

HEALTH BENEFITS PROGRAM

OXFORD AREA SCHOOL DISTRICT
NON-TEACHERS



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

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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 your 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 "Definition 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 Hospital* (including any *Approved Hospital* outside the Independence Blue Cross Plan Area). 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
And
Any Approved Hospital Outside the Independence Blue Cross Plan Area**

Inpatient Services

Deductible	none
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	covered
Obstetrical/Maternity	covered
Elective Abortion	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)	none
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 72 hours of accident)	covered
Follow-up care for emergency accident	covered
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

GENERAL INFORMATION

Dependents Eligible for Enrollment

Your spouse and all unmarried children under 19 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. Unmarried *dependent* children in full-time attendance at an accredited secondary school, college or university, may be included up to age 23.

Upon application to and acceptance by the Blue Cross Plan, 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.

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 19 or if a full-time student as of the first of the month following the date the student reaches age 23.

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* (including any *Approved Hospital* outside the Independence Blue Cross Plan Area) 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.

BlueCard Program

When you obtain health care services through the BlueCard Program outside the geographic area Independence Blue Cross serves the amount you pay for *covered services* is usually calculated on the lower of:

- The actual billed charges for your *covered services*, or
- The negotiated price that the on-site Blue Cross Plan passes on to us.

Often, this "negotiated price" will consist of a simple discount. But sometimes it is an estimated final price that factors in expected settlements or other non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be a discount from billed charges that reflects average expected savings. The estimated or average price may be adjusted in the future to correct for over- or underestimation of past prices.

In addition, laws or rules in a small number of states require Blue Cross Plan to use a basis for calculating your payment for *covered services* that does not reflect the entire savings realized or expected to be realized on a particular claim. When you receive covered health care services in those states, your required payment for these services will be calculated using their required methods.

Release of Information

Any person or entity having information relating to an illness or injury for which benefits are claimed under your coverage by you or your enrolled *dependent* may furnish to Blue Cross, upon its request, any information (including copies of records relating to the illness or injury).

In addition, Blue Cross may furnish similar information to other entities providing similar benefits at your request.

Blue Cross shall provide to your employer at the employer's request certain information regarding claims and charges submitted to Blue Cross. This information will be adjusted to prevent the disclosure of the identity of *subscribers* who are treated by providers.

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 Plan

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 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 may pay their benefits first and determine liability later. If it is determined that this program is the secondary plan, Blue Cross 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 may limit payment so that Blue Cross 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 have the right to reimburse the other plan, the amount which Blue Cross determines is its liability.

Blue Cross 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.

Subrogation

If any benefit is provided to the *subscriber* under this Agreement, Blue Cross 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 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. 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 Blue Cross 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.

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 continuee 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 continuee.

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 continuee.

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 continuee 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 Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the day before the qualified continuee’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 continuee and any other affected qualified continuees 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 continuee’s disability before the earlier of:

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

If, during the 11 month continuation period, the qualified continuee is determined to be no longer disabled under the United States Social Security Act, the qualified continuee 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 continuee 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 continuee 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 continuee 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 continuees 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 continuee. 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 continuee 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 Continuee’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 continuee must notify the Plan Administrator, in writing, of any final determination that the qualified continuee 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 continuee, 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 continuee 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 continuee 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 continuee'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 continuee's timely premium payment to the Plan on time, thereby causing the qualified continuee's group health benefit to end; or
- b. the Plan Administrator fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee 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 continuee receives notice of his or her continuation rights from the Plan Administrator as described above or 60 days of the date the qualified continuee's group health benefits end, if later. Furthermore, the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Plan Administrator by the qualified continuee, 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 continuee 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 continuees 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 continuee 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 continuee's premium payment is timely if, with respect to the first payment after the qualified continuee 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 continuee'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 continuee and his or her family members who are qualified continuees 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 continuee 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 continuee 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.

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 *pre-certification* 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 *pre-certification* with Independence Blue Cross. If *pre-certification* 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 *pre-certification* 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, 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:

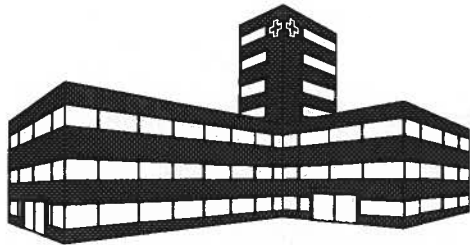
For Blue Cross Claims

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.

COMPREHENSIVE BLUE CROSS HOSPITAL PLANS

Hospital Benefits



Subscribers are eligible for benefits provided in *Member Hospitals* (including any *Approved Hospital* outside the Independence Blue Cross Plan Area) 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. 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* including any *Approved Hospital* outside the Independence Blue Cross Plan Area. Admission to a *Member Hospital* allows you a higher level of benefits than if you are admitted to a *non-member hospital* in the Independence Blue Cross Plan Area.

Benefits will be provided for *inpatient hospital* services furnished by a contracting *hospital* of any other Blue Cross Plan in accordance with the *hospital's* agreement with the other Blue Cross Plan for the number of *inpatient* days then available as shown under the “Inpatient Days” section of “Your Benefits at a Glance”.

