COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
Office of Rate and Policy Regulation
1311 Strawberry Square
Harrisburg, PA 17120
Fax (717) 787-8555 Telephone (717) 787-0684

October 26, 1999

Fiona E. Wilmarth
Regulatory Analyst
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

ORIGINAL: 2046
BUSH
COPIES: Harris
Jewett
Markham
Smith
Wilmarth
Sandusky
Wyatte

Re: Act 68 Compliance – Managed Care Plan Documents

Dear Ms. Wilmarth:

At our meeting on October 14 regarding Act 68, you requested copies of several Act 68 compliance filings submitted to the Department for review by managed care plans. Attached is information from Act 68 compliance filings submitted by Aetna US Healthcare and Keystone Health Plan East.

Enclosed please find the following plan documents: filing correspondences, certificates of coverage, subscriber agreements, and riders to certificates of coverage or handbooks.

Due to the considerable size of Act 68 filings, we did not enclose in this packet copies of all related plan documents. However, we trust that the selected documents will effectively illustrate the scope of the Department's review process.

If you would like any additional information or have any questions on these filings, we can make arrangements for you to meet with a Policy Examiner from the Department. Please contact me at (717) 787-4192 if I can be of further assistance in this matter.

Sincerely,

Geoffrey Dunaway
Director, Accident and Health Bureau

ORIGINAL: 2046
BUSH
COPIES: Harris
Jewett
Markha
Smith
Wilmarth
Sandusky
Wyatte

RIDER

TO

EVIDENCE

OF

COVERAGE

KEYSTONE HEALTH PLAN EAST
ACT 68

KEYSTONE HEALTH PLAN EAST, INC.
(hereafter called "Keystone")

EVIDENCE OF COVERAGE RIDER

[Group Name:]
[Group Number:]
Effective Date of Rider: January 1, 1999

The Commonwealth of Pennsylvania enacted the Quality Health Care Accountability and Protection Act to be effective January 1, 1999. The Act applies to managed care plans that utilize a gatekeeper to coordinate and direct care. The Act applies to Keystone, a health maintenance organization ("HMO"). The Act expands current HMO laws and regulations in Pennsylvania in several areas. This includes, but is not limited to: (a) defining and covering Emergency Services; (b) provider access; (c) uniform complaint and grievance processes; and (d) disclosure of plan information. Your Evidence of Coverage (hereafter "Member Handbook") addresses many of the mandated items. This Rider changes your Member Handbook to include those mandated disclosure items not already in it.

As a result, your Evidence of Coverage is changed as follows:

1. The first item of the Table of Contents is "**Required Disclosure of Information**". This new section is added immediately following the Table of Contents:

   REQUIRED DISCLOSURE OF INFORMATION

   Due to changes in state law, Keystone must make the following information available to you when you make a request in writing to Keystone.

   A. A list of the names, business addresses and official positions of the membership of the Board of Directors or Officers of Keystone Health Plan East, Inc.

   B. The procedures adopted to protect the confidentiality of medical records and other enrollee information.

   C. A description of the credentialing process for health care providers.

   D. A list of the participating health care providers affiliated with participating hospitals.

KE-EOCR-(9868)F Approved, Effective 7/28/99

Pennsylvania Insurance Department

By _____

E. Whether a specifically identified drug is included or excluded from coverage.

F. A description of the process by which a health care provider can prescribe any of the following when either (1) the formulary's equivalent has been ineffective in the treatment of the enrollee's disease; or (2) the drug causes or is reasonably expected to cause adverse or harmful reactions to the enrollee.

(1) specific drugs;

(2) drugs used for an off-label purpose;

(3) biologicals and medications not included in the drug formulary for prescription drugs or biologicals.

G. A description of the procedures followed by Keystone to make decisions about the experimental nature of individual drugs, medical devices or treatments.

H. A summary of the methodologies used by Keystone to reimburse for health care services. (This does not mean that Keystone is required to disclose individual contracts or the specific details of financial arrangements we have with health care providers)

I. A description of the procedures used in Keystone's quality assurance program.

J. Other information that the Pennsylvania Department of Health or the Insurance Department may require.

2. The Table of Contents is also modified by the following:

A. The following statement is added at the bottom of the first page of the Table of Contents.

This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions about the plan, please call Member Services at (215) 241-CARE or if you're outside the local Philadelphia area, 1-800-227-3114.

B. Under "**Using the Keystone System – Summary of Things to Remember**" a new section is added, "**Changing Your Referred Specialist**".

C. Under "**Access to Specialist And Hospital Care**" the following sections are added: "**How to Obtain a Standing Referral**", "**Designating a Referred Specialist as Your Primary Care Physician**" and "**Continuity of Care**".

D. The subsections "**General Rights**" under "**Your Membership Rights**" and

"**General Responsibilities**" under "**Your Membership Responsibilities**" are replaced by "**Member Rights**" and "**Member Responsibilities**", respectively.

E. The subsection "**Grievance Procedure**" is renamed "**Member Complaint and Grievance Process**".

3. The section "**USING THE KEYSTONE SYSTEM**" is modified as follows:

A. The sentence appearing below is added to the first paragraph of the "**USING THE KEYSTONE SYSTEM**":

(Under certain circumstances, continuing care by a non-Participating Provider will be treated in the same way as if the provider were a Participating Provider. See "Continuity of Care" appearing later in the Handbook.)

B. The paragraph that begins "**When you need care**" is replaced by the following:

When you need Specialist Services, you must be Referred by your Primary Care Physician who will give you a written Referral for specific care. A Standing Referral may be available to you if you have a life-threatening, degenerative or disabling disease or condition. Female Members may visit any participating obstetrical/gynecological Specialist without a Referral. This is true whether the visit is for preventive care, routine obstetrical/gynecological care or problem-related obstetrical/gynecological conditions except in the case of treatment for reproductive endocrinology, infertility or gynecological oncology.

C. The paragraph that begins "**Some services must be authorized..**" is replaced by the following:

Some services must be authorized by your Primary Care Physician and Preapproved by Keystone. Your Primary Care Physician works with Keystone's Patient Care Management team during the Preapproval process. Services in this category include, but are not limited to: hospitalization; certain outpatient services; Skilled Nursing Facility services; and home health care. Services that require Preapproval are noted in the Benefit Summary section.

D. The paragraph that begins "**All services must be received...**" is replaced by the following:

All services must be received from Keystone Participating Providers unless Preapproved by Keystone, or except in cases requiring Emergency Services.

Use your Provider Directory to find out more about the individual providers including Hospitals and Primary Care Physicians and Referred Specialists and their affiliated Hospitals. It includes a foreign language index to help you locate a provider who is fluent in a particular language. The directory also lists whether the provider is accepting new patients.

4. The "**ACCESS TO SPECIALIST AND HOSPITAL CARE**" section is modified by the addition of the following subsections:

A. **How to Obtain a Standing Referral**

If you have a life-threatening, degenerative or disabling disease or condition, you may receive a Standing Referral to a Referred Specialist to treat that disease or condition. The Referred Specialist will have clinical expertise in treating the disease or condition. A Standing Referral is granted upon review of a treatment plan by Keystone and in consultation with your Primary Care Physician.

Follow these steps to initiate your Standing Referral request.

(1) Call Member Services at the telephone number shown on the back of your ID Card. (Or, you may ask your Primary Care Physician to call Provider Services or Patient Care Management ("PCM") to request a Standing Referral.)

(2) A "Standing Referral Request Form" will be mailed or faxed to the requestor.

(3) You must complete a part of the form and your Primary Care Physician will complete the clinical part. Your Primary Care Physician will then send the form to PCM.

(4) PCM will either approve or deny the request for the Standing Referral. You, your Primary Care Physician and the Referred Specialist will receive notice of the approval or denial in writing. The notice will include the time period for the Standing Referral.

If the Standing Referral is Approved

If the request for the Standing Referral to a Referred Specialist is approved, the Referred Specialist and your Primary Care Physician will be informed in writing by PCM. The Referred Specialist must agree to abide by all the terms and conditions that Keystone has established with regard to Standing Referrals. This includes but is not limited to the need for the Referred Specialist to keep your Primary Care Physician informed of your condition. When the Standing Referral expires, you or your Primary Care Physician will need to contact PCM and follow the steps outlined above to see if another Standing Referral will be approved.

If the Standing Referral is Denied

If the request for a Standing Referral is denied, you and your Primary Care Physician will be informed in writing. You will be given information on how to file a formal Complaint.

B. **Designating a Referred Specialist as Your Primary Care Physician**

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

Follow these steps to initiate your request for your Referred Specialist to be your Primary Care Physician.

(1) Call Member Services at the telephone number shown on the back of your ID Card. (Or, you may ask your Primary Care Physician to call Provider Services or Patient Care Management ("PCM") to initiate the request.)

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

(3) You must complete a part of the form and your Primary Care Physician will complete the clinical part. Your Primary Care Physician will then send the form to PCM.

(4) The Medical Director will speak directly with the Primary Care Physician and the selected Referred Specialist to apprise all parties of the primary

services that the Referred Specialist must be able to provide in order to be designated as a Member's Primary Care Physician. If PCM approves the request, it will be sent to the Provider Service area. That area will confirm that the Referred Specialist meets the same credentialing standards that apply to Primary Care Physicians. (At the same time, you will be given a Standing Referral to see the Referred Specialist.)

If the Referred Specialist as Primary Care Physician Request is Approved

If the request for the Referred Specialist to be your Primary Care Physician is approved, the Referred Specialist, your Primary Care Physician and you will be informed in writing by PCM.

If the Referred Specialist as Primary Care Physician Request is Denied

If the request to have a Referred Specialist designated to provide and coordinate your primary and specialty care is denied, you and your Primary Care Physician will be informed in writing. You will be given information to file a formal Grievance.

C. **Continuity of Care**

You have the option, if your Physician agrees to be bound by certain terms and conditions as required by Keystone, of continuing an ongoing course of treatment for a period of up to sixty (60) days with that Physician when:

(1) your Physician is no longer a Participating Provider because Keystone terminates its contract with that Physician, for other than cause; or

(2) you first enroll in the group plan and are in an ongoing course of treatment with a non-Participating Provider.

If you are in your second or third trimester of pregnancy, at the time of your enrollment or termination of a Participating Provider's contract, the continuity of care with that Physician will extend through post-partum care related to the delivery.

Follow these steps to initiate your continuity of care:

- Call the Member Services at the number on the back of your ID Card. Ask for a "Request for Continuation of Treatment" form.

- The form will be mailed or faxed to you.

- You must complete the form and send it to the Patient Care Management Department at the address that appears on the form.

If your Physician agrees to continue to provide your ongoing care, the Physician must also agree and be bound by the same terms and conditions as apply to Participating Providers.

You will be notified when the participating status of your Primary Care Physician changes so that you can select another Primary Care Physician.

5. The "**WHEN YOU NEED IMMEDIATE CARE**" section is replaced with the exception of "**Access to Urgent Care Benefits For Student Dependents Not Residing At Home**" and "**Auto Or Work-Related Accidents**" as follows:

What are Emergency Services?

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

A. placing the health of the Member or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

B. serious impairment to bodily functions: or

C. serious dysfunction of any bodily organ or part. Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an Emergency Service.

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

What is Urgent Care?

"Urgent Care" is Medically Necessary Covered Services provided in order to treat an unexpected illness or accidental injury that does not require Emergency Services. Urgent Care Covered Services are required in order to prevent a serious deterioration in the Member's health if treatment were delayed.

Inside The Service Area

Urgent Care

If you are within the Service Area and you need Urgent Care, call your Primary Care Physician first. If your Primary Care Physician is not in the office, leave a message requesting a return call. Your Primary Care Physician provides coverage 24 hours a day, 7 days a week for Urgent Care. Your Primary Care Physician, or the Physician covering for your Primary Care Physician, will arrange for appropriate treatment. Urgent Care services will be covered only when provided or Referred by your Primary Care Physician.

Emergency Services

When Emergency Services are necessary, go immediately to the nearest health care provider. Notify your Primary Care Physician within 48 hours or as soon as possible.

Examples of conditions requiring Emergency Services are:

- excessive bleeding
- broken bones
- sudden onset of acute abdominal pains
- sudden onset of severe chest pain
- serious burns
- poisoning
- unconsciousness
- convulsions
- choking.

Coverage of reasonably necessary costs associated with Emergency Services provided during the period of the Emergency are covered by the plan.

Outside The Service Area

Urgent Care

Your out-of-area Urgent Care coverage will be coordinated through **HMO Blue USA**[sm], a national network of HMOs sponsored by the Blue Cross and Blue Shield Association. A call to **1-800-4-HMO-USA** will connect you with a participating Blue Cross/Blue Shield HMO in the area. If this service is not available in the area you are visiting, seek care from a local Physician. You must notify your Primary Care Physician and Keystone within 48 hours, or as soon as possible after receiving Urgent Care outside the Service Area. You will not be covered for care that could have been provided before you left the Service Area or postponed until after you have returned.

Emergency Services

For Emergency Services out of the Service Area, go immediately to the nearest health care provider. Emergency Services do not require a Referral for treatment from the Primary Care Physician. You must notify your Primary Care Physician and Keystone within 48 hours, or as soon as possible after receiving Emergency Services outside the Service Area.

Emergency Services do include care that could have been provided before you left the Service Area, or that could have been postponed until after you have returned to the Service Area.

Payment for Immediate Care Services

If you have out-of-area Urgent Care or Emergency Services provided by a non-Participating Provider, ask the Provider to submit the bill to Keystone. Show the Provider your ID Card for the necessary information. If direct billing cannot be arranged, send us a letter explaining the reason care was needed and an original itemized bill to the address shown on the back of your ID Card.

Charges for Covered Services coordinated through **HMO Blue USA** are automatically forwarded to Keystone.

Note: **It is your responsibility to forward to Keystone any bill you receive for Emergency Services or out-of-area Urgent Care provided by a non-Participating Provider.**

Follow-up Care

After receiving Emergency Services, ask the health care provider to notify Keystone of the situation and the condition of the Member. If the Member's condition has stabilized and the Member can be moved, Keystone may arrange to relocate the Member to a Participating Provider facility to receive continuing care and treatment.

Call your Primary Care Physician if you need more care after getting Urgent Care.

All follow-up care must be provided or Referred by your Primary Care Physician or coordinated through Member Services.

6. The subsection "**General Rights**" of "**YOUR MEMBERSHIP RIGHTS**" is replaced by the following "**Member Rights**" subsection.

MEMBER RIGHTS

Keystone and the Participating Providers honor the following rights of all Members:

- The Member has the right to information about the health plan, its benefits, policies, participating practitioners, and Members' rights and responsibilities.
- The Member has a right to voice Complaints and appeals about the health plan or care provided, and to receive a timely response.
- The Member has the right to choose practitioners, within the limits of the plan network, including the right to refuse care from specific practitioners.
- The Member has the right to participate in decision making regarding his/her health care. This right includes unrestrained clinical dialogue between participating practitioners and Members.
- The Member has the right to be treated with respect, dignity, and privacy.
- The Member has the right to confidential treatment of medical information. The Member also has the right to have access to his/her medical record in accordance with applicable Federal and State laws.
- The Member has the right to reasonable access to medical services.
- The Member has the right to receive health care services without discrimination based on race, color, religion, gender, sexual orientation, or national origin.

- The Member has the right to formulate advance directives. Keystone will provide information concerning advance directives to Members and practitioners and will support Members through its medical record keeping policies.

7. The "**Grievance Procedure**" subsection of "**YOUR MEMBERSHIP RIGHTS**" is replaced in its entirety by the following.

MEMBER COMPLAINT AND GRIEVANCE PROCESS

Informal Member Complaint Process

Keystone will make every attempt to answer any questions or resolve any concerns you have related to benefits or services. If you have a concern, you should call Member Services at the toll-free telephone number listed on the back of your ID card, or write to the Manager of Member Services, Keystone Health Plan East, P.O. Box 8339, Philadelphia, PA 19101-8339. Most Member concerns are resolved informally at this stage. If Keystone cannot immediately resolve your concern, we will investigate it and respond to you **within thirty (30) days**. If you are not satisfied with the response to your concern from Keystone, you have the right to file a formal Complaint **within sixty (60) days**, through the Formal Member Complaint Process described below.

Formal Member Complaint Process

Keystone Members may file a formal Complaint regarding an unresolved dispute or objection regarding coverage, including contract exclusions and non-covered benefits, participating or non-participating health care provider status, or the operations or management policies of Keystone. The Complaint process consists of two (2) internal levels of review by Keystone, and one external level of review by the Pennsylvania Department of Health or the Pennsylvania Insurance Department. Remember, no legal action can be taken until all of the Complaint procedures have been followed.

Internal First Level Complaint:

You may file a formal first level Complaint **within sixty (60) days** from either your receipt of the original notice from Keystone, or from completion of the informal complaint process described above. To file a first level Complaint, call Member Services toll free at the telephone number listed on the back of your ID card, or write to Member Services, PO Box 8339, Philadelphia, PA, 19101-8339.

Keystone's review of your first level Complaint will be completed **within thirty (30) days** from the date of receipt of that Complaint by Keystone. We will then send you our decision in writing **no later than five (5) business days** after reaching a decision. If you are not satisfied with the decision on your first level Complaint, you may file a second level Complaint with Keystone, **within sixty (60) days** from receipt of the first level Complaint decision letter.

Internal Second Level Complaint:

To file a second level Complaint, call or write the Member Appeals Unit at P.O. Box 41820, Philadelphia, PA 19101-1820, 1-888-671-5276 or fax 1-888-671-5274 **within sixty (60) days** from your receipt of the first level Complaint decision letter from Keystone.

We will contact you to arrange the Second Level Complaint Committee meeting. That Committee will meet and render a decision **within forty-five (45) days** from the date of Keystone's receipt of your second level Complaint. The Second Level Complaint Committee is composed of at least three (3) members who have had no previous involvement with the case. The Second Level Committee members will include Keystone staff, with one third of the Committee being enrollees or other persons who are not employed by Keystone. You have the right to present your second level Complaint to the Committee in person, through a representative, or via conference call.

The Second Level Complaint Committee meetings are a forum where Members are allowed to present their issues in an informal setting that is not open to the public. The Member may be accompanied by two other persons unless the Member receives prior approval from Keystone for additional assistance due to special circumstances. Members of the press may only attend in their personal capacity as a Member's representative. Members may not transcribe, audio- or video-tape the proceedings.

Keystone will send you a written notice of the decision **within five (5) business days** of the decision by the Second Level Complaint Committee. The decision is final unless you choose to appeal to the Pennsylvania Insurance Department or Department of Health **within fifteen (15) days** after your receipt of the second level Complaint decision notice from Keystone.

External Complaint Review:

If you wish to appeal the second level Complaint decision, you may contact the Pennsylvania Insurance Department or Department of Health, as appropriate, **within fifteen (15) days** after your receipt of the second level Complaint decision notice from Keystone, as follows:

Pennsylvania Insurance Department
Bureau of Consumer Services
1321 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388

Bureau of Managed Care
Department of Health
Attn: Complaint Appeals
P.O. Box 90
Harrisburg, PA 17108-0080
1-888-466-2787

Your external Complaint appeal should include your name, address, daytime telephone number, the name of Keystone as your managed care plan, your Keystone ID number, and a brief description of the issue being appealed. Also include a copy of your original Complaint to Keystone and copies of any correspondence and decision letters from Keystone.

Please note that these procedures may change due to changes in the applicable state and federal laws and regulations.

Member Grievance Process For Decisions Based On Medical Necessity:

Keystone Members may file a Grievance of a decision by Keystone regarding a determination of Coverage that was based primarily on Medical Necessity or appropriateness. The Grievance process consists of two (2) internal Grievance reviews by Keystone and an external review through an external utilization review agency assigned by the Pennsylvania Department of Health. Remember, no legal action can be taken until all of the Grievance procedures have been followed.

Internal First Level Grievance:

The first level Grievance must be filed with Keystone by you, or your provider acting on your behalf, with your written consent, within **sixty (60) days** of receipt of the original response by Keystone. When filing the first level Grievance, you (or your provider) must include all necessary supporting information. The first level Grievance may be filed by calling as directed in the original notice from Keystone, by calling Member Services toll-free at the telephone number listed on the back of your ID Card, or by writing to the Patient Care Management Department, P.O. Box 42952, Philadelphia, PA 19101.

The Grievance will be forwarded to the First Level Grievance Committee. The first level Grievance will be reviewed by one or more persons selected by Keystone who did not previously participate in the decision to deny payment for a health care

service and shall include a licensed physician, or, where appropriate, a licensed psychologist, in the same or similar specialty that typically manages or consults on the health care service. The First Level Grievance Committee will complete its review **within thirty (30) days** from the date of receipt of your first level Grievance request by Keystone. We will then send you and your provider a written notice of the decision **within five (5) business days** of the decision. The notice will specify the reason(s) and clinical rationale for the decision and the procedure for appeal. If at that time you, or the provider on your behalf and with your written consent, wishes to appeal the decision of the First Level Grievance Committee, you may appeal to the Second Level Grievance Committee **within sixty (60) days** of receipt of the notice of denial.

Expedited Grievance:

If your case involves a serious medical condition which you believe would jeopardize your life, health or ability to regain maximum function while awaiting a standard Internal First Level Grievance Committee review, you, or your provider acting on your behalf and with your written consent, can ask to have your case reviewed by Keystone in a quicker manner (expedited Grievance). You may request an expedited Grievance by calling Member Services at the toll-free telephone number listed on the back of the Member's ID card. Keystone will arrange to have the Grievance reviewed by a Keystone Medical Director who was not previously involved with the case.

This review will be completed promptly, based on your health condition, but in **no more than forty-eight (48) hours** after receipt of your Grievance request by Keystone. If you are not satisfied with the expedited decision from Keystone, you or your provider, acting on your behalf and with your written consent, may file an internal second level Grievance to the Second Level Grievance Committee, as described below.

Internal Second Level Grievance:

You, or your provider acting on your behalf and with your written consent, may file a second level Grievance by writing or calling the Member Appeal Unit at P.O. Box 41820, Philadelphia, PA 19101-1820, 1-888-671-5276 or fax 1-888-671-5274 **within sixty (60) days** after your receipt of the first level Grievance decision letter from Keystone.

The Second Level Grievance Committee, will meet and render a decision promptly, based on your health condition, but **no later than forty-five (45) days** after receipt of your Grievance request by Keystone. The second level Grievance will be reviewed by three or more persons selected by Keystone–did not previously participate in the decision to deny payment for a health care service–and shall include a licensed physician, or, where appropriate, a licensed psychologist, in the

same or similar specialty that typically manages or consults on the health care or service involved. If you are appealing to the Second Level Grievance Committee, you may designate a representative to participate on your behalf. You have the right to present your second level Grievance in person, through a representative, or via conference call.

The Second Level Grievance Committee meetings are a forum where Members are allowed to present their issues in an informal setting that is not open to the public. The Member may be accompanied by a maximum of two other persons unless the Member receives prior approval from Keystone for additional assistance due to special circumstances. Members of the press may only attend in their personal capacity as a Member's representative. Members may not transcribe, audio- or video-tape the proceedings.

Keystone will send you and your provider a written notice of the decision **within five (5) business days** after the decision by the Second Level Grievance Committee. The decision is final unless you, or your provider with your written consent, choose to file an external Grievance **within fifteen (15) days** of receipt of the second level Grievance decision by Keystone.

External Grievance:

To request an external Grievance by an independent utilization review agency assigned by the Pennsylvania Department of Health, write to the Patient Care Management Department, P.O. Box 42952, Philadelphia, PA 19101 **within fifteen (15) days** of receipt of the second level Grievance decision letter from Keystone. If your health care provider files the Grievance on your behalf, Keystone will verify with you that the provider is acting in your behalf, with your consent. You will not be required to pay any of the costs associated with the external Grievance review, however, there is a $25 filing fee, payable to Keystone that should be forwarded to Patient Care Management at the above address.

Keystone will contact the Pennsylvania Department of Health to request assignment of a certified utilization review agency to your Grievance, and will notify you of the name, address and telephone number of the external agency assigned by the Department of Health to your Grievance **within two (2) business days** of the assignment by the Department. You, your provider, if acting on your behalf, and Keystone **have two (2) business days** to notify the Department of Health, if there is an objection to the assignment of the external review agency on the basis of conflict of interest.

The external review agency will send you, your provider, if acting on your behalf, and Keystone a written decision **within sixty (60) days** of the date you or your provider filed the request for an external review. Upon receiving the decision from the external review agency, Keystone will authorize payment for services or pay

claims if the decision of the external review agency is that the services were Medically Necessary. The external Grievance decision may be appealed to a court of competent jurisdiction **within sixty (60) days** of the decision by the external agency.

Please note that these procedures may change due to changes in the applicable state and federal laws and regulations.

8. The "**Termination of Coverage**" is replaced by the following:

Termination of Coverage

Keystone may cancel your coverage under the following conditions:

A. If you are guilty of fraud or material misrepresentation of fact in applying for or obtaining coverage from Keystone (subject to your rights under the Member Complaint and Grievance Process);

B. If you misuse your ID Card, or allow someone other than your eligible Dependents to use an ID Card to receive care or benefits. (Misuse of the ID card by the Subscriber will result in termination of coverage for the Subscriber's eligible Dependents, too.);

C. If you cease to meet the eligibility requirements;

D. Your group terminates coverage with Keystone;

E. If you display a pattern of non-compliance with your Physician's Plan of Treatment. (You will receive written notice at least thirty (30) days prior to termination. You have the right to utilize the Member Complaint and Grievance Process.);

F. If you do not cooperate with Keystone in obtaining information necessary to determine Keystone's liability under this program.

NOTE: Keystone will **not** terminate your coverage because of your health status, your need for Medically Necessary Covered Services or your having exercised rights under the Complaint and Grievance Process.

When a Subscriber's coverage terminates for any reason, coverage of the Subscriber's covered family members will also terminate.

9. The section, "**Changing Your Referred Specialist**" is added immediately following "**Changing Your Primary Care Physician**".

Changing Your Referred Specialist

You may change the Referred Specialist to whom you have been Referred by your Primary Care Physician or for whom you have a Standing Referral. To do so, ask your Primary Care Physician to recommend another Referred Specialist before services are performed. Or, you may call Member Services at the telephone number shown on the back of your ID Card. Remember, only services authorized on the Referral form will be covered.

10. The subsection "**General Responsibilities**" of "**YOUR MEMBERSHIP RESPONSIBILITIES**" is replaced by the following subsection "**Member Responsibilities**".

MEMBER RESPONSIBILITIES

In support of a person's rights as a Member and to help the Member participate fully in the health plan, Keystone Members have certain responsibilities:

- Members have the responsibility to review all benefit and membership materials carefully and to follow the regulations pertaining to the health plan.
- Members have the responsibility to communicate, to the extent possible, information participating practitioners need in order to care for the Member.
- Members have the responsibility to follow instructions and guidelines given by participating practitioners. This responsibility includes consideration of the possible consequences of failure to comply with recommended treatment.
- Members have the responsibility to ask questions to assure understanding of the explanations and instructions given.
- Members have the responsibility to treat others with the same respect and courtesy expected for oneself.
- Members have the responsibility to keep scheduled appointments or to give adequate notice of delay or cancellation.

11. The following items in the Summary of Benefits are modified as indicated:

A. Under "**1. PRIMARY AND PREVENTIVE CARE**" the fourth statement is replaced by "Gynecological exams and Pap smears".

B. The reference to "(Preapproval)" is deleted from "**Anesthesia**" and "**Radiation Therapy**".

C. The reference to "(Preapproval)" is limited to Speech therapy under the item "**Rehabilitation Therapy Services**".

D. The "**Gynecological Care**" section is replaced by the following:

Gynecological Care

Benefits are provided for female Members for Covered Services provided by any Keystone participating obstetrical/gynecological Specialist without a Referral. Covered Services include:

(1) routine maternity care;

(2) routine gynecological care including Papanicolaou (PAP) smears; and

(3) other gynecological care.

A Referral is required for specialty care provided by a reproductive endocrinologist, infertility specialist, or gynecologic oncologist.

E. The "**Mammograms**" section is replaced by the following"

Mammograms

One routine mammogram per calendar year is covered for women age forty (40) or over and is available with a Referral. This Referral may be provided by your Primary Care Physician or obstetrical/gynecological Specialist or Keystone. Other mammograms will be covered only when recommended by your Primary Care Physician or a Referred Specialist. Approval by your Primary Care Physician is not required for a Referral received from the Member's obstetrical/gynecological Specialist or Keystone.

F. (Preapproval) is added to the item "Prosthetics".

12. The following definitions are added to the "**IMPORTANT DEFINITIONS**" section.

- **COMPLAINT** - an unresolved dispute or objection regarding coverage, including exclusions and noncovered benefits under the plan, participating or non-participating health care provider status, or the operations or management policies of Keystone. This definition does not include a Grievance (Medical Necessity appeal). It also does not include disputes or objections that were resolved by Keystone and did not result in the filing of a

Complaint (written or oral).

