclusions to determine whether a drug, a therapeutic class of drugs, and/or a service is a covered Benefit, to determine the amounts Members are responsible for paying to Pharmacies, and to determine whether any Benefit limitations/maximums apply to this coverage.

Certain Prescription Drugs require Prior Authorization, are subject to Enhanced Prior Authorization or are limited to specific quantities by Keystone or its designee.

OBTAINING BENEFITS FOR COVERED DRUGS AND RELATED SERVICES

Depending on the Member's specific coverage, the level of payment for Benefits is affected by whether the Member chooses a Participating Pharmacy or a Non-Participating Pharmacy.

Members can choose any Retail Pharmacy to obtain Covered Drugs, although their costs are generally less when they obtain Covered Drugs from a Participating Retail Pharmacy. Members have the option to visit a Non-Participating Retail Pharmacy, but it generally costs them more.

Members who obtain Prescription Drugs through the Mail Service Pharmacy must utilize the Mail Service Pharmacy designated by Keystone in order to receive Benefits under this coverage.

Members who use select Specialty Prescription Drugs must utilize the Specialty Prescription Drug vendor designated by Keystone in order to receive Benefits under this coverage.

COVERED DRUGS AND SERVICES PROVIDED BY PARTICIPATING PHARMACIES

A Participating Pharmacy is a Pharmacy or other Prescription Drug Provider that is approved by Keystone and, where licensure is required, is licensed in the Commonwealth of Pennsylvania (or such other jurisdiction approved by Keystone) and has entered into a Provider agreement with or is otherwise engaged by Keystone or its PBM to provide Benefits to Members. Because Participating Pharmacies agree to accept Keystone's payment for covered Benefits - along with any applicable Cost-Sharing Amounts that Members are obligated to pay under the terms of this coverage - as payment in full, Members can maximize their coverage and minimize their out-of-pocket expenses by using a Participating Pharmacy.

All Participating Pharmacies must seek payment, other than Cost-Sharing Amounts, from Keystone through the PBM. Participating Pharmacies may not seek payment from Members for Covered Drugs and/or services that qualify as Benefits under this Supplemental Rider. However, a Participating Pharmacy may seek payment from Members for non-covered drugs and services, including specifically excluded drugs and services, or services in excess of quantity/day supply maximums. The Participating Pharmacy must inform Members prior to providing the non-covered drugs and/or services that they may be liable to pay for these drugs and/or services, and the Members must agree to accept this liability.

The status of a Pharmacy as a Participating Pharmacy may change from time to time. It is the Member's responsibility to verify the current status of a Pharmacy. To find a Participating Pharmacy, Members can call the telephone number on their ID card or 1-800-962-2242 or visit capbluecross.com.

OBTAINING RETAIL DISPENSING BENEFITS

The Identification Card issued by Keystone shall be presented to the Participating Pharmacy when the Member applies for Benefits under this Supplemental Rider. For Covered Drugs dispensed by a Non-Participating Pharmacy, or for Covered Drugs purchased without the Identification Card, the Member must submit a claim for payment to the PBM or Keystone.

For Covered Drugs obtained from a Participating Retail Pharmacy, the Participating Pharmacy will supply Covered Drugs up to a thirty (30) day supply and will not make any charge or collect from the Member any amount, except for any applicable Cost-Sharing Amounts.

Refills may be dispensed under this Supplemental Rider subject to federal and state law limitations, and only in accordance with the number of refills designated on the original Prescription Order. Refills may not be dispensed more than one (1) year after the date of the original Prescription Order. When a Prescription Order is written for a Covered Drug that has previously been dispensed to a Member or a Prescription Order is presented for a refill, the Covered Drug will be dispensed only at such time as the Member has used seventy-five (75%) of the previous supply dispensed through Retail Dispensing in accordance with the associated Prescription Order.

Select Specialty Prescription Drugs are available exclusively through Keystone's Specialty Prescription Drug Provider. To obtain the most current list of Specialty Prescription Drugs, visit Keystone's website at capbluecross.com or call the Specialty Prescription Drug Provider at 1-877-595-3707.

The PBM and Keystone are each authorized, by the Member, to make payments directly to a state or federal governmental agency or its designee whenever the PBM or Keystone are required by law or regulation to make payment to such entity.

OBTAINING MAIL SERVICE DISPENSING BENEFITS

To obtain mail order Benefits, the Member shall mail the following items to the designated Mail Service Pharmacy:

- a completed order form and patient profile;
- applicable Copayment and/or Coinsurance; and
- the Prescription Order.

Members can obtain the mail service order forms in the following ways:

- access Keystone's website at capbluecross.com;
- contact Customer Service at the phone number listed on their Identification Card; or
- with the delivery of the mail order prescription, subsequent order forms will be supplied.

Maintenance Covered Drugs, subject to any applicable Cost-Sharing Amount, may be dispensed such that each Prescription Order shall be up to and not exceed a 90-day supply.

