Keystone HEALTH PLAN® CENTRAL
A Capital BlueCross Company

HMO

GROUP HEALTH MAINTENANCE ORGANIZATION CERTIFICATE OF COVERAGE

Administered by:
Keystone Health Plan Central,
A Subsidiary of Capital BlueCross
2500 Elmerton Avenue
Harrisburg, PA 17110

Please note:

To better serve you, members with questions about their coverage should call the Dedicated Customer Service phone number provided for your group at **1-800-216-9741**. For your convenience, this number is also located on the front of your identification card.

Capital BlueCross

NOTICE FOR PARTICIPANTS IN GRANDFATHERED GROUP HEALTH PLANS

The following notice is being provided in accordance with the Patient Protection and Affordable Care Act (PPACA):

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered heath plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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WELCOME

INTRODUCTION

Thank you for choosing health care *coverage* from the Capital BlueCross family of companies. With the Capital BlueCross family of companies, *members* get outstanding coverage for themselves and their families. *Members* also receive access to a wide variety of *participating providers*, quality customer service and valuable *clinical management* programs.

THE CAPITAL BLUECROSS FAMILY OF COMPANIES

A full range of group health care coverage and related services is available through the Capital BlueCross family of companies.

- Capital BlueCross offers Traditional hospitalization coverage.
- Capital Advantage Insurance Company®, a subsidiary of Capital BlueCross, offers Traditional medical-surgical and major medical benefits, Comprehensive, Preferred Provider Organization (PPO), Point of Service (POS), Prescription Drug, Dental (BlueCross *Dental*), Vision (BlueCross *Vision*), Senior Blue PPO (a Medicare Advantage plan), and Senior (*Medicare* complementary) coverages.
- Keystone Health Plan® Central, a subsidiary of Capital BlueCross, offers Health Maintenance Organization (HMO) and Senior Blue HMO (a Medicare Advantage plan) coverages.

Capital BlueCross, Capital Advantage Insurance Company, and *Keystone Health Plan Central* are independent licensees of the Blue Cross and Blue Shield Association.

***Coverage* is administered by *Keystone Health Plan Central*.**

HOW TO USE THIS DOCUMENT

This *Certificate of Coverage* is provided to *subscribers* as part of the *group contract* entered into between the *contract holder* and *Keystone Health Plan Central*. It explains the terms of this *coverage* with *Keystone Health Plan Central*, including coverage for *benefits* available to *members* and information on how this *coverage* is administered.

Italicized words are defined in the **Definitions** section of this *Certificate of Coverage,* and in the **Definitions** section of the *group contract*.

There are four sections in this *Certificate of Coverage* that will help *members* to better understand their *coverage. Members* should take extra time to review the following sections:

1. **How to Access Benefits**, which serves as a guide to using and making the most of this *coverage*.
2. **Summary of Cost-Sharing and Benefits**, which contains a summary of *benefits* and *benefit* limitations under this *coverage*.
3. **Schedule of Exclusions**, which contains a list of the services excluded from this *coverage*.
4. **Claims Reimbursement**, which contains important information on how to file a claim for *benefits*.

Also enclosed are the following attachments to this *Certificate of Coverage*, which are applicable to this *coverage*:

- **Schedule of Preventive Care Services** guidelines**,** which outlines the preventive care *benefits* available under this *coverage*.
- **Preauthorization Program**, which outlines the services requiring *preauthorization*.
- **Disease/Condition Management Programs**, which outlines the Disease Management Programs offered to *members*.
- **How to File an Appeal**, which outlines how to appeal an *adverse benefit determination*.

IMPORTANT NOTICES

There are a few important points that *members* need to know about their *coverage* with *Keystone Health Plan Central* before reading the remainder of this *Certificate of Coverage*, including, but not limited to, the following:

- When *members* join *Keystone Health Plan Central*, they select a *primary care physician* (*PCP*) for themselves and each of their family *members*. This *physician* provides routine care and arranges or provides most other *medically necessary* services. The *PCP* is the first point of contact for the majority of the *member's* health care needs. ***Benefits*** **are covered only when provided or properly referred by the *member's PCP*, preauthorized by *Keystone Health Plan Central* or as stated herein.**

- All of the *member's* health care expenses may not be covered. *Members* should read this *Certificate of Coverage* carefully to determine which health care services are provided as *benefits* under their *coverage*.

- Except for *emergency services* and obstetrical/gynecological care, to receive *benefits*, the *member's coverage* requires services to be performed or coordinated by the *member's primary care physician* or *behavioral health care vendor*.

- Except for *emergency services* and obstetrical/gynecological care, to receive *benefits*, the *member's coverage* requires services to be preauthorized, when required.

- *Benefits* may be subject to *cost-sharing amounts* such as *copayments*, *deductibles*, *coinsurance*, *out-of-pocket maximums*, *benefit period maximums* and *benefit lifetime maximums*. *Members* should refer to the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* to determine which *cost-sharing amounts* apply to their *coverage*.

- *Benefits* are subject to review for *medical necessity* and may be subject to *clinical management* by *Keystone Health Plan Central*.

- Clinical *medical necessity* determinations are based only on the appropriateness of services and whether *benefits* for such services are provided under this *coverage*. *Keystone Health Plan Central* 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.

- Other companies under contract with *Keystone Health Plan Central* may provide certain services, including administrative services, relating to this *coverage*.

- This *Certificate of Coverage* replaces any other *Certificates of Coverage* or Certificates of Insurance that may have been issued to the *member* previously under the *member's* coverage with the Capital BlueCross family of companies.

- This *group contract* is non-participating in any divisible surplus of premium.

- The *group contract* is available for inspection at the office of the *contract holder* during regular business hours.

- The *benefit period* for this *coverage* is the **calendar year**.

- *Keystone Health Plan Central* does not assume any financial risk or obligation with respect to *benefits* or claims for such *benefits*.

HOW TO CONTACT US

Keystone Health Plan Central is committed to providing excellent service to our *members*. The following pages outline various ways that *members* can contact *Keystone Health Plan Central*. *Members* may contact us if they have any questions or encounter difficulties using their *coverage* with *Keystone Health Plan Central*.

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:	1-800-669-7061
Telephone (TTY):	1-800-669-7075

Physical Disabilities

Keystone Health Plan Central'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 Health Plan Central's* Customer Service Department.

PREAUTHORIZATION OR OTHER CLINICAL MANAGEMENT PROGRAMS

Members can call the telephone number on their *ID card* or call *Keystone Health Plan Central's* Customer Service at 1-800-669-7061 with questions on *preauthorization*. *Members* should refer to the **Preauthorization Program** attachment to this *Certificate of Coverage* for more information.

INTERNET AND ELECTRONIC MAIL (E-MAIL)

Our Web site, www.capbluecross.com, contains information about *Keystone Health Plan Central's* products and how to utilize *benefits* and access services. *Members* may access material on standard *benefits, wellness programs* and search our 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 our Web site. 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 Health Plan Central* through the United States mail. When writing to *Keystone Health Plan Central*, *members* should include their name, the identification number from their *Keystone Health Plan Central 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

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

LANGUAGE ASSISTANCE

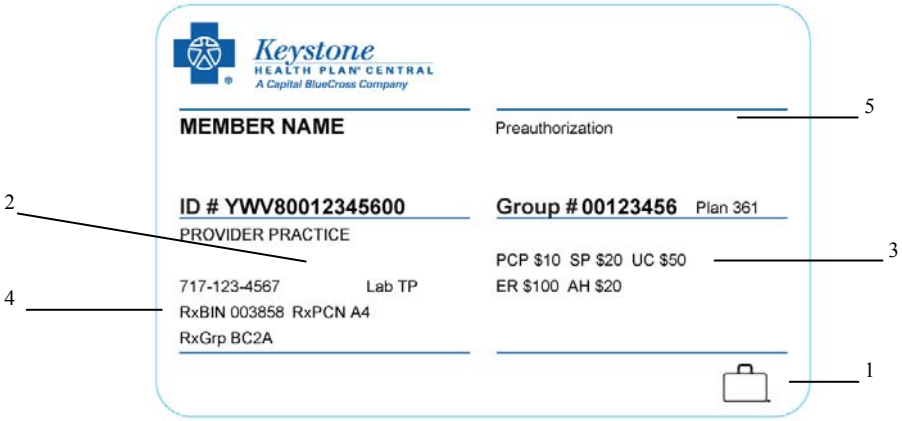
Keystone Health Plan Central offers language assistance for non-English speaking *members.* Language assistance includes interpreting services provided directly in the *member's* preferred language and document translation services available upon request. Language assistance is also available to handicapped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

To access these services, *members* can simply call *Keystone Health Plan Central's* Customer Service Department at the telephone numbers listed above.

HOW TO ACCESS BENEFITS

MEMBER IDENTIFICATION CARD (ID CARD)

The *member's identification card* is the key to accessing the *benefits* provided under this *coverage* with *Keystone Health Plan Central*. *Subscribers* and each of their *dependents* receive a card that looks similar to this:



Members should show this 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*:

1. **Suitcase Symbol**: *Keystone Health Plan Central* provides coverage for *benefits* through Blue Cross and Blue Shield affiliated *providers* when *members* are traveling outside their immediate *service area*. This program is called the national BlueCard® Program. Because *Keystone Health Plan Central* participates in this program, the suitcase symbol is on the front of the *Keystone Health Plan Central ID card*. The suitcase symbol means that *Keystone Health Plan Central members* have access to a national network of *providers* for *urgent care* services whenever they travel outside of the *Keystone Health Plan Central service area*. It also gives *providers* a better understanding of how to submit *urgent care* claims. *Keystone Health Plan Central'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*.

2. **Laboratory Services**: *Keystone Health Plan Central* 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.

3. ***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*)

4. The *member's ID card* may also contain information regarding coverage for dental, vision, and prescription drug *benefits*.
5. ***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 *Certificate of Coverage* 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.
- Emergency care information.

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

OBTAINING BENEFITS FOR HEALTH CARE SERVICES

Members do not need preauthorization from *Keystone Health Plan Central* 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 our network 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 the *Keystone Health Plan Central* Customer Service.

Providers, including, without limitation, *participating providers*, are solely responsible for the medical care rendered to their patients.

NOTE: Except for *emergency services*, all *benefits* are covered only when *members* obtain services from a *participating provider*.

Primary Care Physicians (PCPs)

Keystone Health Plan Central generally requires the designation of a *PCP*. *Members* have the right to designate any *PCP* who participates in our network 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 *PCP*s, contact the *Keystone Health Plan Central* Customer Service.

The *PCP* provides primary care services to *members* who are enrolled with the *PCP* and assumes primary responsibility for arranging and coordinating the overall health care of such *members*. If the *PCP* decides that the *member* needs the services of a specialist, diagnostic testing, or hospitalization, the *PCP* will refer the *member* to an appropriate *participating provider*. *Members* may change their *PCP* selection any time during a *benefit period* by calling *Keystone Health Plan Central* Customer Service. Typically, for *members* who call before the 15th of the month, the change will become effective the next month. For *members* who call after the 15th of the month, the change will become effective the 1st of the following month. For example, for *members* who call on January

11th, the change will be effective February 1st. However, for *members* who call on January 16th, the change will be effective March 1st. Our Customer Service Department will inform *members* of the effective date of their change. *Members* may be required to transfer to a different *PCP* if *Keystone Health Plan Central* and the *PCP* determine that the *member-PCP* relationship is unsatisfactory.

After Hours Services

Members who need medical services after normal office 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.

Referrals

When the *PCP* refers the *member* to a *participating provider*, the *PCP* will issue a *referral*. It is the *PCP's* responsibility to complete and submit the *referral* notification to *Keystone Health Plan Central*.

Keystone Health Plan Central has two (2) types of *referrals*:

- Consult and Treat - This *referral* type allows a specialist the latitude to determine the treatment required for a specific episode of illness, and is valid for up to ninety (90) days after the anticipated date of service. The specialist may also refer the *member* for additional medical services such as durable medical equipment, education/training, and *outpatient* surgeries.

- Specified Service - This *referral* type identifies the specific service(s) to be provided by the specialist or *facility provider*, and is valid for up to ninety (90) days after the anticipated date of service. The specialist or *facility provider* may perform only the service(s) indicated by the *PCP*.

At the end of the ninety (90) day period, the *member* will need to ask the *PCP* for an additional *referral* if continued medical services are necessary.

Certain services will require *Keystone Health Plan Central's preauthorization*. Please consult the **Preauthorization Program** attachment to determine which services 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 Health Plan Central* for the services that require *preauthorization*.

SERVICES COORDINATED BY THE BEHAVIORAL HEALTH CARE VENDOR

Members seeking *mental health care* and *substance abuse* services may obtain *preauthorization* for such services from the *behavioral health care vendor*.

The *behavioral health care vendor* 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 *behavioral health care vendor* 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 *behavioral health care vendor*, 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 *behavioral health care vendor*. If a need for *inpatient* care or *partial*

hospitalization is identified, the *inpatient* stay or *partial hospitalization* must be preauthorized by *Keystone Health Plan Central's behavioral health care vendor*.

HOSPITAL CARE

If hospitalization is necessary, the treating *physician* will arrange the admission to a *hospital* for the *member*. To be eligible for coverage for *benefits*, all non-emergency *hospital* admissions must be preauthorized by *Keystone Health Plan Central's* Clinical Management Department.

SPECIALTY 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* from *Keystone Health Plan Central*. *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 Health Plan Central*. *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 Health Plan Central* for the listed services.

BlueCard® Program Overview

The *BlueCard Program* is a program comprised of Blue Cross and/or Blue Shield Plans, which allows a *member* to access covered health care services for *emergency services*, *urgent care* and related follow-up services from *providers* who have a contract with another Blue Cross or Blue Shield Plan located outside the geographic area served by *Keystone Health Plan Central* ("*Host Licensee participating providers*"). The local Blue Cross and/or Blue Shield Plan, which services the geographic area where covered health care services are provided, is referred to as the Host Licensee.

Through *Keystone Health Plan Central's* affiliation with the Blue Cross and Blue Shield Association's *BlueCard Program*, *members* have access to *Host Licensee participating providers* in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Jamaica. The "Suitcase" symbol on the *member's ID card* shows *providers* that this *coverage* includes BlueCard.

Host Licensee participating providers have agreed to accept payment for covered health care services - along with any applicable *cost-sharing amounts* that *members* are obligated to pay under the terms of this *coverage* - as payment in full. Covered health care services are paid as though a *participating provider* provided services.

When *members* obtain health care services through the *BlueCard Program* outside of the geographic area served by *Keystone Health Plan Central*, the amount they pay for covered health care services is calculated on the lower of either:

- The *Host Licensee participating provider's* billed charges for their covered health care services, or

- The negotiated price that the Host Licensee passes on to *Keystone Health Plan Central*.

Often, this "negotiated price" will be a simple discount that reflects the actual price paid by the Host Licensee to the *Host Licensee participating provider*. But sometimes the negotiated price will be an estimated price that may include expected settlements, amounts withheld in accordance with the Host Licensee's contracts with the *Host Licensee participating providers*, any other contingent payment arrangements, and non-claims transactions with the *member's* health care *provider* or with a specified group of *providers*. In the alternative, the negotiated price may be billed charges reduced to reflect an average expected savings with the *member's* health care *provider* or with a specified group of *providers*. The price that reflects average savings may result in greater variation from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for over or underestimation of past prices. However, the amount the *member* pays is considered a final price.

Statutes in a small number of states may require the Host Licensee to use a basis for calculating *member* liability for covered health care services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate *member* liability calculation methods that differ from the usual *BlueCard Program* method noted in the immediately preceding paragraph or require a surcharge, *Keystone Health Plan Central* would then calculate the *member's* liability for any covered health care services in accordance with the applicable state statute in effect at the time the *member* received the care.

If *members* need *urgent care* outside of the *Keystone Health Plan Central service area*, they can call 1-800-810-BLUE or visit www.bcbs.com to find a *Host Licensee participating provider*. In the event of an emergency, *members* should seek medical care at the nearest appropriate facility.

