HEALTH BENEFITS PROGRAM

ROOFERS LOCAL 30B
HEALTH & WELFARE FUND

INTRODUCTION

This booklet has been prepared so that you may become acquainted with your Independence Blue Cross and Highmark Blue Shield health care programs available to active employees who are eligible and enrolled for them. The benefits described are subject to the terms of the group contract issued by Independence Blue Cross and Highmark Blue Shield (known as the Plan).

Benefits will not be available for services to a greater extent or for a longer period than is ***Medically Necessary,*** as determined by the Plan. The amount of benefits for any covered service will not be more than the amount charged by the health care provider and will not be greater than any ***maximum*** amount or limit described or referred to in this booklet.

Contents

HOW TO USE THIS BOOKLET

This booklet contains pertinent information about your health care program, including covered and non-covered services, copayment and ***deductible*** amounts, program limitations, etc.

The "Your Benefits at a Glance" section provides an overview of your total health care program. It includes a list of ***covered services*** in each program along with co-payment and ***maximum*** amounts and certain benefit limitations and coverage levels.

When you need immediate information about your health care program, check the "Your Benefits at a Glance" section first. If you find you need more detailed information, find the appropriate section listed in the "Contents" and refer there for further details.

The section titled "General Information" includes important information about COBRA (continuation coverage) claims filing information, etc.

The "Definitions of Terms" section is a resource designed to help you better understand the terminology used to describe specific elements of your coverage. All words defined in the "Definitions of Terms" are printed in ***bold italics*** wherever they appear in the text.

YOUR BENEFITS AT A GLANCE

Comprehensive Blue Cross Hospital Plan

Subscribers are entitled to benefits for the covered services described on this chart. This chart reflects covered services provided in ***Member Hospitals***. Benefits for covered services provided in ***non-member hospitals*** are described in the "Comprehensive Blue Cross Hospitalization Plan" section of this booklet. Benefits are subject to the deductible, if any, and must be paid each ***benefit period***.

Benefits Member Hospitals	
Inpatient Services	
Deductible (Co-payment)	$25 per day for the first 10 days of an Inpatient stay
Inpatient days	365
Room & Board	covered
Additional Services	covered
Surgery	covered
Transplant Services	covered
Diagnostic Services	covered (including EEG, ECG, Radiology and Laboratory)
Maternity Benefits Obstetrical/Maternity Elective Abortion	covered covered covered
Newborn Care	covered from date of birth to a maximum of 31 days
Psychiatric Care	30 days per benefit period, benefits renew whenever 365 days have elapsed since most recent discharge
Serious Mental Illness	30 days per calendar year
Alcohol/Drug Treatment (*See complete details about these benefits in the "Comprehensive Blue Cross Hospital Plan" section of this booklet under the heading: "Special Provisions for Treatment of Alcoholism or Drug Abuse."*)	
Detoxification	7 days per admission; lifetime maximum of 4 admissions
Residential Treatment	30 days per calendar year; lifetime maximum of 90 days

Outpatient Services

Deductible (or co-payment)	$25 deductible
Diagnostic Services	
Radiology	covered
Laboratory	covered
EEG, ECG	covered
Therapy Services	
Radiation Therapy	covered
Chemotherapy	covered
Physical Therapy	covered
Respiratory Therapy	covered
Emergency Treatment (must occur within 48 hours of accident)	covered
Follow-up care for emergency accident	covered
Day Rehabilitation Program 30 sessions per Calendar/Contract Year	Covered; No cost sharing applies

Services at Other Facilities

Skilled Nursing Facility	each day counts as 1/2 day against your available inpatient days
Home Health Care	covered
Birth Center	covered
Hospice Care	covered
Respite Care	7 days every six months
Ambulatory Care Facility	covered
Outpatient Diabetic Education Program	covered
Diabetic Supplies and Equipment	covered

Highmark Blue Shield Medical-Surgical Benefits

Your health care program provides the following benefits when performed by a ***professional provider***. When ***subscribers*** receive services from a ***Participating Professional Provider***, the ***Participating Professional Provider*** will accept Blue Shield's allowance as payment in full for covered services.

Benefits Professional Providers	
Surgery	covered
Oral Surgery	covered
Transplant Services	covered
Assistant at Surgery	covered
Anesthesia	covered
Maternity Services	covered
Delivery	covered
Prenatal and Postnatal Care	covered
Routine Newborn Care	covered
Inpatient Medical Care	365 days for each period of hospitalization; 90-day separation between each period of hospitalization
Concurrent Care	covered
Consultations	covered
Second Surgical Opinion	covered
Intensive Care	covered
Skilled Nursing Care	Each day counts as 1/2 day against the available 365 medical days; two visits the first week of confinement, one visit per week of confinement thereafter
Inpatient Psychiatric Care	30 days within a 12-month period
Serious Mental Illness	covered
Psychotherapy	covered
Convulsive Therapy	covered
Diagnostic Services	covered
Diagnostic Radiology	covered
Routine Screening Mammography	covered
Diagnostic Medical Procedures (EKG, EEG)	covered
Diagnostic Laboratory Procedures	covered
Allergy Testing	covered

Emergency Care (initial visit must take place within 72 hours)	
Emergency Medical Visits	covered
Emergency Accident Visits	covered
Therapy Services	covered
Radiation Therapy	covered
Chemotherapy	covered
Dialysis Therapy	covered
Physical Therapy (inpatient only)	covered
Pediatric Immunizations	covered
Routine Gynecological Examination and Routine Pap Smear	covered

GENERAL INFORMATION

Dependents Eligible for Enrollment

Your spouse and all children under 26 years of age (including stepchildren, children legally placed for adoption and your and your spouse's legally adopted children) who are continuously financially supported by you, or whose coverage is your or your spouse's responsibility under the terms of a release or court order, are eligible for enrollment. Coverage of a dependent child will terminate as of the first of the month following the month in which they reach age 26.

If a student is enrolled full-time in an Accredited Educational Institution, the limiting age is either: (a) the date as indicated in the Group Agreement on which the student attains the limiting age; or (b) in the event that the Plan was not notified of the termination date, as provided under the Group Agreement, the date on which the Plan, after verification of loss of full-time student status, terminates coverage.

Upon application to and acceptance by the Blue Cross and Blue Shield Plans, you may also include unmarried, ***dependent*** children 19 years of age or older who are incapable of self-support due to a physical or mental handicap which occurred prior to age 19, and who were eligible for coverage as ***dependents*** prior to age 19.

A full-time student who is eligible for coverage under the Plan who is (1) a member of the Pennsylvania National guard or any reserve component of the U.S. armed forces and who is called or ordered to active duty, other than active duty for training for a period of 30 or more consecutive days; or (2) a member of the Pennsylvania National Guard who is ordered to active state duty, including duty under Pa. C.S. Ch. 76 (relates to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

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

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

Each person included under your coverage is entitled, separately, to the benefits described in this booklet, except where noted otherwise.

Newborn Dependent Provision

Benefits are available for a newborn child of a ***subscriber*** for 31 days immediately following birth.

This benefit does not include routine well-baby care, immunizations and medical examinations or tests not necessary for the treatment of a covered injury, sickness or condition, except to the extent dependency coverage is provided under the contract. To continue coverage beyond this period, application must be made by the ***subscriber*** within 31 days after birth, and the appropriate rate must be paid when billed.

Changes in Your Address or Family Status

It is important that you notify our office promptly of any change in your address or your family status--including marriage, divorce, birth or adoption of a child, marriage of ***dependent*** children, death of spouse or child. Change forms and application cards should not be given directly to the Blue Cross Plan office.

Enrollment of a ***dependent*** child will normally cease as of the first of the month following the date that he or she reaches age 26 or if a full-time student as of the first of the month following the date the student reaches age 26.

If any over-age child does not receive notice of termination, you should apply to the Blue Cross Plan within 60 days of the termination date, for the coverages then available. If you pay charges due beginning with the termination date, the Plan will establish an account for your ***dependent*** and will take previous coverage into consideration in determining length of membership. (This affects waiting periods.)

Whenever any other ***dependent*** no longer qualifies as eligible to be included in your coverage, the same provision for conversion to a direct billing account will apply.

How Benefits Are Received

Blue Cross Plan (Hospital Charges)

It is necessary to show your Blue Cross ***identification card*** to the admitting clerk at a Blue Cross ***Member Hospital*** or other facility. The Plan will pay the ***Member Hospital*** or facility directly for the services covered through this program.

If you use a ***non-member hospital*** or facility, be sure to get an itemized bill listing the name and address of the ***hospital*** or facility, the patient's name and age, date of admission and your name and address. Forward the bill to the Blue Cross Plan named on your ***identification card*** together with your identification number, the name of your doctor and the reason for hospitalization. Blue Cross will make payment directly to you for your eligible services.

For eligible ***outpatient*** services in other than Independence Blue Cross ***Member Hospitals***, you should include the information described previously and, for an accident, specify the date and hour of the accident.

Blue Shield Plan (Professional Provider's Charges)

Participating Professional Provider

Present your Blue Shield ***identification card*** at the time services are provided by a ***Participating Professional Provider***. The ***professional provider*** will submit a claim form directly to Blue Shield on your behalf. The payment will be sent to the ***professional provider*** and Blue Shield will notify you of the final disposition of the claim.

Non-Participating Professional Provider

A ***non-participating professional provider*** may also submit a claim to Blue Shield on your behalf. If not, you must do so within one year from the date of service. Request an itemized bill which shows:

1. patient's name and address
2. date of service
3. type of service and diagnosis
4. itemized charges
5. provider's complete name and address

Then add your name, group number and identification number (as shown on your ***identification card***), and the patient's birthdate. If you need assistance, either contact your nearest Blue Cross/Blue Shield office or call Highmark Blue Shield at (717) 975-7290. Otherwise, please send your receipt to:

Highmark Blue Shield
P.O. Box 890062
Camp Hill, PA 17089-0062

When services are performed by ***non-participating professional providers***, the payment is made directly to the ***subscriber***.

BlueCard Program

I. Out-of-Area Services

Independence Blue Cross ("IBC") has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of the IBC service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between IBC and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the Personal Choice Network service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers. IBC payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, IBC will remain responsible for fulfilling IBC contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers. Whenever you access covered healthcare services outside the IBC service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to IBC.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price IBC uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

B. Non-Participating Healthcare Providers Outside the IBC Service Area

Please refer to the Covered Expense definition in the Definitions section of this booklet.

Release of Information

Each Subscriber agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under this Contract may furnish to the Plan, upon its request, any information (including copies of records relating to the illness or injury).

In addition, the Plan may furnish similar information to other entities providing similar benefits at their request.

The Plan may furnish other plans or plan sponsored entities with membership and/or coverage information for the purpose of claims processing or facilitating patient care.

When the Plan needs to obtain consent for the release of personal health information, authorization of care and treatment, or to have access to information from a Subscriber who is unable to provide it, the Plan will obtain consent from the parent, legal guardian, next of kin, or other individual with appropriate legal authority to make decisions on behalf of the Subscriber.

Consumer Rights

Each Covered Person has the right to access, review and copy their own health and membership records and request amendments to their records. This includes information pertaining to claim payments, payment methodology, reduction or denial, medical information secured from other agents, plans or providers.

For more information about accessing, reviewing or copying records call Member Services at the toll-free number on your ID card.

Coordination of Benefits

Blue Cross and Blue Shield Plans

In addition to this program's broad scope of benefits the program has a Coordination of Benefits provision. The purpose of this provision is to conserve funds associated with health care. Coordination of Benefits is applicable only when you, your spouse or your ***dependent(s)*** are eligible for benefits under more than one group health plan.

When you receive health care services that are also covered under another plan, a determination is made as to which plan is "primary" and which plan is "secondary". The primary plan considers the services without regard to the secondary plan. The secondary plan will then consider the balances on ***covered services*** according to the limitations of its program.

If the plans are determined to be the secondary plan, Blue Cross and Blue Shield will not pay more than they would have, had there been no other coverage.

The primary plan will be determined in the following order:

1. If the other plan does not include a provision to coordinate benefits, it will be the primary plan.

2. If the other plan does include a provision to coordinate benefits then:

    A. The plan covering the patient other than as a ***dependent*** is the primary plan.

    B. Except for situations where the parents of a child are separated or divorced, the plan of the parent whose date of birth (month, day) falls earlier in the calendar year is the primary plan for that child. If both parents have the same birth date, the plan which covered the parent longer shall be primary.

Note: In the event this plan is coordinating with a plan that uses a rule based on the gender of the parent, benefits will be coordinated as follows:

Except for situations where the parents of a child are separated or divorced, the rule of the other plan will control.