Refills may be dispensed under this Supplemental Rider, subject to federal and state law limitations, and only in accordance with the number of refills designated on the original Prescription Order. Refills may not be dispensed more than one (1) year after the date of the original Prescription Order. When a Prescription Order is written for a Covered Drug that has previously been dispensed to a Member or a Prescription Order is presented for a refill, the Covered Drug will be dispensed only at such time as the Member has used sixty percent (60%) of the previous supply dispensed through Mail Service Dispensing in accordance with the associated Prescription Order.

Certain Covered Drugs will not be available for Mail Service Dispensing due to safety and quality concerns. Such Covered Drugs will be subject to Retail Dispensing or Specialty Pharmacy Dispensing only.

COVERED DRUGS AND SERVICES PROVIDED BY NON-PARTICIPATING PHARMACIES

A Non-Participating Pharmacy is a Pharmacy who does not contract with, directly or indirectly, Keystone or the PBM to provide Benefits to Members.

Covered Drugs and/or services provided by Non-Participating Pharmacies may require higher Cost-Sharing Amounts or may not be covered. If such Covered Drugs and/or services are covered, Benefits will be reimbursed based on the Plan Allowance applicable to this coverage with Keystone.

Members may be responsible for the difference between the Non-Participating Pharmacy's charge for a Covered Drug and/or service and the Plan Allowance for that Covered Drug and/or service. This difference between the Pharmacy's charge for a Covered Drug and/or service and the Plan Allowance is called the balance billing charge. There can be a significant difference between what Keystone pays to the Member and what the Pharmacy charges. In addition, all payments are made directly to the Member. Additional information on balance billing charges can be found in the Cost-Sharing Descriptions section of this Schedule of Cost-Sharing, Benefits, Limitations & Exclusions.

THE FORMULARY

The Selectively Closed Formulary provides Members access to quality, affordable medications. The Selectively Closed Formulary includes Generic Drugs, Preferred Brand Drugs, and select Non-Preferred Brand Drugs that have been approved by the U.S. Food and Drug Administration (FDA). The Selectively Closed Formulary is updated by the Capital Pharmacy and Therapeutics Committee on a quarterly basis or when new generic or brand-name medications become available and as discontinued drugs are removed from the marketplace. Members can request a current copy of the Formulary by contacting Customer Service at 1-800-962-2242 or by accessing the Keystone website at capbluecross.com.

SECTION D. LIMITATIONS

The Benefits provided under this Supplemental Rider are subject to the following limitations:

1. A Participating Pharmacy or Non-Participating Pharmacy need not dispense a Prescription Order that for any reason, in its professional judgment, should not be filled.

2. A Member may purchase a non-select Non-Preferred Brand Drug if it could be used to treat his or her condition. If, however, a Member purchases a non-select Non-Preferred Brand Drug, the Member may be responsible for paying the entire cost of the non-select Non-Preferred Brand Drug.

3. A Member may purchase a Brand Drug, even if an approved Generic Drug equivalent could be used to treat his or her condition. If, however, a Member purchases a Brand Drug and such approved Generic Drug equivalent is available, the Member is responsible for paying the applicable Brand Drug Coinsurance and/or Copayment in addition to the difference in cost between the Brand Drug and the approved Generic Drug equivalent, (i.e. Ancillary Charge) even if the Prescriber requests that the Brand Drug be dispensed.

4. Refills may be dispensed subject to federal and state law limitations and only in accordance with the number of refills designated on the original Prescription Order. Refills may not be dispensed more than one (1) year after the date of the original Prescription Order. When a Prescription Order is written for a Covered Drug that has previously been dispensed to a Member or a Prescription Order is presented for a refill, the Covered Drug will be dispensed only at such time as the Member has used sixty percent (60%) of the previous supply dispensed through the designated Mail Service Pharmacy or seventy-five (75%) of the previous supply dispensed through a Retail Pharmacy or Specialty Pharmacy in accordance with the associated Prescription Order.

5. Certain Covered Drugs will not be available for Mail Service Dispensing due to safety or quality concerns. Such Covered Drugs will be subject to Retail Dispensing or Specialty Pharmacy Dispensing only.

6. All Covered Drugs are subject to availability at the Retail Pharmacy, Specialty Pharmacy, or Mail Service Pharmacy.

7. Specialty Prescription Drugs will be subject to dispensing only through a designated Specialty Pharmacy unless otherwise approved by Keystone.

8. Prescription Drugs classified by the federal government as narcotics may be subject to dispensing or dosage limitations based on standards of good pharmaceutical practice or state or federal regulations.

9. Keystone reserves the right to determine the reasonable supply of any Covered Drug based on standards of good pharmaceutical practice.

10. Certain Covered Drugs, which are dispensed pursuant to a Prescription Order for the Outpatient use of the Member, are subject to quantity limits. Benefits for these Covered Drugs shall be available based on the quantity which Keystone will determine, in its sole discretion, is a reasonable per prescription or per day supply for Retail Dispensing, Specialty Pharmacy dispensing, or Mail Service Dispensing.