OUT-OF-AREA SERVICES

When *members* travel outside of the *Keystone Health Plan Central service area* and need health care services, several guidelines apply. *Members* should either utilize the BlueCard Urgent Care Benefit described below or contact their *PCP*.

Subscribers and their eligible *dependents* may receive *emergency services* while traveling out of the *Keystone Health Plan Central service area*. See the **Emergency Services** section of this *Certificate of Coverage*.

Keystone Health Plan Central does not pay for routine care (such as physicals) or other non-*urgent care* provided outside of the *service area*. *Members* should schedule such care while in the *service area* through regular appointments with their *PCP*. *Members* who are going out of the *service area* for vacation or a business trip should contact their *PCP* and schedule routine care before they leave.

Urgent Care Benefit Through the BlueCard Program

For urgent medical situations when traveling out of the *service area*, *members* may be able to receive treatment by using *Keystone Health Plan Central's urgent care benefit*. *Keystone Health Plan Central* participates in BlueCard, a national network of Blue Cross and/or Blue Shield *providers* who have agreed to provide *urgent care* for Blue Cross and/or Blue Shield *members*. When *members* call 1-800-810-2583, a BlueCard representative will provide them with a list of three (3) *providers* in the area who can meet their medical needs. *Members* can also obtain a list of *participating providers* via the Internet at www.bcbs.com. *Members* who experience an emergency situation (at home or away) should go to the closest medical facility to obtain the care they need. *Members* should contact their *PCP* to inform the *PCP* of their visit. If necessary, the *member's PCP* will coordinate services under BlueCard Follow-Up Service. All follow-up services must be coordinated by the *member's PCP*. If *members* do not contact their *PCP* before receiving follow-up services, the services will not be covered by *Keystone Health Plan Central*.

Follow-Up Services Through the BlueCard Program

When follow-up care is required after receiving care under the BlueCard Urgent Care Benefit, the *member's PCP* must be contacted prior to receiving these follow-up services. The *member's PCP* will coordinate and authorize all services deemed necessary for the *member* to receive prior to returning to the *service area*. If *members* do not contact their *PCP* before receiving follow-up services, the services will not be covered by *Keystone Health Plan Central*.

Members who obtain care through their BlueCard Urgent Care Benefit should not be required to pay for their services other than any applicable *cost-sharing amounts*. However, if the *member* obtains care from a *provider* that does not participate with the local BlueCard Plan, the *member* may be required to pay in full for the services received. The back of the *ID card* lists a toll-free number which *providers* can call with questions about the *member's coverage*. *Members* who pay for the services should send to *Keystone Health Plan Central* a copy of the bill which should include itemized charges, the procedure codes, the date of service, description of services provided, and the diagnosis. The *member* will be reimbursed for *emergency services* or otherwise properly referred and preauthorized *benefits*. *Members* should send these bills to:

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

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 Health Plan Central 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 Health Plan Central* 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 www.bcbs.com.

Keystone Health Plan Central does not pay for routine care (e.g., physicals) or other non-*urgent care* provided outside of the *service area*. *Members* should schedule such care while in the *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.

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 or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- Other serious medical consequences.

Transportation and related *emergency services* provided by a licensed ambulance service are *benefits* if the condition qualifies as 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*.

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 Health Plan Central* 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.

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.

AWAY FROM HOME CARE – GUEST MEMBERSHIP PROGRAM

Members who will be out of the *service area* for an extended period of time may wish to enroll in *Keystone Health Plan Central's* Away From Home Care Guest Membership Program. This program gives *members coverage*, similar to that provided by *Keystone Health Plan Central*, at 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 the *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 Health Plan Central's* Customer Service Department by calling the telephone number on their

ID card or as outlined in this *Certificate of Coverage* 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 the *Keystone Health Plan Central service area* for greater than six (6) months or who change their permanent residence to an address outside of the *service area*, are not eligible for the Guest Membership Program.

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 Health Plan Central coverage* when approved by *Keystone Health Plan Central* in advance of receiving services. *Keystone Health Plan Central*, 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 Health Plan Central*. All terms and conditions of this *Certificate of Coverage*, including *preauthorization* requirements, will apply during any transitional period. Additionally, the *non-participating provider* must agree to accept *Keystone Health Plan Central's* reimbursement as payment in full.

Except in the case where a *participating provider* has been terminated for cause, if *Keystone Health Plan Central* initiates termination of the contract with the *provider* or a *participating provider* initiates termination with *Keystone Health Plan Central*, 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 Health Plan Central*, 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 *Certificate of Coverage*, 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 Health Plan Central* under the same terms and conditions as applicable for *participating providers*.

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

If *Keystone Health Plan Central* terminates the contract of a *participating provider* 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 Health Plan Central*, the *member* will be notified by *Keystone Health Plan Central* and must select another *PCP*. *Keystone Health Plan Central* will assist the *member* in the selection of another *PCP*. If the *member* does not select another *PCP*, *Keystone Health Plan Central* may assign the *member* to a new *PCP*. *Keystone Health Plan Central* 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*.

Members with Life-Threatening, Degenerative or Disabling Diseases or Conditions

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 *benefit*

period, 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 Health Plan Central* in consultation with the *member*, the *member's PCP* and, as appropriate, the specialist.

SUMMARY OF COST-SHARING AND BENEFITS

This section of the *Certificate of Coverage* provides a summary of the applicable *cost-sharing amounts* and *benefits* provided under this *coverage* with *Keystone Health Plan Central*.

The *benefits* listed in the **Summary of Benefits** chart in this section are covered when *medically necessary* and preauthorized (when required) in accordance with *Keystone Health Plan Central's clinical management* policies and procedures.

It is important for *members* to remember that this *coverage* is subject to the exclusions, conditions, and limitations as described in this *Certificate of Coverage*. Please see the **Cost-Sharing Descriptions**, **Benefit Descriptions**, and **Schedule of Exclusions** sections of this *Certificate of Coverage* for a specific description of the *benefits* and *benefit* limitations provided under this *coverage*.

The *benefit period* for this *coverage* is the **calendar year**.

SUMMARY OF COST-SHARING	
	Amounts *Members* Are Responsible For:
Copayments	
• Office Visits	PCP: $20 *copayment* per visit Specialist: $20 *copayment* per visit
• After Hours *PCP* Visit	$10 *copayment* per visit (This *copayment* is in addition to the *PCP* office visit *copayment*.)
• Mental Health Care (Outpatient)	Not Applicable
• Substance Abuse (Outpatient)	Not Applicable
• *Outpatient* Facility *Surgery*	Not Applicable
• Outpatient Therapy Services	Not Applicable
• Emergency Room	$25 *copayment* per visit, waived if admitted (Only one ER *copayment* will apply for the administration of the rabies vaccine series at the initial visit/injection.)
• *Urgent Care*	$25 *copayment* per visit
• *Inpatient* (Per Admission)	Not Applicable
***Benefit Period Copayment* Maximum**	Not Applicable
***Deductible* (per *benefit period*)**	Not Applicable
Coinsurance	50% *coinsurance* (where applicable)
Out-of-Pocket Maximum When the *out-of-pocket maximum* is reached, payment for all other *benefits* during the remainder of the *benefit period* are made at 100% of the *allowable amount*.	Not Applicable

SUMMARY OF BENEFITS		
	Amounts *Members* Are Responsible For:	**Limits and Maximums (If Applicable)**
ACUTE CARE HOSPITAL ROOM & BOARD AND ASSOCIATED CHARGES		
Acute Care *Hospital*	Paid in Full	
ACUTE INPATIENT REHABILITATION		
Benefits	Paid in Full	60 days per *benefit period* combined with *skilled nursing facility benefit period maximum*
SKILLED NURSING FACILITY		
Benefits	Paid in Full	60 days per *benefit period* combined with acute inpatient rehabilitation *benefit period maximum*
PROFESSIONAL PROVIDER EVALUATION & MANAGEMENT (E&M) AND CONSULTATIONS		
Inpatient E&M	Paid in Full	
Outpatient E&M (Office Visit)	PCP: $20 *copayment* per visit Specialist: $20 *copayment* per visit $10 *copayment* for *PCP* after hours visit (This *copayment* is in addition to the *PCP* office visit *copayment*.)	
Inpatient Consultations	Paid in Full	
Outpatient Consultations	PCP: $20 *copayment* per visit Specialist: $20 *copayment* per visit	
TRANSPLANT SERVICES		
Evaluation, Acquisition and Transplantation	Paid in Full	
Blue Distinction Centers for Transplant (BDCT) Travel Expenses	Paid in Full	$10,000 per transplant episode
SURGERY		
Evaluation & Management	PCP: $20 *copayment* per visit Specialist: $20 *copayment* per visit	
Surgical Procedure	Paid in Full	
Anesthesia	Paid in Full	
Mastectomy and Related Services	Paid in Full	
Oral *Surgery*	Paid in Full	
INFERTILITY SERVICES		
Benefits	50% *coinsurance*	$2,500 *benefit lifetime maximum* per *subscriber* and spouse each
MATERNITY SERVICES		
Benefits	Paid in Full	

SUMMARY OF BENEFITS		
	Amounts *Members* Are Responsible For:	**Limits and Maximums (If Applicable)**
Initial Office Visit to *PCP* or Obstetrician to Confirm Pregnancy	PCP: $20 *copayment* per visit Specialist: $20 *copayment* per visit	
INTERRUPTION OF PREGNANCY		
Benefits	Paid in Full	
NEWBORN CARE		
Benefits	Paid in Full	
DIAGNOSTIC SERVICES		
Radiology Tests	Paid in Full	
Laboratory Tests	Paid in Full	
Medical Tests	Paid in Full	
ALLERGY SERVICES		
Benefits	Paid in Full	
OUTPATIENT THERAPY SERVICES		
Physical Medicine	Paid in Full	30 visits per condition per *benefit period*
Orthoptic Therapy	Paid in Full	30 visits per condition per *benefit period*
Urinary Incontinency Therapy	Paid in Full	30 visits per condition per *benefit period*
Occupational Therapy	Paid in Full	30 visits per condition per *benefit period*
Speech Therapy	Paid in Full	30 visits per condition per *benefit period*
Respiratory Therapy	Paid in Full	30 visits per condition per *benefit period*
Cardiac Rehabilitation Therapy	Paid in Full	30 visits per condition per *benefit period*
Manipulation Therapy	Paid in Full	2 weeks (14 consecutive days) of acute care service per accident or injury
RADIATION THERAPY		
Benefits	Paid in Full	
DIALYSIS TREATMENT		
Benefits	Paid in Full	
OUTPATIENT CHEMOTHERAPY		
Benefits	Paid in Full	

SUMMARY OF BENEFITS		
	Amounts *Members* Are Responsible For:	**Limits and Maximums (If Applicable)**
EMERGENCY SERVICES		
Emergency Services ***Surgery* performed in conjunction with an emergency room visit is reimbursed at the payment level for *surgery benefits*.** ***Inpatient hospital* stays as a result of an emergency are reimbursed at the level of payment for *inpatient benefits*.**	Paid in Full $25 *copayment* per visit, waived if admitted *inpatient*	
Urgent Care	$25 *copayment* per visit	
MEDICAL TRANSPORT		
Emergency Ambulance	Paid in Full	
Non-Emergency Ambulance (Between *facility providers)*	Paid in Full	
MENTAL HEALTH CARE SERVICES		
Inpatient Services	Not Covered	
Partial Hospitalization	Not Covered	
Outpatient Services	Not Covered	
SUBSTANCE ABUSE SERVICES		
Detoxification - *Inpatient*	Not Covered	
Rehabilitation – *Inpatient*	Not Covered	
Rehabilitation - *Outpatient*	Not Covered	
HOME HEALTH CARE SERVICES		
Benefits	Paid in Full	100 visits per *benefit period*
INFUSION/IV THERAPY		
Benefits	Paid in Full	
HOSPICE CARE		
Benefits *(*includes *Residential Hospice Care)*	Paid in Full	$50,000 *benefit lifetime maximum*, which includes 10 days *inpatient* or 240 hours *outpatient* respite care and *residential hospice care*.
DURABLE MEDICAL EQUIPMENT (DME) & SUPPLIES		
Benefits	Paid in Full	$340 per oral appliance for sleep apnea
PROSTHETIC APPLIANCES		
Prosthetic Appliances (Other Than Wigs)	Paid in Full	

SUMMARY OF BENEFITS		
	Amounts *Members* Are Responsible For:	**Limits and Maximums (If Applicable)**
Wigs	Paid in Full	$400 per wig with a maximum of two (2) wigs per *benefit period*
ORTHOTIC DEVICES		
Benefits	Paid in Full	
DIABETIC SUPPLIES AND EDUCATION		
Benefits	50% *coinsurance* when obtained at a participating pharmacy – supplies, monitors, insulin, injection aids, syringes, and pharmacological agents*	
ENTERAL NUTRITION		
Benefits	Paid in Full	
IMMUNIZATIONS AND INJECTIONS		
Benefits	Paid in Full	
MAMMOGRAMS		
Screening Mammogram	Paid in Full	One (1) per *benefit period* for females forty (40) years of age and older
Diagnostic Mammogram	Paid in Full	
GYNECOLOGICAL SERVICES		
Screening Gynecological Exam	PCP: $20 *copayment* per visit Specialist: $20 *copayment* per visit	One (1) per *benefit period*
Screening Pap Smear	Paid in Full	One (1) per *benefit period*
PREVENTIVE CARE SERVICES		
Pediatric Preventive Care (includes physical examinations, immunizations and tests)	Paid in Full	
Adult Preventive Care (includes physical examinations, immunizations and tests)	Paid in Full	
PERVASIVE DEVELOPMENT DISORDERS (AUTISM SPECTRUM DISORDERS)		
Benefits	Paid in Full	$36,000 per *benefit period maximum*
OTHER SERVICES		
Orthodontic Treatment of Congenital Cleft Palates	Paid in Full	
Diagnostic Hearing Screening	Paid in Full	
Vision Care for Illness or Accidental Injury	Paid in Full	

SUMMARY OF BENEFITS		
	Amounts *Members* Are Responsible For:	**Limits and Maximums (If Applicable)**
Non-Routine Foot Care	Paid in Full	

* Diabetic Supplies – When a generic drug or supply is dispensed, the *member* is responsible for paying 50% of the cost of the generic drug or supply. When a brand drug or supply is dispensed that has a generic equivalent, the *member* is responsible for paying 50% of the cost of the brand drug or supply plus the difference in price between the brand drug or supply and its generic equivalent, up to the original cost of the brand drug or supply. When a brand drug or supply is dispensed that has no generic equivalent, the *member* is responsible for paying 50% of the cost of the brand drug or supply.

This *coinsurance* is waived when supplies are covered under a *Capital Advantage Insurance Company* Prescription Drug Plan and the applicable Prescription Drug *cost-sharing amount* is paid.

COST-SHARING DESCRIPTIONS

This section of the *Certificate of Coverage* describes the cost-sharing that may be required under this *coverage* with *Keystone Health Plan Central*.

Since *cost-sharing amounts* vary depending on the *member's* specific *coverage*, it is important that the *member* refers to the **Summary of Cost Sharing and Benefits** section of this *Certificate of Coverage* 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 Health Plan Central* for *benefits* are based on the *allowable amount*. The *allowable amount* is the maximum amount that *Keystone Health Plan Central* will pay for *benefits* under this *coverage*. Before *Keystone Health Plan Central* 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*
5. *Benefit Period Maximums*
6. *Benefit Lifetime 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 Health Plan Central* pays the healthcare provider amounts that are the *member's* responsibility, such as *deductible*, *copayments* or *coinsurance*, *Keystone Health Plan Central* may collect such amounts directly from the *member*. The *member* agrees that *Keystone Health Plan Central* 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 Health Plan Central* 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 Health Plan Central* 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 Health Plan Central*.

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 Health Plan Central'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 Health Plan Central* 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 **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* 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 Health Plan Central* 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 Health Plan Central* 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 Health Plan Central* 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 *benefit period* 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 Health Plan Central* 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 **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* to determine if any *deductibles* apply 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 Health Plan Central* 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 Health Plan Central* 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 Health Plan Central'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 Health Plan Central* 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 **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* to determine if *coinsurance* applies to their *coverage*.