C. In those situations where the parents are separated or divorced, the primary plan is determined as follows:

1) the plan covering the parent with custody of the child is primary

2) if the parent with custody of the child has remarried, the stepparent's plan will pay for covered services before the plan of the parent without custody

3) a court decree may determine the primary plan. You should advise your employer of any court decree.

D. When the determination cannot be made with the above rules, then the plan that has covered the patient for the longer period of time will be the primary plan, except:

...the plan which covers the patient as an active ***employee~~subscriber*** (or a ***dependent*** of such a person) is the primary plan over a plan that covers a patient as a laid-off or retired person (or a ***dependent*** of such a person).

...if either plan does not have this condition then it does not apply and the plan which has been in effect the longer period of time is primary.

3. If services are provided under a governmental program for which the ***subscriber*** pays a periodic rate, that program is the primary plan, except when prohibited by law or when the ***subscriber*** elects Medicare as secondary coverage. Blue Cross and Blue Shield may pay their benefits first and determine liability later. If it is determined that this program is the secondary plan, Blue Cross and Blue Shield have the right to recover the expense already paid in excess of their liability as the secondary plan. If the other health care plan is the primary plan, Blue Cross and Blue Shield may limit payment so that Blue Cross and Blue Shield will not pay more than the difference, if any, between the primary plan's payment and the charge. Benefits payable under another plan include benefits that would have been payable had the claim been duly made. When this program is determined to be primary, but payment was made by another plan, Blue Cross and Blue Shield have the right to reimburse the other plan, the amount which Blue Cross and Blue Shield determines is its liability.

Blue Cross and Blue Shield may release to or obtain from any person or organization, any information about coverage, expenses and benefits which may be necessary to coordinate benefits. The ***employee*** on his/her own behalf and on behalf of their ***dependent(s)*** may be required to furnish information and to take such other action as is necessary to assure the rights of Blue Cross and Blue Shield.

Subrogation

If any benefit is provided to the ***subscriber*** under this Agreement, Blue Cross and Blue Shield shall be subrogated and succeed to the ***subscriber's*** rights of recovery with respect to the services and supplies involved against a responsible third party and/or insurance company.

Subrogation means that if you or your enrolled ***dependent(s)*** are injured because of the negligence or wrongdoing of another party, Blue Cross and Blue Shield have the right to seek recovery of benefits paid for related expenses. You are expected to take any action necessary to protect and to assure the subrogation rights of Blue Cross and Blue Shield. This provision does not apply to an individual insurance policy covering you or your ***dependents***.

Termination of Coverage

If the ***employee*** ceases to be eligible for this program because of layoff, disability, leave of absence, or termination of employment, arrangements may be made to continue both Blue Cross and Blue Shield under the direct payment (non-group) type of subscription agreements.

If the ***employee*** dies, the surviving spouse and child may continue coverage under the direct payment type of subscription agreements.

Children who reach the ***maximum*** age limit specified in the program also have the privilege of converting to the direct payment type of subscription agreement.

Under your Blue Cross coverage, if the ***subscriber*** is an ***inpatient*** on the day coverage terminates, benefits shall be provided:

1. Until the ***maximum*** amount of benefits has been paid; or

2. Until the ***inpatient*** stay ends, whichever occurs first.

However, the above does not apply to Blue Shield coverage.

Arrangements may also be made to continue your group coverage. See the following information on COBRA.

Continuation of Coverage Provisions - Consolidated Omnibus Budget Reconciliation Act of 1985, As Amended (COBRA)

This may or may not apply to your group. Please contact your employer to find out whether or not you are covered under this provision.

For purposes of this subsection of your booklet, "qualified continue" means any person who, on the day before any event which would qualify him or her for continuation under this subsection, is covered for group health benefits under this Plan as:

a. you, an active, covered ***employee***;
b. your spouse; or
c. your ***dependent*** child.

In addition, any child born to or placed for adoption with you during COBRA continuation will be a qualified beneficiary.

Any person who becomes covered under this Plan during COBRA continuation, other than a child born to or placed for adoption with you during COBRA continuation, will not be a qualified beneficiary.

If An Employee Terminates Employment or Has a Reduction of Work Hours

If your group benefits end due to your termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, if:

a. your termination of employment was not due to gross misconduct; and
b. you are not entitled to Medicare.

The continuation will cover you and any other qualified beneficiary who loses coverage because of your termination of employment (for reasons other than gross misconduct) or reduction of work hours, subject to the **"When Continuation Ends"** paragraph of this subsection.

Extra Continuation for Disabled Qualified Beneficiaries

If a qualified beneficiary is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the day before the qualified beneficiary's health benefits would otherwise end due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours or within 60 days of that date, the qualified beneficiary and any other affected qualified beneficiaries may elect to extend the 18 month continuation period described above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Plan Administrator must be given written proof of Social Security's determination of the qualified beneficiary's disability before the earlier of:

a. The end of the 18 month continuation period; and
b. 60 days after the date the qualified beneficiary is determined to be disabled.

If, during the 11 month continuation period, the qualified beneficiary is determined to be no longer disabled under the United States Social Security Act, the qualified beneficiary must notify the Plan Administrator within 30 days of such determination, and continuation will end, as explained in the **"When Continuation Ends"** paragraph of this subsection.

If an Employee Dies

If you die, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **"When Continuation Ends"** paragraph of this subsection.

If an Employee's Marriage Ends

If your marriage ends due to legal divorce or legal separation, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **"When Continuation Ends"** paragraph of this subsection.

If an Employee Becomes Entitled to Medicare

If you become entitled to Medicare *after* terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months from the date the initial 18 month continuation period started, subject to the **"When Continuation Ends"** paragraph of this subsection.

If you become entitled to Medicare *before* terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours and, during the subsequent 18-month period, you terminate employment (for reasons other than gross misconduct) or have a reduction of work hours, all qualified beneficiaries other than you whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 18 months, but may be extended until 36 months from the date you became entitled to Medicare, subject to the **"When Continuation Ends"** paragraph of this subsection.

If a Dependent Loses Eligibility

If your ***dependent*** child's group health benefits end due to his or her loss of ***dependent*** eligibility as defined in this booklet, other than your coverage ending, he or she may elect to continue such benefits. However, such ***dependent*** child must be a qualified beneficiary. The continuation can last for up to 36 months, subject to the **"When Continuation Ends"** paragraph of this subsection.

Concurrent Continuations

If your ***dependent*** who is a qualified beneficiary elects to continue his or her group health benefits due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours, the ***dependent*** may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period the ***dependent*** becomes eligible for 36 months of group health benefits due to any of the reasons stated above.

The 36 month continuation period starts on the date the initial 18 month continuation period started, and the two continuation periods will run concurrently.

The Qualified Beneficiary's Responsibilities

A person eligible for continuation under this subsection must notify the Plan Administrator, in writing, of:

a. your legal divorce or legal separation from your spouse; or
b. your ***dependent*** child's loss of ***dependent*** eligibility, as defined in this booklet.

The notice must be given to the Plan Administrator within 60 days of either of these events.

In addition, a disabled qualified beneficiary must notify the Plan Administrator, in writing, of any final determination that the qualified beneficiary is no longer disabled under Title II or Title XVI of the United States Social Security Act. The notice must be given to the Plan Administrator within 30 days of such final determination.

The Employer's Responsibilities

Your Employer must notify the Plan Administrator, in writing, of:

a. your termination of employment (for reasons other than gross misconduct) or reduction of work hours;
b. your death; or
c. your entitlement to Medicare.

The notice must be given to the Plan Administrator within 60 days of any of these events.

The Plan Administrator's Responsibilities

The Plan Administrator must notify the qualified beneficiary, in writing, of:

a. his or her right to continue the group health benefits described in this booklet;
b. the monthly premium he or she must pay to continue such benefits; and
c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified beneficiary within 14 days of:

a. the date the Employer notifies the Plan Administrator, in writing, of your termination of employment (for reasons other than gross misconduct) or reduction of work hours, your death, or your entitlement to Medicare; or
b. the date the qualified beneficiary notifies the Plan Administrator, in writing, of your legal divorce or legal separation from your spouse, or your ***dependent*** child's loss of eligibility.

The Employer's Liability

Your Employer will be liable for the qualified beneficiary's continued group health benefits to the same extent as, and in the place of, the Plan, if:

a. the Employer fails to remit a qualified beneficiary's timely premium payment to the Plan on time, thereby causing the qualified beneficiary's group health benefit to end; or
b. the Plan Administrator fails to notify the qualified beneficiary of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified beneficiary must give the Plan Administrator written notice that he or she elects to continue benefits under the coverage. This must be done within 60 days of the date a qualified beneficiary receives notice of his or her continuation rights from the Plan Administrator as described above or 60 days of the date the qualified beneficiary's group health benefits end, if later. Furthermore, the qualified beneficiary must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Plan Administrator by the qualified beneficiary, in advance, at the time and in the manner set forth by the Plan Administrator. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified beneficiary stayed insured under this benefit plan on a regular basis. It includes any amount that would have been paid by the Employer. An additional charge of two percent of the total premium charge may also be required by the Employer.

Qualified beneficiaries who receive the extended coverage due to disability described above may be charged an additional 50% of the total premium charge during the extra 11 month continuation period.

If the qualified beneficiary fails to give the Plan Administrator notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified beneficiary's premium payment is timely if, with respect to the first payment after the qualified beneficiary elects to continue, such payment is made no later than 45 days after such election. In all other cases, the premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified beneficiary's continued group health benefits under this coverage ends on the first to occur of the following:

a. with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

b. with respect to a disabled qualified beneficiary and his or her family members who are qualified beneficiaries who have elected an additional 11 months of continuation, the earlier of:

- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified beneficiary is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c. with respect to continuation upon your death, your legal divorce or legal separation, or the end of your covered ***dependent's*** eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

d. with respect to your ***dependent*** whose continuation is extended due to your entitlement to Medicare,

- *after* your termination of employment or reduction of work hours, the end of the 36 month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours; and
- *before*, your termination of employment or reduction of work hours where, during the 18-month period following Medicare entitlement, you terminate employment or have a reduction of work hours, at least to the end of the 18 month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours, but not less than 36 months from the date you become entitled to Medicare.

e. the date this coverage ends;

f. the end of the period for which the last premium payment is made;

g. the date he or she becomes covered under any other group health plan (as an employee or otherwise) which contains no limitation or exclusion with respect to any pre-existing condition of the qualified beneficiary other than a pre-existing condition exclusion or limitation which he or she satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;

h. the date he or she becomes entitled to Medicare.

THE PLAN'S RESPONSIBILITIES RELATIVE TO THE PROVISION OF CONTINUATION COVERAGE UNDER THIS COVERAGE ARE LIMITED TO THOSE SET FORTH IN THIS SUBSECTION OF YOUR BOOKLET.

THE PLAN IS NOT THE PLAN ADMINISTRATOR UNDER THE COVERAGE OR FOR PURPOSES OF ERISA OR ANY OTHER FEDERAL OR STATE LAW. IN THE ABSENCE OF THE DESIGNATION OF ANOTHER PARTY AS PLAN ADMINISTRATOR, THE PLAN ADMINISTRATOR SHALL BE THE EMPLOYER.

When You Terminate Employment - Continuation Of Coverage Provisions Pennsylvania Act 62 Of 2009 (Mini-Cobra)

This subsection, and the requirements of Mini-COBRA continuation, applies to Groups consisting of two to nineteen employees.

For purposes of this subsection, a "qualified beneficiary" means any person who, before any event which would qualify him or her for continuation under this subsection, has been covered continuously for benefits under this Plan or for similar benefits under any group policy which it replaced, during the entire three-month period ending with such termination as:
1. You, a covered Employee;
2. Your spouse; or
3. Your Dependent child.

In addition, any child born to or placed for adoption with you during Mini-COBRA continuation will be a qualified beneficiary.

Any person who becomes covered under this Plan during Mini-COBRA continuation, other than a child born to or placed for adoption with you during Mini-COBRA continuation, will not be a qualified beneficiary.

If An Employee Terminates Employment or Has a Reduction of Work Hours: If your group benefits end due to your termination of employment or reduction of work hours, you may eligible to continue such benefits for up to nine (9) months, if:
1. Your termination of employment was not due to gross misconduct;
2. You are not eligible for coverage under Medicare;
3. You verify that you are not eligible for group health benefits as an eligible dependent; and
4. You are not eligible for group health benefits with any other carrier.