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

  (1) placing the health of the Member or with respect to a pregnant Member, the health of the pregnant Member or her unborn child, in serious jeopardy'

  (2) serious impairment to bodily functions; or

  (3) serious dysfunction of any bodily organ or part. Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an Emergency Service.

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

- **GRIEVANCE** - a request by a Member or a health care provider, with the written consent of the Member, to have Keystone reconsider a decision that was based primarily on Medical Necessity or appropriateness of a health care service. This definition does not include a Complaint. It also does not include disputes or objections regarding Medical Necessity that were resolved by Keystone and did not result in the filing of a Grievance (written or oral).

- **STANDING REFERRAL OR STANDING REFERRED CARE** - written documentation from Keystone that authorizes Covered Services for a life-threatening, degenerative or disabling disease or condition. The Covered Services will be rendered by the Referred Specialist named on the Standing Referral form. The Referred Specialist will have clinical expertise in treating the disease or condition. A Standing Referral must be issued to the Member prior to receiving Covered Services. The Member, the Primary Care Physician and the Referred Specialist will be notified in writing of the length of time that the Standing Referral is valid. Standing Referred Care includes all primary and Specialist Services provided by that Referred Specialist.

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
Office of Rate and Policy Regulation
1311 Strawberry Square
Harrisburg, PA 17120
Fax (717) 787-8555 Telephone (717) 787-0684

October 26, 1999

Fiona E. Wilmarth
Regulatory Analyst
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

ORIGINAL: 2046
BUSH
COPIES: Harris
Jewett
Markham
Smith
Wilmarth
Sandusky
Wyatte

Re: Act 68 Compliance -- Managed Care Plan Documents

Dear Ms. Wilmarth:

At our meeting on October 14 regarding Act 68, you requested copies of several Act 68 compliance filings submitted to the Department for review by managed care plans. Attached is information from Act 68 compliance filings submitted by Aetna US Healthcare and Keystone Health Plan East.

Enclosed please find the following plan documents: filing correspondences, certificates of coverage, subscriber agreements, and riders to certificates of coverage or handbooks.

Due to the considerable size of Act 68 filings, we did not enclose in this packet copies of all related plan documents. However, we trust that the selected documents will effectively illustrate the scope of the Department's review process.

If you would like any additional information or have any questions on these filings, we can make arrangements for you to meet with a Policy Examiner from the Department. Please contact me at (717) 787-4192 if I can be of further assistance in this matter.

Sincerely,

Geoffrey Dunaway
Director, Accident and Health Bureau

QUALITY HEALTH CARE ACCOUNTABILITY AND PROTECTION PAMPHLET

KEYSTONE HEALTH PLAN EAST
ACT 68

ORIGINAL: 2046
BUSH
COPIES: Harris
Jewett
Markhar
Smith
Wilmarth
Sandusky
Wyatte

Keystone Health Plan East HMO and Point of Service Programs
Pennsylvania Act 68: Quality Health Care Accountability and Protection

The **Pennsylvania Act 68: Quality Health Care Accountability and Protection** became effective January 1, 1999. This Act governs the commercial HMO and Point of Service programs offered by Keystone Health Plan East ("Keystone"). In accordance with the requirements of this Act, Keystone is making this information available. Some of this information is also referenced in the Member Handbook, the Group Master Contract ("Contract") given to employers and the Provider Manual given to participating providers.

The information contained in this communication covers the disclosure requirements of the Act for enrollees, participating providers, prospective enrollees and health care providers. The requirement is noted in bold typeface with Keystone's applicable policy or procedure following in standard type. Keystone may, from time to time, modify, change or develop new policies or procedures and such changes may become effective prior to republication of this document.

Please note that the following information may not be applicable to enrollees or prospective enrollees in self funded or Medicare programs. Please contact your Benefits Administrator or Member Service unit with questions regarding applicability.

1. **A description of coverage, benefits and benefit maximums, including benefit limitations and exclusions of coverage, health care services and the definition of medical necessity used by the plan in determining whether these benefits will be covered.**

Keystone offers a variety of programs that differ in the amount of copayment, deductible or coinsurance. Therefore, this is only a summary of the benefits provided under most plans offered by Keystone. **This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered.**

Keystone defines medical necessity as the requirement that Covered Services or medical supplies are needed, in the opinion of: (a) the Primary Care Physician; (b) the Referred Specialist; and/or (c) Keystone and:

A. are consistent with Keystone policies, coverage requirements and utilization guidelines;
B. are necessary in order to diagnose and/or treat a member's illness or injury;
C. are provided in accordance with accepted standards of American medical practice;
D. are essential to improve the member's net health outcome and may be as beneficial as any established alternatives;
E. are as cost-effective as any established alternative; and
F. are not solely for the member's convenience, or the convenience of the member's family or health care provider.

Approved, Effective 7/29/99
Pennsylvania Insurance Department
By

The following is a summary description of covered benefits, limitations and exclusions offered by Keystone. More detailed information on eligibility, terms and conditions of coverage, and contractual responsibilities is contained in the Member Handbook given to members when they enroll and in the Contract which is available through the group benefits administrator.

Benefits may be subject to coinsurance, copayments and limitations. A Schedule of Coinsurance, Copayments & Limitations is included with the Member Handbook given to members when they enroll.

This summary is not exhaustive and is subject to change by Keystone.

1. **PRIMARY AND PREVENTIVE CARE** as provided by the member's selected participating Primary Care Physician.

2. **ADDITIONAL COVERED SERVICES**
   INPATIENT AND OUTPATIENT SERVICES
   The following benefits are provided on both an inpatient and outpatient basis.
   These benefits are provided only if services are:
   * Medically Necessary;
   * Provided or Referred by your Primary Care Physician; and
   * Pre-approved by Keystone, where specified.

- Allergy Testing and Treatment
- Anesthesia
- Autologous Blood Drawing/Storage/Transfusion
- Cardiac Rehabilitation Therapy (Preapproval)
- Chemotherapy (Preapproval needed for administration in a facility)
- Diagnostic Laboratory and X-ray
- Dialysis
- Family Planning
- Medical Foods (Preapproval)
- Mental Health Care (Preapproval for inpatient services)
- Newborn Care
- Obstetrical Care (Preapproval required for hospital stay)
- Oral Surgery (Preapproval needed if done in a facility)
- Pulmonary Rehabilitation Services (Preapproval)
- Radiation Therapy
- Rehabilitation Therapy Services (Preapproval required for Speech therapy)
- Respiratory Therapy (Preapproval)
- Specialist Services
- Substance Abuse Treatment (Preapproval for inpatient services)
- Surgery (Preapproval)

<u>OUTPATIENT SERVICES</u>
The following benefits are provided on an outpatient basis when:
* Medically Necessary;
* Provided or Referred by your Primary Care Physician; and
* Pre-approved by Keystone, where specified.

- Ambulance Service (Preapproval, unless an Emergency Service)
- Gynecological Care
- Hearing Care
- Injections
- Durable Medical Equipment (Preapproval)
- Home Health Care (Preapproval)
- Home Infusion (Preapproval)
- Mammograms (for women age 40 and over and as determined to be Medically Necessary)
- Orthotics (Preapproval) Benefits are provided for the initial purchase and fitting of orthotics, except foot orthotics. Benefits for replacement of covered orthotics are provided only for Dependent children when due to natural growth
- Prosthetics (Preapproval) The initial purchase and fitting of prosthetic devices and supplies except dental prosthetics are covered. Benefits for replacement of covered prostheses are provided only for Dependent children when due to natural growth.
- Spinal Manipulation Services (Preapproval) Covered Services may be provided by a Primary Care Physician trained to perform such services or a Referred Specialist. Benefits are limited to treatment of an acute condition related to an acute medical episode when determined to be Medically Necessary and Pre-approved by Keystone.

INPATIENT SERVICES

The following services are covered on an inpatient basis when:

* Medically Necessary;
* Provided or Referred by your Primary Care Physician; and
* Pre-approved by Keystone.

PLEASE NOTE: ALL INPATIENT SERVICES MUST BE PRE-APPROVED BY KEYSTONE AT LEAST FIVE (5) WORKING DAYS BEFORE ADMISSION, except for an Emergency admission.

Hospital Services
Inpatient Physician Care
Organ Transplants
Skilled Nursing Facility Services

The following list represents EXCLUSIONS from the coverage offered by Keystone. This list is not exhaustive and is subject to change at any time by Keystone.

1. Services or supplies which are:
   A. not provided by or referred by the member's Primary Care Physician except in an Emergency; or
   B. not medically necessary, as determined by the Primary Care Physician and/or Keystone, for the diagnosis or treatment of illness, injury or restoration of physiological functions. This exclusion does not apply to routine and preventive Covered Services specifically provided under the Contract.

2. The cost of services or supplies which are payable under Worker's Compensation or employer's liability laws or other legislation of similar purpose or services for which the member has no obligation to pay.
3. Care related to military service disabilities and conditions which the member is legally entitled to receive at government facilities which are not Keystone providers, and which are reasonably accessible to the member.
4. Care for conditions that federal, state or local law requires to be treated in a public facility.
5. The cost of services covered under the Medicare program.
6. The cost of Hospital, medical or other health services resulting from accidental bodily injuries arising out of a motor vehicle accident, to the extent such costs are payable under any medical expense payment provision (by whatever terminology used - including benefits mandated by law) of any automobile insurance policy unless otherwise prohibited by applicable law.
7. Dental care including, but not limited to, treatment of teeth, extraction of teeth which are not impacted by bone, treatment of dental abscesses or granuloma, treatment of gingival tissues (other than for tumors), dental examinations, treatment for temporomandibular joint syndrome or dysfunction, orthognathic surgery (to treat non-traumatic jaw deformity), and any other dental product or service unless specifically provided elsewhere in the Contract.
8. Charges for broken appointments, services for which the cost is later recovered through legal action, compromise, or claim settlement, and charges for additional treatment necessitated by lack of patient cooperation or failure to follow a prescribed Plan of Treatment.
9. Medical, surgical or any other health care procedures and treatments which are Experimental Or Investigative.
10. Physical examinations for non-preventive purposes, such as pre-marital examinations, physicals for college, camp or travel, and examinations for insurance, licensing and employment.
11. Cosmetic surgery, including cosmetic dental surgery. Cosmetic surgery is defined as any surgery done primarily to alter or improve the appearance of any portion of the body, and from which no significant improvement in physiological function could be reasonably expected. This exclusion includes surgical excision or reformation of any sagging skin on any part of the body, including, but not limited to, the eyelids, face, neck, arms, abdomen, legs or buttocks; and services performed in connection with enlargement, reduction, implantation or change in appearance of a portion of the body, including, but not limited to the breasts (except reconstruction for post-mastectomy patients), ears, lips, chin, jaw or nose.

    This exclusion does not include those services performed when the patient is a member of Keystone and performed in order to restore bodily function or correct deformity resulting from a disease, recent trauma, or previous therapeutic process any of which occurs while such patient is a member of Keystone.

    This exclusion does not apply to otherwise Covered Services necessary to correct medically diagnosed congenital defects and birth abnormalities for children who are covered as Dependents since birth.
12. All rehabilitative therapy except as described in the Contract and summarized in the Member Handbook.
13. All routine hearing examinations.
14. Hearing aids, or the fitting thereof, or cochlear electromagnetic hearing devices or related services.

15. All procedures performed solely to eliminate the need for or reduce the prescription of corrective vision lenses including, but not limited to, radial keratotomy and refractive keratoplasty;
16. Services for treatment of mental retardation or other mental health services, except as otherwise provided herein.
17. Immunizations required for college, employment, or travel.
18. Custodial and Domiciliary Care, residential care, protective and supportive care, including educational services, rest cures and convalescent care.
19. Weight reduction programs, including all diagnostic testing related to weight reduction programs, unless Medically Necessary. This exclusion does not apply to Keystone's weight reduction program.
20. Nutritional supplements, except when the Member has no other source of nutritional intake due to a metabolic or anatomic disorder;
21. Customized or motorized wheelchairs and other motor devices to assist or replace ambulatory functions, or other customized Durable Medical Equipment.
22. Personal or comfort items such as television, telephone, air conditioners, humidifiers, barber or beauty service, guest service and similar incidental services and supplies which are not Medically Necessary.
23. Normal childbirth deliveries outside the Service Area within thirty (30) days of the expected delivery date established by the Provider in charge of the case.
24. Any procedure or treatment designed to alter physical characteristics of the Member to those of the opposite sex, and any other treatment or studies related to sex transformations.
25. Treatment of bunions (except capsular or bone surgery), toenails (except surgery for ingrown nails), corns, calluses, fallen arches, flat feet, weak feet, chronic foot strain or symptomatic complaints of the feet or other routine podiatry care, unless associated with peripheral vascular disease and/or diabetes and deemed Medically Necessary by the Primary Care Physician or Keystone.
26. Non-medical services for the treatment of Substance Abuse in an acute care Hospital.
27. Marriage counseling.
28. In vitro fertilization, embryo transplant, ovum retrieval including, but not limited to, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and any services required in connection with these procedures.
29. Reversal of voluntary sterilization and services required in connection with such procedures.
30. Foot orthotic devices and the repair or replacement of external prosthetic devices, except as described in the Contract and in the Benefit Summary of the Member Handbook.
31. Cranial prostheses including wigs and other devices intended to replace hair.
32. Outpatient prescription drugs and medications, except if covered by a prescription drug rider; drugs and medications that may be dispensed without a doctor's prescription; contraceptive drugs and devices, except when covered by a prescription drug rider.
33. Ambulance service, unless Medically Necessary.
34. Whole blood or blood plasma.
35. Services required by a member donor related to organ donation. Expenses for donors donating organs to member recipients are covered only as described in the Contract. No payment will be made for human organs which are sold rather than donated.
36. Charges for completion of any insurance form.

37. Treatment for injuries sustained while committing a felony, or while intoxicated or under the influence of any narcotic not prescribed or authorized by the Primary Care Physician.
38. Injectable medications except those necessary for the immediate treatment of an injury or acute illness when provided or Referred by the Primary Care Physician and administered in the physician's office.
39. Any services, supplies or treatments not specifically listed in the Contract as covered benefits, unless the unlisted benefit, service or supply is a basic health service required by the Pennsylvania Department of Health. Keystone reserves the right to specify Providers of, or means of delivery of Covered Services, supplies or treatments under this plan, and to substitute such Providers or sources where medically appropriate.

2. A description of all necessary prior authorizations or other requirements for non-emergency health care services.

In order to assure that our members receive quality, timely and cost-efficient health care services, we have established a preapproval process for inpatient admissions, selected outpatient procedures and certain prescription drugs. Those services that require preapproval are noted above in the list of covered services. Please note that this list is not exhaustive and is subject to change at any time by Keystone.

Members enrolled in Keystone HMO are required to obtain a referral from their Primary Care Physician before receiving covered services from a participating specialist. However, through our Direct Access OB/GYN℠ program, Keystone members are free to receive care from a participating OB/GYN without a referral from the PCP. Non-routine care provided by Reproductive Endocrinologists/Infertility Specialists and Gynecologic Oncologists requires a referral from the PCP.

For services requiring preapproval, it is the responsibility of the physician providing the covered service to obtain the necessary preapproval. If the participating physician fails to obtain prior approval for a service that requires it, the member is not responsible and cannot be billed by the physician for those services.

Members enrolled in Keystone Point of Service are permitted to obtain services without a referral (Self-Referred Care). In the event a member elects self-referred care, **it is the member's responsibility to obtain preapproval for selected services.** These services are enumerated in the Member Handbook, Contract and Provider Manual. If the member fails to obtain preapproval, the service may be denied and the member will be responsible for payment to the physician.

The goal of preapproval is to evaluate the covered service, which may be a procedure, treatment or drug, for medical appropriateness/necessity. For inpatient admissions and selected outpatient procedures, a medical appropriateness review includes a review of the length of stay and setting. This proactive opportunity assures that all elective care is medically appropriate and performed in the most cost effective setting by network providers.

3. **An explanation of an enrollee's financial responsibility for payment of premiums, coinsurance, copayment, deductibles and other charges, annual limits on an enrollee's financial responsibilities and caps on payments for health care services provided under the plan.**

In most cases, the contract for benefits is between the group and Keystone. Therefore, the payment of premiums to Keystone is the responsibility of the employer group, not the enrollee. The employer group may require the enrollee to contribute to the cost of the coverage. If a member is contracting with Keystone directly for any reason (COBRA, Direct Pay) they are responsible for the monthly payment of premiums directly to Keystone.

Keystone members are responsible for the payment of any applicable coinsurance, copayments or deductibles as specified in the Contract or Member Handbook. An applicable copayment maximum is applicable to HMO and Point of Service referred benefits. An out-of-pocket maximum for self-referred care under the Point of Service plan also applies. Information regarding the amounts is specified in the Member Handbook or Contract.

4. **An explanation of an enrollee's financial responsibility for payment when a health care service is provided by a non-participating provider, when a health care service is provided by any health care provider without required authorization or when the care rendered is not covered by the plan.**

Members are financially responsible for the entire cost to the provider when a covered service is provided without a referral from the PCP, and when services are provided by a non-participating provider (except in the case of a medical emergency) and no preapproval is obtained. A member will also be financially responsible for the entire cost of services that are not covered services under the applicable benefits program (e.g. cosmetic procedures).

In the event that a Keystone member receives care from a Keystone participating provider, with a referral, and the provider fails to obtain the required preapproval, the member is not financially liable and cannot be billed by the provider for the service.

Within the POS, self-referred care is subject to plan deductibles and coinsurance. Members may be balanced billed for amounts in excess of provider's charge and plan allowance. In addition, the member will be responsible for payment if they fail to obtain the necessary prior approval from Keystone for selected services.

5. **A description of how the managed care plan addresses the needs of non-English speaking enrollees.**

Keystone publishes in the provider directory a list of participating physicians who speak languages other than English. The Member Services Department uses the AT & T Language Line to assist members who speak a language other than English or Spanish. Keystone employs several Spanish speaking representatives who will handle calls from Spanish speaking members.

6. **A notice of mailing addresses and telephone numbers necessary to enable an enrollee to obtain approval or authorization of a health care service or other information regarding the plan.**

The Patient Care Management Department provides availability of a registered nurse and Medical Director on a 24 hour, 7-day a week basis. After business hours, assistance with emergency services or urgent discharge planning needs, or help with directing members or providers to appropriate settings are handled by our on-call medical professional. Access to Patient Care Management after our regular business hours (Monday through Friday, 8:00 a.m. to 8:00 p.m., and Saturday, 9:00 a.m. to 5:00 p.m.) is achieved through calling our main PCM phone number which appears on the back of the member's ID card. Preapproval requests by physicians or members enrolled in Keystone Point of Service may also be mailed to Patient Care Management, P.O. Box 42952, Philadelphia, PA 19101.

7. **A summary of the plan's utilization review policies and procedures.**

The Patient Care Management Program is comprised of several component programs all of which are focused on assuring a balance of quality, access and cost containment. The focus is on directing providers and members to use the most appropriate site and level of care. This is best accomplished through intervention by the Patient Care Management team before services are rendered.

The Patient Care Management philosophy is member focused. The use of specific medical appropriateness criteria and clinical standards for all key processes encourages high quality care and enables the Patient Care Management Department to direct members to the most appropriate level of care.

Our Patient Care Management guidelines are in accordance with the requirements of Act 68.

8. **A summary of all complaint and grievance procedures used to resolve disputes between the managed care plan and an enrollee or a health care provider.**

Keystone maintains complaint and grievance procedures for members to use to resolve disputes between Keystone and a member or health care provider. There are three levels to the process: Informal Member Complaint, Formal Member Complaint and Member Grievance of Decisions based on Medical Necessity. The process is described below.

Informal Member Complaint Process

Keystone will make every attempt to answer any questions or resolve any concerns the Member has related to benefits or services. If the Member has a concern, he should call Member Services at the toll-free telephone number listed on the back of his ID card, or write to the Manager of Member Services, Keystone Health Plan East, P.O. Box 8339, Philadelphia, PA 19101-8339. Most Member concerns are resolved informally at this stage. If Keystone cannot immediately resolve the Member's concern, Keystone will investigate it and respond to the Member **within thirty (30) days**. If the Member is not satisfied with the response to the Member's concern from Keystone, he has the right to file a formal Complaint **within sixty (60) days**, through the Formal Member Complaint Process described below. ,

Formal Member Complaint Process

A Member may file a formal Complaint regarding an unresolved dispute or objection regarding coverage, including contract exclusions and non-covered benefits, participating or non-participating health care provider status, or the operations or management policies of Keystone. The Complaint process consists of two (2) internal levels of review by Keystone, and one external level of review by the Pennsylvania Department of Health or the Pennsylvania Insurance Department. Remember, no legal action can be taken until all of the Complaint procedures have been followed.

Internal First Level Complaint:

The Member may file a formal first level Complaint **within sixty (60) days** from either his receipt of the original notice from Keystone, or from completion of the informal Complaint process described above. To file a first level Complaint, the Member should call Member Services toll free at the telephone number listed on the back of his ID card, or write to Member Services, PO Box 8339, Philadelphia, PA, 19101-8339.

Keystone's review of the Member's first level Complaint will be completed **within thirty (30) days** from the date of receipt of that Complaint by Keystone. Keystone then sends the Member the decision in writing **no later than five (5) business days** after reaching a decision. If the Member is not satisfied with the decision on his first level Complaint, the Member may file a second level Complaint with Keystone, **within sixty (60) days** from receipt of the first level Complaint decision letter.

Internal Second Level Complaint:

To file a second level Complaint, the Member should call or write the Member Appeals Unit at P.O. Box 41820, Philadelphia, PA 19101-1820, 1-888-671-5276 or fax 1-888-671-5274 **within sixty (60) days** from the Member's receipt of the first level Complaint decision letter from Keystone.

Keystone will contact the Member to arrange the Second Level Complaint Committee meeting. That Committee will meet and render a decision **within forty-five (45) days** from the date of Keystone's receipt of the Member's second level Complaint. The Second Level Complaint Committee is composed of at least three (3) members who have had no previous involvement with the case. The Second Level Committee members will include Keystone staff, with one third of the Committee being enrollees or other persons who are not employed by Keystone. The Member has the right to present his second level Complaint to the Committee in person, through a representative, or via conference call.

The Second Level Complaint Committee meetings are a forum where Members are allowed to present their issues in an informal setting that is not open to the public. The Member may be accompanied by two other persons unless the Member receives prior approval from Keystone for additional assistance due to special circumstances. Members of the press may only attend in their personal capacity as a Member's representative. Members may not transcribe, audio- or video-tape the proceedings.

Keystone will send the Member a written notice of the decision **within five (5) business days** of the decision by the Second Level Complaint Committee. The decision is final unless the Member chooses to appeal to the Pennsylvania Insurance Department or

Department of Health **within fifteen (15) days** after the Member's receipt of the second level Complaint decision notice from Keystone

External Complaint Review:

If the Member wishes to appeal the second level Complaint decision, the Member may contact the Pennsylvania Insurance Department or Department of Health, as appropriate, **within fifteen (15) days** after the Member's receipt of the second level Complaint decision notice from Keystone, as follows:

Pennsylvania Insurance Department
Bureau of Consumer Services
1321 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388

Bureau of Managed Care
Department of Health
Attn: Complaint Appeals
P.O. Box 90
Harrisburg, PA 17108-0080
1-888-466-2787

The Member's external Complaint appeal should include the Member's name, address, daytime telephone number, the name of Keystone as his managed care plan, his Keystone ID number, and a brief description of the issue being appealed. The Member should also include a copy of his original Complaint to Keystone and copies of any correspondence and decision letters from Keystone.

Please note that these procedures may change due to changes in the applicable state and federal laws and regulations.

Member Grievance Process For Decisions Based On Medical Necessity:

A Member may file a Grievance of a decision by Keystone regarding a determination of coverage that was based primarily on Medical Necessity or appropriateness. The Grievance process consists of two (2) internal Grievance reviews by Keystone and an external review through an external utilization review agency assigned by the Pennsylvania Department of Health. Remember, no legal action can be taken until all of the Grievance procedures have been followed.

Internal First Level Grievance:

The first level Grievance must be filed with Keystone by the Member, or the Member's provider acting on the Member's behalf, with the Member's written consent, within **sixty (60) days** of receipt of the original response by Keystone. When filing the first level Grievance, the Member (or the Member's provider) must include all necessary supporting information. The first level Grievance may be filed by calling as directed in the original notice from Keystone, by calling Member Services toll-free at the telephone number listed on the back of the Member's ID Card, or by writing to the Patient Care Management Department, P.O. Box 42952, Philadelphia, PA 19101.

The Grievance will be forwarded to the First Level Grievance Committee. The first level Grievance will be reviewed by one or more persons selected by Keystone who did not previously participate in the decision to deny payment for a health care service and shall include a licensed physician, or, where appropriate, a licensed psychologist, in the same or similar specialty that typically manages or consults on the health care service. The First Level Grievance Committee will complete its review **within thirty (30) days** from the date of receipt of the Member's first level Grievance request by Keystone. We will then send the Member and the Member's provider a written notice of the decision **within five (5) business days** of the decision. The notice will specify the reason(s) and clinical rationale for the decision and the procedure for appeal. If at that time the Member, or the provider on the Member's behalf and with the Member's written consent, wishes to appeal the decision of the First Level Grievance Committee, the Member or the Member's provider may appeal to the Second Level Grievance Committee **within sixty (60) days** of receipt of the notice of denial.

Expedited Grievance:

If the Member's case involves a serious medical condition which he believes would jeopardize his life, health or ability to regain maximum function while awaiting a standard Internal First Level Grievance Committee review, the Member or the Member's provider acting on the Member's behalf and with the Member's written consent can ask to have his case reviewed by Keystone in a quicker manner (expedited Grievance). The Member or the Member's provider may request an expedited Grievance by calling Member Services at the toll-free telephone number listed on the back of his ID card. Keystone will arrange to have the Grievance reviewed by a Keystone Medical Director who was not previously involved with the case.

This review will be completed promptly, based on the Member's health condition, but in **no more than forty-eight (48) hours** after receipt of his Grievance request by Keystone. If the Member is not satisfied with the expedited decision from Keystone, the Member or the Member's provider, acting on the Member's behalf and with the Member's written consent, may file an internal second level Grievance to the Second Level Grievance Committee, as described below.

Internal Second Level Grievance:

The Member, or the Member's provider acting on the Member's behalf and with the Member's written consent, may file a second level Grievance by writing or calling the Member Appeal Unit at P.O. Box 41820, Philadelphia, PA 19101-1820, 1-888-671-5276 or fax 1-888-671-5274 **within sixty (60) days** after the Member's receipt of the first level Grievance decision letter from Keystone.

The Second Level Grievance Committee, will meet and render a decision promptly, based on the Member's health condition, but **no later than forty-five (45) days** after receipt of the Member's Grievance request by Keystone. The second level Grievance will be reviewed by three or more persons selected by Keystone did not previously participate in the decision to deny payment for a health care service and shall include a licensed physician, or, where appropriate, a licensed psychologist, in the same or similar specialty that typically manages or consults on the health care or service involved. If the Member is appealing to the Second Level Grievance Committee, the Member may designate a representative to participate on his behalf. The Member has the right to

present his second level Grievance in person, through a representative, or via conference call.

The Second Level Grievance Committee meetings are a forum where Members are allowed to present their issues in an informal setting that is not open to the public. The Member may be accompanied by a maximum of two other persons unless the Member receives prior approval from Keystone for additional assistance due to special circumstances. Members of the press may only attend in their personal capacity as a Member's representative. Members may not transcribe, audio- or video-tape the proceedings.

Keystone will send the Member and the Member's provider a written notice of the decision **within five (5) business days** after the decision by the Second Level Grievance Committee. The decision is final unless the Member, or the Member's provider with the Member's written consent, chooses to file an external Grievance **within fifteen (15) days** of receipt of the second level Grievance decision by Keystone.

External Grievance:

To request an external Grievance by an independent utilization review agency assigned by the Pennsylvania Department of Health, write to the Patient Care Management Department, P.O. Box 42952, Philadelphia, PA 19101 **within fifteen (15) days** of receipt of the second level decision letter from Keystone. If the Member's health care provider files a Grievance on the Member's behalf, Keystone will verify with the Member that the provider is acting in the Member's behalf, with the Member's consent. The Member will not be required to pay any of the costs associated with the external Grievance review, however, there is a $25 filing fee, payable to Keystone that should be forwarded to Patient Care Management at the above address.

Keystone will contact the Pennsylvania Department of Health to request assignment of a certified utilization review agency to the Member's Grievance, and will notify the Member of the name, address and telephone number of the external agency assigned by the Department of Health to the Member's Grievance **within two (2) business days** of the assignment by the Department. The Member, the Member's provider, if acting on the Member's behalf, and Keystone **have two (2) business days** to notify the Department of Health, if there is an objection to the assignment of the external review agency on the basis of conflict of interest.