OUT-OF-POCKET MAXIMUM

The *out-of-pocket maximum* is the maximum amount of *coinsurance* that an individual *member* or a *subscriber's* entire family must pay during a *benefit period*.

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 *benefit period* 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 *benefit period*. 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 Health Plan Central* 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*.

Members should refer to the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* to determine if any *out-of-pocket maximums* apply to their *coverage*.

BENEFIT PERIOD MAXIMUM

A *benefit period maximum* is the limit of coverage placed on a specific *benefit(s)* provided under this *coverage* within a *benefit period*. Such limits on *benefits* may be in the form of visit limits, day limits, or dollar limits; and there may be more than one limit on a specific *benefit*.

Members should refer to the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* to determine if any *benefit period maximums* apply to their *coverage*.

BENEFIT LIFETIME MAXIMUM

A *benefit lifetime maximum* is the maximum amount for a specific *benefit(s)* payable by *Keystone Health Plan Central* during the duration of the *member's coverage* under the *group contract* or other *group contracts* from the Capital BlueCross family of companies.

Members should refer to the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* to determine if any *benefit lifetime maximums* apply to their *coverage*.

BENEFIT PERIOD COPAYMENT MAXIMUM

A *benefit period copayment* maximum is the maximum amount of *copayments members* are responsible for paying to *providers* during the *benefit period*.

Once the *benefit period copayment* maximum is reached, no future *copayments* will be deducted from payments made to the *provider* by *Keystone Health Plan Central*.

To be eligible for reimbursement under this provision, *members* must demonstrate that *copayments* in the specified amount have been paid during the *benefit period*.

BENEFIT DESCRIPTIONS

Subject to the definitions in this *Certificate of Coverage* and in the *group contract*, and the terms, conditions, and exclusions specified in this *Certificate of Coverage* and subject to the payment by *members* of the applicable *cost-sharing amounts*, if any, *members* shall be entitled to receive the *coverage* for the *benefits* listed below. Services will be covered by *Keystone Health Plan Central*: a) only if they are *medically necessary;* and b) except for obstetrical/gynecological care and *emergency services*, only if they are provided or referred by the *member's PCP* and/or preauthorized (as applicable) by *Keystone Health Plan Central* 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 Cost-Sharing and Benefits section of this *Certificate of Coverage* to determine whether a service described in this section is a covered *benefit*, to determine the amounts *members* are responsible for paying to *providers*, and to determine whether any *benefit* limitations/maximums apply to this *coverage*.

Certain services require *preauthorization* by *Keystone Health Plan Central* or its designee. Please consult the **Preauthorization Program** attachment to determine which services require *preauthorization*.

ACUTE CARE HOSPITAL ROOM & BOARD AND ASSOCIATED CHARGES

Benefits for room and board in an acute care hospital include bed, board and general nursing services when a *member* occupies:

- 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.

Benefits for associated services include, but are not limited to:

- 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.

ACUTE INPATIENT REHABILITATION

Benefits for acute *inpatient* rehabilitation provided in a *rehabilitation hospital* include services provided when a *member* requires an intensive level of skilled *inpatient* rehabilitation services on a daily basis and these skilled rehabilitation services are provided in accordance with a *physician's* order. *Keystone Health Plan Central* must concur with the *physician's* certification that the care and the *inpatient* setting are both *medically necessary*.

SKILLED NURSING FACILITY

Benefits for *skilled nursing facilities* include services provided when a *member* requires *inpatient skilled nursing services* on a daily basis and these *skilled nursing services* are provided in accordance with a *physician*'s order. *Keystone Health Plan Central* must concur with the *physician's* certification that the care and the *inpatient* setting are both *medically necessary*.

PROFESSIONAL PROVIDER EVALUATION & MANAGEMENT (E&M) AND CONSULTATIONS

Evaluation & management and consultation services involve clinical and physical exams required for the prevention, diagnosis and treatment of an illness or injury.

Evaluation and Management

Inpatient – *Benefits* for *inpatient* evaluation and management include medical care services provided by a *physician* or other *professional provider* to a *member* who is a *hospital inpatient*. Medical care includes *inpatient* visits and intensive care. *Inpatient* E&M services for a condition related to *surgery*, maternity, *mental health care*, or *substance abuse* care are addressed elsewhere in this *Certificate of Coverage*.

Outpatient – *Benefits* for *outpatient* evaluation and management include *outpatient* visits to a *professional provider* for the prevention, diagnosis, and treatment of an injury or illness. *Outpatient* E&M services for a condition related to *surgery*, maternity, *mental health care*, or *substance abuse* care are addressed elsewhere in this *Certificate of Coverage*.

In certain situations a facility fee may be associated with an *outpatient* visit to a *professional provider*. M*embers* should consult with the *provider* of the service to determine whether a facility fee may apply to that *provider*. An additional *cost sharing amount* may apply to the facility fee.

Consultations

Consultations are distinguished from evaluation and management services because these services are provided by a *physician* whose opinion or advice is usually requested by another *physician* regarding a specific problem.

Inpatient – *Benefits* for *inpatient* consultations include initial and follow-up *inpatient* consultation services rendered to a *member* by another *physician* at the request of the attending *physician*.

Consultations that are not *benefits* include:

- Staff consultations required by *hospital* rules and regulations; and
- Staff consultations related to teaching interns and resident medical education programs.

Outpatient – *Benefits* for *outpatient* consultations include *outpatient* office consultation visits.

TRANSPLANT SERVICES

Benefits for transplant services are provided for *inpatient* and *outpatient* services related to human organ and tissue transplants that *Keystone Health Plan Central* has found not to be *investigational*.

Pre-Transplant Evaluation

Benefits for pre-transplant evaluations include testing performed to determine donor compatibility, pre-operative testing, medical examination of the donor in preparation for harvesting the organ or tissue, and organ bank registry fees. Costs associated with registration, evaluation, or duplicate services at more than one transplantation institution are not covered. If the *member* assumes financial responsibility for obtaining and maintaining a duplicate organ listing at an additional facility and the organ becomes available at that location, the transplantation may be eligible for coverage.

The cost of screening is covered up to the identification of one viable donor candidate. Additional community or global screenings for a donor are not covered.

Acquisition and Transplantation

Benefits for acquisition and transplantation include the removal of an organ from a living donor or cadaver and implantation of the organ or tissue into a recipient.

When the transplant requires surgical removal of the donated part from a living donor and both the recipient and donor are covered by *Keystone Health Plan Central*, *benefits* are provided to both, each pursuant to the terms of each person's respective contract.

If only the transplant recipient is covered by *Keystone Health Plan Central*, *benefits* are provided for the recipient and for the donor, but only to the extent that donor benefits are not available under any other health benefit plan or paid by a procurement agency. *Benefits* provided for the donor are charged against, and limited by, the recipient's coverage.

If the transplant recipient is covered by *Keystone Health Plan Central* and the donor is deceased, the costs of recovering the organ or tissue (including the cost of transportation) will be paid if billed by a *hospital*. Such costs are charged against, and limited by, the recipient's *benefits* under this *coverage*.

Donor charges accumulate towards the recipient's *benefit period maximums*, *benefit lifetime maximums* or any other applicable limits and maximums.

Payment will not be made for the purchase of human organs that are sold rather than donated to the recipient.

Transplantation of placental umbilical cord blood stem cells from related or unrelated donors may be considered *medically necessary* in patients with an appropriate indication for allogeneic stem-cell transplant.

Collection and storage of cord blood from a neonate may be considered *medically necessary* when an allogeneic transplant is imminent in an identified recipient with a diagnosis that is consistent with the possible need for allogeneic transplant.

Transplantation of cord blood stem cells from related or unrelated donors is considered *investigational* in all other situations.

Post-Transplant Services

Benefits for post-transplant services include 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 Blue Cross and Blue Shield 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. 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, telephone calls, and personal care items.

SURGERY

Benefits for *surgery* include facility and professional services for preoperative care, surgical procedures, and post-operative care.

Evaluation & Management (E&M)

Benefits for evaluation and management related to *surgery* include the initial consultation or evaluation of the problem by the surgeon to determine the need for *surgery*.

Surgical Procedure

Benefits for the surgical procedure include surgical services required for the treatment of a disease or injury when performed by a *physician* or other *professional provider* on a *member* in an *inpatient hospital* or *outpatient* setting. Certain rules and guidelines apply if an additional surgeon or multiple surgeries are needed.

Anesthesia Related to Surgery

Benefits for the administration of anesthesia related to *surgery* include services ordered by the attending *professional provider* and rendered by a *professional provider,* including the operating physician under certain circumstances, but other than the assistant at *surgery*, or the attending *physician*.

Mastectomy and Related Services

A mastectomy is the surgical removal of all or part of a breast. *Benefits* for a mastectomy include a mastectomy performed on an *inpatient* or *outpatient* basis and *surgery* performed to reestablish symmetry or alleviate *functional impairment*, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy. Reconstruction to reestablish symmetry is covered for the unaffected breast as well as the affected breast. *Benefits* are also provided for physical complications due to the mastectomy such as lymphedema.

Oral Surgery

Benefits for oral *surgery* include surgical extractions of full or partial bony impactions, 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 the repair of traumatic injuries, or for the treatment of congenital birth defects in newborns, as required by law.

Other Surgeries

Benefits for other specialized surgical procedures include:

- Routine neonatal circumcisions; and
- Sterilization procedures.

INFERTILITY SERVICES

Benefits for *infertility* services include *infertility* counseling, testing and services, including artificial insemination, but excluding in vitro fertilization. The *benefit period maximum* includes the cost of injectables related to *infertility* services administered and/or dispensed in the *physician's* office. *Infertility* services are available to both male and female *members* but shall not be available if the present condition of *infertility* is due, in part or in its entirety, to either person, regardless if a *Keystone Health Plan Central member* has undergone a voluntary sterilization procedure and/or a reversal of a voluntary sterilization procedure that was not successful.

Treatments or procedures leading to or in connection with assisted fertilization are not covered.

MATERNITY SERVICES

Benefits for maternity services include prenatal, delivery and postpartum services provided to a female *member* for pregnancies.

Prenatal Services

Benefits for prenatal services include an initial examination, tests, and a series of follow-up exams to monitor the health of the mother and fetus. Prenatal services continue up to the date of delivery.

Delivery

Benefits for deliveries include facility and professional services for vaginal and cesarean section deliveries.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage 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.

Postpartum Services

Benefits for postpartum services include post-delivery *hospital* services and office visits.

INTERRUPTION OF PREGNANCY

Benefits for an interruption of pregnancy include procedures for termination of a pregnancy performed through a medical or surgical procedure, including the administration of medication in a *provider's* office. Termination of the pregnancy may be non-elective or elective.

NEWBORN CARE

Benefits for newborn care include ordinary nursery care and physical examinations of the newborn infant while the mother is an *inpatient*; prematurity services; preventive health care services; and services to treat an injury or illness, including care and treatment of medically diagnosed congenital defects and birth abnormalities.

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.

DIAGNOSTIC SERVICES

Diagnostic services are procedures ordered by a *physician* because of specific symptoms to determine a definitive condition or disease, not for screening purposes. *Benefits* for diagnostic services include, but are not limited to: radiology tests, laboratory tests, and medical tests. Some high-risk conditions may result in a service being considered diagnostic, rather than screening, in nature.

Radiology Tests

Benefits for radiology tests include X-rays, MRI's (Magnetic Resonance Imaging), CT Scans, Ultrasounds, Echography, and other radiological services performed for the purpose of diagnosing a condition due to an illness or injury.

Laboratory Tests

Benefits for laboratory tests include diagnostic pathology and laboratory tests for the diagnosis or treatment of a disease or condition.

Medical Tests

Benefits for diagnostic medical tests include EKG's, EEG's, and other diagnostic medical procedures performed for the purpose of diagnosing or treating a disease or condition.

Inpatient admissions that are primarily for diagnostic purposes are not covered.

ALLERGY SERVICES

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

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).

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.

Allergy Serums

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

THERAPY SERVICES

Benefits for therapy services include services provided for evaluation and treatment of a *member's* illness or injury when an expectation exists that the therapy will result in significant, measurable improvement in the *member's* level of functioning within a reasonable period of time appropriate to the *member's* condition.

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.

Maintenance physical medicine is not covered.

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.

Maintenance occupational therapy is not covered.

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.

Maintenance speech therapy is not covered.

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.

Maintenance respiratory therapy is not covered.

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.

Maintenance cardiac therapy is not covered.

Manipulation Therapy

Benefits for manipulation therapy include the therapeutic application of manually guided forces to the spinal or other body regions to improve physiologic function that has been altered by disease or trauma. All services rendered must have a direct therapeutic relationship to the patient's condition, be performed for a musculoskeletal condition, and there must be a reasonable expectation of restoring the patient's level of function lost due to this condition.

Maintenance manipulation therapy is not covered.

RADIATION THERAPY

Benefits for radiation therapy (also known as radiation oncology or therapeutic oncology) include the *inpatient* or *outpatient* treatment of a disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes, including the cost of the radioactive material.

DIALYSIS TREATMENT

Benefits for dialysis include the *inpatient* or *outpatient* treatment of acute renal failure or chronic renal insufficiency for removal of waste materials from the body.

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.

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.

Surgery performed in conjunction with an emergency room visit is reimbursed at the payment level for surgical procedures. *Inpatient hospital* stays as a result of an emergency are reimbursed at the level of payment for *inpatient benefits*.

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 Health Plan Central*, 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*.

Regardless of whether services are determined to be *emergency services*, each emergency room visit shall be subject to a *copayment* unless:

- The *member* is admitted to the *hospital* at the time of the emergency room visit, in which case the *copayment* is waived, or
- The *member* is referred to the emergency room by the *PCP* or *Keystone Health Plan Central* and the services could have been provided in the *PCP's* office, in which case the *copayment* is limited to the amount of the *copayment* for a *PCP* office visit, if any.

URGENT CARE

Urgent care is medical care for an unexpected illness or injury that is not an *emergency service* or life-threatening situation or condition but which may need prompt attention of a *physician* to minimize severity and prevent complications.

MEDICAL TRANSPORT

Benefits for medical transport services include the use of specially designed and equipped vehicles to transport ill or injured patients. Medical transport services may involve ground or air transports in both emergency and non-emergency situations.

Air ambulance transportation is covered only when the transport is *medically necessary* or the point of pick-up is not accessible by land, and the transport is to an *acute care hospital* (whether for initial transport or subsequent transfer to another facility for special care).

Emergency Ambulance

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.

Non-Emergency Ambulance

Benefits for non-emergency ambulance services include services only for inter-facility transportation if the circumstances leading up to the ambulance services do not qualify as *emergency services*, but are *medically necessary*. Inter-facility transportation means transportation between *hospitals* or between a *hospital* and a *skilled nursing facility*.

Transportation by way of wheelchair vans, stretcher vans, or other transportation modalities where advanced or basic life support is unnecessary are not covered. Also, membership fees are excluded from coverage.

MENTAL HEALTH CARE SERVICES

Not covered by Capital BlueCross. Services are administered by a different insurance carrier.

SUBSTANCE ABUSE SERVICES

Not covered by Capital BlueCross. Services are administered by a different insurance carrier.

HOME HEALTH CARE SERVICES

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.

No home health care *benefits* are provided for:

- Drugs provided by the *home health care agency*; with the exception of intravenous drugs administered under a treatment plan approved by *Keystone Health Plan Central*;
- Food or home delivered meals;
- Homemaker services such as shopping, cleaning and laundry;
- Maintenance therapy; and
- *Custodial care*.

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.

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*.

INFUSION/IV THERAPY

Infusion/IV therapy involves the administration of pharmaceuticals, fluids, and biologicals intravenously or through a gastrostomy tube. Infusion/IV 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/IV therapy include the drugs and IV solutions, supplies and equipment used to administer the drugs, and nursing visits to administer the therapy.

HOSPICE CARE

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;
- Respite care up to a maximum of ten (10) days in a *facility provider* or 240 hours of home respite care per *member* per lifetime; and
- 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.
- *Inpatient* services of 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.

Benefits for *Residential Hospice care* include the following services provided to a *member* by a *hospice provider* responsible for the *member's* overall care:

- Room and board in a *hospice* facility that meets *Capital's* criteria for *residential hospice 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; and
- Family counseling services.