The continuation will cover you and any other qualified beneficiary who loses coverage because of your termination of employment (for reasons other than gross misconduct) or reduction of work hours, subject to the "When Continuation Ends" paragraph of this subsection.

The Employer's Responsibilities: Your employer must notify you, the plan administrator, and the Plan, in writing, of:
1. Your termination of employment (for reasons other than gross misconduct) or reduction of work hours;
2. Your death;
3. Your divorce or legal separation from an eligible dependent;
4. You becoming eligible for benefits under Social Security;
5. Your dependent child ceasing to be a dependent child pursuant to the terms of the group health benefits booklet;
6. Commencement of Employer's bankruptcy proceedings.

The notice must be given to you, the plan administrator and the Plan no later than thirty (30) days of any of these events.

The Qualified Beneficiary's Responsibilities: A person eligible for continuation under this subsection must notify, in writing, the administrator or its designee of their election of continuation coverage within thirty (30) days of receipt of the Notice from the Employer.

Continuation coverage shall be effective as of the date of the event.

Upon receipt of your, or your eligible dependent's election of continuation coverage, the administrator, or its designee, shall notify the Plan of the election within fourteen (14) days.

If an Employee Dies: If you (the covered Employee) die, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to nine (9) months, subject to the "When Continuation Ends" paragraph of this subsection.

If an Employee's Marriage Ends: If your marriage ends due to legal divorce or legal separation, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to nine (9) months, subject to the "When Continuation Ends" paragraph of this subsection.

If a Dependent Loses Eligibility: If your Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Booklet, other than your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified beneficiary. The continuation can last for up to nine (9) months, subject to the "When Continued Ends" paragraph of this subsection.

Election of Continuation: To continue his or her group health benefits, the qualified beneficiary must give the plan administrator written notice that he or she elects to continue benefits under the coverage. This must be done within thirty (30) days of the date a qualified beneficiary receives notice of his or her continuation rights from the plan administrator as described above or thirty (30) days of the date the qualified beneficiary's group health benefits end, if later. The Employer must notify the Plan of the qualified beneficiary's election of continuation within fourteen (14) days of the election of continuation. Furthermore, the qualified beneficiary must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the plan administrator by the qualified beneficiary, in advance, at the time and in the manner set forth by the plan administrator. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified beneficiary stayed insured under this benefit plan on a regular basis. It includes any amount that would have been paid by the employer. An additional administrative charge of up to five percent of the total premium charge may also be required by the Plan.

Grace in Payment of Premiums: A qualified beneficiary's premium payment is timely if, with respect to the first payment after the qualified beneficiary elects to continue, such payment is made no later than forty-five (45) days after such election. In all other cases, the premium payment is timely if it is made within thirty-one (31) days of the specified date.

When Continuation Ends: A qualified beneficiary's continued group health benefits under this Plan ends on the first to occur of the following:

1. With respect to continuation upon your termination of employment or reduction of work hours, the end of the nine (9) month period which starts on the date the group health benefits would otherwise end;
2. With respect to continuation upon your death, your legal divorce or legal separation, or the end of your covered Dependent's eligibility, the end of the nine (9) month period which starts on the date the group health benefits would otherwise end;
3. With respect to your Dependent whose continuation is extended due to your entitlement to Medicare, the end of the nine (9) month period which starts on the date the group health benefits would otherwise end;
4. The date coverage under this Plan ends;

5. The end of the period for which the last premium payment is made;
6. The date he or she becomes covered under any other group health plan (as an employee or otherwise) which contains no limitation or exclusion with respect to any pre-existing condition of the qualified beneficiary other than a pre-existing condition exclusion or limitation which he or she satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;
7. The date you and/or eligible dependent become eligible for Medicare.

THE PLAN'S RESPONSIBILITIES RELATIVE TO THE PROVISION OF CONTINUATION COVERAGE UNDER THIS COVERAGE ARE LIMITED TO THOSE SET FORTH IN THIS SUBSECTION OF THIS BOOKLET.

THE PLAN IS NOT THE PLAN ADMINISTRATOR UNDER THE COVERAGE OR FOR PURPOSES OF ERISA OR ANY OTHER FEDERAL OR STATE LAW. IN THE ABSENCE OF THE DESIGNATION OF ANOTHER PARTY AS PLAN ADMINISTRATOR, THE PLAN ADMINISTRATOR SHALL BE THE EMPLOYER.

I. Effective on your group renewal or new issue date on or after October 9, 2009, the first paragraph of the Dependents Eligible for Enrollment subsection of the General Information section in enlarged to include the following:

In addition, a full-time student will be considered eligible for coverage when they are on a Medically Necessary leave of absence from the Accredited Educational Institution. The Plan must receive certification from the full-time student's physician that the full-time student is suffering from a serious illness or injury that requires a Medically Necessary leave of absence from the Accredited Educational Institution or requires the full-time student to become a part-time student. The Dependent child will be eligible for coverage until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate. The limiting age referenced above will be applicable regardless of the status of the Medically Necessary leave of absence.

Patient Care Management® Program

Hospitalization Benefits in Independence Blue Cross ***Member Hospitals*** will be provided when the requirements of the Patient Care Management® Program are met. Under this Program, for any ***inpatient*** admission other than maternity or emergency admissions, the admitting ***physician*** must obtain ***precertification*** of the appropriateness of the admission from Independence Blue Cross before you are admitted to the ***hospital***. At or before your admission, the ***hospital*** will verify the ***precertification*** with Independence Blue Cross. If ***precertification*** is not obtained, Independence Blue Cross will not approve the admission.

Through its provider agreements or otherwise, Independence Blue Cross will hold the ***subscriber*** harmless and the ***subscriber*** will not be financially responsible for admissions which fail to conform to the previously stated ***precertification*** requirements unless the ***hospital*** informs the ***subscriber*** that the proposed admission does not meet the requirements and will not be covered by Independence Blue Cross.

Filing Claims

Whenever you receive services from Blue Cross ***Member Hospitals*** and facilities or from Blue Shield ***Participating Professional Providers***, you will not have to file your own claims. ***Member Hospitals*** and ***Participating Professional Providers*** do that for ***subscribers***.

When you receive services from ***non-member hospitals*** and facilities and ***non-participating professional providers***, you may have to file your own claims. When you must file your own claims, please follow the instructions below:

For Blue Cross Claims

For ***covered services*** you receive from ***non-member hospitals*** and facilities:

1. Obtain a fully-itemized bill from the ***hospital*** or facility that provided the services (Fully-itemized bills should include: the ***hospital*** or facility's letterhead; the patient's name, relationship to the ***employee***, address, age and date of birth; date of service, type of service, diagnosis and amount charged for each service.);
2. Send a copy of the bill along with a completed Blue Cross claim form to the address on the claim form;
3. Eligible benefits are paid directly to you. You will have to pay the provider of the services.

Blue Shield Claims

For ***covered services*** you receive from ***non-participating professional providers***:

1. Obtain a fully-itemized bill from the provider of the services or a Blue Shield claim form filled out by the ***provider's*** office (Fully-itemized bills should include: the provider's letterhead; the patient's name, relationship to the ***employee***, address, age and date of birth; date of service, type of service, diagnosis and amount charged for each service.);
2. Send a copy of the bill along with a completed Blue Shield claim form to the address on the claim form;
3. Since eligible benefits are paid directly to you, you will have to pay the entire charge to the provider of services;
4. Be sure to submit claims within one year of the service date, and to include the subscriber's identification number and group number;
5. Blue Shield will notify you of the disposition of the claim in an Explanation of Benefits form.

Special Circumstances

In the event that Special Circumstances result in a severe impact to the availability of providers and services, to the procedures required for obtaining benefits for Covered Services under this Contract (e.g., obtaining Precertification, use of Participating or Member Providers), or to the administration of the Contract by the Plan, the Plan may on a selective basis, waive certain procedural requirements of this Contract. Such waiver shall be specific as to the requirements that are waived and shall last for such period as required by the Special Circumstances as defined below.

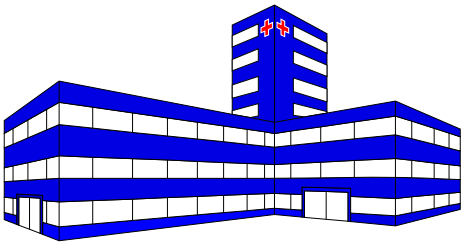
The Plan shall make a good faith effort to provide access to Covered Services in so far as practical and according to its best judgment. Neither the Plan nor the Member and Participating Providers shall incur liability or obligation for delay or failure to provide or arrange for Covered Services if such failure or delay is caused by Special Circumstances.

Special Circumstances, as recognized in the community, and by the Plan and appropriate regulatory authority, are extraordinary circumstances not within the control of the Plan, including but not limited to: (a) major disaster; (b) epidemic; (c) pandemic; (d) the complete or partial destruction of facilities; (e) riot; or (f) civil insurrection.

Discretionary Authority

The Carrier or Plan Administrator, as applicable, retains discretionary authority to interpret the benefit plan and the facts presented to make benefit determinations. Benefits under this plan will be provided only if the Carrier or Plan Administrator, as applicable, determines in its discretion that the Covered Person is entitled to them.

COMPREHENSIVE BLUE CROSS HOSPITAL PLAN



Hospital Benefits

Subscribers are eligible for benefits provided in ***Member Hospitals*** for the number of days shown in the "Your Benefits at a Glance" section in this booklet. If you are discharged from any ***hospital*** or extended care facility and do not receive any ***inpatient*** services for the next 90 days, a new ***benefit period*** will begin. If the Benefit Period applicable to your Plan is a Calendar Year, Benefit Period means: Calendar Year (1/1 – 12/31). Your eligible expenses are covered in full.

Inpatient Services

You are eligible for the services and supplies listed below while an ***inpatient*** of any Blue Cross ***Member Hospital*** or ***non-member hospital***. Admission to a ***Member Hospital*** allows you a higher level of benefits than if you are admitted to a ***non-member hospital***.

Blue Cross covers bed and board in semi-private accommodations; or an allowance toward the cost of a private room equal to the ***hospital's*** most prevalent daily charge for semi-private accommodations. The full cost of a private room will be allowed when your condition requires isolation for your own health or that of other patients and if ordered and certified by the attending ***physician*** prior to the time you are placed in the private room.

Additional services provided and regularly billed for by the ***hospital*** (except personal convenience items), including the following:

- Special dietary service
- Use of operating, delivery, recovery, cystoscopic and treatment rooms and equipment and supplies
- Use of intensive care, cardiac and other such specialty service units
- Surgically inserted devices
- Transplant services to a recipient when the recipient is enrolled in this program (does not include charges for organs or bones)
- Splints, casts and surgical dressings
- Medical and surgical supplies
- Drugs and medications in general use, including intravenous injections and solutions
- Oxygen and oxygen therapy
- X-ray examinations
- Laboratory examinations
- Electrocardiograms
- Physiotherapy and hydrotherapy
- Electroencephalograms
- X-ray and radiation therapy

Blue Cross covers the administration of blood and blood plasma, including the processing of blood from donors and the Red Cross service charge (does not include cost of blood or blood plasma)

Blue Cross covers ***anesthesia*** when administered by a salaried ***hospital*** employee (when administered by a doctor, other than the surgeon or surgical assistant, an allowance is provided by the Blue Shield Plan)

Birth Center

Benefits will be provided for maternity services rendered in a free-standing birth center. Services include those which are normally provided by a ***hospital*** and for which the ***birth center*** is licensed to provide. In order to prevent double payment for the same services, payment will not be made to a ***hospital*** or a facility-based ***physician*** for services performed by a licensed certified nurse/midwife whose services are covered under this agreement as a ***hospital*** or ***physician-***based nurse/midwife or under any other agreement.

When services are provided in a non-member free-standing birth center, an allowance of up to $120.00 will be provided towards the facility's regular charges.

Transplant Services

When ***subscribers*** receive transplanted human organs, bones or tissue, benefits are provided for those services which are directly and specifically related to the transplantation. This includes services for the examination of the transplanted organs, bones or tissue, and the processing of blood. Benefits are also provided for the hospitalization of donors if they are not otherwise insured.

Oral Surgery

Benefits are provided for hospitalization for oral surgery consisting of ***surgery*** for the treatment of diseases and injuries of the jaw or treatment of fractures and dislocations of the jaw or any facial bone; and for the surgical removal of impacted teeth which are partially or completely covered by bone. Other extractions, and care of teeth, are not included.