The external review agency will send the Member, the Member's provider, if acting on the Member's behalf, and Keystone a written decision **within sixty (60) days** of the date when the Member filed the Member's request for an external review. Upon receiving the decision from the external review agency, Keystone will authorize payment for services or pay claims if the decision of the external review agency is that the services were Medically Necessary. The external Grievance decision may be appealed to a court of competent jurisdiction **within sixty (60) days** of the decision by the external agency.

Please note that these procedures may change due to changes in the applicable state and federal laws and regulations.

For Self Funded Members: To the extent the member is enrolled in a self funded plan, please check with the member's Plan Administrator regarding differences in policies and procedures and benefit decisions. Some of the above referenced procedures may not apply to the member or may be administered differently.

9. A description of the procedure for providing emergency services 24 hours a day.

An emergency is defined as the sudden and unexpected onset of a medical or psychiatric condition manifesting itself in acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. placing the member's health or in the case of a pregnant member, the health of the unborn child, in jeopardy;
2. serious impairment to bodily functions; or
3. dysfunction of any bodily organ or part.

Emergency care includes covered services provided to a member in an emergency, including emergency transportation and related emergency services provided by a licensed ambulance service.

In the event of an emergency, the member should go to the nearest appropriate medical facility. The Primary Care Physician should be contacted as soon as reasonably possible in the event of any emergency occurring either within Keystone's service area or outside of the service area.

10. A description for enrollees to select a participating health care provider, including how to determine whether a participating health care provider is accepting new enrollees.

Keystone distributes a provider directory for members to use in selecting a participating Primary Care Physician. Included with each participating physician's listing is the name of the practice, address, telephone number, a list of all the participating physicians in the practice, hospital affiliations, age limitations and whether or not the practice is accepting new patients.

In addition to the provider directory, members may visit our web site at www.ibx.com and search our provider listing on line. This service is available 24 hours a day, seven days a week.

Members can also contact our Health Resource Center at 1-800-ASK-BLUE. This service is available Monday through Friday 8:00 AM to 8:00 PM and Saturday 9:00 AM to 5:00 PM. The staff in the Health Resource Center can answer questions about participating providers, including hours of operation, availability to new patients and languages spoken.

11. A description of the procedures for changing primary care providers and specialists.

Members may change their Primary Care Physician up to two times per year, simply by calling Keystone's Member Services Department. The change will become effective on the first day of the month following their call. Any additional PCP changes require Keystone's approval.

Members should discuss changing specialists with their Primary Care Physician in order that care may continue to be coordinated. A member may change referred specialists, and Keystone will cover the services of a specialist, as long as there is a referral from the PCP, preapproval has been obtained if required, and the specialist is participating with Keystone.

12. A description of the procedures by which an enrollee may obtain referral to a health care provider outside the provider network when that provider network does not include a health care provider with appropriate training and experience to meet the health care service needs of an enrollee.

In the event there is no participating physician to provide the specialty services required, a referral to a non-participating specialist can be arranged by the member's PCP only with Keystone's preapproval.

Member in Keystone Point of Service are free to self-refer to non-participating provider. Members who self-refer will be responsible for any deductibles, coinsurance and balance bills for self-referred care.

13. A description of the procedure that an enrollee with a life-threatening, degenerative or disabling disease or condition shall follow and satisfy to be eligible for a standing referral to a specialist with clinical expertise in treating the disease or condition or the designation of a specialist to provide and coordinate the enrollee's primary and specialty care.

Standing Referrals

Members with life-threatening, degenerative or disabling diseases or conditions are permitted to receive a standing referral to a specialist with clinical expertise in treating the disease or condition. The standing referral will be granted upon approval of the treatment plan by Keystone, in consultation with the member's Primary Care Physician (PCP) and the specialist, as appropriate.

To obtain a standing referral, members are advised to contact the Member Services Department to initiate the request. (The Member Service telephone number is listed on the back of the member's ID card.) Member Services will mail or fax a form to the member, which requires information that the member must provide. The form then needs to be given to the PCP who must complete the clinical portion, and forward to the Keystone Patient Care Management Department. Upon receipt in Patient Care Management (PCM), a nurse will review the clinical information using plan-established criteria to determine if the member is eligible for the standing referral. This criteria includes certain chronic diagnoses, which have been determined to be best managed by a specialist. An example would be a diagnosis of end stage renal disease with the standing

referral approved for a nephrologist. If the nurse is unable to approve the request, it will be reviewed by a Keystone Medical Director.

If the request for the standing referral to a specialist is approved, the specialist and the PCP will be contacted to apprise them of the approval. The specialist must also agree to abide by Keystone's requirements regarding the standing referral, including but not limited to the need to inform the PCP on an ongoing basis of the member's condition and progress. A confirmation letter will also be sent to the member, PCP, and specialist.

Standing referrals will generally be for a one-year period. Upon expiration, the member or PCP will need to contact Patient Care Management to initiate an extension.

Should the request for a standing referral be denied, the member and PCP will be informed in writing of the denial and the rationale for the denial. The member will also be informed of the right to initiate a formal complaint.

The PCP may also initiate a request for a standing referral by contacting Provider Services or Patient Care Management.

Specialist as a PCP

A member with a life-threatening, degenerative or disabling disease or condition is permitted to have a specialist designated to provide and coordinate the member's primary and specialty care. This will occur only after the specialist has agreed to meet all of the plan's requirements to function as a PCP, and Keystone has approved the treatment plan in accordance with the process set forth above and in this section.

To obtain this designation, members should follow the same procedure described above. Upon receipt of the appropriate information from either the specialist or the member, the Medical Director will speak directly with the PCP and selected specialist to apprise all parties of the primary services that the specialist must be able to provide in order to be designated as the member's PCP as well as any other Keystone contractual requirements. If PCM approves the designation, the request will then be forwarded to the Provider Service area to confirm that the specialist meets credentialing standards as a PCP.

Upon approval of the request for the designation of a specialist as a PCP, the member, PCP and specialist will be notified in writing.

Should the request be denied, the member and PCP will be notified of the reason(s) for the denial. The member will also be informed of the right to initiate a formal complaint.

The PCP may also initiate a request for standing referral by contacting Provider Services or Patient Care Management.

14. A list by specialty of the name, address and telephone number of all participating health care providers. The list may be a separate document and shall be updated at least annually.

Members can obtain a copy of our specialist directory by calling the Member Services Department. In addition, members can visit our web site at www.ibx.com for participating providers, including specialists or they can call the Health Resource Center at 1-800-ASK-BLUE.

15. Written disclosure of the continuity of care benefit requirements which allows an enrollee to continue an ongoing course of treatment with a provider whose contract has been terminated for reasons other than cause.

Terminated Providers

Keystone offers members continuation of an ongoing course of treatment with a terminated provider (for reasons other than cause) for up to 60 days from the date that Keystone notified the member of the termination. Keystone will cover such continuing treatment under the same terms and conditions as for participating providers.

If a member is in her second or third trimester of pregnancy at the time of the termination, the transitional period of authorization shall extend through post-partum care related to the delivery.

All authorized health care services provided during this transitional period shall be covered by Keystone under the same terms and conditions applicable for participating health care providers.

New HMO Members

New HMO members may continue an ongoing course of treatment with a non-participating health care provider for a transitional period of up to 60 days from the effective date of enrollment into the plan subject to the requirements set forth herein.

If the new member is in her second or third trimester of pregnancy at the time of the effective date of enrollment, the transitional period of authorization shall extend through post-partum care related to the delivery.

The non-participating provider must agree that all authorized health care services provided during this transitional period shall be covered by Keystone under the same terms and conditions applicable for participating health care providers.

In order to initiate continuity of care, members must complete a Continuity of Care form and submit it to Patient Care Management. The form will be in the enrollment materials and available through Member Services.

Non-participating health care providers whose services are covered during the tranistional period must agree to be bound by the same terms and conditions as participating providers. The plan is NOT required to provide health care services that are not covered benefits.

16. The procedures adopted to protect the confidentiality of medical records and other enrollee information.

All employees upon hire and annually thereafter complete a corporate compliance policy that includes certain codes of conduct that all employees must follow. Guidelines for protecting enrollees Confidential Medical Information is outlined in the corporate compliance policy.

All participating provider agreements with Keystone contain various confidentiality provisions that must be agreed to by providers, including but not limited to the need to maintain the confidentiality of a member's medical records.

17. A description of the credentialing process for health care providers.

Keystone Health Plan East has defined the credentialing criteria and methodology by which practitioners are accepted into their networks. This process is designed to select qualified providers to deliver health care to our members.

Prior to issuing an application for participation, we will review a provider's request to participate in accordance with the following pre-application evaluation, which includes, but is not limited to:

1. Contract with specialists at each network participating hospital to ensure member selection alternatives;
2. Contract with providers based on geographic access and availability;
3. Contract with providers who do not participate in restrictive or exclusive practice arrangements with another managed care entity which would preclude or substantially interfere with accepting patients enrolled in Keystone Health Plan East.
4. Adequate access (hours of operation and after hours coverage) must be provided.

Once the pre-application evaluation described above has been completed, we will evaluate each application based on the following credentialing criteria. Please note that this list may not be exhaustive, however our credentialing requirements are in compliance with both NCQA standards and applicable state laws.

1. A completed application with a signed authorization for the Release of Information;
2. Current, valid license to practice his/her specialty in the state in which the applicant practices;
3. Board Certification; Exemptions are at the sole discretion of Keystone. Continuing Medical Education credits are required for non-board certified physicians.
4. Current Drug Enforcement Agency (DEA) certification when applicable;
5. Must maintain malpractice coverage as specified by the requirements of the state(s) in which the applicant practices;
6. Must maintain staff privileges at a minimum of one (1) participating hospital. Exception may be granted if state laws permit and hospital care is not within the scope of practice.
7. Passing site visit and medical record keeping practices are required for all primary care and OB-GYN sites;
8. Provide coverage 24 hours a day, 7 days a week;
9. Malpractice history: Provider must provide a report detailing involvement and resolution and/or status of all malpractice claims within the past five years;
10. Applicant must be currently eligible to receive payment under Medicare/Medicaid and the Federal Employees Benefit Program.

All plan providers are recredentialed every two years in accordance with NCQA requirements.

18. A list of the participating health care providers affiliated with participating hospitals.

This information is included in the provider directories and on the web site at www.ibx.com.

19. Whether a specifically identified drug is included or excluded from coverage.

Members should consult with their physicians to determine whether a specific drug is the most appropriate drug for use by the member and whether such drug is covered under the member's prescription program.

20. A description of the process by which a health care provider can prescribe specific drugs, drugs used for an off-label purpose, biologicals and medications not included in the drug formulary for prescription drugs or biologicals when the formulary's equivalent has been ineffective in the treatment of the enrollee's disease or if the drug causes or is reasonably expected to cause adverse or harmful reactions to the enrollee.

Physicians with questions regarding Keystone's prescription drug programs should contact Keystone's Pharmacy Management Department for assistance.

21. A description of the procedure followed by the managed care plan to make decisions about the experimental nature of individual drugs, medical devices or treatments.

Technology assessment is the review and evaluation of available clinical and scientific information from expert sources. These sources include and are not limited to articles published by governmental agencies, national peer review journals, national experts, clinical trials, and manufacturer's literature. Keystone uses the technology assessment process to assure that new drugs, procedures or devises are safe and effective before approving them as a covered benefit. When new technology becomes available or at the request of a practitioner or member, Keystone researches all scientific information available from these expert sources. Following this analysis, Keystone makes a decision about when a new drug, procedure or device has been proven to be safe and effective and uses this information to determine when an item becomes a covered benefit.

22. A summary of the methodologies used by the managed care plan to reimburse for health care services. Nothing in this paragraph shall be construed to require disclosure of individual contracts or the specific details of any financial arrangement between a managed care plan and a health care provider.

Keystone's payment programs are intended to encourage physicians to provide our members with high quality, cost effective care. Most primary care physicians (PCPs) are prepaid for their services. Thus, a PCP receives a set dollar amount per member per month for each Keystone member selecting that PCP. This payment provides for most care delivered by the PCP. PCPs usually receive additional incentive payments for meeting certain quality, service and other performance standards.

Most specialist physicians are paid on a fee-for-service basis, meaning that payment is made for each service the specialist performs. Some specialists, e.g., radiologists,

podiatrists and physical therapists, are prepaid a set dollar amount per member per month for their services. Some specialists, e.g., cardiologists and gastroenterologists, receive a single payment covering all necessary tests and specialist services provided during a specific time period called an episode of care. In this case, Keystone members need obtain only one referral for each episode of care, regardless of the number of services received during that time period.

In some instances, Keystone has arrangements with hospital/physician entities, referred to as integrated delivery systems (IDS), where the IDS provides the full range of hospital, physician and ancillary services and is paid a global fee to cover all services, whether provided by the IDS or other providers.

23. A description of the procedures used in the managed care plan's quality assurance program.

A. VISION STATEMENT

The Quality Management Program (QM Program) for Keystone is designed to meet our customer's expectations of high quality, affordable health care. It is the Plan's responsibility to assure that adequate health maintenance, appropriate treatment of illness and timeliness of clinical and administrative services meet those expectations and needs.

Another important aspect of health is satisfaction with the services provided. In recognition of the valid assessments that customers can provide, the QM Program will proactively seek customer feedback and include education in its improvement efforts.

To achieve improved health outcomes and satisfaction with services, a continuous process of monitoring, evaluation and improvement is implemented.

B. OBJECTIVES

The objectives of the QM Program are:

- To improve the care and service provided to the Plans' members through a comprehensive and ongoing system of monitoring, evaluation and improvement. The QM Program provides a link between the Quality Improvement activities and other management functions of the Plans.

- To improve customer satisfaction by utilizing the information obtained through surveys and complaint resolution to advocate for positive change.

- To assure a network of qualified providers through a process of credentialing and recredentialing and by contractually requiring participation in the QM Program. These contracts include access to medical records.

- To develop partnerships with providers of care/service through communication about quality activities, feedback on results of assessments and mutually developed improvement plans. This partnership includes oversight of subcontracted services.

- To comply with all regulatory requirements and to achieve and maintain accreditation and necessary certifications.

- To demonstrate the value of the QM Program by tracking and reporting outcomes. This information is incorporated into the recredentialing and recontracting process for providers and into performance evaluations for QM staff.

C. SCOPE

- The QM Program monitors and evaluates the quality of care/service provided by the Plans and their contracting providers. Quality assessment and improvement activities address all lines of business (Commercial and Government) and monitors for over utilization as well as under utilization. This comprehensive approach depends upon the integration and analysis of data collected by the various Plans departments such as Patient Care Management and Member Service. Members may also offer suggestions for QI initiatives via calls to Member Service.

- The Program is designed to monitor care provided in both the inpatient and outpatient setting including care and service provided by subcontractors. In addition to evaluation of primary care, major specialty services will be targeted. Clinical issues selected for review are based on the demographics of the Plans' subscribers, i.e., studies reflect the age, sex and health status of members. A demographic analysis is included with the Annual Work Plan. Service issues include access and satisfaction.

D. OUTCOMES

Membership in Independence Blue Cross' (IBC) Pennsylvania-based managed care programs continued to increase in 1998. In response, the QM Program was restructured in two ways: a Pennsylvania-specific Quality Management medical director was named, along with a dedicated quality manager; and a new oversight body, the Quality Council, was formed. These steps will help IBC to continue its historic high level of support for its Pennsylvania programs, while supporting its other regional plans as well. In addition, the Plans needed to respond to new regulatory requirements from the Pennsylvania Departments of Health and Insurance, from the Health Care Finance Administration and from the National Committee for Quality Assurance. Compliance workgroups were formed for all three areas, and significant progress was made in understanding the new regulations, and assuring compliance. In particular, the Plans developed a new, centralized approach to member appeals in order to meet turnaround time standards, and assure accurate handling of these important member concerns in both the commercial and Medicare product lines.

Expansion occurred in Health Management Programs, and a new, dedicated Senior Medical Director was named to this team. Two new programs were developed in 1998: one that targeted members with peptic ulcer disease and another that addressed tertiary prevention in coronary heart disease. Improvements were made to the Health Management database. A variety of prevention and disease management interventions occurred. Barriers occurred in the timely release of some program elements.

The Plans expanded their Research and Evaluation efforts and began to develop a large new data warehouse, which will facilitate research and analysis and allow for more comprehensive reports. In addition, HEDIS reports were produced in a timely, complete fashion, and in a way that was acceptable to external auditors, as required. A large number of studies of clinical care and satisfaction were carried out successfully.

However, resource barriers occurred, and reports on outcomes of cardiology care were delayed.

A variety of administrative activities were completed, including continued expansion of the Plan's credentialing program, and efforts to strictly enforce termination procedures for non-compliant practitioners. Productivity was improved, but did not completely meet the Plan's goals in 1998. Delegated activities continued to be monitored closely. In particular, the Mental Health Oversight Committee worked closely with the behavioral health delegate, and a new full-time resource was dedicated to this work.

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
Office of Rate and Policy Regulation
1311 Strawberry Square
Harrisburg, PA 17120
Fax (717) 787-8555 Telephone (717) 787-0684

October 26, 1999

Fiona E. Wilmarth
Regulatory Analyst
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

ORIGINAL: 2046
BUSH
COPIES: Harris
Jewett
Markham
Smith
Wilmarth
Sandusky
Wyatte

Re: Act 68 Compliance – Managed Care Plan Documents

Dear Ms. Wilmarth:

At our meeting on October 14 regarding Act 68, you requested copies of several Act 68 compliance filings submitted to the Department for review by managed care plans. Attached is information from Act 68 compliance filings submitted by Aetna US Healthcare and Keystone Health Plan East.

Enclosed please find the following plan documents: filing correspondences, certificates of coverage, subscriber agreements, and riders to certificates of coverage or handbooks.

Due to the considerable size of Act 68 filings, we did not enclose in this packet copies of all related plan documents. However, we trust that the selected documents will effectively illustrate the scope of the Department's review process.

If you would like any additional information or have any questions on these filings, we can make arrangements for you to meet with a Policy Examiner from the Department. Please contact me at (717) 787-4192 if I can be of further assistance in this matter.

Sincerely,

Geoffrey Dunaway
Director, Accident and Health Bureau

ORIGINAL: 2046
BUSH
COPIES: Harris
Jewett
Markham
Smith
Wilmarth
Sandusky
Wyatte

EVIDENCE

OF

COVERAGE

KEYSTONE HEALTH PLAN EAST
ACT 68

EVIDENCE OF COVERAGE

TABLE OF CONTENTS

This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have questions about the plan, please call Member Services at (215) 241-CARE, or if you're outside of the local Philadelphia area, 1-800-227-3114.

KE 624-HDBK(9968)F Effective 7/29/99

Pennsylvania Insurance Department

By

REQUIRED DISCLOSURE OF INFORMATION

State law requires that Keystone make the following information available to you when you make a request in writing to Keystone.

1. A list of the names, business addresses and official positions of the membership of the Board of Directors or Officers of Keystone Health Plan East, Inc.

2. The procedures adopted to protect the confidentiality of medical records and other enrollee information.

3. A description of the credentialing process for health care providers.

4. A list of the participating health care providers affiliated with participating hospitals.

5. Whether a specifically identified drug is included or excluded from coverage.

6. A description of the process by which a health care provider can prescribe any of the following when either (1) the formulary's equivalent has been ineffective in the treatment of the enrollee's disease; or (2) the drug causes or is reasonably expected to cause adverse or harmful reactions to the enrollee.

   A. specific drugs;

   B. drugs used for an off-label purpose;

   C. biologicals and medications not included in the drug formulary for prescription drugs or biologicals.

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

8. A summary of the methodologies used by Keystone to reimburse for health care services. (This does not mean that Keystone is required to disclose individual contracts or the specific details of financial arrangements we have with health care providers)

9. A description of the procedures used in Keystone's quality assurance program.

10. Other information that the Pennsylvania Department of Health or the Insurance Department may require.

WELCOME

Thank you for joining Keystone Health Plan East, Inc. (Keystone). Our goal is to provide you with access to quality health care coverage. This Evidence of Coverage ("Member Handbook") is a summary of your benefits and the procedures required in order to receive the benefits and services to which you are entitled. Your specific benefits covered by Keystone are described in the Summary of Benefits section of this Member Handbook.

Please remember that this Member Handbook is a summary of the provisions and benefits provided in the program selected by your group. More detailed information is contained in the Group Master Contract available through your group benefits administrator. The information in this Member Handbook is subject to the provisions of the Group Master Contract. If changes are made to your group's program, you will be notified by your group benefits administrator. Contract changes will apply to benefits for services received after the effective date of change.

Please read your Member Handbook thoroughly and keep it handy. It will answer most of your questions regarding Keystone's procedures and services. **If you have any other questions, call or write the Keystone Member Services Department ("Member Services") at the telephone number and address shown on the back of your Keystone ID Card ("ID Card").**

Your ID Card

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

- **Check** the information on your ID Card for completeness and accuracy.
- **Check** that you received one ID Card for each enrolled family Member.
- **Check** that the name of the Primary Care Physician (or office) you selected is shown on your ID Card. Also, please check the ID Card for each family Member to be sure the information on it is accurate.
- **Call** Member Services if you find an error or lose your ID Card.
- **Carry** your ID Card at all times. You must present your ID Card whenever you receive medical care.

On the reverse side of the ID Card, you will find information about medical services, especially useful in Emergencies. There is even a toll-free number for use by Hospitals if they have questions about your coverage.

USING THE KEYSTONE SYSTEM

The Keystone program is different from traditional health insurance coverage. In addition to covering health care services, Keystone actually provides access to your medical care through your Primary Care Physician. **All medical treatment begins with your Primary Care Physician.** (Under certain circumstances, continuing care by a non-Participating Provider will be treated in the same way as if the provider were a Participating Provider. See "Continuity of Care" appearing later in the Handbook.)

Because your Primary Care Physician is the key to using the Keystone program, it is important to remember the following:

- **Always call your Primary Care Physician first** - before receiving medical care (except for conditions requiring Emergency Services). Please schedule routine visits well in advance.

- **When you need Specialist Services**, you must be Referred by your Primary Care Physician who will give you a written Referral for specific care. A Standing Referral may be available to you if you have a life-threatening, degenerative or disabling disease or condition. Female Members may visit any participating obstetrical/gynecological Specialist without a Referral. This is true whether the visit is for preventive care, routine obstetrical/gynecological care or problem-related obstetrical/gynecological conditions except in the case of treatment for reproductive endocrinology, infertility or gynecological oncology.

- **Your Primary Care Physician provides coverage 24 hours** a day, 7 days a week.

- **All follow-up care** as a result of Emergency Services must be provided or Referred by your Primary Care Physician or coordinated through Member Services.

- **Some services must be authorized by your Primary Care Physician and Preapproved by Keystone.** Your Primary Care Physician works with Keystone's Patient Care Management team during the Preapproval process. Services in this category include, but are not limited to: hospitalization; certain outpatient services; Skilled Nursing Facility services; and home health care. Services that require Preapproval are noted in the Benefit Summary section.

- **All services must be received from Keystone Participating Providers unless Preapproved by Keystone, or except in cases requiring Emergency Services.** Use your Provider Directory to find out more about the individual providers, including Hospitals and Primary Care Physicians and Referred Specialists and their affiliated Hospitals. It includes a foreign language index to help you locate a provider who is fluent in a particular language. The directory also lists whether the provider is accepting new patients.

- **To change your Primary Care Physician** call Member Services at the telephone number shown on the back of your ID Card.

ACCESS TO SPECIALIST AND HOSPITAL CARE

Direct Access to Obstetrical/Gynecological Care

Female Members may seek care directly (without a Referral from the Primary Care Physician) from a Keystone participating obstetrician or gynecologist for: routine maternity care; routine gynecological care; or other gynecological care. This does not include specialty care provided by a reproductive endocrinologist, infertility specialist, or gynecologic oncologist. In order to have benefits for specialty services related to reproductive endocrinology/infertility and gynecologic oncology, a Referral from the Primary Care Physician is required. In addition, care provided by any specialist other than a participating obstetrician or gynecologist requires a Referral from the Primary Care Physician.

How to Obtain A Specialist Referral

Always consult your Primary Care Physician first when you need medical care.

If your Primary Care Physician refers you to a specialist or facility just follow these steps:

- Your Primary Care Physician will give you a written Referral form which indicates the services authorized.
- Your Referral is valid for ninety (90) days from issue date as long as you are a Keystone Member.
- Give this form to the Referred Specialist or facility before the services are performed. Only services authorized on the Referral form will be covered.
- Any additional Medically Necessary treatment recommended by the Referred Specialist will require another written Referral from your Primary Care Physician.
- Services by non-Participating Providers require Preapproval by Keystone in addition to the written Referral from your Primary Care Physician.
- You must be an enrolled Member at the time you receive services from a Referred Specialist in order for services to be covered.

How to Obtain a Standing Referral

If you have a life-threatening, degenerative or disabling disease or condition, you may receive a Standing Referral to a Referred Specialist to treat that disease of condition. The Referred Specialist will have clinical expertise in treating the disease or condition. A Standing Referral is granted upon review of a treatment plan by Keystone and in consultation with your Primary Care Physician.

Follow these steps to initiate your Standing Referral request.

(1) Call Member Services at the telephone number shown on the back of your ID Card. (Or, you may ask your Primary Care Physician to call Provider Services or Patient Care Management ("PCM") to request a Standing Referral.)

(2) A "Standing Referral Request Form" will be mailed or faxed to the requestor.

(3) You must complete a part of the form and your Primary Care Physician will complete the clinical part. Your Primary Care Physician will then send the form to PCM.

(4) PCM will either approve or deny the request for the Standing Referral. You, your Primary Care Physician and the Referred Specialist will receive notice of the approval or denial in writing. The notice will include the time period for the Standing Referral.

If the Standing Referral is Approved

If the request for the Standing Referral to a Referred Specialist is approved, the Referred Specialist and your Primary Care Physician will be informed in writing by PCM. The Referred Specialist must agree to abide by all the terms and conditions that Keystone has established with regard to Standing Referrals. This includes but is not limited to the need for the Referred Specialist to keep your Primary Care Physician informed of your condition. When the Standing Referral expires, you or your Primary Care Physician will need to contact PCM and follow the steps outlined above to see if another Standing Referral will be approved.

If the Standing Referral is Denied

If the request for a Standing Referral is denied, you and your Primary Care Physician will be informed in writing. You will be given information to file a formal complaint.

Designating a Referred Specialist as Your Primary Care Physician

If you have a life-threatening, degenerative or disabling disease or condition, you may have a Referred Specialist named to provide and coordinate both your primary and specialty care. The Referred Specialist will be a Physician with clinical expertise in treating the disease or

condition. It is required that the Referred Specialist agree to meet the plan's requirements to function as a Primary Care Physician.

Follow these steps to initiate your request for your Referred Specialist to be your Primary Care Physician.

(1) Call Member Services at the telephone number shown on the back of your ID Card. (Or, you may ask your Primary Care Physician to call Provider Services or Patient Care Management ("PCM") to initiate the request.)

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

(3) You must complete a part of the form and your Primary Care Physician will complete the clinical part. Your Primary Care Physician will then send the form to PCM.

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

If the Referred Specialist as Primary Care Physician Request is Approved

If the request for the Referred Specialist to be your Primary Care Physician is approved, the Referred Specialist, your Primary Care Physician and you will be informed in writing by PCM.

If the Referred Specialist as Primary Care Physician Request is Denied

If the request to have a Referred Specialist designated to provide and coordinate your primary and specialty care is denied, you and your Primary Care Physician will be informed in writing. You will be given information to file a formal complaint.

Hospital Admissions

A. If you need hospitalization or outpatient surgery, your Primary Care Physician will arrange admission to the Hospital or outpatient surgical facility on your behalf.

B. Your Primary Care Physician will coordinate the Preapproval for your outpatient surgery or inpatient admission with Keystone, and Keystone will assign a Preapproval

number.

C. If you are Referred to a Referred Specialist by your Primary Care Physician and the Referred Specialist determines that you need outpatient surgery or hospitalization, the Referred Specialist and your Primary Care Physician will coordinate the Preapproval with Keystone.

D. You do not need to receive a written Referral from your Primary Care Physician for inpatient Hospital services that require Preapproval.

Continuity of Care

You have the option, if your Physician agrees to be bound by certain terms and conditions as required by Keystone, of continuing an ongoing course of treatment with that Physician for up to sixty (60) days from (i) receipt of notice that the status of your Physician has changed or (ii) your effective date of coverage when:

(1) your Physician is no longer a Participating Provider because Keystone terminates its contract with that Physician, for reasons other than cause; or

(2) you first enroll in the group plan and are in an ongoing course of treatment with a non-Participating Provider.