No *hospice* care *benefits* are provided for:

- Volunteers;
- Pastoral services;
- Homemaker services; and
- Food or home delivered meals.

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.

DURABLE MEDICAL EQUIPMENT (DME) & SUPPLIES

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.

Benefits for DME include the rental or, at the option of *Keystone Health Plan Central*, the purchase of DME when prescribed by *professional providers* within the scope of their license. Rental charges cannot exceed the purchase price of the equipment. Furthermore, if the *member* purchases the DME, previous allowances for rental of the DME will be deducted from the amount allowed for the purchase of the DME.

Benefits for DME also include reasonable repairs, adjustments and certain supplies that are necessary to maintain the DME in operating condition. Examples of DME are wheelchairs, canes, walkers, nebulizers, etc. No *benefits*

are provided for repairs due to equipment misuse and/or abuse or for replacement of lost or stolen items. Repair costs cannot exceed the purchase price of the DME.

DME considered to be a convenience item is not covered. Examples of non-covered DME include environmental control equipment, disposable diapers and under pads, certain elastic stockings, and gluco-watches. Back-up or secondary DME, including ventilators and prosthetics, are not covered.

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 for covered durable medical equipment.

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 and may be subject to a *benefit lifetime maximum*. 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.

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.

DIABETIC SUPPLIES AND EDUCATION

Drugs and Supplies

Unless otherwise covered under a prescription drug program, *benefits* for diabetic drugs and supplies include 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 *provider* legally authorized to prescribe such items.

Equipment, agents, and orthotics include:

- Injectable aids (e.g., syringes);
- Pharmacological agents for controlling blood sugar;
- Standard blood glucose monitors and related supplies;
- Insulin infusion devices; and
- Orthotics.

Nutritional Counseling, Self-Management Training and Education

Benefits for nutritional counseling include counseling for the treatment of diabetes and for the treatment of obesity or morbid obesity only in the presence of a comorbid condition of diabetes.

Benefits for diabetes self-management training and education include participation in a diabetes self-management training and education program under the supervision of a licensed health care professional with expertise in diabetes. Self-management education and education relating to diet, prescribed by a licensed *physician*, includes:

- *Medically necessary* visits upon the diagnosis of diabetes; and
- 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* by a licensed *physician*.

For *benefits* to be provided, the *member* must complete a diabetes education program that is:

- Conducted under the supervision of a licensed health care professional with expertise in diabetes;
- Approved by the American Diabetes Association or American Association of Diabetes Educators; and
- Subject to the criteria determined by *Keystone Health Plan Central*. These criteria are based on certification programs for diabetes education developed by the American Diabetes Association or American Association of Diabetes Educators.

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 percent (50%) 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.

IMMUNIZATIONS AND INJECTIONS

Benefits for immunizations and injections include certain immunizations if an individual is determined to be at high risk. *Keystone Health Plan Central* follows guidelines set by the Center for Disease Control in determining high-risk individuals. Immunizations for travel or for employment are not covered except as required by the Patient Protection and Affordable Care Act.

Injectables that cannot be self-administered and are billed by a professional in an office setting are covered. Self-administered injectables may be covered under the *member's* prescription drug program.

MAMMOGRAMS

A mammogram is a radiological examination of the breast(s) used to detect tumors and cysts, and to help differentiate benign and malignant disease.

Screening Mammogram

A screening mammogram is furnished to an individual without signs or symptoms of breast disease, for the purpose of early detection of breast cancer.

Benefits for screening mammograms include one (1) screening mammogram per *benefit period* for females forty (40) years of age and older. This mammogram is exempt from *deductibles*, *benefit period maximums*, and *benefit lifetime maximums*.

Physician-recommended screening mammograms, regardless of age, are covered but may be subject to *cost-sharing amounts*.

Diagnostic Mammogram

A diagnostic mammogram is intended to provide specific evaluation of patients with a detected breast abnormality. *Benefits* for diagnostic mammograms are covered under the **Diagnostic Services, Radiology Tests** section of this *Certificate of Coverage* and may be subject to *cost-sharing amounts*.

Physician-recommended diagnostic mammograms, regardless of age, are covered but may be subject to *cost-sharing amounts*.

GYNECOLOGICAL SERVICES

Screening Gynecological Exam

A screening gynecological exam is a yearly preventive service performed by a gynecologist, primary care physician, or other qualified health care *provider*. The exam generally includes a pelvic examination, a Pap smear, a breast examination, a rectal examination and a review of the patient's past health, menstrual cycle and childbearing history.

Screening Papanicolaou Smear

A Papanicolaou (Pap) Smear is a laboratory study used to detect cancer. The Pap test has been used most often in the diagnosis and prevention of cervical cancers.

Benefits include one (1) routine screening Papanicolaou smear per *benefit period* for all female members. This Pap smear is exempt from *deductibles*, *benefit period maximums*, and *benefit lifetime maximums*.

Diagnostic Pap smears are covered under the **Diagnostic Services, Laboratory Tests** section of this *Certificate of Coverage* and may be subject to *cost-sharing amounts*.

PREVENTIVE CARE SERVICES

Benefits for preventive care are highlighted on the **Schedule of Preventive Care Services** guidelines document attached to this *Certificate of Coverage*. 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.

Pediatric

Benefits for pediatric preventive care include routine physical examinations, immunizations, and tests. For more information, refer to the **Schedule of Preventive Care Services** guidelines attached to this *Certificate of Coverage*.

Adult

Benefits for adult preventive care include routine physical examinations, immunizations, and tests. For more information, refer to the **Schedule of Preventive Care Services** guidelines document attached to this *Certificate of Coverage*.

Services that need to be performed more frequently than stated in the **Schedule of Preventive Care Services** guidelines document attached to this *Certificate of Coverage* due to high-risk situations are covered when the diagnosis and procedure(s) are otherwise covered. *Keystone Health Plan Central* follows guidelines set by the Center for Disease Control in determining high-risk individuals. These services are subject to all applicable *cost-sharing amounts*.

PERVASIVE DEVELOPMENT DISORDERS (AUTISM SPECTRUM DISORDERS)

Autism spectrum disorders include any *pervasive development disorders* as defined by the Diagnostic and Statistical Manual of Mental disorders (DSM), including but not limited to autism, Asperger's Syndrome, childhood disintegrative disorder and Rett's Syndrome.

Benefits include coverage for the diagnostic assessment and treatment of *autism spectrum disorders* for *members* less than twenty-one (21) years of age.

Diagnostic Assessment

Diagnostic assessment of *autism spectrum disorders* consists of *medically necessary* assessments, evaluations or tests performed by a licensed physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner to diagnose whether an individual has *autism spectrum disorder*. The diagnosis is valid for not less than twelve (12) months unless a licensed physician or psychologist determines an assessment is needed sooner.

Treatment

Treatment of *autism spectrum disorders* is identified in a treatment plan or functional behavioral assessment. A treatment plan must be submitted to *Keystone Health Plan Central,* or the *contract holder's* Managed Behavioral Healthcare Organization*,* that is:

- Developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation;
- Includes short and long-term goals which can be measured objectively;
- Includes any *medically necessary* pharmaceutical care, psychiatric care, psychological care, rehabilitative care and therapeutic care that is:
    - Prescribed, ordered or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner; or
    - Provided by an autism service provider; or
    - Provided by a person, entity or group that works under the direction of an autism service provider.

Review of the treatment plan will be required by *Keystone Health Plan Central* prior to authorization of services. Treatment plans will be reviewed every six (6) months unless there is clear evidence of regression necessitating changes in treatment.

Coverage for the treatment of *autism spectrum disorders,* as prescribed in a specific treatment plan, include but are not limited to the following:

- *Medically necessary* medical therapy (e.g. physical therapy, occupational therapy, speech therapy) or psychotherapy specifically for the treatment of pervasive developmental disorders;
- *Medically necessary* behavior therapy and behavior modification including mobile therapy, behavior specialist consultation, therapeutic staff support;
- *Medically necessary* interventions to improve verbal and non-verbal communication skills;
- *Medically necessary* and appropriate treatment for comorbidities, including psychotherapy, behavioral therapy, physical and occupational therapy;
- Applied behavior analysis;
- Continued rehabilitative medical treatment once the therapeutic goals have been achieved to preserve the current level of function and prevent regression (maintenance).

Medical necessity review of behavioral health services will be conducted by the *contract holder's* Managed Behavioral Healthcare Organization.

Treatment and services that are provided as part of the *member's* Individual Education Plan (IEP) or as otherwise provided as part of the *member's* education are not covered.

Benefits for *autism spectrum disorders* are subject to a *benefit period maximum*, as well as *cost-sharing amounts* (i.e. office visit *copayment*, *deductible* and *coinsurance*). *Members* should refer to the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* to determine if a *benefit period maximum* applies to their *coverage*.

OTHER SERVICES

Orthodontic Treatment of Congenital Cleft Palates

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

Diagnostic Hearing Screening

Benefits for hearing services include only hearing screenings for diagnostic purposes.

Hearing aids and exams for the purchase and fitting of *hearing aids* are not covered.

Vision Care for Illness or Accidental Injury

Benefits for vision services include only eye care that is *medically necessary* to treat a condition arising from an illness or accidental injury to the eye. Covered services include *surgery* for medical conditions, symptomatic conditions and trauma. Vision screening related to a medical diagnosis, only for diagnostic purposes, is also covered.

When cataract *surgery* is performed, *benefits* for vision services include lens implants, with limitations, as described in the **Prosthetic Appliances** section of this *Certificate of Coverage*.

Routine eye care examinations, refractive lenses (glasses or contact lenses) and routine tests are not covered. Also, replacement refractive lenses (glasses or contact lenses) prescribed for use with an intra-ocular lens transplant are not covered.

Non-Routine Foot Care

Benefits for non-routine foot care include surgical treatment of structural defects or anomalies such as fractures or hammertoes. *Benefits* also include surgical removal of ingrown toenails and bunions when provided to *members* with specific medical diagnoses. An injectable local anesthetic must be used in order for a foot procedure to be considered “toenail surgery”.

Routine foot care services are not covered unless the services are *medically necessary* for a *member* with specific medical diagnoses.

SCHEDULE OF EXCLUSIONS

Except as specifically provided in this *Certificate of Coverage*, no *benefits* are provided under this *coverage* with *Keystone Health Plan Central* for services, supplies, or equipment described or otherwise identified below.

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*;

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*;

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 *Certificate of Coverage*;

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 *birth defect* or accidental injury. For purposes of this exclusion, prior *surgery* is not considered an accidental injury;

30. For oral *surgery*, except as specifically provided in this *Certificate of Coverage*;

31. For maintenance therapy services except as provided in this *Certificate of Coverage;*

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, mental retardation (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 *Certificate of Coverage*, including but not limited to play, music, and recreational therapy;

36. For sports medicine treatment intended to primarily enhance athletic performance;

37. 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 Health Plan Central* approved trial, which would normally be covered under standard patient therapy *benefits*;

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 *Certificate of Coverage*;

40. For the following *mental health care*/*substance abuse* services: chronic care, educational testing, evaluation testing, hypnosis, marital therapy, methadone maintenance, mental retardation 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 prosthetics 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 prosthetic appliances dispensed to a patient prior to performance of the procedure that will necessitate the use of the device;

45. For personal hygiene, comfort and/or convenience items such as, but not limited to, air conditioners, humidifiers, 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, spa or health club memberships, or any other modification to real or personal property, whether or not recommended by a *provider;*

46. For supportive environmental materials and equipment such as handrails, ramps, telephones, and similar service appliances and devices;

47. For enteral nutrition due to lactose intolerance or other milk allergies;

48. For blenderized baby food, regular shelf food, or special infant formula, except as specified in this *Certificate of Coverage*;

49. 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 *Certificate of Coverage;*

50. For immunizations required for travel or employment except as required by the Patient Protection and Affordable Care Act;

51. 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;

52. 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 as specifically provided in this *Certificate of Coverage*;

53. 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;

54. For *hearing aids*, examinations for the prescription or fitting of *hearing aids*, and all related services;

55. 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;

56. 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;

57. For corneal *surgery* and other procedures to correct refractive errors;

58. For *infertility* services if the present condition of *infertility* is due, in part or in its entirety, to either party having undergone an unsuccessful reversal of a voluntary sterilization procedure;

59. For donor services related to assisted fertilization and *infertility*;

60. For in vitro fertilization and/or embryo transplants;

61. For *infertility services* for *dependent* children, regardless of age;

62. For procedures to reverse sterilization;

63. For the contraceptive therapeutic class of prescription drugs, products, or devices, including any services related to the fitting, insertion, implantation and removal of such devices. This exclusion applies even if such prescription drugs are *medically necessary* to treat an illness or medical condition unrelated to contraception as long as there are other drugs which can be used to treat the non-contraceptive condition besides the contraceptive drug;

64. For *outpatient* oral chemotherapy drugs;

65. For whole blood, blood plasma, or blood components;

66. 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;

67. 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;

68. For treatment, medicines, devices, or drugs in connection with sexual dysfunction, both male and female;

69. For treatment or procedures leading to or in connection with transsexual *surgery* except for sickness or injury resulting from such *surgery*;

70. 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;

71. 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*;

72. For surgical operations or treatment of obesity and/or morbid obesity, including but not limited to gastric stapling or balloon procedures;

73. For all types of nutritional counseling, except where mandated for diabetes and as specifically provided in this *Certificate of Coverage*;

74. For *inpatient* stays to bring about non-surgical weight reduction;

75. For private duty nursing services;

76. For biofeedback;

77. For acupuncture;

78. For newborn deliveries outside the *service area* within twenty-eight (28) days of the expected delivery date.

79. For autopsies or any other services rendered after a *member's* demise;

80. For orthognathic surgery, including surgery for repair of congenital jaw abnormalities, except as mandated by law and as specifically provided in this *Certificate of Coverage;*

81. For all types of skin tag removal, regardless of symptoms or signs that might be present, except when the condition of diabetes is present;

82. For any services related to or rendered in connection with a non-covered service, including but not limited to anesthesia, diagnostic services, etc.;

83. 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;

84. 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;

85. For certain *Autism Spectrum Disorders* services, including manipulation therapy evaluation, myofascial and musculoskeletal treatment and/or manipulation; day treatment services, elimination diets, family based mental

health services, host home services, nutritional supplements, rehabilitative therapy, including but not limited to play, music, and recreational therapy; residential treatment, and summer therapeutic activities program.

86. For services provided at unapproved sites, school settings, or as part of a *member*'s education.

87. Except as required by law, for services that would otherwise be paid for by federal, state or local education related agencies, departments, schools or the like.

88. 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 *contract*; and

89. For any other service or treatment except as provided in this *Certificate of Coverage*.

CLINICAL MANAGEMENT

A wide range of *Clinical Management* Programs are available under this *coverage* with *Keystone Health Plan Central*.

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).

All of *Keystone Health Plan Central's* standard products include the full array of *Clinical Management* Programs. Under specific circumstances, groups may choose not to include all or some of the *Clinical Management* Programs described below in this *coverage*. Therefore, it is important for *members* to determine program eligibility before assuming that all of these programs are available to them.

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 Health Plan Central* Customer Service Representative will return their call the next business day.

Medical Necessity Review

This *coverage* with *Keystone Health Plan Central* provides *benefits* only for services *Keystone Health Plan Central* or its designee determines to be *medically necessary* as defined in the **Definitions** section of this *Certificate of Coverage*.

When *preauthorization* is required, *medical necessity* of *benefits* is determined by *Keystone Health Plan Central* 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 Health Plan Central's* determination of *medical necessity*. The *member* will not be billed by a *participating provider* for services that *Keystone Health Plan Central* 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 Health Plan Central's* definition of *medically necessary* as defined in this *contract*.

The *member* or the *provider* may contact *Keystone Health Plan Central's* Clinical Management Department to determine whether a service is *medically necessary*.

Keystone Health Plan Central 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 Health Plan Central* does not include services *Keystone Health Plan Central* determines to be *investigational* as defined in the **Definitions** section of this *Certificate of Coverage*.