11. Certain Prescription Drugs require Prior Authorization for coverage prior to the delivery of Covered Drugs.

12. Certain Prescription Drugs, which are dispensed pursuant to a Prescription Order for the Outpatient use of the Member, are subject to Enhanced Prior Authorization (Step Therapy).

SECTION E. EXCLUSIONS

Except as specifically provided in this Supplemental rider or this Schedule of Cost-Sharing, Benefits, Limitations & Exclusions, no Benefits are provided under this coverage with Keystone for services, supplies, or Covered Drugs:

1. Which are not Medically Necessary and Appropriate as determined by Keystone or its designee;

2. Unless otherwise set forth in this Supplemental Rider or this Schedule of Cost-Sharing, Benefits, Limitations & Exclusions, drugs that do not legally require a prescription as determined by Keystone unless payment is required by law;

3. For Prescription Drugs that have an Over-the-Counter equivalent unless payment is required by law;

4. For devices or appliances, including but not limited to, therapeutic devices, artificial appliances, or similar devices or appliances, except for Diabetic Supplies;

5. For the administration or injection of Covered Drugs;

6. For Covered Drugs received in and billed by a hospital, nursing home, home for the aged, convalescent home, home health care agency, or similar institution;

7. For allergy serums, desensitization serums, venom;

8. Which are considered by Keystone or its designee to be Investigational;

9. For any illness or injury which occurs in the course of employment if benefits or compensation are available or required, in whole or in part, under a workers' compensation policy and/or any federal, state or local government's workers' compensation law or occupational disease law, including but not limited to, the United States Longshoreman's and Harbor Workers' Compensation Act as amended from time to time. This exclusion applies whether or not the Member makes a claim for the benefits or compensation under the applicable workers' compensation policy/coverage and/or the applicable law;

10. For any illness or injury suffered after the Member's Effective Date of coverage which resulted from an act of war, whether declared or undeclared;

11. Which are received by veterans and active military personnel at facilities operated by the Veteran's Administration or by the Department of Defense, unless payment is required by law;

12. Which are received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group;

13. For the cost of Benefits resulting from accidental bodily injury arising out of a motor vehicle accident, to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used, including such benefits mandated by law) of any motor vehicle insurance policy;

14. For items or services paid for by Medicare;

15. For care of conditions that federal, state or local law requires to be treated in a public facility;

16. Which are court ordered services when not Medically Necessary and Appropriate and/or not a covered Benefit;

17. Which are rendered while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services are provided outside of any such custodial or incarcerating facility or building, unless payment is required by law;

18. Which exceed the Plan Allowance;

19. Which are Cost-Sharing Amounts, differences between Brand Drug and Generic Drug prices (i.e. Ancillary Charges), and balances due to Non-Participating Pharmacies required of the Member under this coverage;

20. For Prescription Drugs that require Prior Authorization if Prior Authorization is not obtained before dispensing the Prescription Drugs;

21. For Prescription Drugs that are subject to Enhanced Prior Authorization if Prior Authorization is not obtained before dispensing the Prescription Drugs;

22. For quantities that exceed the limits/levels established by Keystone;

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

24. Which are incurred prior to the Member's Effective Date of coverage;

25. Which are incurred after the date of termination of the Member's coverage except as provided for in this Supplemental rider or this Schedule of Cost-Sharing, Benefits, Limitations & Exclusions;

26. Which are received by a Member in a country with which United States law prohibits transactions;

27. For Covered Drugs utilized primarily to enhance physical or athletic performance or appearance;

28. For clinical cancer trial costs (e.g., drugs under investigation; patient travel expenses; data collection and analysis services), except for costs directly associated with medical care and complications, related to a Keystone approved trial, which would normally be covered under standard patient therapy Benefits;

29. For travel expenses incurred in conjunction with Benefits unless specifically identified as a covered Benefit elsewhere in this Supplemental Rider or this Schedule of Cost-Sharing, Benefits, Limitations & Exclusions;

30. For all Prescription Drugs and Over-the-Counter drugs dispensed during travel by a Physician employed by a hotel, cruise line, spa, or similar facility;

31. For durable medical equipment;

32. For blenderized baby food, regular shelf food, or special infant formula;

33. For immunization agents, biological sera, blood, blood products;

34. For requests for reimbursement of Covered Drugs submitted after the allowed timeframe for reimbursement;

35. For all Prescription Drugs and Over-the-Counter drugs dispensed in a Physician's office or by a facility provider;

36. For Prescription Drugs utilized in connection with sexual dysfunction. This exclusion applies even if such drugs are Medically Necessary and Appropriate to treat an illness or medical condition unrelated to sexual dysfunction so long as there are other drugs which can be used to treat the non-sexual dysfunction condition besides the sexual dysfunction drug;