If you are in your second or third trimester of pregnancy, at the time of your enrollment or termination of a Participating Provider's contract, the continuity of care with that Physician will extend through post-partum care related to the delivery.

Follow these steps to initiate your continuity of care:

- Call Member Services at the number on your ID Card and ask for a "Request for Continuation of Treatment" form.
- The form will be mailed or faxed to you.
- You must complete the form and send it to the Patient Care Management Department at the address that appears on the form.

If your Physician agrees to continue to provide your ongoing care, the Physician must also agree and be bound by the same terms and conditions as apply to Participating Providers.

You will be notified when the participating status of your Primary Care Physician changes so that you can select another Primary Care Physician.

WHEN YOU NEED IMMEDIATE CARE

What are Emergency Services?

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

(1) placing the health of the Member or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part. Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an Emergency Service

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

What is Urgent Care?

"Urgent Care" is Medically Necessary Covered Services provided in order to treat an unexpected illness or accidental injury that does not require Emergency Services. Urgent Care Covered Services are required in order to prevent a serious deterioration in the Member's health if treatment were delayed.

Inside The Service Area

Urgent Care

If you are within the Service Area and you need Urgent Care, call your Primary Care Physician first. If your Primary Care Physician is not in the office, leave a message requesting a return call. Your Primary Care Physician provides coverage 24 hours a day, 7 days a week for Urgent Care. Your Primary Care Physician, or the Physician covering for your Primary Care Physician, will arrange for appropriate treatment. Urgent Care services will be covered only when provided or Referred by your Primary Care Physician.

Emergency Services

When Emergency Services are necessary, go immediately to the nearest health care provider. Notify your Primary Care Physician within 48 hours or as soon as possible.

Examples of conditions requiring Emergency Services are:

- excessive bleeding
- broken bones
- sudden onset of acute abdominal pains
- sudden onset of severe chest pain
- serious burns
- poisoning
- unconsciousness
- convulsions
- choking.

Coverage of reasonably necessary costs associated with Emergency Services provided during the period of the Emergency are covered by the plan.

Outside The Service Area

Urgent Care

Your out-of-area Urgent Care coverage will be coordinated through **HMO Blue USA℠**, a national network of HMOs sponsored by the Blue Cross and Blue Shield Association. A call to **1-800-4-HMO-USA** will connect you with a participating Blue Cross/Blue Shield HMO in the area. If this service is not available in the area you are visiting, seek care from a local Physician. You must notify your Primary Care Physician and Keystone within 48 hours, or as soon as possible after receiving Urgent Care outside the Service Area. You will not be covered for care that could have been provided before you left the Service Area or postponed until after you have returned.

Emergency Services

For Emergency Services out of the Service Area, go immediately to the nearest health care provider. Emergency Services do not require a Referral for treatment from the Primary

Care Physician. You must notify your Primary Care Physician and Keystone within 48 hours, or as soon as possible after receiving Emergency Services outside the Service Area.

Emergency Services do not include care that could have been provided before you left the Service Area, or that could have been postponed until after you have returned to the Service Area.

Payment for Immediate Care Services

If you have out-of-area Urgent Care or Emergency Services provided by a non-Participating Provider, ask the Provider to submit the bill to Keystone. Show the Provider your ID Card for the necessary information. If direct billing cannot be arranged, send us a letter explaining the reason care was needed and an original itemized bill to the address shown on the back of your ID Card.

Charges for Covered Services coordinated through **HMO Blue USA** are automatically forwarded to Keystone.

Note: **It is your responsibility to forward to Keystone any bill you receive for Emergency Services or out-of-area Urgent Care provided by a non-Participating Provider.**

Follow-up Care

After receiving Emergency Services, ask the health care provider to notify Keystone of the situation and the condition of the Member. If the Member's condition has stabilized and the can be moved, Keystone may arrange to relocate the Member to a Participating Provider facility to receive continuing care and treatment.

Call your Primary Care Physician if you need more care after getting Urgent Care.

All follow-up care must be provided or Referred by your Primary Care Physician or coordinated through Member Services.

Access to Urgent Care Benefits for Student Dependents Not Residing At Home

Dependent students who require Urgent Care while not residing at home and attending classes should follow the procedures listed below:

1. Residing Out Of the Service Area

   For direction on how to access care, call **HMO Blue USA** at 1-800-4-HMO-USA. If HMO Blue USA is not available, call Member Services at the telephone number shown

on the back of your ID Card.

2. Residing In the Service Area

   Call your Primary Care Physician or Keystone Member Services at the telephone number shown on the back of your ID Card for assistance.

If Urgent Care is received from a Provider other than the Member's Primary Care Physician, Member Services must be contacted within 48 hours of the initial treatment or as soon thereafter as possible.

All follow-up care must be provided or Referred by your Primary Care Physician or coordinated through Member Services.

Auto or Work-Related Accidents

Motor Vehicle Accident

If you or a Dependent are injured in a motor vehicle accident, contact your Primary Care Physician as soon as possible.

REMEMBER: Keystone will always be secondary to your auto insurance coverage. However, in order for services to be covered by Keystone as secondary, your care must be provided or Referred by your Primary Care Physician.

Tell your Primary Care Physician that you were involved in a motor vehicle accident and the name and address of your auto insurance company. Give this same information to any Provider to whom your Primary Care Physician refers you for treatment.

Call Member Services as soon as possible and advise us that you have been involved in a motor vehicle accident. This information helps Keystone to coordinate your Keystone Benefits with coverage provided through your auto insurance company. Only services provided or Referred by your Primary Care Physician will be covered by Keystone.

Work-Related Accident

Report any work-related injury to your employer and contact your Primary Care Physician as soon as possible.

REMEMBER: Keystone will always be secondary to your Worker's Compensation coverage. However, in order for services to be covered by Keystone as secondary, your care must be provided or Referred by your Primary Care Physician.

Tell your Primary Care Physician that you were involved in a work-related accident and the name and address of your employer and any applicable information related to your employer's Worker's Compensation coverage. Give this same information to any Provider to whom your Primary Care Physician refers you for treatment.

Call Member Services as soon as possible and advise us that you have been involved in a work-related accident. This information helps Keystone to coordinate your Keystone Benefits with coverage provided through your employer's Worker's Compensation coverage. Only services provided or Referred by your Primary Care Physician will be covered by Keystone.

WHEN TO NOTIFY KEYSTONE OF A CHANGE

Certain changes in your life may affect your Keystone coverage. Please notify us of any changes through the benefits office of your group benefits administrator. To help us effectively administer your health care benefits, Keystone should be notified of the following changes within thirty (30) days: name; address; status or number of Dependents; marital status; or eligibility for Medicare coverage;

Open Enrollment

Your group benefits administrator will have an open enrollment period at least once a year, and will notify you of the time. At this time, you may add eligible Dependents to your coverage.

Newly Hired

Within 30 days of becoming eligible for your new group's health coverage, you may join Keystone. You must add existing eligible Dependents to your coverage at this time or wait until the next open enrollment period.

Marriage

You may add your spouse to your coverage within 30 days of your marriage. Please complete the Keystone Enrollment/Change Form for your new spouse, and give the form to your benefits office. Forms are available through your benefits office or Keystone. Coverage for your spouse will be effective on the date of your marriage.

New Child

Coverage is effective at the time of birth for the newborn child of a Member, and shall continue for a period of thirty-one (31) days after the birth. If you choose to continue coverage for the new child, you must add your eligible child (newborn or adopted child) within thirty-one (31) days of the date of birth or placement of the adopted child. Please

complete the Keystone Enrollment/Change Form for your new child and give the form to your benefits office. Forms are available through your group benefits administrator or Keystone. Coverage will be effective from the date of birth or the day the child was placed for adoption.

In situations where the newborn's father is a Keystone Member but the mother is not a Member, Member Services must be notified prior to the mother's hospitalization for delivery.

Court-Ordered Dependent Coverage

If you are required by a court order to provide health care coverage for your eligible Dependent, your Dependent will be enrolled within thirty (30) days from the date Keystone receives the Enrollment/Change Form and a copy of the court order.

You must notify Keystone of any changes in spouse or Dependent coverage within thirty (30) days of the change in order to ensure coverage for all eligible family members.

CONTINUATION & CONVERSION OF COVERAGE

Continuation

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), under certain circumstances your employer may be required to offer you the option of temporary extension of your coverage, when it would otherwise end. The events that would qualify you or your covered family Members for this continued coverage include:

- the death of the Subscriber;
- termination of employment (except for gross misconduct);
- divorce or legal separation;
- loss of Dependent status;
- a reduction in the number of hours worked.

The continued coverage must be the same as that offered under the group health plan, and it may be continued for 18 to 36 months, depending on the situation. If you would like more details on eligibility, please consult your benefits office.

Conversion

If you or your Dependents become ineligible for coverage through your group plan, you may apply for continuation of Keystone coverage in an appropriate non-group program. Your application for this conversion coverage must be made to Keystone within thirty (30) days of when you become ineligible for group coverage. The benefits provided under the available non-group program may not be identical to the benefits under your group plan.

The conversion privilege is available to you and:

- your surviving Dependents, in the event of your death;
- your spouse, in the event of divorce;
- your Dependent child who has reached the Limiting Age for Dependents.

This conversion privilege is not available if you are terminated by Keystone for cause (such as deliberate misuse of an ID Card, significant misrepresentation of information that is given to Keystone or a Provider, or fraud).

If you need more information regarding your conversion privilege, please call our Member Serviçes at the telephone number shown on the back of your ID Card.

Should you choose continued coverage under COBRA (see above), you become eligible to convert to an individual, non-group plan at the end of your COBRA coverage.

YOUR MEMBERSHIP RIGHTS

If you have questions, suggestions, problems, or concerns regarding benefits or services rendered, Keystone is ready to assist you. Don't hesitate to call our Member Services at the telephone number shown on the back of your ID Card. Our Representatives will respond to any inquiry promptly.

MEMBER RIGHTS

Keystone and the Participating Providers honor the following rights of all Members:

- The Member has the right to information about the health plan, its benefits, policies, participating practitioners, and Members' rights and responsibilities.
- The Member has a right to voice Complaints and appeals about the health plan or care provided, and to receive a timely response.
- The Member has the right to choose practitioners, within the limits of the plan network, including the right to refuse care from specific practitioners.
- The Member has the right to participate in decision making regarding his/her health care. This right includes unrestrained clinical dialogue between participating practitioners and Members.
- The Member has the right to be treated with respect, dignity, and privacy.
- The Member has the right to confidential treatment of medical information. The Member also has the right to have access to his/her medical record in accordance with applicable Federal and State laws.
- The Member has the right to reasonable access to medical services.
- The Member has the right to receive health care services without discrimination based on race, color, religion, gender, sexual orientation, or national origin.
- The Member has the right to formulate advance directives. Keystone will provide information concerning advance directives to Members and practitioners and will support Members through its medical record keeping policies.

MEMBER COMPLAINT AND GRIEVANCE PROCESS

Informal Member Complaint Process

Keystone will make every attempt to answer any questions or resolve any concerns you have related to benefits or services. If you have a concern, you should call Member Services at the toll-free telephone number listed on the back of your ID card, or write to the Manager of Member Services, Keystone Health Plan East, P.O. Box 8339, Philadelphia, PA 19101-8339. Most Member concerns are resolved informally at this stage. If Keystone cannot immediately resolve your concern, we will investigate it and respond to you **within thirty (30) days**. If you are not satisfied with the response to your concern from Keystone, you have the right to file a formal Complaint **within sixty (60) days**, through the Formal Member Complaint Process described below.

Formal Member Complaint Process

Keystone Members may file a formal Complaint regarding an unresolved dispute or objection regarding coverage, including contract exclusions and non-covered benefits, participating or non-participating health care provider status, or the operations or management policies of Keystone. The Complaint process consists of two (2) internal levels of review by Keystone, and one external level of review by the Pennsylvania Department of Health or the Pennsylvania Insurance Department. Remember, no legal action can be taken until all of the Complaint procedures have been followed.

Internal First Level Complaint:

You may file a formal first level Complaint **within sixty (60) days** from either your receipt of the original notice from Keystone, or from completion of the informal complaint process described above. To file a first level Complaint, call Member Services toll free at the telephone number listed on the back of your ID card, or write to Member Services, PO Box 8339, Philadelphia, PA, 19101-8339.

Keystone's review of your first level Complaint will be completed **within thirty (30) days** from the date of receipt of that Complaint by Keystone. We will then send you our decision in writing **no later than five (5) business days** after reaching a decision. If you are not satisfied with the decision on your first level Complaint, you may file a second level Complaint with Keystone, **within sixty (60) days** from receipt of the first level Complaint decision letter.

Internal Second Level Complaint:

To file a second level Complaint, call or write the Member Appeals Unit at P.O. Box 41820, Philadelphia, PA 19101-1820, 1-888-671-5276 or fax 1-888-671-5274 **within sixty (60) days** from your receipt of the first level Complaint decision letter from Keystone.

We will contact you to arrange the Second Level Complaint Committee meeting. That Committee will meet and render a decision **within forty-five (45) days** from the date of Keystone's receipt of your second level Complaint. The Second Level Complaint Committee is composed of at least three (3) members who have had no previous involvement with the case. The Second Level Committee members will include Keystone staff, with one third of the Committee being enrollees or other persons who are not employed by Keystone. You have the right to present your second level Complaint to the Committee in person, through a representative, or via conference call.

The Second Level Complaint Committee meetings are a forum where Members are allowed to present their issues in an informal setting that is not open to the public. The Member may be accompanied by two other persons unless the Member receives prior approval from Keystone for additional assistance due to special circumstances. Members of the press may only attend in their personal capacity as a Member's representative. Members may not transcribe, audio- or video-tape the proceedings.

Keystone will send you a written notice of the decision **within five (5) business days** of the decision by the Second Level Complaint Committee. The decision is final unless you choose to appeal to the Pennsylvania Insurance Department or Department of Health **within fifteen (15) days** after your receipt of the second level Complaint decision notice from Keystone.

External Complaint Review:

If you wish to appeal the second level Complaint decision, you may contact the Pennsylvania Insurance Department or Department of Health, as appropriate, **within fifteen (15) days** after your receipt of the second level Complaint decision notice from Keystone, as follows:

Pennsylvania Insurance Department
Bureau of Consumer Services
1321 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388

Bureau of Managed Care
Department of Health
Attn: Complaint Appeals
P.O. Box 90
Harrisburg, PA 17108-0080
1-888-466-2787

Your external Complaint appeal should include your name, address, daytime telephone number, the name of Keystone as your managed care plan, your Keystone ID number, and a brief description of the issue being appealed. Also include a copy of your original Complaint to Keystone and copies of any correspondence and decision letters from Keystone.

Please note that these procedures may change due to changes in the applicable state and federal laws and regulations.

Member Grievance Process For Decisions Based On Medical Necessity:

Keystone Members may file a Grievance of a decision by Keystone regarding a determination of Coverage that was based primarily on Medical Necessity or appropriateness. The Grievance process consists of two (2) internal Grievance reviews by Keystone and an external review through an external utilization review agency assigned by the Pennsylvania Department of Health. Remember, no legal action can be taken until all of the Grievance procedures have been followed.

Internal First Level Grievance:

The first level Grievance must be filed with Keystone by you, or your provider acting on your behalf, with your written consent, within **sixty (60) days** of receipt of the original response by Keystone. When filing the first level Grievance, you (or your provider) must include all necessary supporting information. The first level Grievance may be filed by calling as directed in the original notice from Keystone, by calling Member Services toll-free at the telephone number listed on the back of your ID Card, or by writing to the Patient Care Management Department, P.O. Box 42952, Philadelphia, PA 19101.

The Grievance will be forwarded to the First Level Grievance Committee. The first level Grievance will be reviewed by one or more persons selected by Keystone who did not previously participate in the decision to deny payment for a health care service and shall include a licensed physician, or, where appropriate, a licensed psychologist, in the same or similar specialty that typically manages or consults on the health care service. The First Level Grievance Committee will complete its review **within thirty (30) days** from the date of receipt of your first level Grievance request by Keystone. We will then send you and your provider a written notice of the decision **within five (5) business days** of the decision. The notice will specify the reason(s) and clinical rationale for the decision and the

procedure for appeal. If at that time you, or the provider on your behalf and with your written consent, wishes to appeal the decision of the First Level Grievance Committee, you may appeal to the Second Level Grievance Committee **within sixty (60) days** of receipt of the notice of denial.

Expedited Grievance:

If your case involves a serious medical condition which you believe would jeopardize your life, health or ability to regain maximum function while awaiting a standard Internal First Level Grievance Committee review, you, or your provider acting on your behalf and with your written consent, can ask to have your case reviewed by Keystone in a quicker manner (expedited Grievance). You may request an expedited Grievance by calling Member Services at the toll-free telephone number listed on the back of the Member's ID card. Keystone will arrange to have the Grievance reviewed by a Keystone Medical Director who was not previously involved with the case.

This review will be completed promptly, based on your health condition, but in **no more than forty-eight (48) hours** after receipt of your Grievance request by Keystone. If you are not satisfied with the expedited decision from Keystone, you or your provider, acting on your behalf and with your written consent, may file an internal second level Grievance to the Second Level Grievance Committee, as described below.

Internal Second Level Grievance:

You, or your provider acting on your behalf and with your written consent, may file a second level Grievance by writing or calling the Member Appeal Unit at P.O. Box 41820, Philadelphia, PA 19101-1820, 1-888-671-5276 or fax 1-888-671-5274 **within sixty (60) days** after your receipt of the first level Grievance decision letter from Keystone.

The Second Level Grievance Committee, will meet and render a decision promptly, based on your health condition, but **no later than forty-five (45) days** after receipt of your Grievance request by Keystone. The second level Grievance will be reviewed by three or more persons selected by Keystone who did not previously participate in the decision to deny payment for a health care service and shall include a licensed physician, or, where appropriate, a licensed psychologist, in the same or similar specialty that typically manages or consults on the health care or service involved. If you are appealing to the Second Level Grievance Committee, you may designate a representative to participate on your behalf. You have the right to present your second level Grievance in person, through a representative, or via conference call.

The Second Level Grievance Committee meetings are a forum where Members are allowed to present their issues in an informal setting that is not open to the public. The Member may be accompanied by a maximum of two other persons unless the Member receives prior approval from Keystone for additional assistance due to special circumstances.

Members of the press may only attend in their personal capacity as a Member's representative. Members may not transcribe, audio- or video-tape the proceedings.

Keystone will send you and your provider a written notice of the decision **within five (5) business days** after the decision by the Second Level Grievance Committee. The decision is final unless you, or your provider with your written consent, choose to file an external Grievance **within fifteen (15) days** of receipt of the second level Grievance decision by Keystone.

External Grievance:

To request an external Grievance by an independent utilization review agency assigned by the Pennsylvania Department of Health, write to the Patient Care Management Department, P.O. Box 42952, Philadelphia, PA 19101 **within fifteen (15) days** of receipt of the second level Grievance decision letter from Keystone. If your health care provider files the Grievance on your behalf, Keystone will verify with you that the provider is acting in your behalf, with your consent. You will not be required to pay any of the costs associated with the external Grievance review, however, there is a $25 filing fee, payable to Keystone that should be forwarded to Patient Care Management at the above address.

Keystone will contact the Pennsylvania Department of Health to request assignment of a certified utilization review agency to your Grievance, and will notify you of the name, address and telephone number of the external agency assigned by the Department of Health to your Grievance **within two (2) business days** of the assignment by the Department. You, your provider, if acting on your behalf, and Keystone **have two (2) business days** to notify the Department of Health, if there is an objection to the assignment of the external review agency on the basis of conflict of interest.

The external review agency will send you, your provider, if acting on your behalf, and Keystone a written decision **within sixty (60) days** of the date you or your provider filed the request for an external review. Upon receiving the decision from the external review agency, Keystone will authorize payment for services or pay claims if the decision of the external review agency is that the services were Medically Necessary. The external Grievance decision may be appealed to a court of competent jurisdiction **within sixty (60) days** of the decision by the external agency.

Please note that these procedures may change due to changes in the applicable state and federal laws and regulations.

Recommended Plan of Treatment

You agree, when joining Keystone, to receive care according to the recommendations of your Primary Care Physician. You have the right to give your informed consent before the start of any procedure or treatment. You also have the right to refuse any drugs, treatment or other procedure offered to you by Keystone providers, and to be informed by your physician of the medical consequences of your refusal of any drugs, treatment, or procedure. Keystone and your Primary Care Physician will make every effort to arrange a professionally acceptable alternative treatment. However, if you still refuse the recommended Plan of Treatment, Keystone will not be responsible for the costs of further treatment for that condition and you will be so notified. You may use the Grievance Procedure to have your case reviewed.

Changing Your Primary Care Physician

You may change your Primary Care Physician up to two times within each calendar year. To do so, simply call Member Services at the telephone number shown on the back of your ID Card. Your change will be effective on the first of the month following your phone call. Please remember to have your medical records transferred to your new Primary Care Physician.

If the participating status of your Primary Care Physician changes, you will be notified in order to select another Primary Care Physician.

Changing Your Referred Specialist

You may change the Referred Specialist to whom you have been Referred by your Primary Care Physician or for whom you have a Standing Referral. To do so, ask your Primary Care Physician to recommend another Referred Specialist before services are performed. Or, you may call Member Services at the telephone number shown on the back of your ID Card. Remember, only services authorized on the Referral form will be covered.

Termination of Coverage

Keystone may cancel your coverage under the following conditions:

1. If you are guilty of fraud or material misrepresentation of fact in applying for or obtaining coverage from Keystone (subject to your rights under the Member Complaint and Grievance Process);

2. If you misuse your ID Card, or allow someone other than your eligible Dependents

to use an ID Card to receive care or benefits.

3. If you cease to meet the eligibility requirements;

4. Your group terminates coverage with Keystone;

5. If you display a pattern of non-compliance with your Physician's Plan of Treatment. (You will receive written notice at least thirty (30) days prior to termination. You have the right to utilize the Member Complaint and Grievance Process.);

6. If you do not cooperate with Keystone in obtaining information necessary to determine Keystone's liability under this program.

NOTE: Keystone will **not** terminate your coverage because of your health status, your need for Medically Necessary Covered Services or your having exercised rights under the Complaint and Grievance Process.

When a Subscriber's coverage terminates for any reason, coverage of the Subscriber's covered family members will also terminate.

Confidentiality and Disclosure of Medical Information

You have the right to have all records pertaining to your medical care treated as confidential. Information may be released only for:

1. internal use by Keystone or Hospitals in bona fide medical research or education;

2. use in the administration of your benefits;

3. compliance with government requirements established by law.

Member Liability

Except when certain Copayments or other Limitations are specified in the Group Master Contract and this Member Handbook or the Schedule of Copayments & Limitations, you are not liable for any charges for Covered Services when these services have been provided or Referred by your Primary Care Physician.

YOUR MEMBERSHIP RESPONSIBILITIES

MEMBER RESPONSIBILITIES

In support of a person's rights as a Member and to help the Member participate fully in the health plan, Keystone Members have certain responsibilities:

- Members have the responsibility to review all benefit and membership materials carefully and to follow the regulations pertaining to the health plan.

- Members have the responsibility to communicate, to the extent possible, information participating practitioners need in order to care for the Member.

- Members have the responsibility to follow instructions and guidelines given by participating practitioners. This responsibility includes consideration of the possible consequences of failure to comply with recommended treatment.

- Members have the responsibility to ask questions to assure understanding of the explanations and instructions given.

- Members have the responsibility to treat others with the same respect and courtesy expected for oneself.

- Members have the responsibility to keep scheduled appointments or to give adequate notice of delay or cancellation.

Coordination of Benefits

If you or any of your Dependents have other group health insurance coverage which provides benefits for Hospital, medical, or other health expenses, your benefit payments may be subject to Coordination of Benefits (COB). COB refers to the administration of health benefit coverage when a person is covered by more than one group plan. COB provisions:

1. determine which health plan will be the primary payor and which will be the secondary payor;

2. regulate benefit payments so that total payments by all insurers do not exceed total charges for Covered Services;

3. apply to all your benefits, however, Keystone will provide access to Covered Services first and apply the applicable COB rules later;

4. allow Keystone to recover any expenses paid in excess of its obligation as a non-primary payor;

5. apply to services for the treatment of injury resulting from the maintenance or use of a motor vehicle.

Coordination of Benefits Administration

1. If another plan under which you have coverage does not have a COB provision, that plan will be primary and Keystone will be secondary. In order for services to be covered by Keystone as secondary, your care must be provided or Referred by your Primary Care Physician.

2. For those plans which have COB clauses, the following provisions apply:

   A. The plan which covers a Member as a Subscriber (meaning not a Dependent) will be primary. The plan which covers the Member as Dependent will be secondary;

   B. If there is a court decree which establishes financial responsibility for the health care expenses of the Dependent child, the plan which covers the child as a Dependent of the parent with such financial responsibility will be the primary plan;

   C. Where both plans cover a Member as a Dependent child, the plan of the parent whose date of birth (excluding year) occurs earlier in the calendar year will be primary (the Birthday Rule). If both parents have the same birthday, the plan covering the parent longer will be primary;

   D. If parents are separated or divorced, and no court decree applies, the benefits for the child will be determined as follows:

      (1) the plan of the parent with custody of the child will be primary;

      (2) the plan of the spouse of the parent with custody of the child will be secondary;

      (3) the plan of the parent not having custody of the child will be third;

      (4) in cases of joint custody, benefits will be determined by paragraph 2.C. above, the Birthday Rule.

Subrogation

In the event that legal grounds for the recovery of health care costs exist (such as when an illness or injury is caused by the negligence or wrong doing of another party), Keystone has the right to seek recovery of such costs, unless prohibited by statute or regulation. When requested, you must cooperate with Keystone to provide information, sign necessary documents, and take any action necessary to protect and assure the subrogation rights of Keystone.

SUMMARY OF BENEFITS

A description of covered benefits, Limitations and exclusions may be found in this Summary of Benefits section and the Schedule of Copayments & Limitations included with this Member Handbook. Sometimes additional benefits may be provided by your group through the addition of a rider. If applicable, this benefit information is also included with this Handbook.

More detailed information on eligibility, terms and conditions of coverage, and contractual responsibilities is contained in your group's contract with Keystone. This is available through your group benefits administrator.

If you should have questions about any information in this Member Handbook or need assistance at any time, please feel free to contact Member Services by calling the telephone number shown on the back of your ID Card.

Benefits may be subject to Copayments and Limitations. A Schedule of Copayments & Limitations is included with this Member Handbook. Please take time to read this Summary of Benefits and the Schedule of Copayments & Limitations, and use them as references whenever services are required.

1. PRIMARY AND PREVENTIVE CARE

Each Member, upon enrollment, will select a Primary Care Physician. The following benefits are available through the Primary Care Physician listed on your ID Card.

Treatment for illness and injury

Physical examinations

Routine child care including well-baby visits

Gynecological exams and Pap smears

Immunizations except those required for college, travel or work (see definition for Immunization)

Hearing screening for diagnostic purposes

Routine allergy injections

Vision screening

Office visits during and after regular office hours, including visits for Emergency Services, and home visits when Medically Necessary

Referrals to a Referred Specialist for Medically Necessary care

2. ADDITIONAL COVERED SERVICES

INPATIENT AND OUTPATIENT SERVICES

The following benefits are provided on both an inpatient and outpatient basis. These benefits are provided only if services are:

- Medically Necessary;
- Provided or Referred by your Primary Care Physician; and
- Preapproved by Keystone, where specified.

Allergy Testing and Treatment

Anesthesia

Autologous Blood Drawing/Storage/Transfusion (Preapproval)

Benefits are available for services provided in conjunction with a planned episode of care that requires transfusion

Cardiac Rehabilitation Therapy (Preapproval)

Chemotherapy (Preapproval)

Diagnostic Laboratory and X-ray

Dialysis

Family Planning

Covered Services include sterilization procedures, such as tubal ligation and vasectomy, elective abortion, and limited infertility services (see list of exclusions). [Changes to this benefit, if any, are described in an insert in the back of this Handbook.]

Medical Foods (Preapproval)

Benefits are provided for nutritional products specifically formulated for the therapeutic treatment of phenylketonuria, branch-chain ketonuria, galactosemia, and

homocystinuria. This treatment must be administered by the Primary Care Physician or Referred Specialist

Mental Health Care (Preapproval for inpatient services)

In addition to inpatient and outpatient services, benefits are provided for partial hospitalization services.

Newborn Care

Benefits are provided for the routine and Medically Necessary care of a newborn child of a Member for the first thirty-one (31) days following birth. Continuing benefits are available if the child meets the eligibility requirements (See page XX, When To Notify Keystone Of A Change).

Obstetrical Care

Obstetrical care including prenatal and postnatal care, complications of pregnancy and childbirth.