Inpatient Childhood Immunizations

Childhood Immunizations will be provided in a ***Hospital*** or Extended Care Facility. The immunization must be ordered by a ***physician*** and performed by a ***physician*** or a nurse. The services must be performed in accordance with a specific plan of treatment related to the ***Subscriber's*** condition or as an appropriate Pediatric preventive measure. These benefits are not subject to any ***deductible***, co-payment or ***maximum*** amounts.

Psychiatric Care

The number of benefit days which may be used each calendar year for psychiatric care is shown in the "Your Benefits at a Glance" section in this booklet. These benefits renew whenever 365 days have elapsed since the most recent discharge from any hospital or extended care facility for treatment of any psychiatric condition.

Serious Mental Illness

The number of benefit days which may be used each calendar year for the inpatient treatment of ***Serious Mental Illness*** is shown in the "Your Benefits at a Glance" section in this booklet. You may trade on a one (1) for two (2) basis, inpatient days for ***Partial Hospitalization*** days. After the 60 outpatient visits available under the Major Medical coverage are exhausted, you may also trade on a one (1) for two (2) basis, any available inpatient ***Serious Mental Illness*** days for additional Outpatient facility visits. Blue Cross will pay an allowance equal to 50% of the Outpatient charges in Member and Non-Member facilities. These benefits are provided in addition to the benefits provided to you for inpatient treatment of ***Mental Illness*** other than those defined as ***Serious Mental Illness***.

Special Provisions for Treatment of Alcoholism or Drug Abuse -- Hospital and Non-Hospital Facility Billed Services

A ***physician*** or licensed psychologist must precertify you as suffering from alcohol abuse or drug addiction or dependency prior to qualifying for the following benefits.

Benefits in Contracting Hospitals of any other Blue Cross Plan

Benefits will be provided for ***inpatient hospital*** services furnished by a Contracting Hospital of any other Blue Cross Plan in accordance with the agreement which Blue Cross has with the Inter-Plan Service Benefit Bank for the number of ***inpatient*** days then available as shown under the "Inpatient Days" section of "Your Benefits at a Glance" but in no case shall such benefits be less than the benefits provided below in a ***Non-Member Hospital***.

Benefits in Non-Member Hospitals

All benefits and Covered Services as described above are covered in ***Non-Member Hospitals***. Upon receipt of a valid bill, itemized as required by Blue Cross, for a covered individual's hospitalization as an ***inpatient*** in a ***Non-Member Hospital***, Blue Cross will pay to such individual an allowance of up to $100.00 per day for the first day and up to $50.00 per day for each day thereafter toward the ***hospital's*** regular charges.

In computing the number of days of benefits, the day of admission, but not the date of discharge shall be counted. If you are admitted and discharged on the same day, it shall be counted as one day.

Inpatient Detoxification

You will be eligible for Inpatient Covered Services for ***detoxification***, for a ***maximum*** lifetime limit of four (4) admissions, with each admission not to exceed seven (7) days of treatment. The following services are covered:

- Lodging and dietary services;
- ***Physician***, psychologist, nurse, certified addictions counselor and trained staff services;
- Diagnostic X-ray;
- Psychiatric, psychological and medical laboratory testing;
- Drugs, medicines, equipment use and supplies.

When provided by a ***Member Hospital*** or Member ***Non-hospital Facility***, eligible benefits shall be payable to the ***Member Hospital*** or Member ***Non-hospital Facility***.

When provided by a ***Contracting Hospital*** of another Blue Cross Plan or ***Contracting Non-hospital Facility***, benefits will be provided for ***inpatient*** covered services in accordance with the provisions set forth under the subsection entitled "BlueCard Program" in the General Information section of this booklet.

When provided by a ***Non-Member Hospital***, Independence Blue Cross will pay to you upon receipt of a valid bill, itemized as required by Independence Blue Cross, an allowance of up to $100.00 per day for the first day and up to $50.00 per day for each day thereafter up to the limits described in this section for Inpatient Detoxification.

No benefits are provided for services received from a Non-Member ***Non-hospital Facility*** or a Non-Contracting ***Non-hospital Facility***.

Residential Services

You will be eligible for covered Residential ***Alcohol or Drug Abuse*** services for a ***maximum*** of thirty (30) days per calendar year for residential care subject to a lifetime ***maximum*** of ninety (90) days. Such Residential services shall be covered if performed by a ***hospital*** or ***non-hospital facility***. You may trade-off, on a two-for-one basis, thirty (30) separate additional, ***outpatient*** or Partial Hospitalization visits per year for up to fifteen (15) additional Residential Alcohol or Drug Abuse Treatment days. ***Covered services*** for Residential Alcohol or Drug Abuse Treatment include:

- Lodging and dietary services;
- ***Physician***, psychologist, nurse, certified addictions counselor and trained staff services;
- Rehabilitation therapy and counseling;
- Family counseling and intervention;

- Psychiatric, psychological and medical laboratory testing;
- Drugs, medicines, equipment use and supplies.

When provided by a ***Member Hospital,*** Member ***Non-hospital Facility,*** Contracting ***Hospital*** or Contracting ***Non-hospital Facility***, eligible benefits shall be payable to the ***Member Hospital,*** Member ***Non-hospital Facility,*** Contracting ***Hospital*** or Contracting ***Non-hospital Facility***.

When provided by a ***Non-Member Hospital***, Independence Blue Cross will pay to you upon receipt of a valid bill, itemized as required by Independence Blue Cross, an allowance of up to $100.00 per day for the first day and up to $50.00 per day for each day thereafter up to the limits described in this section for ***hospital*** and ***Non-hospital Residential Treatment***.

No benefits are provided for services received from a Non-Member ***Nonhospital Facility*** or a Non-Contracting ***Non-hospital Facility***.

Outpatient Alcohol and Drug Abuse Services

You will be eligible for Covered Outpatient Alcohol and Drug Abuse services for a ***maximum*** of thirty (30) ***outpatient*** full session visits or equivalent ***Partial Hospitalization*** visits per calendar year subject to a lifetime limit of one hundred and twenty (120) ***outpatient*** full session visits or equivalent ***Partial Hospitalization*** visits. You may trade-off on a two-for-one basis, thirty (30) separate, additional ***outpatient*** visits or ***Partial Hospitalization*** visits per year for up to fifteen (15) additional Residential Alcohol and Drug Abuse treatment days. These additional ***outpatient*** visits or ***Partial Hospitalization*** visits are subject to, and do not increase, the overall lifetime limits.

Covered services for ***outpatient*** treatment of Alcohol and Drug Abuse include:

- ***Physician***, psychologist, nurse, certified addictions counselor and trained staff services.
- Rehabilitation therapy and counseling.
- Family counseling and intervention.
- Psychiatric, psychological and medical laboratory tests.
- Drugs, medicines, equipment use and supplies.

When received from a ***Member Hospital*** or Member ***Non-hospital Facility***, eligible benefits shall be payable to the ***Member Hospital*** or Member ***Non-hospital Facility***.

When received from a Contracting ***Hospital*** or Contracting ***Nonhospital Facility*** of another Blue Cross Plan or a ***Non-Member Hospital***, Independence Blue Cross will pay to you, upon receipt of a valid bill, itemized as required by Independence Blue Cross, for your care as an ***outpatient*** in a Contracting ***Hospital,*** an allowance equal to 75% of the charges for ***outpatient*** visits or ***Partial Hospitalization*** visits that would be covered in a ***Member Hospital*** subject to the limits and provisions described in this section for Outpatient Alcohol and Drug Abuse Services.

No benefits are provided for services received from a Non-Member ***Non-hospital Facility*** or a Non-Contracting ***Non-hospital Facility***.

Diagnostic Study

When hospitalization is required for diagnosis of a definite symptomatic condition of disease or injury, benefits will be provided for such items as X-ray examinations and laboratory examinations. However, benefits are not paid for room and board charges, nursing care or other services included in the ***hospital's*** regular charges for accommodations. Admissions primarily for diagnostic study are covered only in Blue Cross Plan ***member hospitals***.

Outpatient Services

Outpatient hospital benefits are provided in full, in any Blue Cross Plan ***Member hospital***. When any of these types of care are received in other ***approved hospitals***, the benefit allowance will be limited to 75% of the ***hospital's*** charges for ***covered services***.

Emergency Treatment; Minor Surgery; Radiation Therapy

The ***hospital*** benefits of this program are available to you as an ***outpatient***, for:

- ***Emergency care*** received within 48 hours of an ***accidental injury*** or of the onset of a severe and sudden ***medical emergency***
- Surgical operations
- Radiation therapy

Benefits for ***emergency care*** include follow-up care for an ***accidental injury*** when provided as a ***hospital*** service, if benefits were provided for the initial treatment.

Physical and Respiratory Therapy

Benefits are available in the ***outpatient*** department where provided and billed for as a ***hospital*** service. Such care is approved, where ***medically necessary***, after the patient has been released from a covered ***inpatient*** stay at a ***hospital*** for the condition necessitating therapy. Benefits commence with the first ***outpatient*** therapy treatment and continue up to 60 consecutive days during each calendar year.

Chemotherapy

Intravenously administered chemotherapy (injections made directly into the veins) is covered in the ***outpatient*** department where provided as a ***hospital*** service. This benefit does not include oral chemotherapy (pills and liquid medicines taken by mouth), subcutaneous injections (beneath the skin, hypodermic) nor intramuscular injections (within or into muscle substance); nor antibiotic therapy or experimental or research chemotherapy drugs.

Diagnostic Services

Radiology services, electrocardiograms, electroencephalograms and laboratory tests are covered in the ***outpatient*** department to the extent that they are provided as a ***hospital*** service, when required for the diagnosis of a definite symptomatic condition of disease or injury.

One routine mammogram every calendar year for a female ***subscriber*** age 40 or older, and for any mammogram recommended by a ***physician*** for a female ***subscriber*** under age 40.

Outpatient Childhood Immunizations

Childhood Immunizations will be provided for services rendered within a ***hospital outpatient*** department. The immunization must be ordered by a ***physician*** and performed by a ***physician*** or a nurse. The services must be performed in accordance with a specific plan of treatment related to the ***Subscriber's*** condition or as an appropriate Pediatric preventive measure. These benefits are not subject to any ***deductible***, co-payment or ***maximum*** amounts.

Gynecological Examinations and Pap Smears

Female ***Subscribers*** are covered for one annual gynecological examination, including a pelvic examination and clinical breast examination, and routine pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists. These benefits are not subject to any ***deductible***, co-payment or ***maximum*** amounts.

Free-Standing Ambulatory Care Facility

Benefits will be provided for diagnostic and/or therapeutic procedures that are covered under this Program and approved by Blue Cross when provided by a Blue Cross Member ***Free-Standing Ambulatory Care Facility*** or a contracting ***free-standing ambulatory care facility*** of another Blue Cross Plan. No benefits will be provided for services rendered by a non-member ***free-standing ambulatory care facility***.

Skilled Nursing Facility (Extended Care Facility)

Benefits will be provided when you need skilled nursing care for continued treatment of an illness or injury which required at least three days of hospitalization, and are admitted to a ***skilled nursing facility*** that is a member of a Blue Cross Plan, within 14 days following discharge from the ***hospital***. You will be entitled to bed and board in semi-private accommodations (or an allowance toward the cost of private accommodations equal to the facility's most prevalent charge for semi-private accommodations) and other services which are usually provided and billed for by the facility. These "other services" include only those services which are ordinarily provided by ***hospitals*** to ***inpatients***.

In a ***skilled nursing facility*** which is not a member of any Blue Cross Plan but which is approved by the Joint Commission on the Accreditation of Healthcare Organizations or by the Blue Cross Plan, the Plan will pay you an allowance of up to $12.00 per day toward the facility's regular charges for ***covered services*** described in this section.

Each day that benefits are provided for services rendered by any facility will count as one-half day of hospitalization. Payment of these benefits will be subject to continuing review of the ***medical necessity*** for remaining in the facility.

Hospice Care

When the ***subscriber's*** attending ***physician*** certifies that the ***subscriber*** has a terminal illness with a medical prognosis of six (6) months or less and when the ***subscriber*** elects to receive care primarily to relieve pain rather than other types of care, the ***subscriber*** shall be eligible for ***hospice*** benefits when provided in the home by a ***Member Hospice***.

When hospice care is provided primarily in the home, such care on a short-term ***inpatient*** basis in a Medicare Certified or Blue Cross Plan Member ***Skilled Nursing Facility*** will also be covered when the ***Member Hospice*** considers such care necessary to relieve primary caregivers in the patient's home. Up to seven (7) days of such care every six (6) months will be covered.