37. For Prescription Drugs and Over-the-Counter Drugs utilized for weight loss purposes;

38. For all Prescription and Over-the-Counter Drugs utilized to promote hair growth;

39. For all Prescription and Over-the-Counter Drugs utilized for cosmetic purposes;

40. For injectable medications that cannot be self-administered;

41. For coverage through coordination of Benefits;

42. Which are received through the designated and/or Non-Participating Mail Service Pharmacy for Mail Service Dispensing and submitted for reimbursement under Retail Dispensing Benefits;

43. Which are received through a Retail Pharmacy for Retail Dispensing and submitted for reimbursement under Mail Service Dispensing Benefits;

44. For select Specialty Drugs that are received through a Retail or Mail Service Pharmacy and submitted for reimbursement under Specialty Prescription Drug dispensing Benefits;

45. For replacement of lost, stolen or damaged drugs;

46. For Covered Drugs utilized in connection with non-covered medical services; and

47. For any other Prescription and Over-the-Counter Drugs, service or treatment, except as provided in this Supplemental Rider or this Schedule of Cost-Sharing, Benefits, Limitations & Exclusions.

Issued by

CAPITAL ADVANTAGE ASSURANCE COMPANY

2500 Elmerton Avenue
Harrisburg, PA 17110

Individual Pediatric Vision Subscriber Policy

Guaranteed Renewable

This Policy provides benefits for certain Pediatric Vision services and is offered solely in connection with and integrated into the KEYSTONE HEALTH PLAN CENTRAL SUBSCRIBER AGREEMENT FORM KHPC-Ind-HMO-BroadNetwk-21ctyAGRMT-v0115 (the SUBSCRIBER AGREEMENT).

IMPORTANT NOTICE

This Policy does not participate in any divisible surplus of Premiums. This Policy is guaranteed renewable subject to timely payment of Premiums under this Policy and timely payment of Premiums under and renewal of the Subscriber Agreement issued by Keystone Health Plan Inc. ("KHPC"). Premiums under this Policy are subject to change on a uniform basis for all Subscribers covered under this Policy form.

NOTICE OF SUBSCRIBER'S RIGHT TO EXAMINE POLICY FOR TEN DAYS: If for any reason Subscriber is not satisfied with this Policy, he/she may return the Policy to the Plan within 10 days of receipt of Policy, and the Premiums paid will be promptly refunded to the Subscriber. This Policy is issued in connection with and is coordinated with the medical Policy issued by KHPC (the "Subscriber Agreement"). This Policy may only be returned with the Subscriber Agreement.

DESCRIPTION OF COVERAGE:

This Policy sets forth vision benefits coverage for Subscribers' eligible Dependents who are under the age of 19, and who reside in the following 21 counties in Pennsylvania: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union and York (collectively, the "Service Area").

ELIGIBILITY

To be eligible for coverage under this Policy, you must be a Dependent as defined in the Subscriber Agreement who has not attained the age of 19.

Coverage is issued by Capital Advantage Assurance Company. Capital Advantage Assurance Company, a wholly owned subsidiary of Capital BlueCross (hereinafter referred to as "Plan") certifies that the Member is covered under and subject to all the provisions, definitions, limitations and conditions of this Policy for the benefits approved herein, and is eligible for benefits stated in the Summary of Cost-sharing and Benefits as of the Member's effective date.

The address of the principal administrative office of Plan is: National Vision Administrators, P.O. Box 2187 Clifton, NJ 07015. The telephone number is 1-800-905-4102.

On behalf of Plan, National Vision Administrators LLC. assists in the administration of these vision benefits. National Vision Administrators LLC is an independent company.

Article I - HOW TO CONTACT US

A. Telephone

Members can call the following telephone number and speak with a Customer Service Representative 24/7, including weekends and holidays. Telephone: 1-800- 905-4102

B. Language Assistance

Plan offers language assistance for non-English speaking Members. Language assistance includes interpreting services provided directly in the Member's preferred language and document translation services available upon request. Language assistance is also available to handicapped Members. Information in Braille, large print or other alternate formats are available upon request.

To access these services, Members can simply call Plan Customer Service Department at the telephone numbers listed above.

C. Mail

Members can contact the Plan through the United States mail. When writing to the Plan, Members should include their name, the identification number from their Plan ID card, and explain their concern or question. Inquiries should be sent to:

BlueCross Vision
c/o National Vision Administrators
P.O. Box 2187
Clifton, NJ 07015

Article II - YOUR IDENTIFICATION (ID) CARD

Members should show their card and any other identification cards they may have evidencing other vision coverage each time they seek vision care services. ID cards assist providers in submitting claims to the proper location for processing and payment.

The following is important information about the ID card:

- BlueCross Vision: The words "BlueCross Vision" on the front of the card inform providers that the Member has vision coverage with the Plan.
- On the back of the ID card, Members can find the BlueCross Vision telephone number.

Article III - ADDITIONAL AND AMENDED DEFINITIONS

Terms used in this Policy but which are not defined in this Policy have the meanings defined in the Subscriber Agreement. Otherwise, and solely for this Policy, the following terms have the following meanings:

Allowance Amount - The payment level that Plan reimburses for benefits provided to a Member under this Policy.