However, *Keystone Health Plan Central* recognizes that situations occur when a *member* elects to pursue *investigational* treatment at the *member's* own expense. If the *member* receives a service *Keystone Health Plan Central* considers to be *investigational*, 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 Health Plan Central* to determine whether *Keystone Health Plan Central* considers a service to be *investigational*.

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 **Preauthorization Program** attachment to this *Certificate of Coverage* for information on this program. *Members* should carefully review this attachment to determine whether services they wish to receive must be preauthorized by *Keystone Health Plan Central*. 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 Health Plan Central'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 Health Plan Central* 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:

- for services that do not require *preauthorization*;
- in situations such as an emergency; or
- for services that are potentially *investigative* or cosmetic in nature.

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 Health Plan Central* 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 Health Plan Central* 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 Health Plan Central 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 Health Plan Central'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.

DISEASE MANAGEMENT

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*.

Members should refer to the **Disease/Condition Management Programs** attachment to this *Certificate of Coverage* for a description of Disease Management Programs available to them.

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 Health Plan Central members*. The program is multidisciplinary, involving all departments within *Keystone Health Plan Central* 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;
- 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 Health Plan Central's Health Education and Wellness Programs are provided through a special unit within the *Clinical Management* Department. *Keystone Health Plan Central* 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 Web site are dedicated to providing health and wellness education for our *members*. For more information, visit www.capbluecross.com and www.healthforums.com.

24-Hour Nurse Line

The *Keystone Health Plan Central* 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 Health Plan Central's Nicotine Cessation Program is designed to assist *members* who are interested in nicotine cessation. *Members* may access information via our Web site, including contact information for the PA Quit Line, Pennsylvania's nicotine cessation counseling services. Additional resources available via www.capbluecross.com Web site include:

- Nicotine Cessation Kit – kit, which is available for purchase by the member, includes a book and relaxation audio CD, along with other nicotine cessation related resources;
- 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;
- Web site links to credible organizations and programs focused on nicotine cessation; and
- References to available community programs.

HOW WE EVALUATE NEW TECHNOLOGY

Changes in medical procedures, behavioral health procedures, drugs, and devices occur at a rapid rate. *Keystone Health Plan Central* 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 Health Plan Central* concerning our medical policies, with an emphasis on community practice standards. The Committee, along with *Keystone Health Plan Central'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 Health Plan Central'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 Health Plan Central'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, the *contract holder* 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 Health Plan Central*. All decisions regarding the treatment to be provided to a *member* remain the responsibility of the treating *physician* and the *member*.

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

MEMBERSHIP STATUS

In order to be considered a *subscriber,* child or *dependent* under this *coverage* with *Keystone Health Plan Central*, an individual must meet certain eligibility requirements and enroll (apply) for coverage within a specific timeframe.

There is a limited period of time to submit an *enrollment application* for initial enrollment and enrollment changes. *Subscribers* should consult with the *contract holder* to determine the specific timeframes applicable to them. *Subscribers* who fail to submit an *enrollment application* within these specific timeframes may not be allowed to enroll themselves and/or their newly eligible *dependents* until the next *open enrollment* period. *Subscribers* should refer to the Timelines for Submission of Enrollment Applications section of this *Certificate of Coverage* for more details.

ELIGIBILITY

Individuals must meet specific eligibility requirements to enroll or to continue being enrolled for coverage, unless otherwise approved in writing by *Keystone Health Plan Central* in advance of the *effective date of coverage*.

Subscriber

To be eligible to be a *subscriber*, an individual must reside in the *Keystone Health Plan Central service area* or agree to obtain non-*emergency services* within *Keystone Health Plan Central's service area* as documented on the *enrollment application*. The individual must meet all eligibility criteria specified by the *contract holder* and approved by *Keystone Health Plan Central* to enroll in this *coverage* as a *subscriber*. This criteria includes meeting all requirements to participate in the *contract holder's* health benefit program, including compliance with any probationary or waiting period established by the *contract holder*.

Dependent - Spouse

An individual must be the lawful spouse of the *subscriber* to enroll in this *coverage* as a *dependent* spouse.

Keystone Health Plan Central reserves the right to require that a spouse of a *subscriber* provide documentation demonstrating marriage to the *subscriber*, including, but not limited to, marriage certificate, court order or, joint statement of common law marriage as determined by *Keystone Health Plan Central.*

Dependent –Domestic Partner

An individual must qualify as the *domestic partner* of the *subscriber* to enroll in this *coverage* as a *dependent domestic partner*.

Keystone Health Plan Central reserves the right to request documentation evidencing the *domestic partnership* by submission of proof of three (3) or more of the following documents:

- a *domestic partnership* agreement;
- a joint mortgage or lease;
- a designation of one of the partners as beneficiary in the other partner's will;
- a durable property and health care powers of attorney;
- a joint title to an automobile, or joint bank account or credit account; or

- such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

Child

To enroll under this coverage as a child, an individual must be under the age of twenty-six (26) and be:

- A birth child of the *subscriber,* the *subscriber's* spouse, or the *subscriber's domestic partner*;
- A child legally adopted by or placed for adoption with the *subscriber,* the *subscriber's* spouse, or the *subscriber's domestic partner*;
- A *ward* of the *subscriber,* the *subscriber's* spouse, or the *subscriber's domestic partner*; or
- A child for whom the *subscriber,* the *subscriber's* spouse, or the *subscriber's domestic partner* is required to provide health care coverage pursuant to a *Qualified Medical Child Support Order* (QMCSO).

Dependent - Handicapped Child

An individual must be an unmarried child age twenty-six (26) or older to enroll under this *coverage* as a handicapped *dependent* child. The child must be:

- A birth child, adopted child, or *ward* of the *subscriber,* the *subscriber's* spouse or the *subscriber's domestic partner*;
- Mentally or physically incapable of earning a living; and
- Chiefly dependent upon the *subscriber, subscriber's* spouse or the *subscriber's domestic partner* for support and maintenance, provided that:
    - ◊ The incapacity began before age twenty-six (26);
    - ◊ The *subscriber* provides *Keystone Health Plan Central* with proof of incapacity within thirty-one (31) days after the *dependent* handicapped child reaches age twenty-six (26); and
    - ◊ The *subscriber* provides information as otherwise requested by *Keystone Health Plan Central*, but not more frequently than annually.

Extension of Eligibility for Students on Military Duty

Eligibility to enroll under this *coverage* 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 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 Web site.

Rules of Eligibility/Health Factors

No *member* will be refused enrollment or re-enrollment by *Keystone Health Plan Central* because of health status, age (except as provided in this **Membership Status** section of this *Certificate of Coverage*), requirements for health services, or the existence, on the effective date of *coverage* under this *Certificate of Coverage*, of a pre-existing physical or mental condition, including pregnancy. In addition, *Keystone Health Plan Central* shall not terminate any *member's coverage* due to health status or health care needs.

ENROLLMENT

When *members* "enroll" with *Keystone Health Plan Central*, they agree to participate in a contract for *benefits* between the *contract holder* and *Keystone Health Plan Central*. All qualified requests to enroll or to change enrollment must be made through the *contract holder*.

Every *member* must complete and submit to *Keystone Health Plan Central*, through the *contract holder*, an application for *coverage*, which is available from the *contract holder*. Each *member* must also enroll within certain time periods after becoming eligible. These requirements are described in the *group policy*.

Timelines for Submission of Enrollment Applications

There is a limited period of time to submit an *enrollment application* for initial enrollment and enrollment changes. *Subscribers* should consult with the *contract holder* to determine the specific timeframes applicable to their *coverage*. However, *Keystone Health Plan Central* will only accept from the *contract holder enrollment applications* for initial enrollment or enrollment changes up to sixty (60) days after the *member* is eligible for *coverage* under the *group contract*. Therefore, the *subscriber* should immediately submit an *enrollment application* to the *contract holder* to allow the *contract holder* ample time to submit the *enrollment application* to *Keystone Health Plan Central*.

Subscribers who fail to submit an *enrollment application* within these specific timeframes may not be allowed to enroll themselves and/or their newly eligible *dependents* until the next *open enrollment* period.

Initial Enrollment

"Initial" is the term used to represent eligible *members* enrolling for *Keystone Health Plan Central coverage* for the first time. The initial *group enrollment period* is during the time-period designated by the *contract holder*. *Members* should refer to the sections below for more information on eligibility outside of the initial *group enrollment period*.

Newly Eligible Members

Eligible *subscribers* and *dependents* may enroll for *coverage* when they first meet the appropriate requirements described in the **Eligibility** section of this *Certificate of Coverage*. This may occur during the initial *group enrollment period* or at some other time, based on the eligibility rules established by the *contract holder* and *Keystone Health Plan Central*.

Subscriber

A new *subscriber* may enroll with *Keystone Health Plan Central* for *coverage* after becoming eligible, even though a *group enrollment period* is not in progress. *Subscribers* must immediately submit an *enrollment application* through the *contract holder* to ensure that they enroll within the required timeframes. Newly eligible *subscribers* should consult with the *contract holder* to determine the timeframes applicable to their *coverage*. *Members* should refer to the **Timelines for Submission of Enrollment Applications** section of this *Certificate of Coverage* for more details.

Dependent - Newborns

For thirty-one (31) days following birth, a *member's* newborn child is covered under this *coverage*.

Eligible newborns **must** be enrolled as a *dependent* under the *group contract* within thirty-one (31) days of birth to have ongoing *coverage*. If the newborn child qualifies as a *dependent*, the *member* must notify the *contract holder* immediately and application must be made through the *contract holder* within the required timeframes to add the newborn child as a *dependent*. *Subscribers* should consult with the *contract holder* to determine the timeframes applicable to enrolling a newborn as a *dependent*. *Members* should refer to the **Timelines for Submission of Enrollment Applications** section of this *Certificate of Coverage* for more details.

If the newborn child does not qualify as a *dependent*, the newborn child may be converted to an individual contract under the terms and conditions described in the **Continuation of Coverage After Termination** section of this *Certificate of Coverage.*

Life Status Change

An individual who does not enroll when first eligible must wait until the next *group enrollment period*. However, individuals who experience a life status change may enroll in *coverage* as a new *subscriber* or *dependent* even though a *group enrollment period* is not in progress. A life status change is an event based on, but not limited to:

- A change in job status;
- A change in marital status;
- A change in *domestic partnership*;
- The birth or adoption of a child;
- Acquiring a stepchild or becoming a legal guardian for a child;
- A court order;
- A change in *Medicare* status; or
- A change in the status of other insurance.

If one of these events occurs, the *member* must notify the *contract holder* immediately. To enroll with *Keystone Health Plan Central* for *coverage*, *members* must enroll within the required timeframe after one of the following, as applicable:

- The date of marriage, existence of a *domestic partnership*, birth, adoption or placement for adoption, or in the case of a *ward*, the date specified in the legal custody order; or
- The date of the loss of the other health insurance coverage.

The *subscriber* must submit an *enrollment application* through the *contract holder* within the required timeframes after the newly eligible *dependent* becomes eligible for *coverage* under the *group contract*. *Subscribers* should consult with the *contract holder* to determine the timeframes applicable to enrolling newly eligible *dependents*. *Members* should refer to the **Timelines for Submission of Enrollment Applications** section of this *Certificate of Coverage* for more details.

Group Enrollment Period

During a *group enrollment period*, *members* have the opportunity to make health care coverage changes, if applicable, and to add eligible *dependents* previously not enrolled. A *group enrollment period* occurs at least once annually.

EFFECTIVE DATE OF COVERAGE

Initial and Newly Eligible Members

Initial and newly eligible *members* are effective as of the date specified by the *contract holder* and approved by *Keystone Health Plan Central*. *Members* should contact their *contract holder* for details regarding specific *effective dates of coverage*. These requirements are also described in the *group policy*.

Life Status

Individuals who enroll within the required timeframes are covered as of the following dates, as applicable:

- The date of birth, adoption or placement for adoption;
- The date specified in the legal custody order, in the case of a *ward*;
- The date of marriage;
- The date of domestic partnership; or
- First date after loss of other health insurance coverage.

TERMINATION OF COVERAGE

TERMINATION OF GROUP CONTRACT

Termination of the *group contract* automatically terminates *coverage* with *Keystone Health Plan Central* for all *members*. The terms and conditions related to the termination and renewal of the *group contract* are described in the *group contract*, a copy of which is available for inspection at the office of the *contract holder* during regular business hours.

TERMINATION OF COVERAGE FOR MEMBERS

A *member* cannot be terminated based on health status or health care need.

However, there are situations where a *member's coverage* is terminated even though the *group contract* is still in effect. These situations include, but are not limited to:

- *Subscriber* - *Coverage* ends on the date in which a *subscriber* is no longer employed by, or a member of, the company or organization sponsoring this *coverage*. When *coverage* of a *subscriber* is terminated, *coverage* for all of the *subscriber's dependents* is also terminated.

- *Dependent* Spouse - *Coverage* of a *dependent* spouse ends on the date in which the *dependent* spouse ceases to be eligible under this *coverage*.

- *Dependent Domestic Partner* - *Coverage* of a *dependent domestic partner* ends on the date in which the *dependent domestic partner* ceases to be eligible under this *coverage*.

- Child - *Coverage* of a child ends on the date in which the child is no longer eligible as described in the **Enrollment** section of this *Certificate of Coverage*. However, *coverage* of a child may continue as a *dependent* handicapped child as described in the **Membership Status** section of this *Certificate of Coverage*.

- *Dependent* Handicapped Child - *Coverage* of a *dependent* handicapped child ends when the *subscriber* does not submit to *Keystone Health Plan Central*, through the *contract holder*, the appropriate information as described in the **Membership Status** section of this *Certificate of Coverage*. The *subscriber* must notify *Keystone Health Plan Central* of a change in status regarding a *dependent* handicapped child.

In addition, *coverage* terminates for *members* if they participate in fraudulent behavior or intentionally misrepresent material facts, including but not limited to:

- Using an *ID card* to obtain goods or services:

  ◊ Not prescribed or ordered for the *subscriber* or the *subscriber's dependents* or

  ◊ To which the *subscriber* or the *subscriber's dependents* are otherwise not legally entitled.

- Allowing any other person to use an *ID card* to obtain services. If a *dependent* allows any other person to use an *ID card* to obtain services, *coverage* of the *dependent* who allowed the misuse of the *ID card* is terminated.

- Knowingly misrepresenting or giving false information, or making false statements that materially affect either the acceptance of risk or the hazard assumed by *Keystone Health Plan Central*, on any *enrollment application* form.

The actual termination date is the date specified by the *contract holder* and approved by *Keystone Health Plan Central*. *Members* should check with the *contract holder* for details regarding specific termination dates. Except

as provided for in this *Certificate of Coverage*, if a *member's benefits* under this *coverage* are terminated under this section, all rights to receive *benefits* cease at 11:59:59 PM, local Harrisburg, Pennsylvania time, on the date of termination, including maternity *benefits*.

CERTIFICATES OF CREDITABLE COVERAGE

A Certificate of Creditable Coverage is a document that is provided by a health insurance carrier or employer to a *member* who is no longer enrolled in the employer's health benefits plan and that specifies the *member's* dates of coverage. Creditable coverage is the amount of time a *member* was covered under a health plan without a break in coverage of more than sixty-three (63) days.

Keystone Health Plan Central will produce Certificates of Creditable Coverage both on an automatic basis and on demand for former *members*. A Certificate of Creditable Coverage is issued to any *member* upon request within twenty-four (24) months after *coverage* ceases.

The Certificates of Creditable Coverage issued by *Keystone Health Plan Central* reflect only the period that the *member* had creditable coverage with *Keystone Health Plan Central*.

CONTINUATION OF COVERAGE AFTER TERMINATION

COBRA COVERAGE

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a Federal law, which requires that, under certain circumstances, the *contract holder* give the *subscriber* and the *subscriber's dependents* the option to continue under this *coverage* with *Keystone Health Plan Central*.

Members should contact the *contract holder* if they have any questions about eligibility for *COBRA* coverage. The *contract holder* is responsible for the administration of *COBRA* coverage.

Members should refer to the section below for any other coverage they may be eligible for if they do not qualify for *COBRA* coverage or when *COBRA* coverage ends.