Benefits for covered ***hospice*** services shall be provided until the earlier of patient's death or discharge from the ***Member Hospice.*** These benefits are in addition to and not in lieu of any other benefits described in this benefit booklet.

When any of the previously stated ***hospice*** services are provided by a ***contracting hospice*** of another Blue Cross Plan, such services shall be covered in accordance with the contractual arrangement between the ***hospice*** and the Blue Cross Plan. No benefits are provided for ***hospice*** services provided by a ***nonmember hospice***.

Home Health Benefits

A ***subscriber*** will be entitled to home health benefits when provided by a ***Member Home Health Care Agency*** or contracting ***home health care agency*** of another Blue Cross Plan in accordance with a plan of treatment approved by the ***subscriber's*** attending ***physician*** and Independence Blue Cross. Home health benefits are provided for the following primary services and supplies when provided by a ***Member Home Care Health Agency*** or contracting ***home health care agency*** of another Blue Cross Plan in the home by appropriately licensed and certified individuals:

- Intermittent skilled nursing care;
- ***Physical therapy***;
- ***Speech therapy***.

Benefits are also provided for certain other medical services and supplies when provided along with primary service through a ***Member Home Health Care Agency*** or contracting ***home health care agency*** of another Blue Cross Plan. Such other services and supplies include:

- ***Occupational therapy***;
- Medical social services;

- Home health aides in conjunction with skilled services;
- Other services which may be approved by Independence Blue Cross.

When any of the previously stated home health services are provided by a contracting ***home health care agency*** of another Blue Cross Plan, such services will be covered when provided under a plan of treatment approved by Independence Blue Cross.

No Home Health benefits will be provided for:

- Home health services provided by a Non-Member Home Health Agency.
- Services which exceed the specified limits of liability.
- Custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance.
- Private duty nurses.
- Rental or purchase of ***durable medical equipment***.
- Rental or purchase of medical appliances (e.g., braces) and prosthetic devices (e.g., artificial limbs); supportive environmental materials and equipment, such as handrails, ramps, telephones, air conditioners and similar services, appliances and devices.
- Services provided by a member of the patient's family or the family of the patient's spouse.
- Patient's transportation, including services provided by voluntary ambulance associations for which the patient is not obligated to pay.
- Emergency ambulance service or non-emergency ambulance service.
- Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional ***occupational therapy*** and/or social services.
- Services provided to individuals who are not essentially homebound for medical reasons.
- Visits by any provider personnel solely for the purpose of assessing an individual's condition and determining whether or not the individual requires and qualifies for home health services and will or will not be provided services by the provider.
- ***Prescription drugs***.
- Services, facilities, supplies or charges which are determined by Blue Cross not to be ***medically necessary***.

Outpatient Diabetic Education Program

Benefits are provided for diabetes ***outpatient*** self-management training and education, including medical nutrition for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes when prescribed by a ***Professional Provider*** legally authorized to prescribe such items under law.

The attending ***Physician*** must certify that a ***Subscriber*** requires diabetic education on an ***outpatient*** basis under the following circumstances: (1) upon the initial diagnosis of diabetes; (2) a significant change in the patient's symptoms or condition; or (3) the introduction of new medication or a therapeutic process in the treatment or management of the patient's symptoms or condition.

Outpatient diabetic education services will be covered when provided by a ***Member Hospital*** or other entity under contract with ***Blue Cross***. The diabetic education program must be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of Blue Cross. These requirements are based upon the certification programs for outpatient diabetes education developed by the American Diabetes Association and the Pennsylvania Department of Health.

Covered services include ***outpatient*** sessions that include, but may not be limited to, the following information:

- Initial assessment of the patient's needs;
- Family involvement and/or social support;
- Psychological adjustment for the patient;
- General facts/overview on diabetes;

- Nutrition including its impact on blood glucose levels;
- Exercise and activity;
- Medications;
- Monitoring and use of the monitoring results;
- Prevention and treatment of complications for chronic diabetes, (i.e., foot, skin and eye care);
- Use of community resources; and
- Pregnancy and gestational diabetes, if applicable.

Diabetic Supplies and Equipment

A. Benefits shall be provided for the following diabetic equipment and diabetic supplies furnished by a ***Durable Medical Equipment Supplier***.

1. Diabetic Equipment
   a) blood glucose monitors;
   b) insulin pumps;
   c) insulin infusion devices; and
   d) orthotic and podiatric appliances for the prevention of complications associated with diabetes.

2. Diabetic Supplies
   a) monitor supplies
   b) blood testing strips;
   c) visual reading and urine test strips;
   d) injection aids;
   e) insulin syringes;
   f) lancets and lancet devices;
   g) glucagon emergency kits.

B. Benefits shall be provided, subject to a Copayment of $10.00 per 30-day supply for a prescription order or refill, for the following diabetic supplies furnished by a Pharmacy:

   a) insulin and insulin analogs; and
   b) pharmacological agents for controlling blood sugar levels

Day Rehabilitation Program

Benefits will be provided for a Medically Necessary Day Rehabilitation Program when provided by a Hospital under the following conditions:

1. The Subscriber requires intensive Therapy services, such as Physical, Occupational and/or Speech Therapy five (5) days per week for 4-7 hours per day;

2. The Subscriber has the ability to communicate (verbally or non-verbally) his/her needs; the ability to consistently follow directions and to manage his/her own behavior with minimal to moderate intervention by professional staff;

3. The Subscriber is willing to participate in a Day Rehabilitation Program; and

4. The Subscriber's family must be able to provide adequate support and assistance in the home and must demonstrate the ability to continue the rehabilitation program in the home.

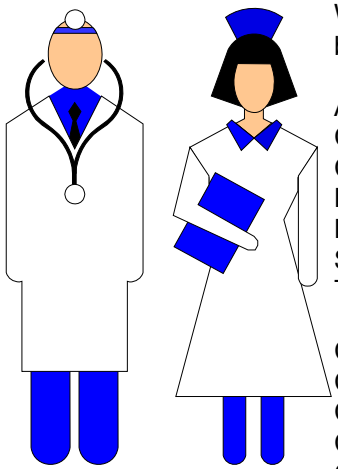
Benefits for Day Rehabilitation Program Covered Services provided in a Member Hospital (or an Approved Hospital, if such coverage is applicable to your group's Hospitalization program), will be provided at 100%. Benefits for Day Rehabilitation Program Covered Services provided in a Non-Member Hospital are subject to the same cost-sharing requirements as for all other Outpatient Hospital Services.

Blue Cross Exclusions - What Is Not Covered

Some of the following services may be covered under other parts of your health benefits program.

- Services for any occupational illness or bodily injury which occurs in the course of employment if benefits or compensation are available in whole or part under the provisions of the Worker's Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not you claim the benefits or compensation;
- Services to the extent their cost is recovered from any person or organization other than an insurer of the patient;
- Services which the patient is entitled to receive under the laws or regulations of any government or its agencies;
- For ***custodial care***, care in a convalescent home, domiciliary care or rest cures;
- Services not ordered by the attending physician or not ***Medically Necessary*** for the diagnosis or treatment of illness or injury or restoration of physiological function;
- Service for the treatment of injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;
- Services for oral ***surgery*** except as described previously;
- Services for which benefits are provided by the Veteran's Administration or by the Department of Defense for active military personnel for which you are eligible. This applies even if you have not taken the necessary action to obtain such benefits, except to the extent provided by law;
- Except as otherwise required by law, for services and operations for cosmetic purposes except those performed to correct a condition resulting from an injury which occurs while you are covered by the Plan. You must be enrolled without interruption from the date of the injury to the date of operation in order to be eligible for cosmetic ***surgery***;
- For diagnostic examinations in connection with the care of teeth, or services related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as previously described in this booklet;
- Research studies, screening, premarital examinations, routine physical examinations or check-ups;
- Weight reduction;
- Ambulance service;
- Blood or blood plasma;
- Procurement or use of special braces, appliances or equipment;
- Services of a ***physician***, surgeon or private duty nurse, or of technicians not employed by the ***hospital***;
- Assisted fertilization techniques such as, but not limited to, artificial insemination, in-vitro fertilization, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT);
- Charges, services or supplies which are not ***Medically Necessary*** as determined by Independence Blue Cross.
- For services paid or payable by Medicare when Medicare is primary. For purposes of this Plan, a service, supply or charge is "payable under Medicare" when the Subscriber is eligible to enroll for Medicare benefits, regardless of whether the Subscriber actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits;
- For care in a nursing home, home for the aged, convalescent home, school, camp, institution for Intellectually Disabled children;

HIGHMARK BLUE SHIELD
MEDICAL SURGICAL BENEFITS



Professional Providers

When you are ill or injured, your coverage helps pay for ***covered services*** by a ***professional provider***. These ***professional providers*** are:

Audiologist
Chiropractor
Clinical Laboratory
Doctor of Medicine
Doctor of Osteopathic Medicine
Speech/Language Pathologist
Teacher of the Hearing Impaired
Optometrist
Physical Therapists
Podiatrist
Psychologist
Dentist
Nurse Midwife

Certified Clinical Nurse Specialist*
Certified Community Health Nurse*
Certified Enterostomal Therapy Nurse*
Certified Psychiatric Mental Health Nurse*
Certified ***Registered Nurse*** Anesthetist*
Certified ***Registered Nurse*** Practitioner*

*Excluded from eligibility are registered professional nurses employed by a health care facility or by an anesthesiology group.

Payment of Benefits

Payment will be made in accordance with the Highmark Blue Shield 5000S Fee Schedule or the charge, whichever is less.

You are not required to make any payment for services covered by this program (except where a ***deductible*** or amounts exceeding the ***maximum*** are specified) when ***covered services*** are performed by a Highmark Blue Shield ***Participating Professional Provider*** (those ***professional providers*** with whom Highmark Blue Shield has a contract with respect to payment for ***covered services***) provided you meet the following conditions:

1. Your total income from all sources (wages, profits, rents, dividends, interest, etc.) does not exceed:

   a. Total income for an individual $18,000
   b. Total income for a family or husband and wife $36,000

2. You pay any ***deductible*** or amount exceeding the ***maximum*** to the ***Participating Professional Provider***. If you are within the above income limits the sum of your payment and the Blue Shield payment will be accepted as payment in full provided that your payment is made to the ***Participating Professional Provider*** within 60 days of notification by Blue Shield. If your payment is not made within 60 days the ***Participating Professional Provider*** may bill you the difference between the charge and the Plan 5000S allowance.

Annual income is the total income of the Applicant-***Subscriber***, including spouse, eligible ***dependents*** and any other persons whose chief support is furnished by the Applicant-***Subscriber*** or spouse for the calendar year preceding the date of performance of each covered service.

If the covered services are not performed by a Highmark Blue Shield ***Participating Professional Provider*** or if your income exceeds these amounts, you are required to pay the difference (if any) between the charge and the Blue Shield allowance.

Service Benefits

If you had services performed by a Highmark Blue Shield ***Participating Professional Provider*** and are under the income limits stated under Payment of Benefits, and the ***provider*** should bill you for other than the ***deductible***, ***co-insurance***, amounts exceeding the ***maximum*** or ineligible services, do the following:

Discuss the situation with the provider.

If you do not come to a mutually satisfactory settlement of the disagreement, then:

1) Contact Highmark Blue Shield in writing at:
   P.O. Box 898847, Camp Hill, PA 17089-8847.
2) Advise Blue Shield of the situation.

Blue Shield will review the situation to resolve the disagreement. Any dispute between a ***participating Professional Provider*** and a ***Subscriber*** with respect to annual income shall be submitted to Blue Shield for decision. It is your responsibility to show evidence of income when requested. This information must be supplied to Blue Shield within 90 days of the request. The decision by Blue Shield shall be final.

Medical Surgical Benefits

You are entitled to payment for the following ***covered services***, provided they are deemed medically necessary by Blue Shield. This professional care can be performed ***inpatient,*** in the ***outpatient*** department of the ***hospital*** or in the doctor's office, unless otherwise stated.

Surgery

Surgery for the treatment of disease or injury. Separate payment will not be made for ***inpatient*** pre-operative care or any post-operative care normally provided by the surgeon as part of the surgical procedure.

If more than one surgical procedure is performed by the same ***professional provider*** during the same operative session, Blue Shield shall pay 100% of the Plan 5000S Fee Schedule allowance for the highest paying procedure and no allowance for additional procedures except where Blue Shield deems that an additional amount is warranted.

Surgery includes coverage for the following when performed in connection with a mastectomy; surgery to reestablish symmetry or to alleviate functional impairment, including but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy; initial and subsequent prosthetic devices to replace the removed breast or portions thereof; and physical complications of all stages of mastectomy, including lymphedemas.