Benefit Frequency - The limit of coverage for a benefit(s) under this Policy within a benefit period.

Benefits - Those vision services and supplies covered under, and in accordance with, this Policy.

Member - An individual who has been enrolled in the Plan by Member's Personal Representative and who is under the age of 19.

Member's Personal Representative - A parent, custodial parent, grandparent, legal guardian, or emergency guardian who has paid the Premium on behalf of Member for Pediatric Services under the Plan.

Non-Participating Vision Provider - A licensed Optician, Optometrist, Ophthalmologist or a retail eyeglass and frames supplier that is not a Member of the network of Participating Vision Providers in the Service Area.

Ophthalmologist - A person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology.

Optically Necessary/Optical Necessity - A prescription or a change of prescription is required to correct visual function.

Optician - A person or business licensed by the state in which services are rendered to manufacture, grind and/or dispense lenses and frames prescribed by either an Optometrist or an Ophthalmologist.

Optometrist - A person licensed to practice Optometry as defined by the laws of the state in which his or her services are rendered.

Participating Vision Provider - a licensed independent Optician, Optometrist, Ophthalmologist who is properly licensed, or a retail eyeglass and frames supplier, and has an agreement with the Plan, or its designee, to provide eye care services for Members under this Policy. Participating Eye Care Providers are not employees of, nor supervised by the Plan.

Pediatric Services - services covered under this Policy for Members.

Standard Lenses - Any size lenses manufactured from glass or plastic, which are optically clear; standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, glass trifocals through flat top 28 and plastic trifocals through flat top 35.

Vision Examination - An examination of principal vision functions. A vision examination includes, but is not limited to, case history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing and tonometry, if indicated. The exam will be consistent with the community standards, rules and regulations of the jurisdiction in which the provider practice is located.

Vision Services - Treatment performed for a Member by an Ophthalmologist, Optometrist, or Optician or under his/her supervision and direction and when necessary, customary and reasonable, as determined by Plan using standards of generally accepted vision practice, or a retail eyeglass and frames supplier.

Usual and Customary Fees - Fees that the Participating Eye Care Provider usually charges its patients for Vision Services when a person is not affiliated with any vision program.

Article IV - FILING CLAIMS

In order to receive payment for benefits under this Policy, a claim for benefits must be submitted to the Plan. The claim is based upon the itemized statement of charges for Vision Services and/or supplies provided by a provider. After receiving the claim, the Plan will process the request and determine if the services and/or supplies provided under this Policy with the Plan are benefits, and if applicable, make payment on the claim. The method by which the Plan receives a claim for Benefits is dependent upon the type of provider from which the Member receives services. Providers that are excluded or debarred from governmental plans are not eligible for payment by the Plan.

A. Participating Providers

When Members receive services and/or supplies from a Participating Vision Provider, they should show their Plan identification card to the provider. The Participating Vision Provider will submit a claim for benefits directly to Plan. Members will not need to submit a claim. Payment for benefits is made directly to the Participating Vision Provider.

B. Non-Participating Providers

If Members visit a Non-Participating Vision Provider, they may be required to pay for the service and/or supplies at the time the service is rendered. Although some Non-Participating Vision Providers file claims on behalf of Plan's Members, they are not required to do so. Therefore, Members need to be prepared to submit their claim to Plan for reimbursement. Payment for services provided by Non-Participating Vision Providers is made directly to the Member. It is then the Member's or Member's Representative's responsibility to pay the Non-Participating Vision Provider, if payment has not already been made.

C. Allowance Amount

The benefit payment amount is based on the allowance amount on the date the service is rendered or on the date the expense is deemed incurred by Plan.

D. Filing A Claim

Participating Vision Providers will fill out and submit the claims. Some Non-Participating Vision Providers may also provide this service upon request. If Members receive services from a Non-Participating Vision Provider who does not provide this service, Members can submit their own claim directly to Plan at the mailing address listed below. A separate claim form must be completed for each Member who received vision services. For Member convenience, Members can print a claim form from our website site at capbluecross.com.

BlueCross Vision
c/o National Vision Administrators
P.O. Box 2187
Clifton, NJ 07015

Members must also provide additional information, if applicable, including but not limited to, other insurance payment information. Members who need help submitting a vision claim can contact Customer Service at 1-800-905-4102.

Plan will contact the Member and/or the provider if additional information is needed.

E. Out-of-Country Claims

When a Member obtains vision services outside of the United States, the Member must pay for the treatment at the time of service, get a detailed receipt from the treating provider, and then submit the claim to Plan.

In addition to providing the provider's name and address (including country), the receipt should describe the vision services performed by the provider. It should also indicate whether the provider's charges were billed in U.S. dollars or another currency.

Reimbursement is subject to the terms and conditions of this Policy, and is based on the out-of-network benefit provided through this Policy.

F. Time Frames for Submitting Vision Claims

All claims must be submitted within twelve (12) months from the date of service.