Oral Surgery (Preapproval)

Benefits are provided for the following services:

A. the removal of teeth which are partially or totally covered by bone;

B. treatment for accidental injury to the jaw or to sound natural teeth;

C. the correction of a non-dental physiological condition which has resulted in a severe functional impairment;

D. treatment for tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Pulmonary Rehabilitation Services (Preapproval)

Benefits are limited to treatment received within a sixty (60) consecutive day period.

Radiation Therapy

Rehabilitation Therapy Services (Preapproval required for Speech therapy)

Covered Services are subject to the determination that significant improvement can be expected. Covered therapies include:

- Occupational
- Physical
- Speech

Respiratory Therapy (Preapproval)

Specialist Services

Services provided by a participating specialist are covered with a Referral from your Primary Care Physician. Services provided by a non-participating specialist require Keystone Preapproval.

Substance Abuse Treatment (Preapproval for inpatient services)

Benefits include services necessary for the diagnosis, medical treatment, and non-medical rehabilitation of Substance Abuse, including detoxification in an acute care Hospital or a Substance Abuse Treatment Facility. Benefits include:

A. diagnostic services, including psychiatric, psychological and medical laboratory tests;

B. services provided by a staff physician, psychologist, registered or licensed practical nurse, and/or certified addictions counselor;

C. rehabilitation therapy and counseling;

D. family counseling and intervention;

E. drugs, medicines, supplies and use of equipment provided by a Substance Abuse Treatment Facility; and

F. lodging and dietary services.

Surgery (Preapproval)

OUTPATIENT SERVICES

The following benefits are provided on an outpatient basis when:

- Medically Necessary;

- Provided or Referred by your Primary Care Physician; and
- Preapproved by Keystone, where specified.

Ambulance Service (Preapproval, unless an Emergency Service)

Gynecological Care

Benefits are provided for female Members for Covered Services provided by any Keystone participating obstetrical/gynecological Specialist without a Referral. Covered Services include:

A. routine maternity care;

B. routine gynecological care including Papanicolaou (PAP) smears; and

C. other gynecological care.

A Referral is required for specialty care provided by a reproductive endocrinologist, infertility specialist, or gynecologic oncologist.

Hearing Care

Benefits are provided for hearing screenings performed for diagnostic purposes.

Injections

Benefits are provided for injectable medications for the immediate treatment of an injury or acute illness when administered in the physician's office.

Mammograms

One routine mammogram per calendar year is covered for women age forty (40) or over and is available with a Referral. This Referral may be provided by your Primary Care Physician or obstetrical/gynecological Specialist or Keystone. Other mammograms will be covered only when recommended by your Primary Care Physician or a Referred Specialist. Approval by your Primary Care Physician is not required for a Referral received from the Member's obstetrical/gynecological Specialist or Keystone.

Orthotics

Benefits are provided for the initial purchase and fitting of orthotics, except foot orthotics. Benefits for replacement of **covered** orthotics are provided only for

Dependent children when due to natural growth

Prosthetics (Preapproval)

The initial purchase and fitting of prosthetic devices and supplies except dental prosthetics are covered. Benefits for replacement of **covered** prostheses are provided only for Dependent children when due to natural growth.

[Spinal Manipulation Services (Preapproval)

Covered Services may be provided by a Primary Care Physician trained to perform such services or a Referred Specialist. Benefits are limited to treatment of an acute condition related to an acute medical episode when determined to be Medically Necessary and Preapproved by Keystone.]

INPATIENT SERVICES

The following services are covered on an inpatient basis when:

- Medically Necessary;
- Provided or Referred by your Primary Care Physician; and
- Preapproved by Keystone.

PLEASE NOTE: ALL INPATIENT SERVICES MUST BE PREAPPROVED BY Keystone AT LEAST FIVE (5) WORKING DAYS BEFORE ADMISSION, except for an Emergency admission.

Hospital Services (Preapproval)

Benefits are provided for unlimited days in a Hospital. Inpatient mental health services, rehabilitation therapy, and Substance Abuse treatment may be subject to Limitations. These Limitations, if applicable, are shown on the Schedule of Copayments & Limitations. Unless otherwise included in an insert in the back of this Handbook, the following inpatient Hospital services are covered:

A. semi-private room and board (other accommodations if Medically Necessary);

B. general nursing care (private duty nursing if Medically Necessary);

C. drugs, medications, and biologicals;

D. use of operating room and related services;

E. use of intensive care or cardiac units and related services;

F. oxygen services;

G. administration of whole blood and blood plasma; and

H. other Medically Necessary supplies and equipment.

Inpatient Physician Care (Preapproval)

Benefits are provided for Covered Services received during a Preapproved inpatient admission.

Organ Transplants (Preapproval)

Benefits are provided for transplant services for a Member recipient. Covered Services include procedures which are generally accepted as not Experimental Or Investigative by medical organizations of national reputation. These organizations are recognized by Keystone as having special expertise in the area of medical practice involving transplant procedures.

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

If a Member is an organ donor, expenses related to organ donation are not covered unless the recipient is also a Keystone Member. If the recipient is a Member, covered expenses of a Member donor are:

- removal of the organ;
- preparatory pathologic and medical examinations; and
- post-surgical care.

Skilled Nursing Facility Services (Preapproval)

Benefits are provided for care in a Skilled Nursing Facility (SNF) as long as the services are not considered Custodial or Domiciliary Care. Benefits are limited to semi-private accommodations (or an allowance equal to this rate which may be applied to private accommodations).

EXCLUSIONS - WHAT IS NOT COVERED

The following are excluded from your coverage:

Services or supplies which are:

1. not provided by or Referred by the Member's Primary Care Physician except in an Emergency; or

2. not Medically Necessary, as determined by the Primary Care Physician and/or Keystone, for the diagnosis or treatment of illness, injury or restoration of physiological functions. This exclusion does not apply to routine and preventive Covered Services specifically provided under this Contract.

3. The cost of services or supplies which are payable under Worker's Compensation or employer's liability laws or other legislation of similar purpose or services for which the Member has no obligation to pay.

4. Care related to military service disabilities and conditions which the Member is legally entitled to receive at government facilities which are not Keystone Providers, and which are reasonably accessible to the Member.

5. Care for conditions that federal, state or local law requires to be treated in a public facility.

6. The cost of services covered under the Medicare program.

7. The cost of Hospital, medical or other health services resulting from accidental bodily injuries arising out of a motor vehicle accident, to the extent such costs are payable under any medical expense payment provision (by whatever terminology used - including benefits mandated by law) of any automobile insurance policy unless otherwise prohibited by applicable law.

8. Dental care including, but not limited to, treatment of teeth, extraction of teeth which are not impacted by bone, treatment of dental abscesses or granuloma, treatment of gingival tissues (other than for tumors), dental examinations, treatment for temporomandibular joint syndrome or dysfunction, orthognathic surgery (to treat non-traumatic jaw deformity), and any other dental product or service unless specifically provided elsewhere in the Group Master Contract.

9. Charges for broken appointments, services for which the cost is later recovered through legal action, compromise, or claim settlement, and charges for additional treatment necessitated by lack of patient cooperation or failure to follow a

prescribed Plan of Treatment.

10. Medical, surgical or any other health care procedures and treatments which are Experimental Or Investigative.

11. Physical examinations for non-preventive purposes, such as pre-marital examinations, physicals for college, camp or travel, and examinations for insurance, licensing and employment.

12. Cosmetic surgery, including cosmetic dental surgery. Cosmetic surgery is defined as any surgery done primarily to alter or improve the appearance of any portion of the body, and from which no significant improvement in physiological function could be reasonably expected.

13. This exclusion includes surgical excision or reformation of any sagging skin on any part of the body, including, but not limited to, the eyelids, face, neck, arms, abdomen, legs or buttocks; and services performed in connection with enlargement, reduction, implantation or change in appearance of a portion of the body, including, but not limited to the breasts (except reconstruction for post-mastectomy patients), ears, lips, chin, jaw or nose.

14. This exclusion does not include those services performed when the patient is a Member of Keystone and performed in order to restore bodily function or correct deformity resulting from a disease, recent trauma, or previous therapeutic process any of which occurs while such patient is a Member of Keystone.

15. This exclusion does not apply to otherwise Covered Services necessary to correct medically diagnosed congenital defects and birth abnormalities for children who are covered as Dependents since birth.

16. All rehabilitative therapy except as described in the Group Master Contract and summarized in this Member Handbook.

17. All routine hearing examinations.

18. Hearing aids, or the fitting thereof, or cochlear electromagnetic hearing devices or related services.

19. All procedures performed solely to eliminate the need for or reduce the prescription of corrective vision lenses including, but not limited to, radial keratotomy and refractive keratoplasty;

20. Services for treatment of mental retardation or other mental health services, except as otherwise provided herein.

21. Immunizations required for college, employment, or travel.

22. Custodial and Domiciliary Care, residential care, protective and supportive care, including educational services, rest cures and convalescent care.

23. Weight reduction programs, including all diagnostic testing related to weight reduction programs, unless Medically Necessary. This exclusion does not apply to Keystone's weight reduction program.

24. Nutritional supplements, except when the Member has no other source of nutritional intake due to a metabolic or anatomic disorder;

25. Customized or motorized wheelchairs and other motor devices to assist or replace ambulatory functions, or other customized Durable Medical Equipment.

26. Personal or comfort items such as television, telephone, air conditioners, humidifiers, barber or beauty service, guest service and similar incidental services and supplies which are not Medically Necessary.

27. Normal childbirth deliveries outside the Service Area within thirty (30) days of the expected delivery date established by the Provider in charge of the case.

28. Any procedure or treatment designed to alter physical characteristics of the Member to those of the opposite sex, and any other treatment or studies related to sex transformations.

29. Treatment of bunions (except capsular or bone surgery), toenails (except surgery for ingrown nails), corns, calluses, fallen arches, flat feet, weak feet, chronic foot strain or symptomatic complaints of the feet or other routine podiatry care, unless associated with peripheral vascular disease and/or diabetes and deemed Medically Necessary by the Primary Care Physician or Keystone.

30. Non-medical services for the treatment of Substance Abuse in an acute care Hospital.

31. Marriage counseling.

32. In vitro fertilization, embryo transplant, ovum retrieval including, but not limited to, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and any services required in connection with these procedures.

33. Reversal of voluntary sterilization and services required in connection with such procedures.

34. Foot orthotic devices and the repair or replacement of external prosthetic devices, except as described in the Group Master Contract and in the Benefit Summary of this Member Handbook.
35. Cranial prostheses including wigs and other devices intended to replace hair.

36. Outpatient prescription drugs and medications, except if covered by a prescription drug rider; drugs and medications that may be dispensed without a doctor's prescription; contraceptive drugs and devices, except when covered by a prescription drug rider.

37. Ambulance service, unless Medically Necessary.

38. Whole blood or blood plasma.

39. Services required by a Member donor related to organ donation. Expenses for donors donating organs to Member recipients are covered only as described in the Group Master Contract. No payment will be made for human organs which are sold rather than donated.

40. Charges for completion of any insurance form.

41. Treatment for injuries sustained while committing a felony, or while intoxicated or under the influence of any narcotic not prescribed or authorized by the Primary Care Physician.

42. Injectable medications except those necessary for the immediate treatment of an injury or acute illness when provided or Referred by the Primary Care Physician and administered in the physician's office.

43. Any services, supplies or treatments not specifically listed in the Group Master Contract as covered benefits, unless the unlisted benefit, service or supply is a basic health service required by the Pennsylvania Department of Health. Keystone reserves the right to specify Providers of, or means of delivery of Covered Services, supplies or treatments under this plan, and to substitute such Providers or sources where medically appropriate.

- [Artificial insemination;]

- [Spinal manipulation services;]

IMPORTANT DEFINITIONS

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

- **CARDIAC REHABILITATION THERAPY** - a medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.

- **CHEMOTHERAPY** - the treatment of malignant disease by chemical or biological antineoplastic agents.

- **COMPLAINT** - a dispute or objection regarding coverage, including exclusions and noncovered benefits under the plan, Participating or non-Participating Providers' status or the operations or management policies of Keystone. This definition does not include a Grievance (Medical Necessity appeal). It also does not include disputes or objections that were resolved by Keystone and did not result in the filing of a Complaint (written or oral).

- **COPAYMENT** - a specified dollar amount applied to a specific Covered Service for which the Member is responsible per Covered Service. Copayments, if any, are identified in the SCHEDULE OF COPAYMENTS & LIMITATIONS.

- **COVERED SERVICE** - a service or supply specified in the Group Master Contract and summarized in the Summary of Benefits section of this Member Handbook, for which benefits will be provided.

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

- **DEPENDENT** - an individual who resides in the Service Area, who meets all the eligibility requirements established by Keystone, who is enrolled under Keystone coverage, and who is:

  A. the Subscriber's legal spouse; or

  B. the Subscriber's unmarried child (natural, legally adopted or placed for adoption, or stepchild), or child for whom the Subscriber or the Subscriber's spouse is a court appointed legal guardian. Such child must be within the

Limiting Age For Dependents.

- **DIALYSIS** - treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body.

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

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

  A. placing the health of the Member or with respect to a pregnant Member, the health of the pregnant Member or her unborn child, in serious jeopardy;

  B. serious impairment to bodily functions; or

  C. serious dysfunction of any bodily organ or part. Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an Emergency Service

- **ENROLLMENT/CHANGE FORM** - the properly completed, written request for enrollment for Keystone membership submitted in a format provided by Keystone, together with any amendments or modifications thereof.

- **EXPERIMENTAL OR INVESTIGATIVE** - a drug, device, medical treatment or procedure:

  A. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is furnished; or

  B. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or

  C. if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated

dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

D. if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

- **GRIEVANCE** - a request by a Member or a health care provider, with the written consent of the Member, to have Keystone reconsider a decision solely concerning the Medical Necessity or appropriateness of a health care service. This definition does not include a Complaint. It also does not include disputes or objections regarding Medical Necessity that were resolved by Keystone and did not result in the filing of a Grievance (written or oral).

- **HMO BLUE USA** - a national network of HMOs, sponsored by the Blue Cross and Blue Shield Association, that provides access to Covered Services for Keystone Members when Urgent Care for an unexpected illness or accidental injury is required while the Member is temporarily outside of the Service Area.

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

- **HOSPITAL** - any institution duly licensed, certified and operated as a Hospital. In no event shall the term Hospital include a convalescent facility, nursing home, or any institution or part thereof which is used as a convalescent facility, rest facility, nursing facility or facility for the aged.

- **IMMUNIZATIONS** - Pediatric and Medically Necessary adult Immunizations (except those required for college, employment, or travel. Coverage will be provided for those child Immunizations, including the immunizing agents, which, as determined by the Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services. Benefits will be exempt from deductibles or dollar limits, but not applicable Copayments.

- **KEYSTONE HEALTH PLAN EAST, INC. ("Keystone")** - a health maintenance organization providing access to comprehensive health care to Members.

- **LIFETIME BENEFIT MAXIMUM** - the maximum benefits that Keystone will provide under one (1) Contract for a Member during that Member's lifetime.

- **LIMITATIONS** - the maximum number of Covered Services, measured in number of visits or days, or the maximum dollar amount of Covered Services that are eligible for coverage. Limitations may vary depending on the type of program and Covered Services provided. Limitations, if any, are identified in the Schedule of Copayments & Limitations.

- **LIMITING AGE FOR DEPENDENTS** - the age at which a Dependent child is no longer eligible as a Dependent under the Subscriber's coverage. A Dependent child shall be removed from the Subscriber's coverage at the end of the month in which the Limiting Age For Dependents is attained unless otherwise agreed to by Keystone and the group.

- **MAINTENANCE CARE OR SERVICE** - continued care and management of the Member when the therapeutic goals of a treatment plan have been achieved or when no additional functional progress is apparent or expected to occur.

- **MEDICALLY NECESSARY or MEDICAL NECESSITY** - the requirement that Covered Services or medical supplies are needed, in the opinion of: (a) the Primary Care Physician; (b) the Referred Specialist; and/or © Keystone and:

  A. are consistent with Keystone policies, coverage requirements and utilization guidelines;

  B. are necessary in order to diagnose and/or treat a Member's illness or injury;

  C. are provided in accordance with accepted standards of American medical practice;

  D. are essential to improve the Member's net health outcome and may be as beneficial as any established alternatives;

  E. are as cost-effective as any established alternative; and

  are not solely for the Member's convenience, or the convenience of the Member's family or health care Provider.

- **MEMBER** - a Subscriber or Dependent who meets the eligibility requirements for enrollment.

- **OCCUPATIONAL THERAPY** - medically prescribed treatment concerned with improving or restoring neuromusculoskeletal functions which have been impaired by illness or injury, congenital anomaly or prior therapeutic intervention. Occupational Therapy also includes medically prescribed treatment concerned with improving the

Member's ability to perform those tasks required for independent functioning where such function has been permanently lost or reduced by illness or injury, congenital anomaly or prior therapeutic intervention. This does not include services specifically directed towards the improvement of vocational skills and social functioning.

- **OFFICE VISITS** - Covered Services provided in the physician's office and performed by or under the direction of the Primary Care Physician or a Referred Specialist.

- **OUT-OF-AREA SERVICES** - services provided outside Keystone's Service Area. Covered Services are limited to Emergency Services and services that are arranged or Referred by a Keystone Primary Care Physician and Preapproved by Keystone or Covered Services coordinated by HMO Blue USA.

- **PARTICIPATING PROVIDER** - a Provider with whom Keystone has contracted to render Covered Services.

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

  B. **Referred Specialist** - a Provider who provides Covered Specialist Services upon Referral from a Primary Care Physician. In the event there is no Participating Provider to provide the specialty or subspecialty services, Referral to a non-participating specialist will be arranged by the Primary Care Physician with Preapproval by Keystone. The benefits under the plan will be the same terms and conditions as for Participating Providers. A Referred Specialist also includes a participating obstetrician or gynecologist who provides to female Members, routine maternity care, routine gynecological care, or specialty gynecological care in the Provider's office other than reproductive endocrinology/infertility care and gynecologic oncology care.

  C. **Participating Hospital** - a Hospital that has contracted with Keystone to provide Covered Services to Members.

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

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

- **PREAPPROVED or PREAPPROVAL** - the approval which the Primary Care Physician or Referred Specialist must obtain from Keystone to confirm Keystone coverage for certain Covered Services. Such approval must be obtained prior to providing Members with Covered Services or Referrals. Approval will be given by the appropriate Keystone staff, under the supervision of the Medical Director. If the Primary Care Physician or Referred Specialist is required to obtain a Preapproval, and provides Covered Services or Referrals without obtaining such Preapproval, the Member will not be responsible for payment.

- **PROVIDER** - any health care institution or practitioner that is licensed to render health care services including, but not limited to, a physician, allied health professional, certified nurse midwife, Hospital, Skilled Nursing Facility, rehabilitation hospital, birthing facility or Home Health Care Provider.

- **PULMONARY REHABILITATION** - multidisciplinary treatment which combines physical therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.

- **RADIATION THERAPY** - the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

- **REFERRED or REFERRAL** - written documentation from the Member's Primary Care Physician that authorizes Covered Services to be rendered by a Keystone Participating Provider or Provider specifically named on the Referral. Referred care includes all services provided by a Referred Specialist. Referrals to non-Participating Providers must be Preapproved by Keystone. A Referral must be issued to the Member prior to receiving Covered Services and is valid for ninety (90) days from the date of issue for an enrolled Member.

- **RESPIRATORY THERAPY** - medically prescribed treatment of diseases or disorders of the respiratory system with therapeutic gases and vaporized medications delivered by inhalation.

- **SERVICE AREA** - the geographical area within which Keystone is approved to provide access to Covered Services.

- **SKILLED NURSING FACILITY** - an institution that is licensed as a Skilled Nursing Facility and has contracted with Keystone to provide Covered Services to Members.

- **SPECIALIST SERVICES** - all physician services providing medical care in any generally accepted medical or surgical specialty or subspecialty.

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

- **STANDING REFERRAL OR STANDING REFERRED** - written documentation from Keystone that authorizes Covered Services for a life-threatening, degenerative or disabling disease or condition. The Covered Services will be rendered by the Referred Specialist named on the Standing Referral form. The Referred Specialist will have clinical expertise in treating the disease or condition. A Standing Referral must be issued to the Member prior to receiving Covered Services. The Member, the Primary Care Physician and the Referred Specialist will be notified in writing of the length of time that the Standing Referral is valid. Standing Referred Care includes all primary and Specialist Services provided by that Referred Specialist.

- **SUBSCRIBER** - the person who is eligible and is enrolled for coverage.

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

- **SUBSTANCE ABUSE TREATMENT FACILITY** - a facility which is licensed by the Department of Health and has contracted with Keystone to provide Covered Services to Members and that is primarily engaged in providing detoxification and rehabilitation treatment for Substance Abuse.

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

OTHER COVERAGE

A. Worker's Compensation

Any benefits provided by Worker's Compensation are not duplicated under Keystone.

B. Medicare

Any services provided by Medicare are not duplicated under Keystone. For working Members over age 65, the primary payor will be determined in accordance with TEFRA or existing regulations regarding Medicare reimbursement.

NOTE: For more information regarding other coverage, see pages XX and XX, "Coordination of Benefits" and "Subrogation", in this Member Handbook.

INDEPENDENT CORPORATION

The Group Master Contract is between the group and Keystone. Keystone is a controlled affiliate of Independence Blue Cross operating under a license from Blue Cross and Blue Shield Association (the "Association"), which is a national association of independent Blue Cross and Blue Shield Plans throughout the United States. Although all of these independent Blue Cross and Blue Shield Plans operate from a license with the Association, each of them is a separate and distinct corporation. The Association allows Keystone to use the familiar Blue Cross and Blue Shield words and symbols. Keystone, which is entering into the contract, is not contracting as an agent of the national Association. Only Keystone shall be liable to the Subscriber for any of the obligations as stated under the Group Master Contract. This paragraph does not add any obligations to this contract.

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
Office of Rate and Policy Regulation
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October 26, 1999

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Re: Act 68 Compliance – Managed Care Plan Documents

Dear Ms. Wilmarth:

At our meeting on October 14 regarding Act 68, you requested copies of several Act 68 compliance filings submitted to the Department for review by managed care plans. Attached is information from Act 68 compliance filings submitted by Aetna US Healthcare and Keystone Health Plan East.

Enclosed please find the following plan documents: filing correspondences, certificates of coverage, subscriber agreements, and riders to certificates of coverage or handbooks.

Due to the considerable size of Act 68 filings, we did not enclose in this packet copies of all related plan documents. However, we trust that the selected documents will effectively illustrate the scope of the Department's review process.

If you would like any additional information or have any questions on these filings, we can make arrangements for you to meet with a Policy Examiner from the Department. Please contact me at (717) 787-4192 if I can be of further assistance in this matter.

Sincerely,

Geoffrey Dunaway
Director, Accident and Health Bureau

HMC COPIES?

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
Office of Rate and Policy Regulation
1311 Strawberry Square
Harrisburg, PA 17120
Fax (717) 787-8555 Telephone (717) 783-2852

July 29, 1999

Lila J. Tyson
Manager, Product Analysis & Compliance
Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103-1480

ORIGINAL: 2046
BUSH
COPIES: Harris
Jewett
Markham
Smith
Wilmarth
Sandusky
Wyatte

RE: Department Filing ID **#A26736001**
(Reference this number in all correspondence)
Keystone Health Plan East, Inc.
Act 68/Forms Filing
Your 7/27/99 letter, received 7/28/99

Dear Ms. Tyson:

Thank you for the resubmission of the above captioned forms. The changes that you have made, now comply with Act 68 of 1998. The review of these forms was only to certify your compliance with Act 68 and is not to imply that all of the "content" of your filing complies with other Pennsylvania and Federal statutes and regulations.

Enclosed, please find a copy of the above forms bearing the Department's stamp showing approval, per Act 68.

Thank you for your cooperation in this matter.

Sincerely,

7/29/99

Jeffrey V. Russell, MHP
Policy Examiner
Accident & Health Bureau

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
Office of Rate and Policy Regulation
1311 Strawberry Square
Harrisburg, PA 17120
Fax (717) 787-8555 Telephone (717) 787-0684

October 26, 1999

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Sandusky
Wyatte

Fiona E. Wilmarth
Regulatory Analyst
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

Re: Act 68 Compliance – Managed Care Plan Documents

Dear Ms. Wilmarth:

At our meeting on October 14 regarding Act 68, you requested copies of several Act 68 compliance filings submitted to the Department for review by managed care plans. Attached is information from Act 68 compliance filings submitted by Aetna US Healthcare and Keystone Health Plan East.

Enclosed please find the following plan documents: filing correspondences, certificates of coverage, subscriber agreements, and riders to certificates of coverage or handbooks.

Due to the considerable size of Act 68 filings, we did not enclose in this packet copies of all related plan documents. However, we trust that the selected documents will effectively illustrate the scope of the Department's review process.

If you would like any additional information or have any questions on these filings, we can make arrangements for you to meet with a Policy Examiner from the Department. Please contact me at (717) 787-4192 if I can be of further assistance in this matter.

Sincerely,

Geoffrey Dunaway
Director, Accident and Health Bureau

HMO Forms

66

**[UNITED STATES HEALTH CARE SYSTEMS OF PENNSYLVANIA, INC.
d/b/a THE HEALTH MAINTENANCE ORGANIZATION OF PENNSYLVANIA, INC.
d/b/a U.S. HEALTHCARE
[d/b/a AETNA U.S. HEALTHCARE]]
(PENNSYLVANIA)**

CERTIFICATE OF COVERAGE

This Certificate of Coverage ("**Certificate**") is part of the Group Agreement ("**Group Agreement**") between [United States Health Care Systems of Pennsylvania, Inc. d/b/a The Health Maintenance Organization of Pennsylvania, Inc. d/b/a U.S. Healthcare [d/b/a Aetna U S. Healthcare]], hereinafter referred to as **HMO**, and the **Contract Holder**. The **Group Agreement** determines the terms and conditions of coverage. Provisions of this **Certificate** include the Schedule of Benefits, and any amendments, riders or endorsements. Amendments, riders or endorsements may be delivered with the **Certificate** or added thereafter.

[The **Certificate** is part of a dual contract, to be used in conjunction with the [Corporate Health Insurance] ([CHI]) Certificate of Insurance, which is made up of the [CHI] Certificate of Coverage, Schedule of Benefits, and any amendments, riders, or endorsements. The two contracts combined detail the benefits provided under the Quality Point-of-Service Program.]

HMO agrees with the **Contract Holder** to provide coverage for benefits, in accordance with the conditions, rights, and privileges as set forth in this **Certificate**. **Members** covered under this **Certificate** are subject to all the conditions and provisions of the **Group Agreement**.

This **Certificate** describes covered health care benefits. Coverage for services or supplies is provided only if it is furnished while an individual is a **Member**. This means that coverage is provided only for health care services furnished while this coverage is in force. Except as shown in the Continuation and Conversion section of this **Certificate**, coverage is not provided for any services received before coverage starts or after coverage ends.

Certain words have specific meanings when used in this **Certificate**. The defined terms appear in bold type with initial capital letters. The definitions of those terms are found in the Definitions section of this **Certificate**.

This Certificate is not in lieu of insurance for Worker's Compensation. This Certificate is governed by applicable federal law and the laws of Pennsylvania.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE RIGHTS AND OBLIGATIONS OF MEMBERS AND HMO. IT IS THE CONTRACT HOLDER'S AND THE MEMBER'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PREAUTHORIZATION BY HMO.

NO SERVICES ARE COVERED UNDER THIS CERTIFICATE IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS SUBJECT TO THE [30-120] DAY GRACE PERIOD AND THE PREMIUMS SECTION OF THE GROUP AGREEMENT.

5/11/99

Department

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BUSH
COPIES: Harris
Jewett
Markham
Smith Wyatte
Wilmarth
Sandusky

THIS CERTIFICATE APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT A MEMBER'S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS CERTIFICATE.

NO PARTICIPATING PROVIDER OR OTHER PROVIDER, INSTITUTION, FACILITY OR AGENCY IS AN AGENT OR EMPLOYEE OF HMO.

Contract Holder: [ ]

Contract Holder Number: [ ]

Contract Holder Group Agreement Effective Date: [ ]

[**Subscriber** Name: [ ]

Subscriber Number: [ ]

Subscriber Effective Date: [ ]

Coverage Type: [ ]]

TABLE OF CONTENTS

HMO PROCEDURE

A. **Selecting a Participating Primary Care Physician.**

At the time of enrollment, each **Member** should select a **Participating Primary Care Physician (PCP)** from **HMO's** Directory of Participating Providers to access **Covered Benefits** as described in this **Certificate**. The choice of a **PCP** is made solely by the **Member**. If the **Member** is a minor or otherwise incapable of selecting a **PCP**, the **Subscriber** should select a **PCP** on the **Member's** behalf. Until a **PCP** is selected, benefits will be limited to coverage for **Medical Emergency** care.