ELIGIBILITY FOR CONVERSION COVERAGE

A *member* whose *coverage* is about to terminate may be eligible to convert to an individual contract available from the Capital BlueCross family of companies. This opportunity to enroll in other coverage is available without medical examination, regardless of whether the *member* is disabled at the time of conversion.

Examples of situations in which a *member* may be offered this conversion privilege include, but are not limited to:

- Termination of employment;
- Ineligibility to remain on this *coverage* due to a divorce, reaching a specific age limit, a change in job status; or
- Termination of the *group contract* due to the *contract holder's* non-payment of *fees*.

Examples of situations in which a *member* will NOT be offered this conversion privilege include, but are not limited to:

- The *contract holder* cancelled this *coverage* with *Keystone Health Plan Central* for coverage with another carrier;
- The *member* failed to pay any required contribution or premium to the *contract holder* and, as a result, the *contract holder* terminated the *member's coverage*;
- The *member* is eligible to enroll in Part A or Part B of *Medicare*;
- The *member* is enrolled in other coverage which, together with the benefits provided under a conversion policy from the Capital BlueCross family of companies, would result in overinsurance if such overinsurance standards are on file with the Pennsylvania Insurance Department; or
- The *member* is provided similar medical coverage under any state or Federal law.

Coverage under the individual conversion contract begins the day after termination of this *coverage*, subject to receipt of premium payments. *Keystone Health Plan Central* is not liable for the cost of *benefits* provided to *members* after the date of termination if they do not exercise the conversion privilege as specified herein.

Notification of conversion is sent to the *subscriber*. This notice contains information on the conversion options as well as applications for coverage. Written application for a conversion contract must be made to *Keystone Health Plan Central* no later than:

- Thirty-one (31) days after termination of coverage under this *coverage*; or
- Thirty-one (31) days after the *member* has been given written notice of the existence of the conversion privilege.

Enrollment forms for conversion are available from *Keystone Health Plan Central's* Customer Service Department and can be obtained by calling the customer service number located on the *identification card*.

APPLYING FOR CONVERSION COVERAGE IS THE *MEMBER'S* RESPONSIBILITY.

COVERAGE FOR MEDICARE-ELIGIBLE MEMBERS

If a *member* is no longer eligible for this *coverage*, is age 65 or older, and is enrolled in *Medicare* Parts A and B; the *member* can enroll in a *Medicare* Supplemental or a *Medicare* Advantage product offered by the Capital BlueCross family of companies.

Enrollment forms are available from *Keystone Health Plan Central's* Customer Service Department and can be obtained by calling the customer service number located on the *identification card*.

APPLYING FOR *MEDICARE* SUPPLEMENTAL OR *MEDICARE* ADVANTAGE COVERAGE IS THE *MEMBER'S* RESPONSIBILITY.

EXTENSION OF INPATIENT BENEFITS

When this *Certificate of Coverage* 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, *benefit*s 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.

CLAIMS REIMBURSEMENT

CLAIMS AND HOW THEY WORK

In order to receive payment for *benefits* under this *coverage,* a claim for *benefits* must be submitted to *Keystone Health Plan Central*. 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 Health Plan Central* will process the request and determine if the services and/or supplies provided under this *coverage* with *Keystone Health Plan Central* are *benefits* provided by the *member's coverage*, and if applicable, make payment on the claim. The method by which *Keystone Health Plan Central* 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 Health Plan Central*.

When *members* receive services from a *participating provider*, they should show their *Keystone Health Plan Central identification card* to the *provider*. The *participating provider* will submit a claim for *benefits* directly to *Keystone Health Plan Central*. *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 the *Keystone Health Plan Central 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 Health Plan Central* for processing. *Keystone Health Plan Central* 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 Health Plan Central*, they should be sure to request an itemized bill from their health care *provider*. The itemized bill should be submitted to *Keystone Health Plan Central* 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 Health Plan Central's* Web site at www.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. Group Number – number of the sponsoring *group* or employer.

3. Name of *Subscriber* – full name of the person enrolled for *coverage* through the grou*p*.
4. Address – full address of the *subscriber* including: number and street, city, state, country, and ZIP code.
5. Patient's Name – last and first name of the patient who received the service.
6. Patient's Gender – indicate male or female.
7. Patient's Date of Birth – patient's date of birth by month, day, and year.
8. Patient's Relationship to *Subscriber* – relationship of the patient to the *subscriber*.
9. *Provider* Name – full name, address, city, state, country, and ZIP code of the facility, *physician*, or supplier rendering the services.
10. Procedure Code – procedure code or description of each service rendered.
11. Type of Admission/*Surgery* – Type of service such as *inpatient* or *outpatient* and what was done, if applicable.
12. Date(s) of Service – dates on which patient received services, including initial admission date and final discharge date if applicable.
13. Diagnosis, Illness, or Injury – complete diagnosis or injury for particular admission.
14. 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 Health Plan Central* 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 **1-800-669-7061** (TTY: **1-800-669-7075**).

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 72017, Richmond, VA 23255-2017.

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 72017, Richmond, VA 23255-2017. 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 www.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 Health Plan Central* will process the claim within thirty (30) days of receiving the claim. *Keystone Health Plan Central* may

extend the thirty (30)-day time period one (1) time for up to fifteen (15) days for circumstances beyond *Keystone Health Plan Central's* control. *Keystone Health Plan Central* will notify the *member* prior to the expiration of the original time period if an extension is needed. The *member* and *Keystone Health Plan Central* may also agree to an extension if the *member* or *Keystone Health Plan Central* 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 Health Plan Central* 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* believe 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 Health Plan Central's* Customer Service Department, toll-free, at **1-800-669-7061.** *Keystone Health Plan Central* will review the *member's* request and will notify the *member* of *Keystone Health Plan Central'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. The **How to File an Appeal** attachment 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 Health Plan Central's* Customer Service Department.

COORDINATION OF BENEFITS (COB)

The coordination of *benefits* provision of this *Certificate of Coverage* 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.

Definitions Unique to Coordination of Benefits

In addition to the defined terms in the **Definitions** section of this *Certificate of Coverage*, 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 Health Plan Central*.

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*.

NOTE: When *benefits* are reduced under the primary contract because a *member* does not comply with the provisions of the Other Plan, the amount of such reduction will not be considered an Allowable Expense under This Coverage. Examples of such provisions are those related to second surgical opinions and *preauthorization* of admissions or services.

Keystone Health Plan Central 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 Health Plan Central* is furnished with information regarding Other Plans by the *contract holder* 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 benefit 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.

      For information regarding coordination of benefits with *Medicare*, please refer to the **Coordination of Benefits with Medicare** section of this *Certificate of Coverage*.

   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 Health Plan Central* 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 Health Plan Central* 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 Health Plan Central* any facts needed to apply those rules and determine *benefits* payable.

Failure to complete any forms required by *Keystone Health Plan Central* 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 Health Plan Central* 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 Health Plan Central* 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 Health Plan Central* is more than the amount that should have been paid under this COB provision, *Keystone Health Plan Central* may recover the excess amount. The excess amount may be recovered from one or more of the persons or organization 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.

COORDINATION OF BENEFITS WITH MEDICARE

Active Employees and Spouses Age 65 and Older

If a *subscriber* (or his/her spouse), age sixty-five (65) or older, is entitled to benefits under *Medicare* and the *subscriber* works for an employer that did not employ twenty (20) or more employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding calendar year, then *Medicare* shall be primary for the *subscriber* or spouse. The *benefits* of the *group contract* will then be the secondary form of coverage.

If a *subscriber* (or his/her spouse), age sixty-five (65) or older, is entitled to benefits under *Medicare* and the *subscriber* works for an employer that employed twenty (20) or more employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding calendar year, the following rules apply:

- The *group contract* will be primary for any person age sixty-five (65) or older who is an Active Employee (defined as a person with "current employment status" under applicable *Medicare* Secondary Payer Laws) or the spouse of an Active Employee of any age.
- A *member* may decline *coverage* under the *group contract* and elect *Medicare* as the primary form of coverage. If the *member* elects *Medicare* as the primary form of coverage, the *group contract*, by law, cannot pay *benefits* secondary to *Medicare* for *Medicare*-covered *members*. However, the *member* will continue to be covered by the *group contract* as primary unless: (a) the *member*, or the *contract holder* on behalf of the *member*, notifies *Keystone Health Plan Central*, in writing, that the *member* does not want *benefits* under the *group contract*; or (b) the *member* otherwise ceases to be eligible for *coverage* under the *group contract*.

Disability

If a *member* is under age sixty-five (65), and the *subscriber* has current employment status with an employer with fewer than one hundred (100) employees (as defined under the *Medicare* Secondary Payer Laws), and the *member* becomes disabled and entitled to benefits under *Medicare* due to such disability, then *Medicare* shall be primary for the *member*; and the *group contract* will be the secondary form of *coverage*.

If a *member* is under age sixty-five (65), and the *subscriber* has current employment status with an employer with at least one hundred (100) employees (as defined under the *Medicare* Secondary Payer Laws), and the *member* becomes disabled and entitled to benefits under *Medicare* due to such disability (other than ESRD as discussed below) the *group contract* will be primary for the *member*, and *Medicare* will be the secondary form of coverage.

End Stage Renal Disease (ESRD)

The *group contract* will remain primary for the first thirty (30) months of a *member's* eligibility or entitlement to *Medicare* due to End Stage Renal Disease (as defined under applicable *Medicare* statutes). However, if the *group contract* is currently paying *benefits* as secondary to *Medicare* for a *member*, the *group contract* will remain secondary upon a *member's* entitlement to *Medicare* due to ESRD.

Retirees

Upon the effective date of the *member's* enrollment in *Medicare* Part A and B, *Medicare* shall become primary for the *member* to the extent permitted under the *Medicare* Secondary Payer Laws; and the *group contract* will be the secondary form of *coverage*.

THIRD PARTY LIABILITY/SUBROGATION

Subrogation is the right of the *contract holder* 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 the *contract holder* 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 the *contract holder* more than any amount recovered from the third party.

In lieu of payment above, and to the extent permitted by law, the *contract holder* 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 *group contract*. The *member* shall cooperate with the *contract holder* should the *contract holder* exercise its right of subrogation. The *member* shall cooperate with *Keystone Health Plan Central* if the *contract holder* chooses to have *Keystone Health Plan Central* pursue the right of subrogation on behalf of the *contract holder*. The *member* shall not take any action or refuse to take any action that would prejudice the rights of the *contract holder* under this **Third Party Liability/Subrogation** section.

The right of subrogation is not enforceable if prohibited by applicable controlling statute or regulation.

There are three basic categories of medical claims that are included in *the contract holder'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 the *contract holder* to recover the amounts already paid by the *contract holder* for claims related to the injury or illness. The *contract holder* does not require reimbursement from the *member* for more than any amount recovered. The *contract holder* may choose to have *Keystone Health Plan Central* pursue these rights on its behalf.

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. The *contract holder* 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, the *contract holder* may consider the charges in accordance with the *coverage* available under the *group contract*. *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 the *contract holder*.

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 the *contract holder* 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 *Certificate of Coverage.*

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 *group contract* 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 *group contract*, including, but not limited to, an action based upon a denial of *benefits*.

PAYMENTS MADE IN ERROR

Keystone Health Plan Central 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.

MEMBER RIGHTS AND RESPONSIBILITIES

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 Health Plan Central*, 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 Health Plan Central 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 appeals about *Keystone Health Plan Central*, services requested, or the care rendered by their *provider*.

MEMBER RESPONSIBILITIES

Members have a responsibility:

- To follow the rules of membership and to read all materials carefully.
- To carry their *Keystone Health Plan Central ID card* with them and present it when seeking health care services.
- To provide *Keystone Health Plan Central* with relevant information concerning any additional health insurance coverage which they or any of their *dependents* may have.
- To timely notify *Keystone Health Plan Central* 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 Health Plan Central* 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 Health Plan Central* informed of any concerns regarding the medical care they receive.
- To provide information, to the extent possible, that *Keystone Health Plan Central* 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.

APPEAL PROCEDURES

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 *coverage* with *Keystone Health Plan Central* for a service:

- Based on a determination of a *member*'s eligibility to enroll under the *group contract*;
- Resulting from the application of any utilization review; or
- Not provided because it is determined to be *investigational* or not *medically necessary*.

Members who disagree with an *adverse benefit determination* with respect to *benefits* available under this *coverage* may seek review of the *adverse benefit determination* by submitting a written appeal within 180 days of receipt of the *adverse benefit determination*.

For more information, *members* should refer to the **How to File an Appeal** attachment included with this *Certificate of Coverage*.

Members can call Customer Service at **1-800-669-7061** if they have questions on this attachment or if they would like another copy of the attachment.

GENERAL PROVISIONS

ADDITIONAL SERVICES

From time to time, *Keystone Health Plan Central*, in conjunction with contracted companies, may offer other programs under this *coverage* with *Keystone Health Plan Central* to assist *members* in obtaining appropriate care and services. Such services may include a 24-hour nurse line, *case management*, maternity management, and Disease Management Programs.

Keystone Health Plan Central may also make available to its *members* access to health education and wellness related programs offered through contracted companies. Participation in these programs is optional to each *Member*. These programs are not insurance and are not an insurance *benefit* or promise under the *group contract*. M*ember* access to these programs is provided by *Keystone Health Plan Central* separately or independently from the *group contract*. There is no additional charge to *members* for accessing these programs. Contact the Plan Administrator for information on these programs.

BENEFITS ARE NON-TRANSFERABLE

No person other than a *member* is entitled to receive payment for *benefits* to be furnished by *Keystone Health Plan Central* under the *group contract*. Such right to payment for *benefits* is not transferable.

CHANGES

By this *Certificate of Coverage*, the *contract holder* makes *Keystone Health Plan Central coverage* available to eligible *members*. However, this *Certificate of Coverage* shall be subject to amendment, modification, and termination in accordance with any provision hereof or by mutual agreement between *Keystone Health Plan Central* and *contract holder* without the consent or concurrence of the *members*. By electing *Keystone Health Plan Central* or accepting *Keystone Health Plan Central benefits*, all *members* legally capable of contracting, and the legal representatives of all *members* incapable of contracting, agree to all terms, conditions, and provisions hereof.

Changes in State or Federal Laws and/or Regulations and/or Court or Administrative Orders

Changes in state or federal law or regulations or changes required by court or administrative order may require *Keystone Health Plan Central* to change *coverage* for *benefits* and any *cost-sharing amounts*, or otherwise change *coverage* for *benefits* in order to meet new mandated standards. Such changes can occur on the earlier of either the *group contract* renewal date or the date such change is required by law, regulation or court or administrative order.

Keystone Health Plan Central will provide the *contract holder* with an *official notice of change* at least thirty (30) days prior to the effective date of any change in coverage for *benefits.* However, if such change occurred due to a change in law, regulation or court or administrative order which makes the provision of such notice within thirty (30) days not possible, *Keystone Health Plan Central* will provide such notice to the *contract holder* as soon as reasonably practicable.

Discretionary Changes by Keystone Health Plan Central

Keystone Health Plan Central may change *coverage* for *benefits* and any *cost-sharing amounts*, or otherwise change *coverage* upon the renewal of the *group contract*.

Keystone Health Plan Central will provide the *contract holder* with an *official notice of change* at least thirty (30) days prior to the effective date of any change in coverage for *benefits.*

Notwithstanding the above, changes in *Keystone Health Plan Central's* administrative procedures, including but not limited to changes in medical policy, *preauthorization* requirements, and underwriting guidelines, are not *benefit* changes and are, therefore, not subject to these notice requirements.

In the future, should terms and conditions associated with this coverage change, updates to these materials will be issued. These updates must be kept with this document to ensure the *member's* reference materials are complete and accurate.

CHANGES IN LAW

The parties recognize that the *group contract* at all times is subject to applicable federal, state and local law. The parties further recognize that the *group contract* is 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 *coverage* or that would cause one or both of the parties to be in violation of the law, is deemed to have superseded the terms of this *coverage*; provided that the parties exercise their best efforts to accommodate the terms and intent of the *group contract* consistent with the requirements of law.