G. Time Frames Applicable to Vision Claims

The Plan will process the claim within thirty (30) days of receiving the claim. Plan may extend the thirty (30)-day time period one (1) time for up to fifteen (15) days for circumstances beyond Plan's control. Plan will notify the Member prior to the expiration of the original time period if an extension is needed. The Member and Plan may also agree to an extension if the Member or Plan requires additional time to obtain information needed to process the claim.

Article V - TO APPEAL AN ADVERSE BENEFIT DETERMINATION

An adverse benefit determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) under this Policy with Plan for a service:

- Based on a determination of a Member's eligibility to enroll under this Policy;
- Not provided because it is determined to be investigational or not of optical necessity.

Members who disagree with an adverse benefit determination with respect to benefits available under this policy may seek review of the adverse benefit determination by submitting a written appeal within 180 days of receipt of the adverse benefit determination.

Members must mail their written appeal to the appropriate address below:

BlueCross Vision
c/o National Vision Administrators
1200 Route 46 West
Clifton, NJ 07013

Members have the right to submit written comments, documents, records, and other information relating to their claim for benefits. Members also have the right to receive, upon request and free of charge, copies of all documents, records, and other information related to their adverse benefit determination. A request for information does not constitute an appeal. To receive copies of this information, requests should be mailed to the above listed address.

If the notice of an adverse benefit determination advises the Member that he/she needs to submit additional information in order to perfect the claim, then the Member should make arrangements to submit all requested information if and when he/she files an appeal. Failure to promptly submit any additional information may result in the denial of the Member's appeal.

The following time frames apply to Plan's review of the Member's appeal. Plan will notify the Member of its decision within:

- Sixty (60) days of receiving the Member's appeal if the appeal involves a claim for Benefits and the Member files the appeal after receiving the vision service.
- Thirty (30) days of receiving the Member's appeal if the Member files an appeal prior to receiving the vision service.

Members who are dissatisfied with the outcome of the appeal are encouraged to voluntarily pursue further appeals through our Customer Service Department. For information about the available voluntary appeals process, Members can call Plan's Customer Service Department at 1-800-905-4102. The Member's decision as to whether or not to submit a benefit dispute to the voluntary level of appeal will not affect his/her rights to other Benefits.

Designating an Individual to Act on the Member's Behalf

Members may designate another individual to act on their behalf in pursuing a benefit claim or appeal of an unfavorable benefit decision.

To designate an individual to serve as their "authorized representative", Members must complete, sign, date, and return a Member Authorization Form. Members may request this form from our Customer Service Department at 1-800-905-4102.

Capital communicates with the Member's authorized representative only after Plan receives the completed, signed, and dated authorization form. The Member's authorization form will remain in effect until the Member notifies Plan in writing that the representative is no longer authorized to act on the Member's behalf, or until the Member designates a different individual to act as his/her authorized representative.

Article VI - TERMINATION OR CANCELLATION

Benefits shall cease upon the earliest of the following events:

- Upon the date of Member attaining the age of 19 years.
- Termination and cessation of benefits coverage under the Subscriber Agreement.

Article VII - SUMMARY OF BENEFITS

Benefit frequencies are based on the date of service.	Amounts Members Are Responsible For:	
	Participating Providers	Non-Participating Providers
EXAMINATION		
Benefit frequency once every twelve months	Paid in Full	Balance of retail charge after $32 allowance
FRAMES		
Benefit frequency once every twelve months	Standard Frames: Paid in Full on frames selected from a frame collection. All other frames: Balance of retail charge less 30% after $100 allowance*	Balance of retail charge after $30 allowance
EYEGLASS LENSES (PER PAIR)		
Benefit frequency once every twelve months		
Single Vision Standard Lenses	Paid in Full	Balance of retail charge after $24 allowance
Bifocal Standard Lenses	Paid in Full	Balance of retail charge after $36 allowance
Trifocal Standard Lenses	Paid in Full	Balance of retail charge after $46 allowance

*Frame allowance at Walmart® Vision Centers is 50% of the frame allowance shown above with no additional retail discount.

Article VIII - SUMMARY OF VALUE ADDED DISCOUNTS

In addition to the standard benefits program. Value Added discounts are available when services are rendered by participating network providers. These discounts are not considered insurance under this coverage with Capital.

Lens Options purchased from a participating provider will be provided to the Member at the amounts listed below. Lens Options not listed will be discounted 20% of the retail charge. Lens Options that are purchased from a non-participating provider will not be discounted and are the full responsibility of the Member.