B. **The Primary Care Physician.**

The **PCP** coordinates a **Member's** medical care, as appropriate, either by providing treatment or by issuing **Referrals** to direct the **Member** to a **Participating Provider**. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization. Except in a **Medical Emergency** or for certain direct access **Specialist** benefits as described in this **Certificate**, only those services which are provided by or referred by a **Member's PCP** will be covered. **Covered Benefits** are described in the Covered Benefits section of this **Certificate**. It is a **Member's** responsibility to consult with the **PCP** in all matters regarding the **Member's** medical care.

C. **Availability of Providers.**

HMO cannot guarantee the availability or continued participation of a particular **Provider**. Either **HMO** or any **Participating Provider** may terminate the **Provider** contract or limit the number of **Members** that will be accepted as patients. If the **PCP** initially selected cannot accept additional patients, the **Member** will be notified and given an opportunity to make another **PCP** selection. The **Member** must then cooperate with **HMO** to select another **PCP**. Until a **PCP** is selected, benefits are limited to coverage for **Medical Emergency** care.

If the **HMO** terminates the agreement between the **HMO** and the **PCP**, the **HMO** will notify all **Members** served by that **PCP** of the termination and will request that the **Member** select another **PCP**.

D. **Changing a PCP.**

A **Member** may change the **PCP** at any time by calling the Member Services 800 telephone number listed on the **Member's** identification card or by written or electronic submission of the **HMO's** change form. A **Member** may contact **HMO** to request a change form or for assistance in completing that form. The change will become effective upon **HMO's** receipt and approval of the request.

E. **Ongoing Reviews.**

HMO conducts ongoing reviews of those services and supplies which are recommended or provided by **Health Professionals** to determine whether such services and supplies are **Covered Benefits** under this **Certificate**. If **HMO** determines that the recommended services and supplies are not **Covered Benefits**, the **Member** will be notified. If a **Member** wishes to appeal such determination, the **Member** may then contact **HMO** to seek a review of the determination.

F. **Authorization.**

Certain services and supplies under this **Certificate** may require authorization by **HMO** to determine if they are **Covered Benefits** under this **Certificate**. Those services and supplies requiring **HMO** authorization are indicated in this **Certificate**.

G. **Continuity of Care.**

If a **Member's** health care **Provider** stops participation with **HMO** for reasons other than imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the **Health Professional's** ability to practice, **HMO** will continue coverage for the **Member** to continue an ongoing course of treatment with the **Member's** current health care **Provider** during a transitional period.

They shall continue for up to ninety (90) days from the date of notice to the **Member** of the **Provider's** termination of participation with **HMO** or if the **Member** has entered the second trimester of pregnancy, for a transitional period that includes the provision of postpartum care directly related to the delivery. The coverage will be authorized by **HMO** for the transitional period only if the health care **Provider** agrees to accept reimbursement at the rates applicable prior to the start of transitional period as payment in full; to adhere to quality standards and to provide medical information related to such care; and to adhere to **HMO's** policies and procedures. This paragraph shall not be construed to require **HMO** to provide coverage for benefits not otherwise covered.

For new **Members** of **HMO**, coverage will be provided for new **Members** to continue an ongoing course of treatment with **Member's** current health care provider for a transitional period of up to sixty (60) days from the effective date of enrollment. If the **Member** has entered the second trimester of pregnancy as of the effective date of enrollment, the transitional period shall include the provision of postpartum care directly related to the delivery. The coverage will be authorized by **HMO** for the transitional period only if the health care **Provider** agrees to accept reimbursement rates established by **HMO** as payment in full to adhere to **HMO's** quality standards and to provide medical information related to such care; and to adhere to **HMO's** policies and procedures. This paragraph shall not be construed to require **HMO** to provide coverage for benefits not otherwise covered.

H. **Ongoing Specialist Care.**

A **Member** with a condition which requires ongoing care from a specialist may request a standing referral to such specialist. Circumstances which may warrant this type of referral include, but are not limited to, a high risk pregnancy or dialysis treatment. The **Member** should initially make this request through the **Member's Primary Care Physician**. If **HMO**, or the **Primary Care Physician** in consultation with an **HMO** medical director and **Specialist**, if any, determines that such standing referral is appropriate, **HMO** will authorize such a referral to a **Specialist**. **HMO** is not required to permit a **Member** to elect to have a nonparticipating **Specialist**, unless such a **Specialist** is not available within **HMO's** network of **Participating Specialists**. Any authorized referral shall be made pursuant to a treatment plan approved by **HMO** in consultation with the **Primary Care Physician**, the **Specialist**, the **Member** or the **Member's** designee. The treatment plan may limit the number of visits or the period during which the visits are authorized and may require the **Specialist** to provide the **Primary Care Physician** with regular updates on the specialty care provided, as well as all necessary medical information.

I. **Life Threatening Conditions.**

Any member with (i) a life-threatening condition or disease or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request that a specialist or specialty care center assume responsibility for providing or coordinating the member's medical care, including primary and specialty care. A member may make this request through the member's selected primary care physician. If Aetna U.S. Healthcare, or the primary care physician, in consultation with a medical director of Aetna U.S. Healthcare and specialist, if any, determines that the member's care would most appropriately be coordinated by such a specialist or specialty care center, Aetna U.S. Healthcare will authorize a referral to such specialist or specialty care center. Aetna U.S. Healthcare is not required to permit a member to elect to have a non-participating specialist, unless such a specialist is not available within Aetna U.S. Healthcare's network of participating providers. Any authorized referral shall be made pursuant to a treatment plan approved by Aetna U.S. Healthcare in consultation with the

primary care physician (if appropriate), the specialist or specialty care center, the member or the member's designee. The approved specialist or specialty care center will be permitted to treat the member without a referral from the member's primary care physician and may authorize such referrals, procedures, tests and other medical services as the member's primary care physician would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan. If the member's referral is to a nonparticipating provider, services provided pursuant to the approved treatment plan will be provided at no extra cost to the member beyond what the member would otherwise pay for services received within the Aetna U.S. Healthcare network of participating providers. For the purposes of this coverage, a specialty care center means only centers that are accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

ELIGIBILITY AND ENROLLMENT

A. **Eligibility.**

1. To be eligible to enroll as a **Subscriber**, an individual must:

   a. meet all applicable eligibility requirements agreed upon by the **Contract Holder** and **HMO**; and

   b. live or work in the **Service Area**.

2. To be eligible to enroll as a **Covered Dependent**, the **Contract Holder** must provide dependent coverage for **Subscribers**, and the dependent must be:

   a. the legal spouse of a **Subscriber** under this **Certificate**; or

   b. a dependent unmarried child (including natural, foster, step, legally adopted children, proposed adoptive children, a child under court order, [dependents of dependents]) who meets the eligibility requirements described on the Schedule of Benefits.

3. A **Member** who resides outside the **Service Area** is required to choose a **PCP** and return to the **Service Area** for **Covered Benefits**. **Members** shall be covered for **Emergency Services** and **Urgent Care** services when obtained either in or out of the **Service Area**.

B. **Enrollment.**

Unless otherwise noted, an eligible individual and any eligible dependents may enroll in **HMO** regardless of health status, age, or requirements for health services within [31-90] days from the eligibility date.

1. Newly Eligible Individuals and Eligible Dependents.

   An eligible individual and any eligible dependents may enroll within [31-90] days of the eligibility date.

2. Open Enrollment Period.

   Eligible individuals or dependents who are eligible for enrollment but do not enroll as stated above, may be enrolled during any subsequent **Open Enrollment Period** upon submission of complete enrollment information and **Premium** payment to **HMO**.

3. Enrollment of Newly Eligible Dependents.

   a. Newborn Children.

      A newborn child is covered for 31 days from the date of birth. To continue coverage beyond this initial period, the child must meet the eligibility requirements described in this **Certificate** and be enrolled in **HMO** within the initial 31 day period. If coverage does not require the payment of an additional **Premium** for a **Covered Dependent**, the **Subscriber** must still enroll the child within 31 days after the date of birth. A newborn child who fails to meet the eligibility requirements described in this **Certificate** is eligible for conversion as provided in the Continuation and Conversion section of this **Certificate**.

The coverage for newly born, adopted children, and children placed for adoption consists of coverage of injury and sickness, including the necessary care and treatment of congenital defects and birth abnormalities, and within the limits of this **Certificate** Coverage includes necessary transportation costs from place of birth to the nearest specialized **Participating** treatment center

b Adopted Children

A legally adopted child or a child for whom a **Subscriber** is a court appointed legal guardian, and who meets the definition of a **Covered Dependent**, will be treated as a dependent from the date of adoption or upon the date the child was placed for adoption with the **Subscriber** "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child The placement must take effect on or after the date a **Subscriber's** coverage becomes effective, and the **Subscriber** must make a written request for coverage within 31 days of the date the child is adopted or placed with the **Subscriber** for adoption

The initial coverage will not be affected by any provision in this **Certificate** which

i requires evidence of good health acceptable to **HMO** for coverage to become effective,
ii delays coverage due to a confinement, or
iii limits coverage as to a preexisting condition

4 Special Rules Which Apply to Children

a Qualified Medical Support Order

Coverage is available for a dependent child not residing with a **Subscriber** and who resides outside the **Service Area**, if there is a qualified medical child support order requiring the **Subscriber** to provide dependent health coverage for a non-resident child, and is issued on or after the date the **Subscriber's** coverage becomes effective The child must meet the definition of a **Covered Dependent**, and will be enrolled within 30 days of receipt of the court order

The initial coverage will not be affected by any provision in this **Certificate** which.

i requires evidence of good health acceptable to **HMO** for coverage to become effective,
ii delays coverage due to a confinement, or
iii limits coverage as to a preexisting condition

b Handicapped Children

Coverage is available for a child who is chiefly dependent upon the **Subscriber** for support and maintenance, and who is 19 years of age or older but incapable of self-support due to mental or physical incapacity The incapacity must have commenced prior to the age the dependent lost eligibility In order to continue coverage for a handicapped child, the **Subscriber** must provide evidence of the child's incapacity and dependency to **HMO** within 31 days of the date the child's coverage would otherwise terminate Proof of continued incapacity, including a medical examination, must be submitted to **HMO** as requested, but not more frequently than annually beginning after the two year period following the child's attainment of the age specified on the Schedule of Benefits This eligibility provision will no longer apply on the date the dependent's incapacity ends

5 Notification of Change in Status

It shall be a **Member's** responsibility to notify **HMO** of any changes which affect the **Member's** coverage under this **Certificate** Such status changes include, but are not limited to, change of address, change of **Covered Dependent** status, and enrollment in Medicare or any other group health plan of any **Member** Additionally, if requested, a **Subscriber** must provide to **HMO**, within 31 days of the date of the request, evidence satisfactory to **HMO** that a dependent meets the eligibility requirements described in this **Certificate**

An eligible individual and any eligible dependents may be enrolled during a special enrollment period A special enrollment period occurs when

a an eligible individual or an eligible dependent is covered under another group health plan or other health insurance coverage when initially eligible for coverage under **HMO**,

b the eligible individual or eligible dependent declines coverage [in writing] under **HMO**,

c the eligible individual or eligible dependent loses coverage under the other group health plan or other health insurance coverage for one of the following reasons:

i the other group health coverage is COBRA continuation coverage under another plan, and the COBRA continuation coverage under that other plan has since been exhausted, or

ii the other coverage is a group health plan or other health insurance coverage, and the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated

Loss of eligibility includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing

Loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of the **HMO** Certificate of Coverage, and

d the eligible individual or eligible dependent enrolls within [30-31] days of the loss.

The effective date of coverage will be the first day of the first calendar month following the date the completed request for enrollment is received.

The eligible individual or the eligible dependent enrolling during a special enrollment period will not be subject to any late enrollment or preexisting condition provision described in this **Certificate**.

[6. Late Enrollment.

Eligible individuals and their dependents may also be enrolled at any other time upon submission of complete enrollment information, acceptable evidence of good health, and payment of **Premium** to **HMO**. Coverage shall not become effective until confirmed, in writing, by **HMO**.]

C. **Effective Date of Coverage**.

Coverage shall take effect at 12:01 a.m. on the **Member's** effective date. Coverage shall continue in effect from month to month subject to payment of **Premiums** made by the **Contract Holder** and subject to the Contract Holder Termination section of the **Group Agreement**.

[1. Hospital Confinement on Effective Date of Coverage.

If a **Member** is an inpatient in a **Hospital** on the **Effective Date of Coverage**, the **Member** will be covered as of that date. Such services are not covered if the **Member** is covered by another health plan on that date and the other health plan is responsible for the cost of the services. **HMO** will not cover any service that is not a **Covered Benefit** under this **Certificate**. To be covered, the **Member** must utilize **Participating Providers** and is subject to all the terms and conditions of this **Certificate**.]

[[2.] Actively at Work.

If a **Subscriber** is not **Actively at Work** on the date coverage would otherwise become effective, coverage for the eligible individual and any eligible dependents will not become effective until the date the eligible individual is **Actively at Work** for one full day.]

[[3.] Non-Confinement Rule.

If on the date coverage would otherwise become effective, a dependent [or retired employee] is confined in a **Hospital**, at home, or elsewhere, as a result of, or for treatment of, an illness or injury on the date coverage would otherwise become effective, coverage will be deferred for that person ~~until~~ such person is no longer so confined and a final release from such confinement is provided by the **Physician**.]

COVERED BENEFITS

A **Member** shall be entitled to the **Covered Benefits** as specified below, in accordance with the terms and conditions of this **Certificate**. Unless specifically stated otherwise, in order for benefits to be covered, they must be **Medically Necessary**. For the purpose of coverage, **HMO** may determine whether any benefit provided under the **Certificate** is **Medically Necessary**, and **HMO** has the option to only authorize coverage for a **Covered Benefit** performed by a particular **Provider**. Preventive care, as described below, will be considered **Medically Necessary**.

To be **Medically Necessary**, the service or supply must:

- be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;
- be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well baby care, as determined by **HMO**;
- be a diagnostic procedure, indicated by the health status of the **Member** and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;
- include only those services and supplies that cannot be safely and satisfactorily provided at home, in a **Physician's** office, on an outpatient basis, or in any facility other than a **Hospital**, when used in relation to inpatient **Hospital** services; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining if a service or supply is **Medically Necessary**, **HMO's** Patient Management Medical Director or its **Physician** designee will consider:

- information provided on the **Member's** health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- the opinion of **Health Professionals** in the generally recognized health specialty involved;
- the opinion of the attending **Physicians**, which have credence but do not overrule contrary opinions; and
- any other relevant information brought to **HMO's** attention.

The issuance of a prior written **Referral** in accordance with the **HMO's** policies and procedures by the **Member's PCP**, or other **Physician** providing service at the direction of the **PCP**, shall constitute proof of **Medical Necessity** for the purposes of determining a **Member's** potential liability.

All **Covered Benefits** will be covered in accordance with the guidelines determined by **HMO**.

If a **Member** has questions regarding coverage under this **Certificate**, the **Member** may call the Member Services 800 telephone number listed on the **Member's** identification card.

THE MEMBER IS RESPONSIBLE FOR PAYMENT OF THE APPLICABLE COPAYMENTS LISTED ON THE SCHEDULE OF BENEFITS.

EXCEPT FOR DIRECT ACCESS SPECIALIST BENEFITS OR IN A MEDICAL EMERGENCY OR URGENT CARE SITUATION AS DESCRIBED IN THIS CERTIFICATE, THE FOLLOWING BENEFITS MUST BE ACCESSED THROUGH THE PCP'S OFFICE THAT IS SHOWN ON THE MEMBER'S IDENTIFICATION CARD, OR ELSEWHERE UPON PRIOR REFERRAL ISSUED BY THE MEMBER'S PCP.

A. **Primary Care Physician Benefits.**

1. Office visits during office hours.

2. Home visits.

3. After-hours **PCP** services. **PCPs** are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a **Member** becomes sick or is injured after the **PCP's** regular office hours, the **Member** should:

   a. call the **PCP's** office; and

   b. identify himself or herself as a **Member**; and

   c. follow the **PCP's** or covering **Physician's** instructions.

   If the **Member's** injury or illness is a **Medical Emergency**, the **Member** should follow the procedures outlined under the Emergency Care/Urgent Care Benefits section of this **Certificate**.

4. Hospital visits.

5. Periodic health evaluations to include:

   a. well child care from birth including immunizations and booster doses of all immunizing agents used in child immunizations which conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services. Immunization benefits are exempt from deductible and dollar limits.

   b. routine physical examinations.

   c. routine gynecological examinations, including pap smears, for routine care, administered by the **PCP**. Or the **Member** may also go directly to a **Participating** gynecologist without a **Referral** for routine GYN examinations and pap smears. See the Direct Access Specialist Benefits section of this **Certificate** for a description of these benefits.

   d. routine hearing screenings.

   e. immunizations (but not if solely for the purpose of travel or employment).

f. routine vision screenings.

6. Injections, including allergy desensitization injections.

7. Casts and dressings.

8. Health education counseling and information.

B. **Diagnostic Services.**

Services include, but are not limited to, the following:

1. diagnostic, laboratory, and x-ray services.

2. mammograms, by a **Participating Provider**. The **Member** is required to obtain a **Referral** from her **PCP** or gynecologist, or obtain prior authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit.

   Screening mammogram benefits for female **Members** are provided as follows:

   - age 40 and older, one routine mammography every year; or
   - when **Medically Necessary**.

C. **Specialist Physician Benefits.**

Covered Benefits include outpatient and inpatient services, including cancer chemotherapy and cancer hormone treatments and services in any medically appropriate treatment setting which have been approved by the United States Food and Drug Administration for general use in treatment of cancer.

D. **Direct Access Specialist Benefits.**

The following services are covered without a **Referral** when rendered by a **Participating Provider**.

- Routine Gynecological Examination(s). Routine gynecological visit(s) and pap smear(s). The number of visits, if any, is listed on the Schedule of Benefits.
- Open Access to Gynecologists. Benefits are provided to female **Members** for services performed by a **Participating** gynecologist for diagnosis and treatment of gynecological problems. See the Infertility Services section of this **Certificate** for a description of **Infertility** benefits.
- [• Routine Eye Examinations, including refraction, as follows:

  1. if **Member** is age [1 through 18] [and wears eyeglasses or contact lenses], [one] exam every [12]-month period.

  2. if **Member** is age [19 and over] [and wears eyeglasses or contact lenses], [one] exam every [24]-month period.

  3. if **Member** is age [1 through 45] [and does not wear eyeglasses or contact lenses], [one] exam every [36]-month period.

4. if **Member** is age [46 and over] [and does not wear eyeglasses or contact lenses], [one] exam every [24]-month period.]

[• Preventive Dental Care for Members under the age of 12. Benefits are limited to:

1. Oral prophylaxis (cleaning) as necessary;

2. Topical application of fluorides and the prescription of fluorides for systematic use when not available in the community water supply; and

3. Oral examination and hygiene instruction.]

E. **Maternity Care and Related Newborn Care.**

Outpatient and inpatient pre-natal and postpartum care and obstetrical services provided by **Participating Providers** are a **Covered Benefit**. To be covered for these benefits, the **Member** must choose a **Participating** obstetrician from **HMO's** list of **Participating Providers** and inform **HMO** by calling the Member Services 800 telephone number listed on the **Member's** identification card, prior to receiving services. The **Participating Provider** is responsible for obtaining prior authorization for all obstetrical care from **HMO** after the first prenatal visit.

Coverage does not include routine maternity care (including delivery) received while outside the **Service Area** unless the **Member** receives prior authorization from **HMO**. As with any other medical condition, **Emergency Services** are covered when **Medically Necessary**.

F. **Inpatient Hospital & Skilled Nursing Facility Benefits.**

A **Member** is covered for services only at **Participating Hospitals** and **Participating Skilled Nursing Facilities**. All services are subject to preauthorization by **HMO**. In the event that the **Member** elects to remain in the **Hospital** or **Skilled Nursing Facility** after the date that the **Participating Provider** and/or the **HMO** Medical Director has determined and advised the **Member** that the **Member** no longer meets the criteria for continued inpatient confinement, the **Member** shall be fully responsible for direct payment to the **Hospital** or **Skilled Nursing Facility** for such additional **Hospital, Skilled Nursing Facility, Physician** and other **Provider** services, and **HMO** shall not be financially responsible for such additional services.

As an exception to the **Medically Necessary** requirements of this **Certificate**, the following coverage is provided for a mother and newly born child:

1. a minimum of 48 hours of inpatient care in a **Participating Hospital** following a vaginal delivery;

2. a minimum of 96 hours of inpatient care in a **Participating Hospital** following a cesarean section; or

3. a shorter **Hospital** stay, if the treating or attending **Physician** determines that the mother and newborn meet medical criteria for safe discharge contained within guidelines developed by or in cooperation with treating physicians which recognize treatment standards.

The **Member** will be covered for one home health care visit scheduled to occur within 24 hours of discharge when discharge occurs after a shorter **Hospital** stay as described above. This benefit is in addition to the home health maximum number of visits, if any, shown on the Schedule of Benefits. A **Copayment** will not apply for home health care visits.

Coverage for **Skilled Nursing Facility** benefits is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

G. **Transplants.**

Transplants which are non-experimental or non-investigational are a **Covered Benefit**. Covered transplants must be ordered by the **Member's PCP** and **Participating Specialist Physician** and approved by **HMO's** Medical Director in advance of the surgery. The transplant must be performed at **Hospitals** specifically approved and designated by **HMO** to perform these procedures. A transplant is non-experimental and non-investigational hereunder when **HMO** has determined, in its sole discretion, that the **Medical Community** has generally accepted the procedure as appropriate treatment for the specific condition of the **Member**. Coverage for a transplant where a **Member** is the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program.

H. **Outpatient Surgery Benefits.**

Coverage is provided for outpatient surgical services and supplies in connection with a covered surgical procedure when furnished by a **Participating** outpatient surgery center. All services and supplies are subject to preauthorization by **HMO**.

I. **Substance Abuse Benefits.**

A **Member** is covered for the following services as authorized and provided by **Participating Behavioral Health Providers**.

1. Outpatient care benefits are covered for **Detoxification**. Benefits include diagnosis, medical treatment and medical referral services (including referral services for appropriate ancillary services) by the **Member's PCP** for the abuse of or addiction to alcohol or drugs.

   The **Member** is entitled to outpatient visits to a **Participating Behavioral Health Provider** upon **Referral** by the **PCP** for diagnostic, medical or therapeutic **Rehabilitation** services for **Substance Abuse**. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

2. Inpatient care benefits are covered for **Detoxification**. Benefits include medical treatment and referral services for **Substance Abuse** or addiction. The following services shall be covered under inpatient treatment: lodging and dietary services; **Physicians**, psychologist, nurse, certified addictions counselor and trained staff services; diagnostic x-ray; psychiatric, psychological and medical laboratory testing; and drugs, medicines, equipment use and supplies.

The **Member** is entitled to medical, nursing, counseling or therapeutic **Rehabilitation** services in an inpatient, non-hospital residential facility, appropriately licensed by the Department of Health, upon referral by the **Member's Participating Behavioral Health Provider** for alcohol or drug abuse or dependency. Coverage is subject to the limits, if any, shown on the Schedule of Benefits

J **Mental Health Benefits.**

A **Member** is covered for services for the treatment of the following **Mental or Behavioral Conditions** through **Participating Behavioral Health Providers.**

1 Outpatient benefits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services, and is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

[2 Inpatient benefits may be covered for medical, nursing, counseling or therapeutic services in an inpatient, non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent. Coverage, if applicable, is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

3 Inpatient benefit exchanges are a **Covered Benefit**. When authorized by **HMO**, 1 mental health inpatient day may be exchanged for up to 4 outpatient or home health visits. This is limited to an exchange of up to a maximum of 10 inpatient days for a maximum of 40 additional outpatient visits. One (1) inpatient day may be exchanged for 2 days of treatment in a **Partial Hospitalization** and/or outpatient electroshock therapy (ECT) program in lieu of hospitalization up to the maximum benefit limitation upon approval by **HMO**.

Requests for a benefit exchange must be initiated by the **Member's Participating Behavioral Health Provider** under the guidelines set forth by the **HMO**. **Member** must utilize all outpatient mental health benefits, if any, available under the **Certificate** and pay all applicable **Copayments** before an inpatient and outpatient visit exchange will be considered. The **Member's Participating Behavioral Health Provider** must demonstrate **Medical Necessity** for extended visits and be able to support the need for hospitalization if additional visits were not offered. Request for exchange must be approved in writing by **HMO** prior to utilization.]

K. **Emergency Care/Urgent Care Benefits.**

1 A **Member** is covered for **Emergency Services** 24 hours a day, provided the service is a **Covered Benefit**, and **HMO's** review determines that a **Medical Emergency** existed at the time medical attention was sought by the **Member**. A **Medical Emergency** is any health care service provided to a **Member** after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a. placing the health of the **Member**, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

b serious impairment to bodily functions; or;

c. serious dysfunction of any bodily organ or part.

HMO will pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency. The **HMO** covers emergency care screening and stabilization

for conditions that reasonably appear to constitute an emergency, based on the **Member's** presenting symptoms.

The **Copayment** for an emergency room visit as described on the Schedule of Benefits will not apply either in the event that the **Member** was referred for such visit by the **Member's PCP** for services that should have been rendered in the **PCP's** office or if the **Member** is admitted into the **Hospital**.

The **Member** will be reimbursed for the cost for **Emergency Services** rendered by a non-participating **Provider** located either within or outside the **HMO Service Area**, for those expenses, less **Copayments**, which are incurred up to the time the **Member** is determined by **HMO** and the attending **Physician** to be medically able to travel or to be transported to a **Participating Provider**. In the event that transportation is **Medically Necessary**, the **Member** will be reimbursed for the cost as determined by **HMO**, minus any applicable **Copayments**. Reimbursement may be subject to payment by the **Member** of all **Copayments** which would have been required had similar benefits been provided during office hours and upon prior **Referral** to a **Participating Provider**.

Medical transportation is covered during a **Medical Emergency**.

A Medical Emergency is not subject to preauthorization.

2. The **Member** will be covered for **Urgent Care** services obtained from a licensed **Physician** or facility outside of the **Service Area** if:

   a. the service is a **Covered Benefit**;

   b. a **Member** could not reasonably have anticipated the need for such care prior to leaving the **Service Area**; and

   c. a delay in receiving services and supplies until a **Member** could reasonably return and receive care from a **Participating Provider** would have caused serious deterioration of the **Member's** health.

3. A **Member** is covered for any follow-up care. Follow-up care is any care directly related to the need for emergency care which is provided to a **Member** after the **Medical Emergency** care or **Urgent Care** situation has terminated. All follow-up and continuing care must be provided or arranged by a **Member's PCP**. The **Member** must follow this procedure, or the **Member** will be responsible for payment for all services received.

L. **Rehabilitation Benefits.**

1. Inpatient and Outpatient Rehabilitation Benefits.

   The following benefits are covered by **Participating Providers** upon **Referral** issued by the **Member's PCP** and approved by **HMO** in advance of treatment. Outpatient coverage is subject to the limits, if any, shown on the Schedule of Benefits.

   a. Cardiac rehabilitation benefits are available as part of a **Member's** inpatient **Hospital** stay. A limited course of outpatient cardiac rehabilitation is covered when **Medically Necessary** following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.

b Pulmonary rehabilitation benefits are available as part of a **Member's** inpatient **Hospital** stay A limited course of outpatient pulmonary rehabilitation is covered when **Medically Necessary** for the treatment of reversible pulmonary disease states

2 Outpatient Rehabilitation Benefits

The following benefits are covered through **Participating Providers** upon **Referral** issued by the **Member's PCP** and approved by **HMO** in advance of treatment Coverage is subject to the limits, if any, shown on the Schedule of Benefits

a Cognitive therapy associated with physical rehabilitation is covered for non-chronic conditions and acute illnesses and injuries as part of a treatment plan coordinated with **HMO**

b Physical therapy is covered for non-chronic conditions and acute illnesses and injuries

c Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses

d Speech therapy is covered for non-chronic conditions and acute illnesses and injuries Services rendered for the treatment of delays in speech development, unless resulting from disease, injury, or congenital defects, are not covered

M **Home Health Benefits.**

The following services are covered when rendered by a **Participating** home health care agency Preauthorization must be obtained from the **Member's** attending **Participating Physician** **HMO** shall not be required to provide home health benefits when **HMO** determines the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide appropriate care Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits

1 Skilled nursing services for a **Homebound Member** Treatment must be provided by or supervised by a registered nurse

2 Services of a home health aide These services are covered only when the purpose of the treatment is **Skilled Care**

3 Medical social services Treatment must be provided by or supervised by a qualified medical **Physician** or social worker, along with other **Home Health Services** The **PCP** must certify that such services are necessary for the treatment of the **Member's** medical condition

4 Short-term physical, speech, or occupational therapy is covered Services are subject to the limitations listed in the Rehabilitation Benefits section of this **Certificate**

N **Hospice Benefits.**

Hospice Care services for a terminally ill **Member** are covered when preauthorized by **HMO** Services may include home and **Hospital** visits by nurses and social workers, pain management and symptom control, instruction and supervision of a family **Member**, inpatient care, counseling and emotional support, and other home health benefits listed above

Coverage is not provided for bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling Homemaker or caretaker services, and any service not solely related to the care of the **Member**, including but not limited to, sitter or companion services for the **Member** or other **Members** of

the family, transportation, house cleaning, and maintenance of the house are not covered. [Coverage is not provided for **Respite Care**.]