Also covered is the 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. Sterilization procedures and procedures to reverse sterilization regardless of their medical necessity are also covered.

Transplant Services

Human organ transplant services, including the ***covered services*** for the removal of an organ from a donor when the donor is not a ***subscriber*** and not covered under another health care plan.

Oral Surgery

Oral surgery for surgical removal of impacted teeth which are partially or totally covered by bone.

Assistant Surgery

Services of an assistant surgeon who actively assists the operating surgeon when the condition of the patient or the type of ***surgery*** performed requires assistance.

Surgical assistance is not covered when performed by a ***professional provider*** who performs and bills for another surgical procedure during the same operative session.

Anesthesia

Administration of ***anesthesia*** in connection with the performance of ***covered services*** when rendered by a ***professional provider***, other than the surgeon, assistant surgeon or attending ***professional provider***.

The medical direction (supervision) of ***anesthesia*** services administered by a nurse anesthetist not employed by a ***professional provider*** will be paid at 50% of the Plan 5000S allowance.

Anesthesia services, administered by an independently practicing certified ***registered nurse*** anesthetist (CRNA) working "in cooperation with" the surgeon, assistant surgeon, or attending ***professional provider*** will be paid at 100% of the Plan 5000S allowance.

Anesthesia services administered by an independently practicing certified ***registered nurse*** anesthetist (CRNA) under the medical direction (supervision) of a ***professional provider*** other than the surgeon, assistant surgeon, or attending ***professional provider*** will be paid at 50% of the Plan 5000S allowance.

Second Surgical Opinion

Second opinion consultation to determine the medical necessity of an elective surgical procedure. Elective ***surgery*** is that ***surgery*** which is not of an emergency or life threatening nature.

Such services must be performed and billed for by a ***professional provider*** other than the consultant who provided the patient with the initial surgical consultation. One additional consultation, as a third opinion, is eligible in cases where the second opinion disagrees with the first recommendation. In such instances, you will be eligible for a maximum of two such out-of-***hospital*** consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

Medical Care

Medical care by the ***professional provider*** in charge of the case to a ***subscriber*** who is an ***inpatient*** in a ***Hospital*** or Rehabilitation Hospital or a ***Skilled Nursing Facility*** for a condition not related to ***surgery***, maternity services, radiation therapy, or mental illness. These covered services are available for a total of 365 days for each period of hospitalization. At least 90 consecutive days must elapse between discharge from and subsequent admission to a ***Hospital*** or Rehabilitation Hospital or a ***Skilled Nursing Facility*** before ***inpatient*** stays will be considered a new period of hospitalization.

Concurrent Care

Inpatient medical care rendered by a ***professional provider*** who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the patient, stand-by services, routine pre-operative physical examinations or medical care routinely performed in the pre- or post-operative or pre- or post-natal periods.

Consultation

Inpatient consultations if the condition requires it and the ***professional provider*** in charge of the case requests the consultation. There is a limit of one consultation per consultant during any one ***inpatient*** stay.

Skilled Nursing Care

Medical care in a ***skilled nursing facility***. The ***subscriber*** shall be eligible if:

a. the ***subscriber's*** illness or injury requires at least three days of hospitalization;
b. the ***subscriber's*** condition requires skilled nursing care for continued treatment; and

c. the ***subscriber*** is admitted to the ***skilled nursing facility*** within 14 days following discharge from an accredited ***hospital***.

Skilled Nursing Care is limited to two visits during the first week of confinement and one visit a week for each consecutive week of confinement thereafter. Each day of confinement in a ***skilled nursing facility*** counts as one-half day against the ***benefit period*** of 365 days available for ***inpatient*** medical care.

Maternity Services

Maternity services, including pre- and post-natal care, performed by a ***professional provider*** for all females.

Routine Newborn Care

Professional visits to examine the newborn while the mother is an ***inpatient*** in a ***hospital*** or ***birthing center***.

Psychiatric Care

Treatment of ***mental illness*** including visits for drug addiction or alcoholism rendered by the ***professional provider*** in charge of the case to a ***subscriber*** who is an ***inpatient*** in a ***hospital***. Such care is available for 30 days in any period of 12 consecutive months. All psychiatric visits are applied toward the ***benefit period*** of 365 days available for ***inpatient*** medical care.

Serious Mental Illness

Inpatient visits by a ***Professional Provider*** for the treatment of ***Serious Mental Illness*** are available for up to 30 days per ***Benefit Period***. The benefit also provides up to 60 Outpatient psychiatric visits for ***Serious Mental Illness*** per ***Benefit Period***. You may trade on a one (1) for two (2) basis, inpatient visits for additional Outpatient visits. These benefits are provided in addition to the benefits provided to you for all other Psychiatric care.

Convulsive Therapy

Convulsive therapy including ***anesthesia*** for electroshock therapy.

Diagnostic Services

Diagnostic services required to determine a definite condition or disease.

A. Diagnostic radiology, consisting of x-ray, ultrasound and nuclear medicine.
B. One screening mammography is covered per calendar year for females 40 years of age and older. For females under age 40, all ***physician***-recommended mammographies are covered. Benefits for mammography screening are payable only if performed by a mammography service provider who is properly certified by the Department of Health in accordance with the Mammography Quality Assurance Act of 1992.
C. Diagnostic medical, consisting of ECG, EEG and other diagnostic medical procedures approved by Blue Shield.
D. Diagnostic laboratory consisting of pathology tests performed, billed for, or ordered by a ***professional provider***.
E. Allergy testing

Emergency Care

The initial treatment within 72 hours following an ***accidental injury*** or medical emergency.

Medical emergency is a sudden onset of a medical condition with acute symptoms of severity that the absence of immediate medical attention could result in:

A. Permanently placing the patient's health in jeopardy,

B. Causing other serious medical consequences,
C. Causing serious impairment to bodily functions,
D. Causing serious and permanent dysfunction of any body part.

These benefits will not be provided if any other benefit of this program is payable. For example: If the accident services are classified as ***surgery*** (suturing, fracture care, etc.), payment will be made as a surgical benefit.

Therapy and Rehabilitative Services

A. Radiation Therapy
B. Chemotherapy - Including the cost of the drugs approved by the Food and Drug Administration (FDA) as antineoplastic agents.
C. Dialysis Treatment
D. Physical Medicine/Physical Therapy - To a ***subscriber*** who is an ***inpatient***.

Pediatric Immunizations

Benefits are provided for childhood immunizations which, as determined by the Pennsylvania Department of Health, conform with the standards of the (Advisory Committee on Immunization Practices of the Center for Disease Control), U.S. Department of Health and Human Services.

Benefits for immunizations are limited to ***dependent*** children and are not subject to ***deductibles*** or ***maximums***. Under your Fee Schedule Program, Blue Shield's Fee Schedule allowance is not considered a ***maximum***.

Routine Gynecological Examination and Routine Papanicolaou Smear

Benefits are provided for one (1) routine gynecological examination, including a pelvic examination and clinical breast examination, and one (1) routine pap smear per calendar year for all female Members. Benefits are exempt from all ***deductibles*** or ***maximums***. Under your Fee Schedule Program, Blue Shield's Fee Schedule allowance is not considered a ***maximum***.

Example of 5000S Allowances

The listing is a partial one and does not indicate the full scope of benefits available to 5000S ***subscribers***.

Blue Shield will pay the lesser of the Provider's actual charge or Fee Schedule Allowance for specific services covered under this program. Allowances shown are neither intended to indicate the value of your ***professional provider's*** services, nor do they relate to such value.

Procedure Performed	**Fee Schedule Allowance**
Surgery	
Cardiovascular	
Right and left heart catheterization	$ 763.00
Coronary artery balloon dilation	1,010.00
Digestive	
Hemorrhoidectomy, simple (e.g., rubber band)	$ 61.00
Appendectomy (independent procedure)	506.00
Ear	
Insertion of tube(s) into middle ear, general ***anesthesia***	$ 99.00
Eye	
Cataract removal with insertion of lens	$1,100.00
Female Genital	
Dilation and curettage, nonobstetrical, D & C (independent procedure)	$267.00
Total abdominal hysterectomy	985.00
Male Genital	
Vasectomy	$294.00
Maternity Care and Delivery	
Routine obstetric care including prenatal care, vaginal delivery, and postnatal care	$1,000.00
Cesarean delivery, including prenatal and postnatal care	1,000.00
Musculoskeletal	
Arthroscopic knee ***surgery***	$752.00
Respiratory	
Control of nasal hemorrhage, anterior, simple	$32.00
Bronchoscopy, diagnostic (flexible or rigid)	252.00
Diagnostic Services	
Medical	
EKG with interpretation and report	$29.00
Pathology	
Urinalysis, complete	$5.27
Blood count, complete, automated	11.00

X-ray

Chest, two views, frontal and lateral	$33.00
Screening mammography; bilateral	44.00

Emergency Accident Care

Initial emergency accident visit	$35.00

Blue Shield Exclusions - What Is Not Covered

Some of the following services may be covered under other parts of your health benefits program.

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

- Which are not ***medically necessary*** as determined by the Plan;
- Rendered by other than ***professional providers***;
- Which are ***experimental*** or ***investigative*** in nature;
- For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any legislation of the Workers' Compensation Act as amended from time to time. This exclusion applies whether or not the ***subscriber*** claims the benefits or compensation;
- Provided by the Veteran's Administration or by the Department of Defense for active military personnel for which a ***subscriber*** is eligible even if the ***subscriber*** has not taken the necessary action to obtain such benefits, to the extent provided by law;
- For any illness or injury suffered as a result of an act of war;
- For which a ***subscriber*** would have no legal obligation to pay;
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
- For operations for cosmetic purposes except those performed to correct a condition resulting from an accident;
- Which were or are ***incurred*** prior to the ***subscriber's effective date*** of coverage;
- Which were or are ***incurred*** after the date of termination of the ***subscriber's*** coverage except as provided in this booklet;
- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, whether or not recommended by a ***professional provider***;
- For telephone consultations, charges for failure to keep a scheduled appointment, or charges for completion of a claim form;
- For custodial care, domiciliary care or rest cures;
- For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone ***surgery***), calluses, toe nails (except ***surgery*** for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
- For routine or periodic physical examinations, except for routine gynecological examinations and routine pap smears as stated in this booklet;
- For diagnostic screening examinations and routine medical visits, except for mammograms, childhood immunization and preventive care;
- For the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column;
- For well-baby care;
- For immunizations, except for childhood immunizations as stated in this booklet;
- Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates as provided for and defined in the Benefits Section;
- For hearing aids or examinations for the prescription or fitting of hearing aids;
- For any treatment leading to or in connection with transsexual ***surgery***;
- For assisted fertilization techniques such as, but not limited to, artificial insemination, in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT);
- For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;
- For treatment of obesity, except for surgical treatment of morbid obesity when weight is at least twice the ideal weight specified for frame, age, height and sex;

- For payment made under Medicare when Medicare is primary or would have been made if the ***subscriber*** had enrolled for Medicare and claimed Medicare benefits; however, this exclusion shall not apply when the group is obligated by law to offer the ***subscriber*** all the benefits of this booklet and the ***subscriber*** so elects this coverage as primary;
- For treatment of sexual dysfunction not related to organic disease;
- For treatment of temporomandibular joint syndrome with intra-oral devices, or any other method to alter vertical dimension;
- For equipment costs related to services performed on high cost technological equipment as defined by Blue Shield, such as but not limited to computed tomography (CT) scanners, magnetic resonance imagers (MRI) and extracorporeal shock wave lithotripters;
- For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in the manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;
- For local infiltration anesthetic;
- For pre-operative care when the ***subscriber*** is not an ***inpatient*** and any post-operative care other than that normally provided following operative or cutting procedures;
- Performed in a facility by a ***professional provider*** who in any case is compensated by the facility for similar services performed for patients;
- For which the fees or charges are billed by ***hospitals*** or other facilities;
- Performed by a ***professional provider*** enrolled in an education or training program when such services are related to the education or training program;
- For clinical pathology services for which a ***hospital*** or other facility bills;
- For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses;
- Which are paid, or payable, in whole or in part, by a Blue Cross Plan;
- For routine neonatal circumcision;
- Which are submitted by a certified ***registered nurse*** and another ***professional provider*** for the same services performed on the same date for the same patient;
- For any other medical or dental service or treatment except as provided in this booklet.

DEFINITION OF TERMS

For the purposes of this booklet, the terms below have the following meaning.