In the event that any provision of the *group contract* is rendered invalid or unenforceable by law, or by a regulation, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of the *group contract* remain in full force and effect.

CHOICE OF FORUM

The *contract holder* and *members* hereby irrevocably consent and submit to the jurisdiction of the federal and state courts within Dauphin County, Pennsylvania and waive any objection based on venue or forum non conveniens with respect to any action instituted therein arising under the *group contract* whether now existing or hereafter and whether in contract, tort, equity, or otherwise.

CHOICE OF LAW

All issues and questions concerning the construction, validity, enforcement, and interpretation of the *group contract* is governed by, and construed in accordance with, the laws of the Commonwealth of Pennsylvania, without giving effect to any choice of law or conflict of law rules or provisions, other than those of the federal government of the United States of America, that would cause the application of the laws of any jurisdiction other than the Commonwealth of Pennsylvania.

CHOICE OF PROVIDER

The choice of a *provider* is solely the *member's*. *Keystone Health Plan Central* does not furnish *benefits* but only makes payment for *benefits* received by *members*. *Keystone Health Plan Central* is not liable for any act or omission of any *provider*. *Keystone Health Plan Central* has no responsibility for a *provider'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 *provider* is not a statement as to the ability, cost or quality of the *provider*.

Keystone Health Plan Central cannot guarantee continued access during the term of the *member's Keystone Health Plan Central* enrollment to a particular health care *provider*. If the *member's participating provider* ceases participation, *Keystone Health Plan Central* will provide access to other *providers* with similar training and experience.

CLERICAL ERROR

Clerical error, whether of the *contract holder* or *Keystone Health Plan Central*, in keeping any record pertaining to the *coverage* hereunder, will not invalidate *coverage* otherwise validly in force or continue *coverage* otherwise validly terminated.

ENTIRE AGREEMENT

The *group contract* sets forth the terms and conditions of coverage of *benefits* under this Pennsylvania Health Maintenance Organization, (sometimes referred to in this *Certificate of Coverage* as "HMO") that is administered by *Keystone Health Plan Central* and offered by the *contract holder* to *subscribers* and their *dependents* due to the *subscriber's* relationship with the *contract holder*. The *group contract* (including all of its attachments) and any riders or amendments to the *group contract* constitute the entire agreement between the *contract holder* and *Keystone Health Plan Central*. If there is a conflict of terms between the *group policy* and the *Certificate of Coverage*, the terms of the *group policy* shall control and be enforceable over the terms of the *Certificate of Coverage*.

EXHAUST ADMINISTRATIVE REMEDIES FIRST

Neither the *contract holder* nor any *member* may bring a cause of action in a court or other governmental tribunal (including, but not limited to, a Magisterial District Justice hearing) unless and until all administrative remedies described in the *group contract* have first been exhausted.

FAILURE TO ENFORCE

The failure of either *Keystone Health Plan Central*, the *contract holder*, or a *member* to enforce any provision of the *group contract* shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of the *group contract* shall not be deemed or construed to be a waiver of such default.

FAILURE TO PERFORM DUE TO ACTS BEYOND KEYSTONE HEALTH PLAN CENTRAL'S CONTROL

The obligations of *Keystone Health Plan Central* under the *group contract* shall be suspended to the extent that *Keystone Health Plan Central* is hindered or prevented from complying with the terms of the *group contract* because of labor disturbances (including strikes or lockouts); acts of war; acts of terrorism, vandalism, or other aggression; acts of God; fires, storms, accidents, governmental regulations, impracticability of performance or any other cause whatsoever beyond its control. In addition, *Keystone Health Plan Central's* failure to perform under the *group contract* shall be excused and shall not be cause for termination if such failure to perform is due to the *contract holder* undertaking actions or activities or failing to undertake actions or activities so that *Keystone Health Plan Central* is or would be prohibited from the due observance or performance of any material covenant, condition, or agreement contained in the *group contract.*

FAILURE TO PERFORM DUE TO ACTS BEYOND CONTRACT HOLDER'S CONTROL

The obligations of the *contract holder* under the *group contract* shall be suspended to the extent that the *contract holder* is hindered or prevented from complying with the terms of the *group contract* because of labor disturbances (including strikes or lockouts); acts of war; acts of terrorism, vandalism, or other aggression; acts of God; fires, storms, accidents, governmental regulations, or any other cause whatsoever beyond that party's control. In addition, the *contract holder's* failure to perform under the *group contract* shall be excused and shall not be cause for termination if such failure to perform is due to *Keystone Health Plan Central* undertaking actions

or activities or failing to undertake actions or activities so that *contract holder* is or would be prohibited from the due observance or performance of any material covenant, condition, or agreement contained in the *group contract.*

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).

HEADINGS

The headings of sections and paragraphs contained in the *group contract* are for reference purposes only and shall not affect in any way the meaning or interpretation of the *group contract*.

IDENTIFICATION CARDS

Keystone Health Plan Central provides *identification cards* to all *subscribers* and other *members* as appropriate. For purposes of identification and specific coverage information, a *member's ID card* must be presented when service is requested.

Identification cards are the property of *Keystone Health Plan Central* and should be destroyed when a *member* no longer has *coverage*. Upon request, *identification cards* must be returned to *Keystone Health Plan Central* within thirty-one (31) days of the *member's* termination. *Identification cards* are for purposes of identification only and do not guarantee eligibility to receive *benefits*.

LEGAL ACTION

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Notwithstanding the foregoing, *Keystone Health Plan Central* does not waive or otherwise modify any defense, including the defense of the statute of limitations, applicable to the type or theory of action or to the relief being sought, including but not limited to the statute of limitations applicable to actions in tort.

LEGAL NOTICES

Any and all legal notices under the *group contract* shall be given in writing and by the United States mail, postage prepaid, addressed as follows:

- If to a *member*: to the latest address reflected in *Keystone Health Plan Central's* records.
- If to the *contract holder*: to the latest address provided by the *contract holder* to *Keystone Health Plan Central*.
- If to *Keystone Health Plan Central*: to Legal Department, PO Box 772132, Harrisburg, PA 17177-2132.

MEMBER'S PAYMENT OBLIGATIONS

A *member* has only those rights and privileges specifically provided in the *group contract*. Subject to the provisions of the *group contract*, a *member* is responsible for payment of any amount due to a *provider* in excess

of the *benefit* amount paid by *Keystone Health Plan Central*. If requested by the *provider*, a *member* is responsible for payment of *cost sharing amounts* at the time service is rendered.

PAYMENTS

Keystone Health Plan Central is authorized by the *member* to make payments directly to *participating providers* furnishing services for which *benefits* are provided under the *group contract*. In addition, *Keystone Health Plan Central* is authorized by the *member* to make payments directly to a state or federal governmental agency or its designee whenever *Keystone Health Plan Central* is required by law or regulation to make payment to such entity.

Once a *provider* renders services, *Keystone Health Plan Central* will not honor *member* requests not to pay claims submitted by the *provider*. *Keystone Health Plan Central* 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 the *group contract*.

PAYMENT RECOUPMENT

Under certain circumstances, federal and state government programs will require *Capital* to reimburse costs for services provided to *members*. *Capital* reserves the right to recoup these reimbursements from *members* when services were provided to the *members* which should not have been paid by *Capital.*

POLICIES AND PROCEDURES

Keystone Health Plan Central may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this *Certificate of Coverage*, with which *members* shall comply.

RELATIONSHIP OF PARTIES

Health care *providers* maintain the physician-patient relationship with *members* and are solely responsible to *members* for all medical services. The relationship between *Keystone Health Plan Central* and health care *providers* (including *PCPs* and other *physicians*) is an independent contractor relationship. Health care *providers* are not agents or employees of *Keystone Health Plan Central*, nor is any employee of *Keystone Health Plan Central* an employee or agent of a health care *provider*. *Keystone Health Plan Central* 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 health care *provider*.

Neither the *contract holder* nor any *member* is an agent or representative of *Keystone Health Plan Central*, and neither is liable for any acts or omissions of *Keystone Health Plan Central* for the performance of services under the *group contract*.

The *contract holder* is the agent of the *members*, not of *Keystone Health Plan Central*.

Certain services, including administrative services, relating to the *benefits* provided under the *group contract* may be provided by *Keystone Health Plan Central* or other companies under contract with Capital Advantage Insurance Company, Capital BlueCross, or *Keystone Health Plan Central*.

INDEPENDENT LICENSEE OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION

The *contract holder* hereby expressly acknowledges its understanding this *group contract* constitutes a contract solely between *contract holder* and *Keystone Health Plan Central*, which is an independent corporation operating

under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting *Keystone Health Plan Central* to use the Blue Cross and/or Blue Shield Service Marks in the Commonwealth of Pennsylvania, and that *Keystone Health Plan Central* is not contracting as the agent of the Association. The *contract holder* further acknowledges and agrees that it has not entered into this *group contract* based upon representations by any person other than *Keystone Health Plan Central* and that no person, entity, or organization other than *Keystone Health Plan Central* shall be held accountable or liable to *contract holder* for any of *Keystone Health Plan Central* obligations to *contract holder* created under this *group contract*. 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.

WAIVER OF LIABILITY

Keystone Health Plan Central shall not be liable for injuries or any other harm or loss resulting from negligence, misfeasance, nonfeasance or malpractice on the part of any *provider*, whether a *participating provider* or *non-participating provider*, in the course of providing *benefits* for *members*.

WORKERS' COMPENSATION

The *group contract* is NOT in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

ADDITIONAL INFORMATION

Keystone Health Plan Central members may submit a written request for any of the following written information:

1. A list of the names, business addresses and official positions of the membership of the board of directors or officers of *Keystone Health Plan Central*.

2. The procedures adopted by *Keystone Health Plan Central* to protect the confidentiality of medical records and other *member* information.

3. A description of the credentialing process for *participating providers*.

4. A list of the *participating providers* affiliated with participating *hospitals*.

5. If prescription drugs are provided as a *benefit* under this *coverage,* whether a specifically identified drug is included or excluded from this *coverage*.

6. A description of the process by which a *participating provider* can prescribe specific drugs, drugs used for an off-label purpose, biologicals and medications not included in the *Keystone Health Plan Central* drug formulary for prescription drugs or biologicals when the formulary's equivalent has been ineffective in the treatment of the *member's* disease or if the drug causes or is reasonably expected to cause adverse or harmful reactions in the *member's* case, if prescription drugs are provided as a *benefit* under the *member's coverage*.

7. A description of the procedures followed by *Keystone Health Plan Central* to make decisions about the nature of individual drugs, medical devices or treatments.

8. A summary of the methodologies used by *Keystone Health Plan Central* to reimburse *providers* for covered services. Please note that we will not disclose the terms of individual contracts or the specific details of any financial arrangement between *Keystone Health Plan Central* and a *participating provider*.

9. A description of the procedures used in *Keystone Health Plan Central's* Quality Management Program as well as progress towards meeting goals.

Requests must specifically identify what information is being requested and should be sent to:

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

Members may also fax their requests to 717-703-8494 or by accessing www.capbluecross.com, an email can be sent to the Customer Service Department.

Members may also inform *Keystone Health Plan Central* of their dissatisfaction with care or service by writing to the address above or by faxing *Keystone Health Plan Central* at the number above.

DEFINITIONS

For the purpose of the *group contract*, the terms below have the following meanings whenever italicized in the *group contract*:

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*.

After Hours Primary Care Physician Office Visit: An office visit to the *primary care physician* occurring during hours other than those regularly scheduled for appointments by that *provider*. Each *after hours primary care physician office visit* shall be subject to an after hours *PCP copayment*. This *copayment* is in addition to the *PCP* office visit *copayment*. After hours *primary care physician* office visit *copayments* are described in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage*.

Allowable Amount: The payment level that *Keystone Health Plan Central* 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 Health Plan Central*, unless otherwise specified in this *Certificate of Coverage*.

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*.

Autism Spectrum Disorders: A subclass of *pervasive developmental disorders* which is characterized by impaired verbal and nonverbal communication skills, poor social interaction, limited imaginative activity and repetitive patterns of activities and behavior.

Behavioral Health Care Vendor: The agent of *Keystone Health Plan Central* who is a *mental health care* and *substance abuse* professional and who coordinates, manages, or refers services for *mental health care* and *substance abuse*.

Benefit Lifetime Maximum: The limit of *coverage* for a *benefit* payable by *Keystone Health Plan Central* under the *group contract* during the duration of a *member's coverage* under the *group contract*. Such limits may be in the form of visits, days, or dollars. Benefit lifetime maximums are described in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage*.

Benefit Period: The specified period of time during which charges for *benefits* must be incurred to be eligible for payment by *Keystone Health Plan Central*. A charge for *benefits* is incurred on the date the service or supply was provided to a *member*. However, the benefit period does not include any part of a calendar year during which a

person has no *coverage* under the *group contract*, or any part of a year before the date of this *Certificate of Coverage* or similar provision(s) takes effect. **The benefit period for this *coverage* is the calendar year.**

Benefit Period Maximum: The limit of coverage for a *benefit(s)* under the *group contract* within a *benefit period*. Such limits may be in the form of visits, days, or dollars. Benefit period maximums are described in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage*.

Benefits: Those *medically necessary* health care services, supplies, equipment and facilities charges covered under, and in accordance with, this *coverage*.

Birth Defect: An internal or external congenital abnormality that is present at birth and that does not develop, appear, or manifest later in life.

Birthing 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 allows a *member* to access covered health care services from *Host Licensee participating providers* of a Blue Cross and/or Blue Shield licensee located outside the *service area*. The local Blue Cross and/or Blue Shield licensee servicing the geographic area where the covered health care service is provided is referred to as the "Host Licensee."

Case Management: A *Clinical Management* Program that coordinates and manages complicated medical care.

Certificate of Coverage: This document that is issued to *subscribers* as part of the *group contract* entered into between the *contract holder* and *Keystone Health Plan Central*. It explains the terms of this *coverage*, including the *benefits* available to *members* and information on how this *coverage* is administered.

Clinical Management: Programs used to approve, review, and facilitate health care services.

COBRA: Collectively, the Consolidated Omnibus Budget Reconciliation Act of 1985 and its related regulations, each as amended.

Coinsurance: The percentage of the *allowable amount* that will be paid by the *member*. Coinsurance percentages, if any, are identified in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* or in the applicable rider to this *Certificate of Coverage*.

Contract Holder: The organization or firm, usually an employer, union, or association, that contracts with *Keystone Health Plan Central* to provide coverage for *benefits* to *members*. The contract holder is identified in the *group policy*.

Contract Year: A period of twelve (12) consecutive months, beginning on each *group effective date* during which charges for *benefits* must be incurred in order to be eligible for payment under the *group plan*. A charge for *benefits* shall be considered incurred on the date the service or supply was provided to a *member*.

Copayment: The fixed dollar amount that a *member* must pay for certain *benefits*. The *member* must pay copayments directly to the *provider* at the time services are rendered. Copayments, if any, are identified in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* or in the applicable rider to this *Certificate of Coverage*.

Cosmetic Surgery or Procedure: An elective procedure performed primarily to restore a person's appearance by surgically altering a physical characteristic that does not prohibit normal function, but is considered unpleasant or unsightly.

Cost-Sharing Amount: The amount subtracted from the *allowable amount* which the *member* is obligated to pay before *Keystone Health Plan Central* makes payment for *benefits*. Cost-sharing amounts include: *copayments*, *deductibles*, *coinsurance*, and *out-of-pocket maximums*.

Coverage: The program offered and/or administered by *Keystone Health Plan Central* which provides *benefits* for *members* covered under the *group contract*.

Custodial Care: Care provided primarily for maintenance of the *member* or which is designed essentially to assist the *member* in meeting the activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial care includes but is not limited to help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over 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 *benefit period* before *benefits* are covered under the *group contract*. Deductibles are described in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage*.

Dependent: Any member of a *subscriber's* family, including a *domestic partner,* who satisfies the applicable eligibility criteria, who enrolled under the *group contract* by submitting an *enrollment application* to *Keystone Health Plan Central* and for whom such *enrollment application* has been accepted by *Keystone Health Plan Central*.