O. **Prosthetic Appliances.**

The **Member's** initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects is covered, when such device is prescribed by a **Participating Provider** and authorized in advance by **HMO**. Coverage includes repair and replacement when due to congenital growth. Instruction and appropriate services required for the **Member** to properly use the item (such as attachment or insertion) are covered.

[Replacement prosthetic devices that temporarily or permanently replace all or part of an external body part lost or impaired as a result of disease or injury or congenital defects are covered, when such devices are prescribed by a **Participating Provider** and authorized in advance by **HMO**. Instruction and appropriate services required for the **Member** to properly use the item (such as attachment or insertion) are covered.]

P. **Injectable Medications.**

Injectable medications, including those medications intended to be self administered, are a **Covered Benefit** when an oral alternative drug is not available, unless specifically excluded as described in the Exclusions and Limitations section of this **Certificate**. Medications must be prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines, and approved in advance of treatment by **HMO**. If the drug therapy treatment is approved for self-administration, the **Member** is required to obtain covered medications at an **HMO Participating** pharmacy designated to fill injectable prescriptions.

Injectable drugs or medication used for the treatment of cancer or HIV are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.

Q. **Infertility Services.**

Infertility services are covered upon prior authorization by **HMO** when provided by a **Participating Provider**. Benefits include, but are not limited to, services to diagnose and treat the underlying medical cause of **Infertility** which are furnished to a **Member**.

R. **Reconstructive Breast Surgery Services.**

Covered services for reconstructive breast surgery resulting from a mastectomy, include:

1. reconstruction of the breast on which the mastectomy is performed, including aereolar reconstruction and the insertion of a breast implant;

2. surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed; and

3. **Medically Necessary** physical therapy to treat the complications of the mastectomy, including lymphedema.

[S. **Additional Benefits.**

[• **Limited Advanced Reproductive Technology (ART) Benefit.**

1. To be eligible under the Infertility Program, a **Member** must be:

   a. covered under the **Certificate** as a **Subscriber** or a **Covered Dependent**; and

   b. diagnosed as **Infertile**.

   The ART benefit is not covered for male **Members** when the cause of **Infertility** is a vasectomy or orchiectomy or for female **Members** when the cause of **Infertility** is a tubal ligation or hysterectomy.

2. To obtain the ART benefit described in this section, a **Member** must be:

   a. referred by the **Member's PCP** or gynecologist to the Infertility Program, or the **Member** may directly contact **HMO's** Infertility Program case management unit by calling the Member Service 800 telephone number listed on **Member's** ID card;

   b. determined to be eligible for the ART benefit after an initial intake evaluation and consultation with a **Participating** ART **Specialist,** and recommendation is made by the ART **Specialist** that the **Member** be accepted into the **Infertility** program. Eligibility is also based on the **Participating** ART **Specialist's** determination of the reasonable possibility of success based on the **Member's** medical history and the standards established by **HMO**;

   c. preauthorized by **HMO** for this benefit; and

   d. issued a claim authorization for ART services from **HMO's** Infertility Program case management unit to a **Participating** ART **Specialist**. Claim authorizations for all services related to **Infertility** care and treatment will only be issued by the Infertility Program case management unit.

3. This benefit covers one (1) egg harvesting and up to two (2) transfers through In Vitro Fertilization (IVF), Zygote Intra-Fallopian Transfer (ZIFT), or Gamete Intra-Fallopian Transfer (GIFT) only, during each twenty-four (24) month period from the date of the first visit for actual treatment from the **Participating** ART **Specialist** and after the determination of eligibility as described above. Services under this benefit are only available from the **Participating** ART **Specialists** for whom the **Member** has been issued a claim authorization by the **Infertility** program case management unit. Treatment received from a non-participating **Provider** or without a claim authorization will not be covered and the **Member** will be responsible for payment of all claims.]

[• **Subluxation Benefits.** Services by a **Participating Provider** when **Medically Necessary** [and upon prior **Referral** issued by the **PCP**] are covered. Services must be consistent with **HMO** guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation which could be documented by diagnostic x-rays performed by an **HMO Participating** radiologist. Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

A **Copayment,** a maximum annual out-of-pocket payment, and a maximum annual benefit may apply to this service. Refer to the Schedule of Benefits attached to this **Certificate**.]

[• **Durable Medical Equipment Benefits. Durable Medical Equipment** will be provided when preauthorized by **HMO**. The wide variety of **Durable Medical Equipment** and continuing development of patient care equipment makes it impractical to provide a complete listing, therefore, the **HMO** Medical Director has the authority to approve requests on a case-by-case basis. **HMO** reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **HMO**.

Instruction and appropriate services required for the **Member** to properly use the item, such as attachment or insertion, is also covered upon preauthorization by **HMO**. Replacement, repairs and maintenance are covered only if it is demonstrated to the **HMO** that:

1. it is needed due to a change in the **Member's** physical condition; or

2. it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

All maintenance and repairs that result from a misuse or abuse are a **Member's** responsibility.

A **Copayment,** a maximum annual out-of-pocket payment, and a maximum annual benefit may apply to this service. Refer to the Schedule of Benefits attached to this **Certificate**.]]

EXCLUSIONS AND LIMITATIONS

A. **Exclusions.**

The following are not **Covered Benefits** except as described in the Covered Benefits section of this **Certificate** or by a rider attached to this **Certificate**:

- Ambulance services, for routine transportation to receive outpatient or inpatient services.
- Beam neurologic testing.
- Biofeedback, except as specifically approved by **HMO**.
- Blood and blood plasma, including but not limited to, provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis or plasmapheresis. Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.
- Care for conditions that state or local law require to be treated in a public facility, including but not limited to, mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- **Cosmetic Surgery**, or treatment relating to the consequences of, or as a result of, **Cosmetic Surgery**, other than **Medically Necessary Services**. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary** by an **HMO** Medical Director, is not covered. **The following are not considered to be Cosmetic Surgery**:

1. Surgery to correct the results of injuries when performed within 2 years of the event causing the impairment, or as a continuation of a staged reconstructive procedure.

2. Surgery to reconstruct a breast after a mastectomy performed for the treatment of disease or as a continuation of a staged reconstructive procedure, within 6 years of the mastectomy.

3. Surgery necessary to treat congenital defects in order to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

- Costs for services resulting from the commission or attempt to commit a felony by the **Member**.

- Court ordered services, or those required by court order as a condition of parole or probation, other than **Medically Necessary Services** provided by **Participating Providers** upon prior **Referral** issued by the **Member's PCP**.

- **Custodial Care.**

- Dental services, including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, prosthetic restoration of dental implants, and dental implants. This exclusion does not include [bony impacted teeth,] bone fractures, removal of tumors, and orthodontogenic cysts.

- **Durable Medical Equipment**, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a **Member's** house or place of business, and adjustments made to vehicles.

- Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a **Member**, whose ability to speak has been lost or impaired, to function without that ability, are not covered.

- **Experimental or Investigational Procedures**, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes as determined by **HMO**, unless approved by **HMO** prior to the treatment being rendered.

  This exclusion will not apply with respect to drugs:

  1. that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;

  2. that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or

3 **HMO** has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease

- False teeth
- Hair analysis
- Health services, including those related to pregnancy, rendered before the effective date or after the termination of the **Member's** coverage, unless coverage is continued under the Continuation and Conversion section of this **Certificate**
- Hearing aids
- Household equipment, including but not limited to, the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds
- Household fixtures, including but not limited to, the purchase or rental of escalators, elevators, and swimming pools
- Hypnotherapy, except when specifically approved by **HMO**
- Implantable drugs.
- **Infertility** services, including the treatment of male and female **Infertility**, injectable **Infertility** drugs, charges for the freezing and storage of cryopreserved embryos, charges for storage of sperm, and donor costs, including but not limited to, the cost of donor eggs and donor sperm, the costs for ovulation predictor kits and the costs for donor egg program or gestational carriers
- Military service related diseases, disabilities or injuries for which the **Member** is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the **Member**
- Missed appointment charges, including any charge incurred for a missed appointment with a **Participating Provider**
- Non-medically necessary services, including but not limited to, those services and supplies

1 which are not **Medically Necessary**, as determined by **HMO**, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;

2. that do not require the technical skills of a medical, mental health or a dental professional,

3 furnished mainly for the personal comfort or convenience of the **Member**, or any person who cares for the **Member**, or any person who is part of the **Member's** family, or any **Provider**,

4 furnished solely because the **Member** is an inpatient on any day in which the **Member's** disease or injury could safely and adequately be diagnosed or treated while not confined,

5 furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **Physician's** or a dentist's office or other less costly setting

- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Orthotics.
- Outpatient prescription or non-prescription drugs and medicines.
- Outpatient supplies, including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips.
- Payment for benefits for which Medicare or a third party payer is the primary payer.
- Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other like items and services.
- Private duty or special nursing care, unless pre-authorized by **HMO**.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational, and sleep therapy, including any related diagnostic testing.
- Rehabilitation services, for **Substance Abuse**, including treatment of chronic alcoholism or drug addiction.
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.
- Reversal of voluntary sterilizations, including related follow-up care.
- Routine foot/hand care, including routine reduction of nails, calluses and corns.
- Services for which a **Member** is not legally obligated to pay in the absence of this coverage.
- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Services or supplies covered by any automobile insurance policy up to the amount of coverage limitation under such policy.
- Services performed by a close relative of a **Member** (i.e., spouse, child, brother, sister or parent of you or your spouse) for which, in the absence of any health benefits coverage, no charge would be made.
- Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.

- Any service in connection with or required by a non-covered procedure or benefit.

- Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.

- Specific injectable drugs, including:

  1. experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration (FDA) and the National Institutes of Health (NIH);

  2. needles, syringes and other injectable aids;

  3. drugs related to the treatment of non-covered services; and

  4. drugs related to the treatment of **Infertility**, contraception, and performance enhancing steroids.

- Special medical reports, including those not directly related to treatment of the **Member**, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

- Surgical operations, procedures or treatment of obesity, except when specifically approved by **HMO**.

- Therapy or rehabilitation, including but not limited to, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training, and carbon dioxide.

- Thermograms and thermography.

- Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a **Member's** physical characteristics from the **Member's** biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.

- Treatment in a federal, state, or governmental entity, including care and treatment provided in a non-participating **Hospital** owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.

- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded **Members** in accordance with the benefits provided in the Covered Benefits section of this **Certificate**.

- Treatment of sickness or injury covered by a workmen's compensation act or occupational disease law or by United States Longshoreman's and Harbor Worker's Compensation Act.

- Treatment of spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or dislocation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of, or related to, distortion, misalignment, or dislocation of or in the vertebral column.

- Unauthorized services, including any service obtained by or on behalf of a **Member** without prior **Referral** issued by the **Member's PCP** or certified by **HMO.** This exclusion does not apply in a **Medical Emergency**, in an **Urgent Care** situation, or when it is a direct access benefit.

- Vision care services and supplies.

- Weight reduction programs, or dietary supplements.

[• Acupuncture and acupuncture therapy, except when performed by a **Participating Physician** as a form of anesthesia in connection with covered surgery.]

[• Services related to the care, filling, removal or replacement of impacted teeth.]

[• Family planning services.]

[• [Non-surgical treatment of] [T][t]emporomandibular joint disorder treatment (TMJ), including treatment performed by prosthesis placed directly on the teeth.]

[• Charges incurred in connection with an abortion except where the life of the mother would be endangered if the fetus were carried to term or where medical complications arise from the abortion.]

[• Voluntary sterilizations, including related follow-up care.]

B. **Limitations.**

- In the event there are two or more alternative **Medical Services** which in the sole judgment of **HMO** are equivalent in quality of care, **HMO** reserves the right to provide coverage only for the least costly **Medical Service**, as determined by **HMO**, provided that **HMO** approves coverage for the **Medical Service** or treatment in advance. This limitation is subject to the complaint and grievance procedures set forth in the Complaint and Grievance Procedures section of this **Certificate**.

- Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this **Certificate** are at the sole discretion of **HMO,** subject to the terms of this **Certificate.**

DETERMINATIONS REGARDING DENIAL OF BENEFITS DUE TO INAPPROPRITE USE OF THE HMO NETWORK ARE AT THE SOLE DISCRETION OF THE HMO.

TERMINATION OF COVERAGE

A **Member's** coverage under this **Certificate** will terminate upon the earliest of any of the conditions listed below, and termination will be effective on the date indicated on the Schedule of Benefits.

A. **Termination of Subscriber Coverage.**

A **Subscriber's** coverage will terminate for any of the following reasons:

1. employment terminates;

2. the **Group Agreement** terminates;

3. the **Subscriber** is no longer eligible as outlined on the Schedule of Benefits; or

4. the **Subscriber** becomes covered under an alternative health benefit plan or under any other plan which is offered by, through, or in connection with, the **Contract Holder** in lieu of coverage under this **Certificate**.

B. **Termination of Dependent Coverage.**

A **Covered Dependent's** coverage will terminate for any of the following reasons:

1. a **Covered Dependent** is no longer eligible, as outlined on the Schedule of Benefits;

2. the **Group Agreement** terminates; or

3. the **Subscriber's** coverage terminates[;

Coverage of a dependent will not terminate if the **Subscriber** becomes enrolled under a group Medicare risk plan offered by **HMO** or one of its affiliates. However, the dependent's coverage will terminate if the **Subscriber** terminates the group Medicare risk plan].

C. **Termination For Cause.**

HMO may terminate coverage for cause:

1. subject to the Grievance Procedure described in this **Certificate,** upon [30-90] days advance written notice, if the **Member** is unable to establish or maintain, after repeated attempts, a satisfactory physician-patient relationship with a **Participating Provider**. Notice shall be given by certified mail and return receipt requested. At the effective date of such termination, prepayments received by **HMO** on account of such terminated **Member** or **Members** for periods after the effective date of termination shall be refunded to the **Contract Holder**.

2. upon [30-90] days advance written notice, if the **Member** has failed to make any required **Copayment** or any other payment which the **Member** is obligated to pay. Upon the effective date of such termination, prepayments received by **HMO** on account of such terminated **Member** or **Members** for periods after the effective date of termination shall be refunded to **Contract Holder**.

3. upon [30-90] days advance written notice, if the **Member** refuses upon request to cooperate and provide any facts necessary for **HMO** to administer the **Coordination of Benefits** provisions set forth in this **Certificate.**

4. upon [30-90] days advance written notice, if the **Member** refuses to cooperate with **HMO** as required by the **Group Agreement.**

5. upon [30-90] days advance written notice, in the event that **HMO** or **Participating Providers,** after reasonable efforts, are unable to establish and maintain what it and **Member** agree to be a satisfactory relationship with each other, subject to the Grievance Procedure described in this **Certificate.** A **Member's** failure to establish and maintain an acceptable physician-patient relationship with a **Provider** will not result in termination of coverage for the **Member's** entire family unless the **Member** is the **Subscriber**.

6. immediately, upon discovering a material misrepresentation by the **Member** in applying for or obtaining coverage or benefits under this **Certificate** or discovering that the **Member** has committed fraud against **HMO**. This may include, but is not limited to, furnishing incorrect or misleading information to **HMO**, or allowing or assisting a person other than the **Member** named on the identification card to obtain **HMO** benefits. A **Member's** misuse of the identification card will not result in termination of coverage for the **Member's** entire family unless the **Member** who misuses the identification card is the **Subscriber**. **HMO** may, at its discretion, recover from the **Member** the reasonable and recognized charges for **Covered Benefits**, plus **HMO**'s cost of recovering those charges, including court-awarded attorneys' fees. In the absence of fraud or material misrepresentation, all statements made by any **Member** or any person applying for coverage under this **Certificate** will be deemed representations and not warranties. No statement made for the purpose of obtaining coverage will result in the termination of coverage or reduction of benefits unless the statement is contained in writing and signed by the **Member**, and a copy of same has been furnished to the **Member** prior to termination.

7. immediately, if a **Member** acts in such a disruptive manner as to prevent or adversely affect the ordinary operations of **HMO** or a **Participating Provider**.

HMO shall have no further liability or responsibility under this **Certificate** except for coverage for **Covered Benefits** provided prior to the date of termination of coverage.

The fact that **Members** are not notified by the **Contract Holder** of the termination of their coverage due to the termination of the **Group Agreement** shall not deem the continuation of a **Members'** coverage beyond the date coverage terminates.

A **Member** may request that **HMO** conduct a grievance hearing, as described in the Grievance Procedure section of this **Certificate**, within 15 working days after receiving notice that **HMO** has or will terminate the **Member's** coverage as described in the Termination For Cause subsection of this **Certificate**. **HMO** will continue the **Member's** coverage in force until a final decision on the grievance is rendered, provided the **Premium** is paid throughout the period prior to the issuance of that final decision. **HMO** may terminate coverage, to the date coverage would have terminated had the **Member** not requested a grievance hearing, if the final decision is in favor of **HMO**. If coverage is terminated, **HMO** will refund any **Premiums** paid for that period after the termination date, minus the cost of **Covered Benefits** provided to a **Member** during this period.

Coverage will not be terminated on the basis of a **Member's** health status or health care needs, nor if a **Member** has exercised the **Member's** rights under the **Certificate's** Grievance Procedure to register a complaint against **HMO**. The grievance process described in the preceding paragraph applies only to those terminations affected pursuant to the Termination for Cause subsection of this **Certificate**.

CONTINUATION AND CONVERSION

A. **COBRA Continuation Coverage.**

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986. This Act permits **Members** or **Covered Dependents** to elect to continue group coverage as follows:

Employees and their Covered Dependents will not be eligible for the continuation of coverage provided by this section if the Contract Holder is exempt from the provisions of COBRA.

1. Minimum Size of Group:

   The **Contract Holder** must have normally employed more than 20 employees on a typical business day during the preceding calendar year. This refers to the number of employees employed, not the number of employees covered by a health plan, and includes full-time and part-time employees.

2. Loss of coverage due to termination (other than for gross misconduct) or reduction of hours of employment:

   Member may elect to continue coverage for 18 months after eligibility for coverage under this **Certificate** would otherwise cease.

3. Loss of coverage due to:

   a. divorce or legal separation, or

   b. **Subscriber's** death, or

   c. **Subscriber's** entitlement to Medicare benefits, or,

   d. cessation of **Covered Dependent** child status under the Eligibility and Enrollment section of this **Certificate**:

   The **Member** may elect to continue coverage for 36 months after eligibility for coverage under this **Certificate** would otherwise cease.

4. Continuation coverage ends at the earliest of the following events:

   a. the last day of the 18-month period.

   b. the last day of the 36-month period.

   c. the first day on which timely payment of **Premium** is not made subject to the Premiums section of the **Group Agreement**.

   d. the first day on which the **Contract Holder** ceases to maintain any group health plan.

   e. the first day on which a **Member** is actually covered by any other group health plan. In the event the **Member** has a pre-existing condition, and the **Member** would be denied coverage under the new plan for a pre-existing condition, continuation coverage will not be terminated until the last day of the continuation period, or the date upon which the **Member's** pre-existing condition becomes covered under the new plan, whichever occurs first.

   f. the date the **Member** is entitled to Medicare.

5. Extensions of Coverage Periods:

   a. The 18-month coverage period may be extended if an event which would otherwise qualify the **Member** for the 36-month coverage period occurs during the 18-month period, but in no event may coverage be longer than 36 months from the event which qualified the **Member** for continuation coverage initially.

b. In the event that a **Member** is determined, within the meaning of the Social Security Act, to be disabled and notifies the **Contract Holder** before the end of the initial 18-month period, continuation coverage may be extended up to an additional 11 months for a total of 29 months., This provision is limited to **Members** who are disabled at any time during the first 60 days of continuation coverage under this subsection (A) and only when the qualifying event is the **Members** reduction in hours or termination. The **Member** may be charged a higher rate for the extended period.

6. Responsibility to provide **Member** with notice of Continuation Rights:

The **Contract Holder** is responsible for providing the necessary notification to **Members**, within the defined time period (sixty (60) days), as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

7. Responsibility to pay **Premiums** to **HMO**:

Coverage for the sixty (60) day period as described above to initially enroll, will be extended only where the **Subscriber** or **Member** pays the applicable **Premium** charges due within forty-five (45) days of submitting the application to the **Contract Holder** and **Contract Holder** in turn remitting same to **HMO**.

8. **Premiums** due **HMO** for the continuation of coverage under this section shall be due in accordance with the procedures of the Premiums section of the **Group Agreement** and shall be calculated in accordance with applicable federal law and regulations.

B. **Continuation of Coverage by HMO.**

In the event a **Subscriber's** employment with **Contract Holder** is terminated involuntarily and without cause, **Subscriber** shall be entitled to continue coverage, including coverage of **Covered Dependents**, immediately thereafter, without payment of additional **Premium**, for a period equal to one month (i.e., the corresponding day of the following month, for example from February 15th to March 15th) for each year that **Subscriber** has continuously (i.e., no lapse of more than thirty (30) days) maintained coverage with **HMO** under an eligible **Group Agreement**, commencing with the date that **Subscriber** is effective under this section, to a maximum of three months of such coverage. All continued coverage utilized by **Subscriber** pursuant to this section shall be deducted from **Subscriber's** accumulated eligibility for continued coverage under this subsection (i.e., if **Subscriber** has used one (1) month of a three (3) month accumulated continued coverage period, two (2) months will remain until such time as **Subscriber** again becomes eligible for three (3) months of continued coverage.) To be eligible for and obtain such continued coverage an application must be received by **HMO** within thirty (30) days after **Subscriber's** termination of employment and shall include (x) a signed representation from the **Subscriber** that the **Subscriber** is not eligible for other comprehensive group health coverage (such as through a spouse or other employer) or Medicare, and (y) a signed written certification from the **Contract Holder** that the **Subscriber's** employment was terminated involuntarily and without cause. In the event **Subscriber** exercises **Subscriber's** COBRA or other continuation rights under this **Certificate**, continuation of coverage hereunder shall be in the form of the waiver of the applicable COBRA **Premium** or other continuation **Premium**.

C. **Conversion Privilege.**

This subsection does not continue coverage under the **Group Agreement**. It permits the issuance of an individual health care coverage agreement (conversion coverage) under certain conditions.

Conversion is not initiated by **HMO**. The conversion privilege set forth in this subsection must be initiated by the eligible **Member**. The **Contract Holder** is responsible for giving notice of the conversion privilege

in accordance with its normal procedures, however, in the event continuation coverage ceases pursuant to expiration of COBRA benefits as described in the COBRA Continuation Coverage section of this **Certificate**, the **Contract Holder** shall notify the **Member** at some time during the 180-day period prior to the expiration of coverage.

1 Eligibility

In the event a **Member** ceases to be eligible for coverage under this **Certificate**, such person may, within 31 days after termination of coverage under this **Certificate**, convert to individual coverage with **HMO**, effective as of the date of such termination, without evidence of insurability provided that **Member's** coverage under this **Certificate** terminated for one of the following reasons

a Coverage under this **Certificate** was terminated, and was not replaced with continuous and similar coverage by the **Contract Holder**; or

b The **Subscriber** ceased to meet the eligibility requirements as described in the Eligibility and Enrollment section of this **Certificate**, in which case the **Subscriber** and **Subscriber's** dependents who are **Members** pursuant to this **Certificate**, if any, are eligible to convert, or

c A **Covered Dependent** ceased to meet the eligibility requirements as described in the Eligibility and Enrollment section of this **Certificate** because of the **Member's** age or the death or divorce of **Subscriber**; or

d. Continuation coverage ceased under the COBRA Continuation Coverage section of this **Certificate**.

Any **Member** who is eligible to convert to individual coverage, may do so in accordance with the rules and regulations governing items such as initial payment, the form of the agreement and all terms and conditions thereunder as **HMO** may have in effect at the time of **Member's** application for conversion, without furnishing evidence of insurability. The conversion coverage will provide benefits no less than what is then required by, and no benefits contrary to, any applicable law or regulation. However, the conversion coverage may not provide the same coverage, and may be less than what is provided under the **Group Agreement**. Upon request, **HMO** or the **Contract Holder** will furnish details about conversion coverage.

2. A spouse has the right to convert upon the death of or divorce from the **Subscriber** and a **Covered Dependent** child has the right to convert upon reaching the age limit or upon death of the **Subscriber** (subject to the ability of minors to be bound by contract).

[D. **Continuation Coverage for Dependents.**

If a **Subscriber** dies while covered under any part of this plan, any coverage then in force for the **Covered Dependents** will be continued, provided the **Contract Holder** continues to make **Premium** payments. A **Subscriber's** spouse's coverage will cease when the spouse remarries. Any **Covered Dependent's** coverage, including a spouse's, will cease upon the earliest of:

1 the end of the 12 month period right after the **Subscriber's** death;

2 a **Covered Dependent** no longer meets the eligibility requirements as outlined on the Schedule of Benefits;

3. a **Covered Dependent** becomes eligible for like coverage under this Plan or any other plan providing group health benefits

4. when the **Contract Holder** no longer provides coverage for the class of eligible enrollees of which the **Subscriber** was part of right before the **Subscriber's** death, or

5 any required contributions cease.

If coverage is being continued for a **Covered Dependent**, a child born after the **Subscriber's** death will also be covered]

[[E]. **Continuation of Coverage During Temporary Lay-off or Approved Leave of Absence.**

If a **Subscriber's** coverage would terminate due to a temporary lay-off or an approved leave of absence, coverage may be continued for up [60] days, or as otherwise agreed upon by the **Contract Holder** and **HMO**, if the **Contract Holder**: (1) pays the **Premium** for such continued coverage, and (2) provides continued coverage from **HMO** or its other sponsored health benefit plans to all eligible enrollees in the same class as the **Subscriber** whose coverage would otherwise terminate because of a temporary lay-off or approved leave of absence]

[F] **Extension of Benefits While Member is Receiving Inpatient Care.**

Any **Member** who is receiving inpatient care in a **Hospital** or **Skilled Nursing Facility** on the date coverage under this **Certificate** terminates is covered in accordance with the **Certificate** only for the specific medical condition causing that confinement or for complications arising from the condition causing that confinement, until the earlier of·

1 the date of discharge from such inpatient stay; or

2 determination by the **HMO** Medical Director in consultation with the attending **Physician**, that care in the **Hospital** or **Skilled Nursing Facility** is no longer **Medically Necessary**; or

3 the date the contractual benefit limit has been reached.

The extension of benefits shall not extend the time periods during which a **Member** may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of **Premium** for such coverage

[[G] **Extension of Benefits Upon Total Disability.**

Any **Member** who is **Totally Disabled** on the date coverage under this **Certificate** terminates is covered in accordance with the **Certificate**.

This extension of benefits shall only·

1 provide **Covered Benefits** that are necessary to treat medical conditions causing or directly related to the disability as determined by **HMO**; and

2. remain in effect until the earlier of the date that:

   a. the **Member** is no longer **Totally Disabled**; or

   b. the **Member** has exhausted the **Covered Benefits** available for treatment of that condition; or

   c. the **Member** has become eligible for coverage from another health benefit plan which does not exclude coverage for the disabling condition; or

   d. after a period of twelve (12) months in which benefits under such coverage are provided to the **Member**.

The extension of benefits shall not extend the time periods during which a **Member** may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of **Premium** for such coverage.]

COMPLAINT AND GRIEVANCE PROCEDURES

The following procedures govern complaints, grievances, and grievance appeals made or submitted by **Members**.

A. **Definitions.**

1. An "inquiry" is a **Member's** request for administrative service, information, or to express an opinion, including but not limited to, claims regarding scope of coverage for health services, denials, cancellations, terminations or renewals, and the quality of services provided.

2. A "grievance" is a request by a **Member** or a **Provider** with the written consent of the **Member**, to have **HMO** reconsider a decision solely concerning the **Medical Necessity** and appropriateness of a health care service. If **HMO** is unable to resolve the matter, a grievance may be filed regarding the decision that:

   a. disapproves full or partial payment for a requested health care service;

   b. approves the provision of a requested health care service for a lesser scope or duration than requested; or

   c. disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service.

   A grievance does not include a complaint.

3. A "complaint" is a dispute or objection regarding a **Participating Provider** or the coverage, operations or management policies of **HMO**, which has not been resolved by **HMO** and has been filed with **HMO** or with the Department of Health or the Insurance Department of the Commonwealth. The term does not include a grievance.