ACCIDENTAL INJURY - a bodily injury which results from an accident directly and independently of all other causes and which occurs after the ***effective date*** of coverage.

ALCOHOL OR DRUG ABUSE - any use of alcohol or other drugs which produce a pattern of pathological use causing impairment in social or occupational functions or which produces physiological dependency evidenced by physical tolerance or withdrawal.

AMBULATORY SURGICAL FACILITY - a ***facility provider***, with an organized staff of ***physicians***, which has been approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health Care, Inc., or by the Plan and which:

A. has permanent facilities and equipment for the primary purposes of performing surgical procedures on an ***outpatient*** basis;
B. provides treatment by or under the supervision of ***physicians*** and nursing services whenever the patient is in the facility;
C. does not provide ***inpatient*** accommodations; and
D. is not, other than incidentally, a facility used as an office or clinic for the private practice of a ***professional provider***.

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

ANNUAL INCOME - means the total income of the ***employee*** including spouse, eligible ***dependents*** and any other persons whose chief support is furnished by the ***employee*** or spouse for the calendar year preceding the date of performance of each ***covered service***.

APPROVED HOSPITAL - (1) any ***hospital*** located in the Philadelphia five-county area (Bucks, Chester, Delaware, Montgomery and Philadelphia Counties) which has a contract with Independence Blue Cross; (2) any ***hospital*** located outside of the Philadelphia five-county area which has a contract with any Blue Cross Plan; and (3) any ***hospital*** located outside of the Philadelphia five-county area which is approved by the Joint Commission on Accreditation of Healthcare Organizations, by the American Osteopathic Hospital Association or by the appropriate Blue Cross Plan.

BASIC PLANS - the Blue Cross Basic ***hospital*** benefits, the Blue Shield Basic Medical-Surgical benefits, and/or other benefits provided for the ***subscribers*** under the group's program of benefits.

BENEFIT PERIOD. the specified period of time as shown in the “Your Benefits at a Glance” section in this booklet, during which charges for ***covered services*** must be ***incurred*** in order to be eligible for payment by the Plan. A charge shall be considered ***incurred*** on the date the service or supply was provided to a ***subscriber***.

BIRTH CENTER - means a ***Facility Provider*** approved by the Plan which (1) is licensed as required in the state where it is situated, (2) is primarily organized and staffed to provide maternity care, and (3) is under the supervision of a ***physician*** or a licensed certified nurse-midwife.

BLUE CROSS - for the purpose of this booklet, Independence Blue Cross.

BLUE SHIELD - for the purpose of this booklet, Highmark Blue Shield.

COINSURANCE - the specific percentage of ***covered expenses*** which must be paid by the ***subscriber***.

CONTRACTING FACILITY PROVIDER - a Facility Provider of health care services and/or medical supplies that has a contractual relationship with another Blue Cross Plan for the provision of services to ***subscribers.***

CONTRACTING HOSPITAL PROVIDER - means any ***hospital*** that has a contractual relationship with another Blue Cross Plan for the provision of services to ***subscribers***.

COVERED EXPENSE - means charges for a service or supply for which benefits will be provided.

COVERED SERVICE - a service or supply specified in this booklet for which benefits will be provided.

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

DAY REHABILITATION PROGRAM – is a level of Outpatient care consisting of four (4) to seven (7) hours of daily rehabilitative therapies and other medical services five (5) days per week. Therapies provided may include a combination of therapies, such as Physical Therapy, Occupational Therapy, and Speech Therapy, as otherwise defined in this booklet/certificate and other medical services such as nursing services, psychological therapy and Case Management services. Day Rehabilitation sessions also include a combination of one-to-one and group therapy. The Covered Person returns home each evening and for the entire weekend.

DEDUCTIBLE - a specified amount of covered expenses for the ***covered services*** usually expressed in dollars that must be paid by the ***subscriber*** before the Plan will assume any liability.

DEPENDENT - a ***subscriber's*** spouse and unmarried children who meet the eligibility requirements outlined in the “General Information” section of this booklet.

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

DURABLE MEDICAL EQUIPMENT - is equipment which:

A. can withstand repeated use;
B. is primarily and customarily used to service a medical purpose;
C. generally is not useful to a person in the absence of an illness or injury; and
D. is appropriate for use in the home.

DURABLE MEDICAL EQUIPMENT SUPPLIER – an entity that provides ***Durable Medical Equipment*** and Supplies.

EFFECTIVE DATE - the date on which coverage for a ***subscriber*** begins.

EMERGENCY CARE - the initial treatment of a sudden, unexpected onset of a medical condition or traumatic injury. This shall not include treatment for an occupational injury for which benefits are provided under any Worker's Compensation Law or any similar Occupational Disease Law. The symptoms or injury must be of sufficient severity to warrant immediate attention.

A. Emergency Accident Services - the initial treatment of traumatic bodily injuries resulting from an accident.
B. Emergency Medical Services - the initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:
    1. permanently placing the ***subscriber's*** health in jeopardy;
    2. causing other serious medical consequences;
    3. causing serious impairment to bodily functions; or

4. causing serious and permanent dysfunction of any bodily organ or part.

EMPLOYEE - an individual of the ***group*** who meets the eligibility requirements for enrollment, who is so specified for enrollment, and in whose name the ***identification card*** is issued.

ENTERAL NUTRITION - is the provision of nutritional requirements through a tube into the stomach or small intestine.

EXPERIMENTAL OR INVESTIGATIVE - the use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which the Plan, relying on the advise of the general medical (which includes, but is not limited to, medical consultants, peer reviewed medical journals and/or governmental regulations) does not accept as standard medical treatment of the condition being treated, or any such items requiring federal or other governmental agency approval which approval has not been granted at the time services were rendered.

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

- Birth Center
- Free-Standing Dialysis Facility
- Free-Standing Ambulatory Care Facility
- Ambulatory Surgical Facility
- Home Health Care Agency
- Hospice
- Non-hospital Facility
- Hospital
- Psychiatric Hospital
- Rehabilitation Hospital
- Residential Treatment Facility
- Short Procedure Unit
- Skilled Nursing Facility

FREE-STANDING AMBULATORY CARE FACILITY - a facility, other than a ***hospital***, which provides treatment or services on an ***outpatient*** or partial basis and is not, other than incidentally, used as an office or clinic for the private practice of a ***physician***. This facility shall be licensed by the state in which it is located and be accredited by the appropriate regulatory body.

FREE-STANDING DIALYSIS FACILITY - A ***facility provider***, licensed or approved by the appropriate governmental agency and approved by the Plan, which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an ***outpatient*** or home care basis.

HOME HEALTH CARE AGENCY - a ***facility provider***, approved by the Plan, that is engaged in providing, either directly or through an arrangement, health care services on an intermittent basis in the patient's home in accordance with an approved home health care Plan of treatment.

HOSPICE - a ***facility provider*** that is engaged in providing palliative care rather than curative care to terminally ill individuals. The hospice must be (1) certified by Medicare to provide hospice services, or accredited as a Hospice by the Joint Commission on Accreditation of Healthcare Organizations; and (2) appropriately licensed in the state where it is located.

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

(a) is a duly licensed institution;
(b) is primarily engaged in providing ***inpatient*** diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of ***physicians***;
(c) has organized departments of medicine and major ***surgery***;
(d) provides 24-hour nursing service by or under the supervision of ***registered nurses***;

(e) is not, other than incidentally, a:
Skilled Nursing Facility;
Nursing Home;
Custodial Care Home;
Health Resort, spa or sanitarium;
Place for rest;
Place for aged;
Place for treatment of Mental Illness;
Place for treatment of alcoholism or drug abuse;
Place for provision of rehabilitation care;
Place for treatment of pulmonary tuberculosis;
Place for provision of hospice care.

IDENTIFICATION CARD - the currently effective card issued to the Applicant-***Subscriber*** by the Plan.

IMMEDIATE FAMILY - the ***subscriber's*** legal spouse, parent, child, stepchild, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law.

INCURRED - a charge shall be considered incurred on the date a ***subscriber*** receives the service or supply for which the charge is made.

INPATIENT ADMISSION or (INPATIENT) - the actual entry into a ***hospital***, extended care facility or ***facility provider*** of a ***subscriber*** who is to receive ***inpatient*** services as a registered bed patient in such ***hospital***, extended care facility or ***facility provider*** and for whom a room and board charge is made; the ***inpatient*** admission shall continue until such time as the ***subscriber*** is actually discharged from the facility.

INPATIENT DETOXIFICATION AND REHABILITATION - the provision of medical, nursing, counseling or therapeutic services twenty-four hours a day in a ***hospital*** or ***non-hospital facility***, according to individual treatment plans.

LICENSED PRACTICAL NURSE (LPN) a nurse who has graduated from a formal practical or nursing education program and is licensed by the appropriate state authority.

MAXIMUM - the greatest amount payable by the Plan for ***covered services***. This could be expressed in dollars, number of days, or number of services for a specified period of time.

A. Benefit ***Maximum*** - the greatest amount payable by the Plan for a specific ***covered service***.
B. Lifetime ***Maximum*** - the greatest amount payable by the Plan in a ***subscriber's*** lifetime.

MEDICAL FOODS - liquid nutritional products which are specifically formulated to treat one of the following genetic diseases: phenylketonuria, branched-chain ketonuria, galactosemia, homocystinuria.

MEDICALLY NECESSARY (or MEDICAL NECESSITY) - health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

MEDICARE ALLOWABLE PAYMENT – the payment amount, as determined by the Medicare program, for a ***Covered Service***.

MEMBER HOME HEALTH CARE AGENCY - a home health care agency which has a contract with Independence Blue Cross for the provision of services to ***subscribers***.

MEMBER HOSPICE - a hospice which has a contract with Independence Blue Cross for the provision of hospice services to ***subscribers***.

MEMBER HOSPITAL - a hospital that is approved by and has a contract with Independence Blue Cross or any other Blue Cross Plan for the provision of services to ***subscribers***.

MEMBER OUTPATIENT PSYCHIATRIC FACILITY - a ***facility provider*** which is approved by and has a contract with Independence Blue Cross for the provision of ***outpatient*** diagnostic and therapeutic psychiatric services to ***subscribers***.

MEMBER PROVIDER - any ***facility provider*** of health care services, medical supplies, or ***prescription drugs*** which has a contract with Independence Blue Cross for the provision of such services, supplies or ***prescription drugs*** to ***subscribers***.

MENTAL ILLNESS - includes mental disorders, psychiatric illnesses, mental conditions and psychiatric conditions. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

NON-HOSPITAL FACILITY - a ***facility provider***, licensed by the Department of Health and approved by the Plan, for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities.

NON-HOSPITAL RESIDENTIAL TREATMENT - the provision of medical, nursing, counseling or therapeutic services to patients suffering from ***alcohol or drug abuse*** or dependency in a residential environment, according to individualized treatment plans.

NON-MEMBER HOSPICE - a hospice which does not have a contract with Independence Blue Cross or any other Blue Cross Plan for the provision of hospice services to ***subscribers***.

NON-MEMBER HOSPITAL - a hospital which does not have a contract with Independence Blue Cross for the provision of services to ***subscribers***.

NON-MEMBER OUTPATIENT PSYCHIATRIC FACILITY - a ***facility provider*** which does not have a contract with Independence Blue Cross for the provision of ***outpatient*** diagnostic and therapeutic psychiatric services to ***subscribers***.

NON-MEMBER PROVIDER - any ***facility provider*** of health care services, medical supplies, or ***prescription drugs*** that does not have a contract with Independence Blue Cross for the provision of such services, supplies or ***prescription drugs*** to ***subscribers***.

NON-PARTICIPATING PROFESSIONAL PROVIDER - a ***professional provider*** who does not meet the definition of a ***Participating Professional Provider***.

NUTRITIONAL FORMULA - liquid nutritional products which are formulated to supplement or replace normal food products.

OUT-OF-POCKET LIMIT - a specified dollar amount of coinsurance expense ***incurred*** by a ***subscriber*** for ***covered services*** in a ***benefit period***. Such expense does not include any ***deductible***, penalties, psychiatric care services, copayment amounts, or charges in excess of the ***provider's*** reasonable charge. When the out-of-pocket limit is reached, the level of benefits is increased as specified in the “Your Benefits at a Glance” section in this booklet.

OUTPATIENT - a ***subscriber*** who receives services or supplies while not an ***inpatient***.

OUTPATIENT DIABETIC EDUCATION PROGRAM - an outpatient diabetic education program provided by a ***Member Hospital*** of Independence Blue Cross, which has been recognized by the Pennsylvania Department of Health or the American Diabetes Association as meeting the national standards for Diabetes Patient Education Programs established by the National Diabetes Advisory Board.