All benefits and *covered services* as described above are covered in *Non-Member Hospitals* within the Independence Blue Cross service area. 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.

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*.

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*, copayment 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 pre-certify 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 provisions set forth under the subsection entitled "BlueCard Program" in the General Information section of this booklet 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* within the Independence Blue Cross service area, 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 their agreements with the other Blue Cross Plan, and shall ordinarily be payable to the *contracting hospital* or the *contracting non-hospital facility*.

When provided by a *non-member hospital* within the Independence Blue Cross Plan Area, 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* within the Independence Blue Cross Plan Area, 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 *non-hospital 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* in the Independence Blue Cross service area, and any *approved hospital* outside the Independence Blue Cross service area, eligible benefits shall be payable to the facility.

When received from a *non-member hospital* within the Independence Blue Cross service area, 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*, an allowance equal to 75% of the lesser of the: (a) Non-Member Hospital's charges, (b) Medicare Allowable Payment, and (c) Reasonable and Customary amount.

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* or any *approved hospital* outside the Independence Blue Cross Plan Area. When any of these types of care are received in *non-member hospitals* within the Independence Blue Cross Plan Area, the benefit allowance will be limited to 75% of the lesser of the: (a) Non-Member Hospital's charges, (b) Medicare Allowable Payment, and Customary amount.

Emergency Treatment; Minor Surgery; Radiation Therapy

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

- *Emergency care* received within 72 hours of an *accidental injury* or of the onset of a severe and sudden *medical emergency*
- *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 appropriate*.

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 will be provided, subject to a Co-payment 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.**

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;
- *Custodial care*, care in a convalescent home, domiciliary care or rest cures;
- Services not ordered by the attending physician or not *Medically Appropriate* 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 selfinsured 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*;
- 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 checkups;
- 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/Medically Appropriate* as determined by Independence Blue Cross.

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, 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.

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.

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 advice 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
- FreeStanding Dialysis Facility
- FreeStanding Ambulatory Care Facility
- Ambulatory Surgical Facility
- Home Health Care Agency
- Hospice
- Nonhospital Facility
- Hospital
- Psychiatric Hospital
- Rehabilitation Hospital
- Residential Treatment Facility
- Short Procedure Unit
- Skilled Nursing Facility

FREESTANDING 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.

FREESTANDING 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 24hour 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, motherinlaw, fatherinlaw, sisterinlaw, brotherinlaw, daughterinlaw, soninlaw.

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 twentyfour hours a day in a *hospital* or *nonhospital 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, branchedchain ketonuria, galactosemia, homocystinuria.

MEDICALLY APPROPRIATE (OR MEDICAL APPROPRIATENESS) – services or supplies provided by a *Facility Provider* that the Plan determines are:

- (A) Ordered by a *professional provider* or other appropriately licensed health care professional;
- (B) Required for the diagnosis, or the direct care and treatment of the *subscriber's* condition, illness, disease or injury;
- (C) Appropriate for the symptoms and diagnosis or treatment of the *subscriber's* condition, illness, disease or injury;

- (D) In accordance with standards of good medical practice as generally recognized and accepted by the medical community;
- (E) Not primarily for the convenience of the *subscriber's* family, or of the *facility provider* or *professional provider*;
- (F) The most efficient and economical supply or level of service that can safely be provided to the *subscriber*. When applied to hospitalization, this further means that the *subscriber* requires acute care as a bed patient due to the nature of the services rendered or the *subscriber's* condition, and the *subscriber* cannot receive safe and adequate care in some other setting without adversely affecting the *subscriber's* condition or quality of medical care.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY) – services or supplies provided by a *professional provider* that the Plan determines are:

- A. Appropriate for the symptoms and diagnosis or treatment of the *subscriber's* condition, illness, disease or injury;
- B. Provided for the diagnosis, or the direct care and treatment of the *subscriber's* condition, illness, disease or injury;
- C. In accordance with current standards of good medical practice;
- D. Not primarily for the convenience of the *subscriber*, or the *subscriber's professional provider*; and
- E. The most appropriate supply or level of service that can safely be provided to the *subscriber*. When applied to hospitalization, this further means that the *subscriber* requires acute care as a bed patient due to the nature of the services rendered or the *subscriber's* condition, and the *subscriber* cannot receive safe or adequate care as an *outpatient*.

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, co-payment 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.

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.

PRE-CERTIFICATION – a preadmission review program which contains two components: Presurgical certification and preadmission certification.

- A. Pre-surgical certification a process whereby the medical necessity and appropriate place of service is reviewed prior to the performance of such surgical procedures;
- B. Pre-admission 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 accordance with applicable laws and regulations for medication issued by a *professional provider*.

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 SERVICE – the following services or supplies prescribed by a *physician* and used for the treatment of an illness or injury to promote the recovery of the *subscriber*.

- 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 or 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 Therapy** - The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neurophysiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.
- 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.

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 or Medical Appropriateness 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 and Medical Appropriateness, 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.

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

NOTES

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. 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 *identification card*), so he or she can access information about your coverage.

03-3928-76847