SUMMARY OF VALUE ADDED DISCOUNTS	Amounts Members Are Responsible For:	
	Participating Providers	Non-Participating Providers
LENS OPTIONS		
Solid Tint	$10	No discount
Fashion/Gradient Tint	$12	No discount
Standard Scratch-Resistant Coating	$10	No discount
Ultraviolet Coating	$12	No discount
Standard Anti-Reflective Coating	$40	No discount
Glass Photogrey	$20 single vision $30 bifocal or trifocal	No discount
Polarized	$75	No discount
Standard Progressive Lenses	$50	No discount
Premium Progressive Lenses	$100	No discount
Transitions	$65 single vision $70 bifocal or trifocal	No discount
Polycarbonate Standard Lenses	$25 single vision $30 bifocal or trifocal	No discount
Blended Bifocal (segment)	$30	No discount
High Index	$55	No discount
ADDITIONAL SUPPLIES		
Additional purchases of Lenses and Frames (excluding contact lenses)	Retail less 20%	No discount
LASIK SURGERY		
Lasik Surgery	Standard pricing less 15% or promotional pricing less 5%	No discount

Article IX - LIMITATIONS

In addition to the exclusions listed in the Schedule of Exclusions in this Policy, the benefits provided under this vision coverage are subject to the following limitations:

1. Participating providers are not contractually obligated to offer sale prices in addition to the outlined coverage.

2. Vision benefits may be subject to limitations or not applicable when used in conjunction with promotional offers.

3. Regardless of optical necessity, vision benefits are not available more frequently than and are subject to the other limitations as specified in the Summary of Cost-Sharing and Benefits section of this Supplemental Rider.

Article X - EXCLUSIONS

Except as specifically provided in this Policy, no benefits are provided under this coverage with Capital for services, supplies, or equipment described or otherwise identified below.

1. Services or supplies which are provided by any federal or state government agency except Medicaid, or by any municipality, county, or other political subdivision;

2. Services that are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury;

3. Charges for which benefits or services are provided to the Member by any hospital, medical or vision service corporation, any group insurance, franchise, or other prepayment plan for which an employer, union, trust or association makes contributions or payroll deductions (unless the coordination of benefit provisions provide otherwise);

4. Services provided or supplies furnished or devices started prior to the effective eligibility date of a Member;

5. Treatment or supplies for which the Member would have no legal obligation to pay in the absence of this or any other similar coverage;

6. For professional services and/or materials in connection with blended bifocals, no line, or progressive addition lenses; compensated or special multi-focal lenses; plain (non-prescription) lenses; anti-reflective, scratch, UV400, or any coating of lamination applied to lenses; and tints other than solid; polycarbonate lenses; contact lenses;

7. For examinations or materials which are not listed herein as a covered service;

8. For medical attention or surgical treatment of the eye, eyes or supporting structures;

9. For drugs or any other medications;

10. For procedures determined to be special or unusual (orthoptics, vision training, tonography, etc.);

11. For vision examinations or materials required for employment;

12. For vision examinations or materials sponsored by the subscriber's employer without charge to the subscriber;

13. For duplicate and temporary devices, appliances, and services;

14. For replacement of lost, stolen, broken or damaged lenses, or frames, unless the Member would otherwise meet the frequency limitations;

15. For parts or repair of frames;

16. For lenses which do not require a prescription;
17. For sunglasses;
18. For two pair of glasses in lieu of bifocals;
19. For low vision aids (i.e., magnifying glasses to help people with severe sight issues);
20. For industrial safety lenses and safety frames with or without side shields;
21. For services incurred after the date of termination of the Member's coverage except as provided for in this Policy;
22. For services received by a Member in a country with which United States law prohibits transactions;
23. Which exceed the allowance amount;
24. Which are Member portion of the costs required of the Member under this coverage;
25. For travel expenses incurred in conjunction with benefits;
26. For court ordered services when not of optical necessity and/or not a covered benefit;
27. For any services rendered while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services are provided outside of any such custodial or incarcerating facility or building, unless payment is required under law;
28. Which are not billed by and either performed by or under the supervision of an eligible provider;
29. For vision services rendered by a provider who is a Member of the Member's immediate family;
30. For telephone and electronic consultations between a provider and a Member;
31. For charges for failure to keep a scheduled appoint with a provider, for completion of a claim or insurance form, for obtaining copies of vision records, or for a Member's decision to cancel a vision procedure; and
32. For any other service or treatment, except as provided in this Policy.

Capital Advantage Assurance Company

2500 Elmerton Avenue
Harrisburg, PA 17110

INDIVIDUAL PEDIATRIC VISION BENEFIT CONTRACT

REQUIRED OUTLINE OF COVERAGE

(1) *Read Your Contract Carefully* – This Outline provides a very brief description of the important features of your Contract. This is not the insurance contract and only the actual Contract provisions will control. The Contract itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CONTRACT CAREFULLY!

(2) *Pediatric Vision Benefits* – Coverage for Pediatric Vision under the Contract is subject to age limits. Benefits are not subject to Deductible or Copayment. THIS COVERAGE IS DESIGNED ONLY AS A SUPPLEMENT TO A COMPREHENSIVE HEALTH INSURANCE POLICY.

(3) *Pediatric Vision Schedule of Benefits* – Subject to eligibility requirements, exclusions and limitations of the Contract, a Member is entitled to the Pediatric Vision Benefits described in the Summary of Benefits during the Benefit Period.