Domestic Partner: Shall mean a member of a *domestic partnership* consisting of two (2) partners, each of whom meet the requirements of a *domestic partnership*.

Domestic Partnership: Shall mean a partnership consisting of a *subscriber* and a *domestic partner* each of whom:

- is unmarried, at least eighteen (18) years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time;
- is not related to the other partner by adoption or blood;
- is the sole *domestic partner* of the other partner, with whom he/she has a close committed and personal relationship, and has been a member of this *domestic partnership* for the last six (6) months;
- agrees to be jointly responsible for the basic living expenses and welfare of the other partner;
- meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for domestic partnerships; and
- demonstrates financial interdependence by submission of proof of three (3) or more of the following documents: (a) a domestic partnership agreement; (b) a joint mortgage or lease; (c) a designation of one of the partners as beneficiary in the other partner's will; (d) a durable property and health care powers of attorney; (e) a joint title to an automobile, or joint bank account or credit account; or (f) such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case. *Keystone Health Plan Central* reserves the right to request documentation of any of the foregoing prior to commencing *coverage* for the *domestic partner*.

Effective Date of Coverage: The date the *member's coverage* under the *group contract* begins as shown on the records of *Keystone Health Plan Central*.

Emergency Service: Any health care services 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 or her unborn child, in serious jeopardy;
- serious impairment to bodily functions,
- serious dysfunction of any bodily organ or part; or
- other serious medical consequences.

Transportation and related *emergency services* provided by a licensed ambulance service are *benefits* if the condition is as described in this definition.

Enrollment Application: The properly completed written or electronic application for membership submitted on a form provided by or approved by *Keystone Health Plan Central*, together with any amendments or modifications thereto.

Equivalent Partial Session Visit: A visit consisting of a period of twenty (20) to thirty (30) minutes per session for individual or family medical psychotherapy for the treatment of problems related to *substance abuse*, with continuing medical diagnostic evaluation and drug management when indicated, to include individual psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy.

ERISA: Collectively, the Employee Retirement Income Security Act of 1974 and its related regulations, each as amended.

Facility Provider: Facility *providers* include:

- Ambulance Service *Provider*
- *Ambulatory Surgical Facility*
- *Birthing Facility*
- Durable Medical Equipment Supplier
- Freestanding Outpatient/Diagnostic Facility
- *Freestanding Dialysis Treatment Facility*
- *Home Health Care Agency*
- *Hospice*
- *Hospital*
- *Hospital* Laboratories
- Infusion Therapy *Provider*
- Orthotics Supplier
- Prosthetics Supplier
- *Psychiatric Hospital*
- *Rehabilitation Hospital*

- *Skilled Nursing Facility*
- *Substance Abuse Treatment Facility*
- Urgent Care Center

Information on whether these facility *providers* are covered under the *group contract* can be found in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage*.

Fee Schedule: The predetermined fee maximums that will be paid by *Keystone Health Plan Central* for services performed by *non-participating providers*, which are provided as *benefits* under this *coverage*. The fee schedule may be amended from time to time and may be adjusted based upon factors, including but not limited to, geographic location and *provider* types.

Freestanding Dialysis Facility: A *facility provider* licensed and approved by the state in which it provides health care services, or as otherwise approved by *Keystone Health Plan Central*, and which is primarily engaged in providing dialysis treatment, maintenance or training to *members* on an *outpatient* or home care basis.

Freestanding Outpatient Facility: A *facility provider*, licensed and approved by the state in which it provides health care services, or as otherwise approved by *Keystone Health Plan Central*, and which is primarily engaged in providing *outpatient* diagnostic and/or therapeutic services by or under the supervision of *physicians*.

Full Session Visit: A visit consisting of a period of forty-five (45) to fifty (50) minutes per session for individual or family medical psychotherapy for the treatment of problems related to *substance abuse*, with continuing medical diagnostic evaluation, and drug management when indicated, to include individual psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy.

Functional Impairment: A condition that describes a state where an individual is physically limited in the performance of basic daily activities.

Group Application: The properly completed written and executed or electronic application for coverage the *contract holder* submits on a form provided by or approved by *Keystone Health Plan Central*, together with any amendments or modifications thereto.

Group Contract: An agreement between *Keystone Health Plan Central* and a *contract holder* pursuant to which *Keystone Health Plan Central* provides *coverage* under this contract to persons eligible to enroll in *Keystone Health Plan Central's* programs.

Group Effective Date: The date that is specified in the *group policy* as the original date that the *group contract* became effective.

Group Enrollment Period: A period of time established by the *contract holder* and *Keystone Health Plan Central* from time to time, but no less frequently than once in any twelve (12) consecutive months, during which eligible persons who have not previously enrolled with *Keystone Health Plan Central* may do so; or those who have previously enrolled in a *Keystone Health Plan Central* program may switch to another program.

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.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, and its related regulations, each as amended.

Home Health Care Agency: A *facility provider*, licensed and approved by the state in which it provides health care services, or as otherwise approved by *Keystone Health Plan Central*, which provides skilled nursing and other services on an intermittent basis in the *member's* home; and is responsible for supervising the delivery of such services under a plan prescribed by the attending *physician*.

Hospice: A *facility provider* licensed and approved by the state in which it provides health care services, or as otherwise approved by *Keystone Health Plan Central*, and which is primarily engaged in providing palliative care to terminally ill *members* and their families with such services being centrally coordinated through an interdisciplinary team directed by a *physician*.

Hospital: A *facility provider* that:

- is licensed by the state in which it is located,
- provides twenty-four (24) hour nursing services by certified registered nurses on duty or call,
- provides services under the supervision of a staff of one or more *physicians* to diagnose and treat ill or injured bed patients hospitalized for surgical, medical or psychiatric conditions, and
- is certified by the Joint Commission on the Accreditation of Healthcare Organizations, an equivalent body, or as accepted by *Keystone Health Plan Central*.

Hospital does not include: residential or nonresidential treatment facilities; nursing homes; *skilled nursing facilities*; facilities that are primarily providing custodial, domiciliary or convalescent care; or *ambulatory surgical facilities*.

Host Licensee Participating Provider: A *provider* located outside of *Keystone Health Plan Central's service area* that has a formal and binding agreement with another Blue Cross and/or Blue Shield Plan, which participates in the *BlueCard Program,* regarding claim filing or payment for covered health care services rendered to its members.

Identification Card (ID Card): The card issued to the *member* that evidences *coverage* under the terms of the *group contract*.

Immediate Family: The *subscriber's* or *member's* spouse, *domestic partner*, 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.

Infertility: 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.

Infusion Therapy Provider: An entity that meets the necessary licensing requirements and is legally authorized to provide home infusion/IV therapy services.

Inpatient: A *member* who is admitted as a patient and spends greater than 23 hours in a *hospital*, a *rehabilitation hospital*, a *skilled nursing facility* or a non-residential *substance abuse treatment facility* and for whom a room and board charge is made. This term may also describe the services rendered to such a *member*. The term *inpatient* does not apply to a *member* who is admitted to a *substance abuse treatment facility* for non-*hospital* residential services.

Investigational: For the purposes of the *group contract*, 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 Health Plan Central*, with respect to whether a treatment or procedure is investigational.

Keystone Health Plan Central: The Pennsylvania licensed health maintenance organization (HMO) which administers this *coverage* as indicated on the cover of this *Certificate of Coverage*.

Licensed Practical Nurse (LPN): A nurse who has graduated from a formal practical or vocational nursing educations program and is licensed by the appropriate state authority.

Medicaid: Hospital or medical insurance benefits financed by the United States Government under Title XIX of the Social Security Act of 1965 and its related regulations, each as amended.

Medical Necessity (Medically Necessary): 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.

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: The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965 and its related regulations, each as amended.

Member: A *subscriber*, *dependent* or "Qualified Beneficiary" (as defined under *COBRA*) who enrolled for *coverage* with *Keystone Health Plan Central* and is entitled to receive covered services under the *group contract* in accordance with its terms and conditions.

Member Effective Date: The date when a *member's coverage* under the *group contract* begins. This date is agreed to by *Keystone Health Plan Central* and the *contract holder* and entered on the records of *Keystone Health Plan Central* in accordance with the terms of the *group contract* as described in this *Certificate of Coverage*. *Coverage* begins at 12:00:00 AM, local Harrisburg, Pennsylvania time, on the member effective date.

Mental Health Care: Care received in connection with the treatment of a *mental illness* or a *serious mental illness*.

Mental Illness/Disorder: A health condition as described in the most recent edition of the Diagnostic and Statistical Manual 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 *provider* who is not under contract with *Keystone Health Plan Central* or a *provider* who is not a *BlueCard participating provider*.

Official Notice of Change: The documents issued by *Keystone Health Plan Central* to communicate changes to the *group contract* and which are identified within the document as an "Official Notice of Change". Such documents may be communicated to the *contract holder* or *subscriber* (as applicable) in various formats including, but not limited to:

- Letters;

- Official *Keystone Health Plan Central* publications such as group or *member* newsletters; or

- Contract riders or amendments.

Delivery may be made via U.S. Mail or electronic mail to the address on record with *Keystone Health Plan Central*, and shall be deemed delivered upon mailing.

Open Enrollment: A specific time period during each calendar year when the *contract holder* permits its employees or members to make enrollment changes.

Out-of-Pocket Maximum: The amount of the *allowable amount* that a *member* is required to pay during a *benefit period*. 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 *benefit period*. The amount of the out-of-pocket maximum is described in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage*.

Outpatient: A *member* who receives services or supplies while not an *inpatient*. This term may also describe the services rendered to such a *member*.

Partial Hospitalization: The provision of medical, nursing, counseling, or therapeutic services on a planned and regularly scheduled basis in a *hospital* or non-*hospital* facility licensed as a *mental health care* or *substance abuse* treatment program by the Pennsylvania Department of Health, designed for a patient or client who would benefit from more intensive services than are offered in *outpatient* treatment but who does not require *inpatient* care. To qualify, the partial hospitalization services must be provided for a minimum of four (4) hours, with a maximum of twelve (12) hours per day without incurring a charge for an overnight stay.

Participating Provider(s): A *professional provider*, *facility provider*, or any other eligible health care *provider* or practitioner that is approved by *Keystone Health Plan Central* 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 Health Plan Central* to provide *benefits* to *members* and who satisfies *Keystone Health Plan Central's* credentialing and privileging criteria. The status of a *provider* as a participating *provider* may change from time to time. It is the *member's* responsibility to verify the current status of a *provider*.

Pervasive Developmental Disorders: Are conditions characterized by severe and pervasive impairment in several areas of development:

- Reciprocal social interaction skills;
- Communication skills; or
- Presence of stereotyped behavior, interests, and activities.

Physician: A person who is a Doctor of Medicine (M.D.) or a Doctor of Osteopathic Medicine (D.O.), licensed, and legally entitled to practice medicine in all its branches, and/or perform *surgery* and prescribe drugs.

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 *Certificate of Coverage*.

Pre-Existing Condition: A condition (except maternity *benefits*) for which medical advice, diagnosis, care, or treatment was recommended or received within the ninety (90) day period prior to the *member effective date*.

Primary Care Physician (PCP): The person(s) or legal entity who, through the execution of an agreement with *Keystone Health Plan Central* or its designee, has agreed to provide primary care services to *members* who are enrolled with the PCP, and to assume primary responsibility for arranging and coordinating the overall health care of such *members*. For purposes of this *Certificate of Coverage*, family practitioners, general practitioners, internists, pediatricians, and practitioners in other specialties who may be specifically designated by *Keystone Health Plan Central*, who satisfy *Keystone Health Plan Central's* credentialing criteria and DOH regulations, shall be eligible to participate as PCPs.

Professional Provider: Professional *providers* include:

- Audiologist
- Certified Registered Nurse Anesthetist
- Certified Registered Nurse Midwife
- Certified Registered 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's Assistant
- Podiatrist
- Psychologist
- Respiratory Therapist
- 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 *Certificate of Coverage*. Providers include *participating providers* and *non-participating providers.*

Psychiatric Hospital: A *provider* licensed and approved by the state in which it provides health care services, or as otherwise approved by *Keystone Health Plan Central*, and which is primarily engaged in providing diagnostic and therapeutic services for the *mental health care*. Such services are provided by or under the supervision of an organized staff of *physicians*.

Qualified Medical Child Support Order: An order determined by *Keystone Health Plan Central* to satisfy the requirements of state or federal law.

Reconstructive Surgery: A procedure performed to improve or correct a *functional impairment*, restore a bodily function or correct deformity resulting from *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 *Certificate of Coverage*.

Rehabilitation Hospital: A *provider* licensed and approved by the state in which it provides health care services, or as otherwise approved by *Keystone Health Plan Central*, and which is primarily engaged in providing skilled rehabilitation services for injured or disabled individuals to restore function following an illness or accidental injury. Skilled rehabilitation services consist of the combined use of medical and vocational services to enable *members* disabled by disease or injury to achieve the highest possible level of functional ability. Skilled rehabilitation services are provided by or under the supervision of an organized staff of *physicians*.

Residential Hospice Care: Care provided in a *hospice* facility. *Residential hospice care* is for the express or implied purpose of providing end of life care for the terminally ill patient who is unable to remain in the home and requires facility placement to provide for routine activities of daily living (ADL's) as well as specialized *hospice* care on a twenty-four hour per day basis.

Retiree: A former employee of the *contract holder* who meets the *contract holder's* definition of a retired employee and to whom the *contract holder* offers *coverage* under the *group contract*, if any. The *contract holder* must designate and *Keystone Health Plan Central* must agree that one or more classes of retired former employees of the *contract holder* are eligible to receive *coverage* for *benefits* under the *group contract* in order for a person to qualify as a retiree.

Serious Mental Illness: Any of the following *mental illnesses* as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual or as otherwise approved by *Keystone Health Plan Central*: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder, and delusional disorder.

Service Area: The following Pennsylvania Counties: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, and York.

Skilled Nursing Facility: A *provider*, licensed and approved by the state in which it provides health care services, or as otherwise approved by *Keystone Health Plan Central*, and which is primarily engaged in providing daily *skilled nursing services* and related skilled services to *members* requiring twenty-four (24) hour skilled nursing services but not requiring confinement in an acute care general *hospital*. Such care is rendered by or under the supervision of *physicians*. A skilled nursing facility is not, other than incidentally, a place that provides:

- minimal care, *custodial care*, ambulatory care, or part-time care services; or
- care or treatment of *mental illness* or *substance abuse*.

Skilled Nursing Services: Services that must be provided by a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse, to be safe and effective. In determining whether a service requires the skills of a nurse, consider both the inherent complexity of the service, the condition of the patient, and accepted standards of medical and nursing practice.

Special Accommodations Unit: A designated unit within an acute care *hospital* which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients, including neonatal intensive care and cardiac intensive care that is not critical care.

Subscriber: A person whose employment or other status, except for family dependency, is the basis for eligibility for enrollment for *coverage* under the *group contract*, who enrolled under the *group contract* by submitting an *enrollment application* to *Keystone Health Plan Central* and for whom such *enrollment application* has been accepted by *Keystone Health Plan Central*. Subscriber may include, without limitation, a *retiree*. A subscriber is also a *member*.

Substance Abuse: The use of alcohol and/or other addictive drugs which produce a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal. Drugs are defined as addictive drugs and drugs of abuse listed as scheduled drugs in the Pennsylvania Controlled Substances, Drug, Device and Cosmetic Act.

Substance Abuse Treatment Facility: A *provider* licensed and approved by the state in which it provides health care services, or as otherwise approved by *Keystone Health Plan Central* and which primarily provides non-residential detoxification and/or rehabilitation treatment for *substance abuse*. This facility must also meet all applicable standards set by the state in which health care services are received.

Surgery: The performance of operative procedures, consistent with medical standards of practice, which physically changes some body structure or organ and includes usual and related pre-operative and post-operative care.

Urgent Care: 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.

Ward: A child for whom the *subscriber,* the *subscriber's* spouse, or the *subscriber's domestic partner* has been granted legal custody by a court of competent jurisdiction.

APPLICABLE GROUP NUMBERS

00515044 ASO HMO Plan 1

January, 2012

Attachment (ASOHMOERISADM-E)G01-12