PARTICIPATING PROFESSIONAL PROVIDER - a ***professional provider*** who has an agreement with Highmark Blue Shield pertaining to payment for ***covered services*** rendered to a ***subscriber***.

PARTIAL HOSPITALIZATION - medical, nursing, counseling or therapeutic services provided on a planned and regularly scheduled basis in a ***hospital*** or ***facility provider***, designed for a patient who would benefit from more intensive services than are offered in ***outpatient*** treatment but who does not require ***inpatient*** confinement.

PHARMACIST - an individual who is legally licensed to practice the profession of pharmacology and who regularly practices such profession in a ***pharmacy***.

PHARMACY - any establishment which is registered and licensed as a pharmacy with the appropriate state licensing agency and in which ***prescription drugs*** are regularly compounded and dispensed by a ***pharmacist***.

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, perform ***surgery*** and dispense drugs.

PRECERTIFICATION - a preadmission review program which contains two components: Presurgical certification and preadmission certification.

A. Presurgical certification - a process whereby the medical necessity and appropriate place of service is reviewed prior to the performance of such surgical procedures;
B. Preadmission certification - a process whereby all elective surgical, medical and psychiatric ***hospital*** admissions are reviewed prior to admission. The purpose of the review is to determine if inpatient admission is necessary, and if so, to determine an appropriate length of stay.

PRESCRIPTION DRUG - (a) any medication which by Federal and or State laws may be dispensed with a ***prescription order***, and (b) insulin.

PRESCRIPTION ORDER - the request in acordance with applicable laws and regulations for medication issued by a ***professional provider***.

PROFESSIONAL OTHER PROVIDER – a person or entity other than a Facility Provider or Professional Provider who is licensed, where required, to render Covered Services as prescribed by a Professional Provider within the scope of such licensure or under the supervision of a Professional Provider within the scope of such licensure. Professional Other Providers include:

Occupational Therapist	Respiratory Therapist
Licensed Practical Nurse	Registered Nurse

PROFESSIONAL PROVIDER - a ***facility provider*** or ***professional provider***, licensed where required.

PSYCHIATRIC HOSPITAL - a ***facility provider***, approved by the Plan, which for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the ***inpatient*** treatment of ***mental illness***. Such services are provided by or under the supervision of an organized staff of ***physicians***. Continuous nursing services are provided under the supervision of a ***registered nurse***.

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

REHABILITATION HOSPITAL - a ***facility provider***, approved by the Plan, which is primarily engaged in providing rehabilitation care services on an ***inpatient*** basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of ***physicians***. Continuous nursing services are provided under the supervision of a ***registered nurse***.

RESIDENTIAL TREATMENT FACILITY - a ***facility provider***, licensed and approved by the appropriate government agency and approved by the Plan, which provides treatment for substance (alcohol and drug) abuse to partial, ***outpatient*** or live-in patients who do not require acute medical care. This ***facility provider*** must also meet the Department of Health minimum drug and alcohol standards for client-to-staff ratios and staff qualifications.

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 statistic manual: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.

SHORT PROCEDURE UNIT - a unit which is approved by the appropriate Blue Cross Plan and which is designed to handle either lengthy diagnostic or minor surgical procedures on an ***outpatient*** basis which would otherwise have resulted in an ***inpatient*** stay in the absence of a Short Procedure Unit.

SKILLED NURSING FACILITY - an institution or a distinct part of an institution, other than one which is primarily for the care and treatment of ***mental illness***, tuberculosis, or ***alcohol or drug abuse***, which:

A. Is accredited as a ***skilled nursing facility*** or extended care facility by the Joint Commission on Accreditation of Healthcare Organizations; or
B. Is certified as a ***skilled nursing facility*** or extended care facility under the Medicare Law; or
C. Is otherwise acceptable to the Plan.

SUBSCRIBER - an enrolled ***employee*** or his eligible ***dependents*** who have satisfied the eligibility requirements outlined in the General Information section of this booklet. A ***Subscriber*** does not mean any person who is eligible for Medicare except as specifically stated in this booklet.

SURGERY - the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures. Payment for surgery includes an allowance for related ***inpatient*** pre-operative and all post-operative care. Treatment of burns, fractures and dislocations are also considered surgery.

THERAPY AND REHABILITATIVE SERVICE - the following services or supplies ordered by a Physician or Professional Other Provider used for the treatment of an illness or injury to promote the recovery of the ***subscriber***. Therapy and Rehabilitative Services are covered to the extent specified in the Schedule of Benefits.

A. Radiation Therapy - The treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.
B. Chemotherapy - The treatment of malignant disease by chemical or biological antineoplastic agents.
C. Dialysis Treatments - The treatment of an acute renal failure of chronic irreversible renal insufficiency for removal of waste materials from the body. This includes hemodialysis or peritoneal dialysis.
D. Cardiac Therapy - Medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.
E. Physical Medicine/Physical Therapy - The treatment by physical means or modalitites such as, but not limited to, mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities, and rehabilitative procedures, performed to relieve pain and restore level of function following disease, illness or injury.
F. Respiratory Therapy - Introduction of dry or moist gases into the lungs for treatment purposes.

G. Occupational Therapy - Treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
H. Speech Therapy - Treatment for the correction of a speech impairment resulting from disease, ***surgery***, injury, congenital and developmental anomalies, or previous therapeutic processes.

USUAL, CUSTOMARY AND REASONABLE (UCR) ALLOWANCE
- under the UCR methodology, Highmark Blue Shield determines an allowed amount of Covered Services by applying one or more of the following criteria:

A. USUAL – the allowed amount determined by Blue Shield for a Professional Provider based upon that individual provider's charges for the procedure performed.

B. CUSTOMARY – the allowed amount determined by Blue Shield by considering relevant professional, economic, and market factors, including but not limited to: the degree of professional involvement, charges of professional providers of the same or similar specialty for the procedure performed, the actual cost of equipment and facilities, or other factors which contribute to the cost of the procedure.

C. REASONABLE – the allowed amount (which may differ from the Usual or Customary allowed amounts) determined by Blue Shield by considering unusual clinical circumstances.

Allowed amounts are updated periodically to respond to changing economic and market circumstances. The timing of updates and methodology employed are subject to approval by the Insurance Department of the Commonwealth of Pennsylvania.

CLAIMS APPEAL PROCEDURE

RESOLVING PROBLEMS

For purposes of this section only, the term "Member" replaces the term "Subscriber."

Member Complaint Process

The Plan has a process for Members to express informal complaints. To register a complaint (as opposed to an appeal as discussed below), Members should call the Member Services Department at the telephone number on the back of their identification card or write to the Plan at the following address:

Independence Blue Cross
General Correspondence
1901 Market Street
Philadelphia, PA 19103

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

Member Appeal Process

Filing an Appeal. The Plan maintains procedures for the resolution of Member appeals. Member appeals may be filed within 180 days of the receipt of a decision from the Plan stating an adverse benefit determination. An appeal occurs when the Member or another authorized representative requests a change of a previous decision made by the Plan by following the procedures described here. In order to authorize someone else to be your representative for the appeal, you must complete a valid authorization form. Contact the Plan as directed below to obtain a form for a member/enrollee to authorize an appeal by a provider or other representative or for questions regarding the requirements for an authorized representative.

The Member or other authorized person on behalf of the Member, may request an appeal by calling or writing to the Plan, as stated in the letter notifying the Member of the decision or as follows:

Member Appeals Department	Toll Free Phone: 1-888-671-5276
P.O. Box 41820	Toll Free Fax: 1-888-671-5274 or
Philadelphia, PA, 19101-1820.	Phila. Fax: 215-988-6558

Types of Member Appeals and Timeframe Classifications. Following are the two types of Member appeals and the issues they address:

- Medical Necessity Appeal Issues – An appeal by or on behalf of a Member that focuses on issues of Medical Necessity and requests the Plan to change its decision to deny or limit the provision of a Covered Service. Medical Necessity appeals include appeals of adverse benefit determinations based on the exclusions for experimental/investigative or cosmetic services.

- Administrative Appeal Issues – An appeal by or on behalf of a Member that focuses on unresolved Member disputes or objections regarding a Plan decision that concerns coverage terms such as contract exclusions and non-covered benefits, exhausted benefits, and claims payment issues. Although an administrative appeal may present issues related to Medical Necessity, these are not the primary issues that affect the outcome of the appeal.

The timeframes described below for completing a review of each appeal depend on additional classifications:

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

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

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

Information for the Appeal Review including Matched Specialist's Report. You may submit to the Plan additional information pertaining to your case. You may specify the remedy or corrective action being sought. Upon request at any time during the appeal process, the Plan will provide you or your authorized representative access to, and copies of, documents, records, and other information relevant to the appeal that is provided for the appeal decisionmaker(s) to review.

Input from a matched specialist is obtained for all Medical Necessity Appeals. A matched specialist is a licensed physician or psychologist in the same or similar specialty as typically manages the care under review. The matched specialist cannot be the person who made the adverse benefit determination at issue in the appeal and cannot be a subordinate of the person who made that determination.

Appeal Committee Composition and Role. Each Appeal Committee described below will be comprised of one to three persons designated by the Plan to act as decisionmaker(s) on the appeal. The Committee decisionmaker(s) did not make the adverse benefit determination at issue in the appeal and are not subordinates of the person who made that determination. Each Committee will review all relevant information for the appeal, whether from the Member or his authorized representative or obtained from other sources during the investigation of the appeal issues.

STANDARD APPEALS: Process and timeframes.

An acknowledgement letter and description of the appeal process is mailed following receipt of a Member appeal. A standard appeal consists of one level of internal review for which the evaluation and decision must be completed within the following timeframes:

Standard Pre-service Appeal – within 30 days of receipt of the appeal request
Standard Post-service Appeal – within 60 days of receipt of the appeal request

The appeal review will occur based on the information available for the Appeal Committee's review. You are encouraged to supply additional relevant information to the appeals specialist preparing your appeal.

Written notice of the standard appeal decision will be sent within the timeframes stated above. If your appeal is denied, the decision notice will state the specific reason for the denial, refer to Plan provision(s) and guidelines on which the decision is made, tell you about relevant information that is available free of charge, and describe external appeal rights or other dispute resolution options that may be available to you.

The standard appeal decision is final with respect to your right to appeal through the Plan's internal member appeal process.

EXPEDITED APPEALS: Process and timeframes

If your case involves a serious medical condition which you believe may jeopardize your life, health, ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed while awaiting a standard appeal decision, you may ask to have your case reviewed in a quicker manner, as an expedited appeal. An expedited appeal consists of one level of internal review for which the evaluation and decision must be completed within the following timeframe:

Expedited Pre-service Appeals - within 72 hours of receipt of the appeal request.

To request an expedited appeal by the Plan, call or fax the Member Appeals Department at the phone numbers listed above under “Filing an Appeal.” Information related to your appeal will be requested and you will be promptly informed whether it qualifies for review as an expedited appeal or must instead be processed as a standard appeal.

The Expedited Appeal Committee will review all relevant information for the appeal from the Member or his authorized representative or from other sources that is received in time to permit compliance with the time limits for review of an expedited appeal. You are encouraged to supply additional relevant information to the appeals specialist preparing your appeal.

The Expedited Appeal review will be completed promptly based on your health condition, but no later than seventy-two (72) hours after receipt of your expedited appeal by the Plan. You will be notified of the decision by telephone and a letter mailed in no more than seventy-two (72) hours. If your appeal is denied, the decision notice will state the specific reason for the denial, refer to Plan provision(s) and guidelines on which the decision is made, tell you that relevant information is available free of charge, and describe external appeal rights or other dispute resolution options that may be available to you. The expedited appeal decision is then final with respect to a Member’s right to appeal through the Plan’s internal appeal process.

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The policy and procedures for Member appeals may change due to changes that the Plan makes to comply with applicable state and federal laws and regulations, to satisfy standards of certain recognized accrediting agencies, or to otherwise improve the Member Appeals process.

NOTES

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Customer Service Information

We all have questions about our health care coverage from time to time. To help you get accurate answers to questions and up-to-date information about your health plan, we have included this section.

Call the department or person who handles benefits for your organization first, whenever you have questions about your coverage program. If you still have questions, call Blue Cross or Blue Shield. The Customer Service Representatives have all the current information about your health care coverage at their fingertips.

When you call, give the representative your identification number (printed on your Blue Cross and Blue Shield ***identification card***), so he or she can access information about your coverage.