SUMMARY OF BENEFITS		
Benefit frequencies are based on the date of service.	Amounts Members Are Responsible For:	
	Participating Providers	Non-Participating Providers
EXAMINATION		
Benefit frequency once every twelve months	Paid in Full	Balance of retail charge after $32 allowance
FRAMES		
Benefit frequency once every twelve months	<u>Standard Frames:</u> Paid in Full on frames selected from a frame collection. <u>All other frames:</u> Balance of retail charge less 30% after $100 allowance*	Balance of retail charge after $30 allowance
EYEGLASS LENSES (PER PAIR)		
Benefit frequency once every twelve months Single Vision Standard Lenses	Paid in Full	Balance of retail charge after $24 allowance
Bifocal Standard Lenses	Paid in Full	Balance of retail charge after $36 allowance
Trifocal Standard Lenses	Paid in Full	Balance of retail charge after $46 allowance

(4) *Pediatric Vision Limitations* – Benefits for Pediatric Vision services provided under the Contract are subject to the following limitations:

1. Participating providers are not contractually obligated to offer sale prices in addition to the outlined coverage.
2. Vision benefits may be subject to limitations or not applicable when used in conjunction with promotional offers.
3. Regardless of optical necessity, vision benefits are not available more frequently than and are subject to the other limitations as specified in the Summary of Cost-Sharing and Benefits section of the Supplemental Rider.

(5) *Pediatric Vision Exclusions* – Except as specifically provided in the Contract, no Pediatric Vision Benefits will be provided under the Contract for:

1. Services or supplies which are provided by any federal or state government agency except Medicaid, or by any municipality, county, or other political subdivision;
2. Services that are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury;
3. Charges for which benefits or services are provided to the Member by any hospital, medical or vision service corporation, any group insurance, franchise, or other prepayment plan for which an employer, union, trust or association makes contributions or payroll deductions (unless the coordination of benefit provisions provide otherwise);
4. Services provided or supplies furnished or devices started prior to the effective eligibility date of a Member;
5. Treatment or supplies for which the Member would have no legal obligation to pay in the absence of this or any other similar coverage;
6. For professional services and/or materials in connection with blended bifocals, no line, or progressive addition lenses; compensated or special multi-focal lenses; plain (non-prescription) lenses; anti-reflective, scratch, UV400, or any coating of lamination applied to lenses; and tints other than solid; polycarbonate lenses; contact lenses;
7. For examinations or materials which are not listed herein as a covered service;
8. For medical attention or surgical treatment of the eye, eyes or supporting structures;
9. For drugs or any other medications;
10. For procedures determined to be special or unusual (orthoptics, vision training, tonography, etc.);
11. For vision examinations or materials required for employment;
12. For vision examinations or materials sponsored by the subscriber's employer without charge to the subscriber;
13. For duplicate and temporary devices, appliances, and services;
14. For replacement of lost, stolen, broken or damaged lenses, or frames, unless the Member would otherwise meet the frequency limitations;
15. For parts or repair of frames;
16. For lenses which do not require a prescription;
17. For sunglasses;
18. For two pair of glasses in lieu of bifocals;
19. For low vision aids (i.e., magnifying glasses to help people with severe sight issues);
20. For industrial safety lenses and safety frames with or without side shields;
21. For services incurred after the date of termination of the Member's coverage except as provided for in the Supplemental Rider
22. For services received by a Member in a country with which United States law prohibits transactions;
23. Which exceed the allowance amount;
24. Which are Member portion of the costs required of the Member under this coverage;
25. For travel expenses incurred in conjunction with benefits;
26. For court ordered services when not of optical necessity and/or not a covered benefit;

27. For any services rendered while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services are provided outside of any such custodial or incarcerating facility or building, unless payment is required under law;
28. Which are not billed by and either performed by or under the supervision of an eligible provider;
29. For vision services rendered by a provider who is a Member of the Member's immediate family;
30. For telephone and electronic consultations between a provider and a Member;
31. For charges for failure to keep a scheduled appoint with a provider, for completion of a claim or insurance form, for obtaining copies of vision records, or for a Member's decision to cancel a vision procedure; and
32. For any other service or treatment, except as provided in the Supplemental Rider.

(6) *Terms and Conditions of Renewability of the Contract* – Benefits continue for one (1) month from the Effective Date of the Contract and continue from month-to-month thereafter upon renewal of the Contract and until discontinued, terminated, or voided as provided below. Benefits shall cease upon the earliest of the following events

- Upon the date of Member attaining the age of 19 years.
- Termination and cessation of benefits coverage under the Subscriber Agreement.

(7) *Premium Rates and Benefit Changes* – Subject to the approval of the Pennsylvania Insurance Department, if such approval is required, Capital may increase or change the Benefits or Premiums on a class basis on the renewal date of the Contract. In any such event, Capital shall notify the Subscriber in writing prior to the effective date of a change in Benefits or Premiums.