4. A "utilization review" is a system of prospective, concurrent, or retrospective utilization review of the **Medical Necessity** and appropriateness of health care services prescribed, provided, or proposed to be provided to a **Member**. The term does not include any of the following:

   a. requests for clarification of coverage, eligibility, or health care service verification.

b. a **Provider's** internal quality assurance or utilization review process unless the review results in denial of payment for a health care service.

B. **Internal Complaint Process.**

1. Initial Complaint Review.

Members may submit an oral or written complaint to HMO, including written data or other information.

a. A written notice shall be sent by **HMO** to the **Member:**

i. acknowledging each complaint; and
ii. inviting the **Member** to provide any additional information to assist **HMO** in handling and deciding the complaint; and
iii. informing the **Member** of the **Member's** right to have an uninvolved **HMO** representative assist the **Member** in understanding the complaint process; and
iv. informing the **Member** as to when a response should be forthcoming.

b. The Complaint Coordinator deciding the complaint shall be comprised of one or more employees of **HMO.** It shall not include any person whose decision is being appealed, any person who made the initial decision regarding the claim, or any person with previous involvement with the complaint. The Complaint Coordinator shall review and decide the complaint within 30 days of receipt.

To obtain information regarding the filing of a complaint or grievance, or the status of a Member's complaint or grievance, call [Member Services at 1 (800) 323-9930].

c. A written notice stating the result of the review by the Complaint Committee shall be forwarded by **HMO** to the **Member** within five (5) working days of the date of the decision. Such notice shall include:

i. a description of the Committee's understanding of the **Member's** complaint as presented to the Complaint Committee (i.e., dollar amount of the disputed issue, medical facts in dispute, etc.); and

ii. the Committee's decision in clear terms, including the contract basis or medical rationale, as applicable, in sufficient detail for the **Member** to respond further to **HMO's** position (i.e., the **Member** did not contact the **PCP**, the services were non-emergency services as identified in the medical report, the services were not covered by the **Certificate**, etc.); and

iii. citations to the evidence or documentation used as the basis for the decision (i.e., reference to the **Certificate**, medical records, etc.); and

iv. a statement indicating:

a). that the decision will be final and binding unless the **Member** appeals in writing for a Second Level Review within thirty (30) days of the date of the notice of the decision of the Complaint Committee; and
b). a description of the process of how to appeal to the Complaint Appeal Committee.

2. **Second Level Complaint Review.**

a. Upon receipt of a written appeal by the Complaint Appeal Committee, **HMO** shall provide the **Member** filing the appeal with the procedures governing Second Level Complaint Reviews before the Complaint Appeal Committee. The **Member** shall be notified of the **Member's** right to have an uninvolved **HMO** representative available to assist the **Member** in understanding the appeal process.

b. The Complaint Appeal Committee shall be established by the Board of Directors of the **HMO** and shall be comprised of three members, one of whom shall be a non-employee **Subscriber** of the **HMO**. The Complaint Appeal Committee shall not include any person previously involved with the complaint. An **HMO** Medical Director may serve as a member of the Committee if the Medical Director was not previously involved with the complaint.

c. The Complaint Appeal Committee shall hold appeal hearings in **HMO** offices on a certain day each month to consider all appeals filed seven business days or more in advance of the hearing day. The Second Level Complaint Review will be held and a decision rendered within 45 days of receipt of request for such review. In the event a **Member** is unable to attend the hearing on the scheduled hearing day, the **Member** may request that their appeal be heard on the next scheduled hearing day. If no scheduled hearing day is suitable for the **Member**, the hearing will be scheduled for the following month.

d. The **Member** shall have the right to attend the appeal hearing, question the representative of **HMO** designated to appear at the hearing and any other witnesses, and present their case. The **Member** shall also have the right to be assisted or represented by a person of the **Member's** choice, and submit written material in support of their complaint. The **Member** may bring a **Physician** or other expert(s) to testify on the **Member's** behalf. **HMO** shall also have the right to present witnesses. Counsel for the **Member** may present the **Member's** case and question witnesses; if the **Member** is so represented, **HMO** may be similarly represented by counsel. The Complaint Appeal Committee shall have the right to question the **HMO** representative, the **Member** and any other witnesses.

e. The appeal hearing shall be informal. The Complaint Appeal Committee shall not apply formal rules of evidence in reviewing documentation or accepting testimony at the hearing. The Chair of the Complaint Appeal Committee shall have the right to exclude redundant testimony or excessive argument by any party or witness.

f. A written record of the appeal hearing shall be made by stenographic transcription. All testimony shall be under oath.

g. Before the record is closed, the Chair of the Complaint Appeal Committee shall ask both the **Member** and the **HMO** representative (or their counsel) whether there is any additional evidence or argument which the party wishes to present to the Complaint Appeal Committee. Once all evidence and arguments have been received, the record of the appeal hearing shall be closed. The deliberations of the Complaint Appeal Committee shall be confidential and shall not be transcribed.

h. The Complaint Appeal Committee shall render a written decision within 5 working days of the conclusion of the appeal hearing. The decision shall contain:

   i. a statement of the Complaint Appeal Committee's understanding of the nature of the complaint and the material facts related thereto; and

ii. the Complaint Appeal Committee's decision and rationale; and

iii. a summary of the evidence, including necessary document supporting the decision; and

iv. a statement of the **Member's** right to appeal to the Department of Health or Department of Insurance, with the phone number and complete address of the Department of Health or Department of Insurance, within 15 days from receipt of the notice of the decision.

All records from the initial review and Second Level Review shall be transmitted to the Department of Health or Insurance, as applicable. The **Member**, the **Provider**, or **HMO** may submit additional materials related to the complaint.

The Member may be represented by an attorney or other individual in order to resolve their complaint.

C. **Internal Grievance Process.**

1. Internal Grievance Process.

A **Member** or a **Provider**, with the written consent of a **Member**, may file a written grievance regarding the denial of payment for a health care service. A **Member** who consents to the filing of a grievance by a **Provider** may not file a separate grievanee.

a. A written notice shall be sent by **HMO** to the **Member:**

i. acknowledging each grievance; and
ii. inviting the **Member** to provide any additional information to assist **HMO** in handling and deciding the grievance; and
iii. informing the **Member** as to when a response should be forthcoming.

b. The Grievance Committee deciding the grievance shall be comprised of one or more employees of **HMO**. The Committee will include telecommunication input of or presence of a licensed physician or, where appropriate, an approved licensed psychologist, in the same or similar specialty that typically manages or consults on the health care services in question. It shall not include any person whose decision is being appealed, any person who made the initial decision regarding the utilization review, or any person with previous involvement with the grievance. The Grievance Coordinator shall review and decide the grievance within 30 days of receipt.

c. A written notice stating the result of the review by the Grievance Committee shall be forwarded by **HMO** to the **Member** within five (5) working days of the date of the decision. Such notice shall include:

i. a description of the Committee's understanding of the **Member's** grievance as presented to the Grievance Committee (i.e., medical facts in dispute, etc.); and

ii. the Committee's decision in clear terms, including basis or medical and clinical rationale for the decision, as applicable, in sufficient detail for the **Member** to respond further to **HMO's** position; and

iii. citations to the evidence or documentation used as the basis for the decision (i.e., reference to the **Certificate**, medical records, etc.); and

iv. a statement indicating:

a). that the decision will be final and binding unless the **Member** appeals in writing for a Second Level Review within thirty (30) days of the date of the notice of the decision of the Grievance Committee; and

b). a description of the process of how to appeal to the Grievance Appeal Committee.

2. Second Level Grievance Review.

a. Upon receipt of a written appeal by the Grievance Appeal Committee, **HMO** shall provide the **Member** filing the appeal with the procedures governing Second Level Complaint Reviews before the Grievance Appeal Committee. The **Member** shall be notified of the **Member's** right to have an uninvolved **HMO** representative available to assist the **Member** in understanding the appeal process.

b. The Grievance Appeal Committee shall be established by the Board of Directors of the **HMO** and shall be comprised of three members, one of whom shall be a non-employee **Subscriber** of the **HMO**. The Committee will include telecommunication input of or presence of a licensed physician or, where appropriate, an approved/licensed psychologist, in the same or similar specialty that typically manages or consults on the health care services in question. The Grievance Appeal Committee shall not include any person previously involved with the grievance. An **HMO** Medical Director may serve as a member of the Committee if the Medical Director was not previously involved with the grievance.

c. The Second Level Complaint Review will be held and a decision rendered within 45 days of receipt of request for such review.

d. The Grievance Appeal Committee shall render a written decision within 5 working days of the conclusion of the appeal hearing. The decision shall contain:

i. a statement of the Grievance Appeal Committee's understanding of the nature of the grievance and the material facts related thereto; and

ii. the Grievance Appeal Committee's decision and rationale; and

iii. a summary of the evidence, including necessary document supporting the decision; and

iv. a statement of the **Member's** right to appeal to the Department of Health or Department of Insurance, with the phone number and complete address of the Department of Health or Department of Insurance, within 15 days from receipt of the notice of the decision.

All records from the initial review and Second Level Review shall be transmitted to the Department of Health or Insurance, as applicable. The **Member**, the **Provider**, or **HMO** may submit additional materials related to the complaint.

3. **Expedited Internal Grievance Process.**

a In the event a grievance requires specific action, and the **Member** or **HMO** believes serious medical consequences will arise in the near future, within up to 15 days from **HMO's** denial to pay for the provision of allegedly **Medically Necessary** covered health services, the **Member** shall receive expedited review of their grievance

b In the event the Member's life, health or ability to regain maximum function be in jeopardy, an **HMO** Medical Director shall review the matter as soon as possible or within 48 hours, and communicate a decision to the **Member** and **Provider** by telephone

c In the event the issue is of an urgent nature, an **HMO** Medical Director shall review the matter and make a determination within 96 hours of receipt

d An adverse decision by a Medical Director in either an emergent or urgent medical situation shall be immediately reviewed by an **HMO** Regional Medical Director or his designee The decision of the Regional Medical Director shall be provided to the **Member** by telephone and confirmed in writing

D **External Grievance Process.**

1 A **Member** or **Provider**, with the written consent of the **Member**, may appeal the denial of a grievance within following the completion of the Internal Grievance Process The External Grievance Process shall be conducted by an independent utilization review entity not directly affiliated with **HMO**

2 An external grievance shall be filed with **HMO** within 15-days of receipt of a notice of denial resulting from the Internal Grievance Process The filing shall include any material justification and all reasonably necessary supporting information

3 **HMO** shall notify the **Member** or **Provider** and the Department of Health that an external grievance has been filed within 5 business days of receipt of the filing.

4 The Department of Health shall assign a utilization review entity within 2 business days of receiving the request If the Department fails to select a utilization review entity, **HMO** will designate and notify a certified utilization review entity to conduct the external grievance

5 **HMO** shall notify the **Member** or **Provider** of the name, address, and telephone number of the assigned utilization review entity within 2 business days

6 **HMO** shall forward copies of all written documentation regarding the denial, including the decision, all reasonably necessary supporting information, a summary of applicable issues, and the basis and clinical rationale for the decision, to the utilization review entity conducting the external grievance within 15 days of receipt of notice that the external grievance was filed

7 Any additional written information may be submitted by the **Member** or the **Provider** within 15 days of receipt of notice that the external grievance was filed

8 The utilization review entity conducting the external grievance shall review all information considered in reaching any prior decisions to deny payment for the health care service and any other written submission by the **Member** or the **Provider** A written decision from the utilization review entity shall be forwarded to **HMO**, the **Member** and the **Provider**, if applicable, within 60 days of the filing of the external grievance The written decision shall include the basis and clinical rationale for the decision.

9 The external grievance decision shall be subject to appeal to a court of competent jurisdiction within 60 days of receipt of notice of the external grievance decision There shall be a rebuttal presumption in favor of the decision of the utilization review entity conducting the external grievance.

10 **HMO** shall authorize any health care service or pay a claim determined to be **Medically Necessary** and appropriate if determined by the external review entity, regardless of whether an appeal to a court of competent jurisdiction has been filed.

11. All fees and costs, related to an external grievance, shall be paid by the non-prevailing party, if the external grievance was filed by a **Provider**. The **Provider** and the utilization review entity or **HMO** shall each place in escrow an amount equal to one-half of the estimated costs of the External Grievance Process. If the external grievance was filed by the **Member**, all fees and costs related thereto shall be paid by **HMO**. Fees and costs shall not include attorney fees.

12. **HMO** may impose a $25 00 fee for filing an external grievance.

E. **Exhaustion of Process.**

The foregoing procedures and process are mandatory and must be exhausted prior to:

1 any investigation of a complaint by the Department of Health; or

2. the filing of a complaint with the Department of Health; or

3. the establishing of any litigation or arbitration, or any administrative proceeding regarding either any alleged breach of the **Group Agreement** or **Certificate** by **HMO,** or any matter within the scope of the grievance resolution process of any complaint, grievance or grievance appeal.

F **Record Retention.**

HMO shall retain the records of all grievances for a period of at least 7 years.

G. **Fees and Costs.**

Nothing herein shall be construed to require **HMO** to pay counsel fees or any other fees or costs incurred by a **Member** in pursuing a grievance or appeal.

COORDINATION OF BENEFITS

Some **Members** have health coverage in addition to the coverage provided under this **Certificate.** When this is the case, the benefits paid by other plans will be taken into account. This may mean a reduction in benefits payable under this **Certificate. HMO** will provide health care services first, and then will seek **Coordination of Benefits.**

When coverage under this **Certificate** and coverage under another plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

A. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules

B. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

1. secondary to the plan covering the person as a dependent; and

2. primary to the plan covering the person as other than a dependent;

the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

1. covers the person as other than a dependent; and

2. is secondary to Medicare.

C. Except in the case of a dependent child whose parents are divorced or separated, the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

If the other plan does not have the rule described in this provision (C) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

D. In the case of a dependent child whose parents are divorced or separated:

1. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (C) above will apply.

2. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

3. If there is not such a court decree:

   If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

   If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

E. If A, B, C and D above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person as a:

1. laid-off or retired employee; or

2. the dependent of such person;

shall be determined after the benefits of any other plan which covers such person as:

1. an employee who is not laid-off or retired; or

2. a dependent of such person.

If the other plan does not have a provision:

1. regarding laid-off or retired employees; and

2. as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

1. regarding right of continuation pursuant to federal or state law; and

2. as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

HMO has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

Other plan means any other plan of health expense coverage under:

1. Group insurance.

2. Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.

The term "Other Plan" shall exclude any student accident and group or group-type hospital indemnity benefits of $100 per day or less. This **Certificate** is in excess of the Pennsylvania Motor Vehicle Financial Responsibility Law.

Payment of Benefits.

The combined benefits paid will not be more than the expenses recognized under the plans. In a calendar year, **HMO** will pay its regular benefits in full, or a reduced benefit. The reduced amount will be 100% of **Allowable Expenses** less the benefits payable by the other plans. If the plan provides benefits in the form of services rather than cash payment, the cash value will be used. When this provision operates to reduce the total amount of benefits otherwise payable as to a **Member** covered under this **Certificate** during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this coverage.

The difference between the cost of a private **Hospital** room and the semiprivate rate is not considered an **Allowable Expense** unless the patient's stay in a private **Hospital** room is **Medically Necessary**, either in terms of generally accepted medical practice or as specifically defined in this **Certificate**.

When the benefits under the plan which determines its benefits first are reduced because a **Member** does not comply with the plan provisions, the amount of such reduction will not be considered an **Allowable Expense**. Examples of such provisions include, but are not limited to, those related to second surgical opinions and certification of admissions or services.

Facility of Payment.

A payment made by another plan may include an amount which should have been paid under this **Certificate**. If it does, **HMO** may pay that amount to the plan that made that payment. That amount will then be treated as though it were a benefit paid by **HMO**. **HMO** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Recovery of Overpayments.

If the benefits paid under this **Certificate**, plus the benefits paid by other plans, exceeds the total amount of **Allowable Expenses**, **HMO** has the right to recover the amount of that excess payment if it is the Secondary Plan, from among one or more of the following: (1) any person to or for whom such payments were made; (2) other plans; or (3) any other entity to which such payments were made. This right of recovery shall be exercised at **HMO**'s discretion. A **Member** shall execute any documents and cooperate with **HMO** to secure its right to recover such overpayments, upon request from **HMO**.

Medicare And Other Federal Or State Government Programs.

The provisions of this section will apply to the maximum extent permitted by federal or state law. **HMO** will not reduce the benefits due any **Member** due to that **Member's** eligibility for Medicare where federal law requires that **HMO** determines its benefits for that **Member** without regard to the benefits available under Medicare.

The coverage under this **Certificate** is not intended to duplicate any benefits for which **Members** are, or could be, eligible for under [Medicare or] any other federal or state government programs (such as Workers' Compensation). All sums payable under such programs for services provided pursuant to this **Certificate** shall be payable to and retained by **HMO**. Each **Member** shall complete and submit to **HMO** such consents, releases, assignments and other documents as may be requested by **HMO** in order to obtain or assure reimbursement under Medicare or any other government programs for which **Members** are eligible.

[Medicare benefits will be taken into account for any **Member** who is eligible for Medicare. This will be done whether or not the **Member** is enrolled in Medicare.]

[A **Member** is eligible for Medicare any time the **Member** is covered under it. **Members** are considered to be eligible for Medicare or other government programs if they:

1. Are covered under a program;

2. Have refused to be covered under a program for which they are eligible;

3. Have terminated coverage under a program; or

4. Have failed to make proper request for coverage under a program.]

Active Employees and Their Dependents Who Are Eligible For Medicare.

Certain rules apply to active employees and their **Dependents** who are eligible for Medicare. When a active **Subscriber**, or the **Dependent** of a active **Subscriber**, is eligible for Medicare and the **Subscriber** or **Dependent**

belongs to a group covered by this **Certificate** with twenty (20) or more employees, that **Member** must make a written election to the **Contract Holder** indicating whom that **Member** wants to be his primary carrier. If the **Member** elects the **Contract Holder's** group plan as the primary plan, this **Certificate** will be the primary payer. If the **Member** elects Medicare as the primary plan, all benefits otherwise payable to that **Member** under this **Certificate** shall terminate. If the **Member** belongs to a covered group of less than twenty (20) employees, this **Certificate** will be secondary payer and all benefits otherwise payable with respect to the **Member** will be paid in accordance with the Provision for Coordination with Medicare section below.

Covered Persons Who Are Disabled or Who Have End Stage Renal Disease (ESRD).

Special rules apply to **Members** who are disabled or who have End Stage Renal Disease. This **Certificate** will make primary and secondary payer determination in accordance with the Omnibus Budget Reconciliation Act (OBRA), as amended.

[Retired Employees and Their Dependents Who Are Eligible For Medicare
If the eligible class of employees of this **Certificate** includes coverage for retired employees who are eligible for Medicare, the benefits provided by this **Certificate** will be paid in accordance with the Provision for Coordination with Medicare section below.]

Provision for Coordination with Medicare

[**HMO** will reduce benefits for any medical expenses covered under this **Certificate** by the amount of any Medicare benefits available for such expenses. This will be done before the benefits under this **Certificate** are calculated. Charges for services used to satisfy a **Member's** Medicare Part B deductible will be applied under this **Certificate** in the order received by **HMO**. Two or more charges for services received at the same time will be applied starting with the largest first. Any rules for **Coordination of Benefits**, as outlined in this **Certificate**, will be applied after **HMO's** benefits have been calculated under the rules in this section. **Allowable Expenses** will be reduced by any Medicare benefits available for those expenses.]

[**HMO** reserves the right to cover full benefits or to reduce benefits for any medical expenses covered under this **Certificate**. The amount **HMO** will pay will be figured so that the amount, plus the benefits under Medicare, will equal no more than 100% of plan expenses. Plan expenses means any necessary medical expenses and reasonable charges, part or all of which are covered under **HMO**. Charges for services used to satisfy a **Member's** Medicare Part B deductible will be applied under this **Certificate** in the order received by **HMO**. Two or more charges for services received at the same time will be applied starting with the largest first. Any rules for **Coordination of Benefits**, as outlined in this **Certificate**, will be applied after **HMO's** benefits have been calculated under the rules in this section. **Allowable Expenses** will be reduced by any Medicare benefits available for those expenses.]

[Benefits under this **Certificate** will cease for any **Member** eligible for Medicare. If coverage would cease because a **Subscriber** is, or could be, eligible for Medicare or any other Federal or State government programs (such as Worker's Compensation) any benefits in force for the **Subscriber's Covered Dependents** may be continued. Coverage will then continue until it terminates for some other reason under the rules of this **Certificate**. A conversion privilege may be available in the event that a **Dependent's** coverage under this **Certificate** ends because the **Subscriber** becomes eligible for Medicare. This does not apply if the **Member** is eligible for any Medicare related benefits under this **Certificate**.]

THIRD PARTY LIABILITY AND RIGHT OF RECOVERY

If **HMO** provides health care benefits under this **Certificate** to a **Member** for injuries or illness for which a third party is or may be responsible, then **HMO** retains the right to repayment of the full cost of all benefits provided by **HMO** on behalf of the **Member** that are associated with the injury or illness for which the third party is. **HMO's** rights of recovery apply to any recoveries made by or on behalf of the **Member** from the following third-party sources, as allowed by law, including but not limited to: payments made by a third-party tortfeasor or any insurance

company on behalf of the third-party tortfeasor; any payments or awards under an uninsured or underinsured motorist coverage policy; any worker's compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; any other payments from a source intended to compensate a **Member** for injuries resulting from alleged negligence of a third party.

The **Member** specifically acknowledges **HMO's** right of subrogation. When **HMO** provides health care benefits for injuries or illnesses for which a third party is or may be responsible, **HMO** shall be subrogated to the **Member's** rights of recovery against any third party to the extent of the full cost of all benefits provided by **HMO**, to the fullest extent permitted by law. **HMO** may proceed against any third party with or without the **Member's** consent.

The **Member** also specifically acknowledges **HMO's** right of reimbursement. This right of reimbursement attaches, to the fullest extent permitted by law, when **HMO** has provided health care benefits for injuries or illness for which a third party is and the **Member** and/or the **Member's** representative has recovered any amounts from the third party or any party making payments on the third party's behalf. By providing any benefit under this **Certificate**, **HMO** is granted an assignment of the proceeds of any settlement, judgment or other payment received by the **Member** to the extent of the full cost of all benefits provided by **HMO**. **HMO's** right of reimbursement is cumulative with and not exclusive of **HMO's** subrogation right and **HMO** may choose to exercise either or both rights of recovery.

The **Member** and the **Member's** representatives further agree to:

A. Notify **HMO** promptly and in writing when notice is given to any third party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illness sustained by the **Member** that may be the legal responsibility of a third party; and

B. Cooperate with **HMO** and do whatever is necessary to secure **HMO's** rights of subrogation and/or reimbursement under this **Certificate**; and

C. Give **HMO** a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from a third party to the extent of the full cost of all benefits associated with injuries or illness provided by **HMO** for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement); and

D. Pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due **HMO** as reimbursement for the full cost of all benefits associated with injuries or illness provided by **HMO** for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by **HMO** in writing; and

E. Do nothing to prejudice **HMO's** rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by **HMO**.

HMO may recover the full cost of all benefits provided by **HMO** under this **Certificate** without regard to any claim of fault on the part of the **Member**, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from **HMO's** recovery without the prior express written consent of **HMO**. In the event the **Member** or the **Member's** representative fails to cooperate with **HMO**, the **Member** shall be responsible for all benefits paid by **HMO** in addition to costs and attorney's fees incurred by **HMO** in obtaining repayment.

RESPONSIBILITY OF MEMBERS

A. **Members** or applicants shall complete and submit to **HMO** such application or other forms or statements as **HMO** may reasonably request. **Members** represent that all information contained in such applications, forms and statements submitted to **HMO** incident to enrollment under this **Certificate** or the administration herein shall be true, correct, and complete to the best of the **Member's** knowledge and belief.

B. The **Member** shall notify **HMO** immediately of any change of address for the **Member** or any of the **Member's Covered Dependents**.

C. The **Member** understands that **HMO** is acting in reliance upon all information provided to it by the **Member** at time of enrollment and afterwards and represents that information so provided is true and accurate.

D. By electing coverage pursuant to this **Certificate**, or accepting benefits hereunder, all **Members** who are legally capable of contracting, and the legal representatives of all **Members** who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions hereof.

E. **Members** are subject to and shall abide by the rules and regulations of each **Provider** from which benefits are provided.

GENERAL PROVISIONS

A. **Identification Card.** The identification card issued by **HMO** to **Members** pursuant to this **Certificate** is for identification purposes only. Possession of an **HMO** identification card confers no right to services or benefits under this **Certificate**, and misuse of such identification card may be grounds for termination of **Member's** coverage pursuant to the Termination of Coverage section of this **Certificate**. If the **Member** who misuses the card is the **Subscriber**, coverage may be terminated for the **Subscriber** as well as any of the **Covered Dependents**. To be eligible for services or benefits under this **Certificate**, the holder of the card must be a **Member** on whose behalf all applicable **Premium** charges under this **Certificate** have been paid. Any person receiving services or benefits which such person is not entitled to receive pursuant to the provisions of this **Certificate** shall be charged for such services or benefits at billed charges.

If any **Member** permits the use of the **Member's HMO** identification card by any other person, such card may be retained by **HMO**, and all rights of such **Member** and their **Covered Dependents**, if any, pursuant to this **Certificate** shall be terminated immediately, subject to the Grievance Procedure set forth in the Grievance Procedure section of this **Certificate**. A **Member's** misuse of the identification card will only result in termination of coverage for the **Member's** entire family if the **Member** who misuses the identification card is the **Subscriber**.

B. **Reports and Records.** **HMO** is entitled to receive from any **Provider** of services to **Members**, information reasonably necessary to administer this **Certificate** subject to all applicable confidentiality requirements as defined in the General Provisions section of this **Certificate**. By accepting coverage under this **Certificate**, the **Subscriber**, for himself or herself, and for all **Covered Dependents** covered hereunder, authorizes each and every **Provider** who renders services to a **Member** hereunder to:

1. disclose all facts pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim;

2. render reports pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim; and

3. permit copying of the **Member's** records by **HMO**.

C. **Refusal of Treatment.** A **Member** may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a **Participating Provider**. If the **Participating Provider** (after a second **Participating Provider's** opinion, if requested by **Member**) believes that no professionally acceptable alternative exists, and if after being so advised, **Member** still refuses to follow the recommended treatment or procedure, neither the **Participating Provider**, nor **HMO**, will have further responsibility to provide any of the benefits available under this **Certificate** for treatment of such condition or its consequences or related conditions. **HMO** will provide written notice to **Member** of a decision not to provide further benefits for a particular condition. This decision is subject to the Grievance Procedure set forth in the Grievance Procedure section of this **Certificate**. Coverage for treatment of the condition involved will be resumed in the event **Member** agrees to follow the recommended treatment or procedure.

D. **Assignment of Benefits.** All rights of the **Member** to receive benefits hereunder are personal to the **Member** and may not be assigned.

E. **Legal Action.** No action at law or in equity may be maintained against **HMO** for any expense or bill unless and until the appeal process has been exhausted, and in no even prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in this **Group Agreement**. No action shall be brought after the expiration of 3 years after the time written submission of claim is required to be furnished.

F. **Independent Contractor Relationship.**

1. No **Participating Provider** or other **Provider**, institution, facility or agency is an agent or employee of **HMO**. Neither **HMO** nor any **Member** of **HMO** is an agent or employee of any **Participating Provider** or other **Provider**, institution, facility or agency.

2. Neither the **Contract Holder** nor a **Member** is the agent or representative of **HMO**, its agents or employees, or an agent or representative of any **Participating Provider** or other person or organization with which **HMO** has made or hereafter shall make arrangements for services under this **Certificate**.

3. **Participating Physicians** maintain the physician-patient relationship with **Members** and are solely responsible to **Member** for all **Medical Services** which are rendered by **Participating Physicians**.

4. **HMO** cannot guarantee the continued participation of any **Provider** or facility with **HMO**. In the event a **PCP** terminates its contract or is terminated by **HMO**, **HMO** shall provide notification to **Members** in the following manner:

   a. within [thirty] days of the termination of a **PCP** contract to each affected **Subscriber**, if the **Subscriber** or any **Dependent** of the **Subscriber** is currently enrolled in the **PCP's** office; and

   b. services rendered by a **PCP** or **Hospital** to an enrollee between the date of termination of the Provider Agreement and five business days after notification of the contract termination is mailed to the **Member** at the **Member's** last known address shall continue to be **Covered Benefits**.

5. **Restriction on Choice of Providers:** Unless otherwise approved by **HMO**, **Members** must utilize **Participating Providers** and facilities who have contracted with **HMO** to provide services.

G. **Inability to Provide Service.** In the event that due to circumstances not within the reasonable control of **HMO**, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the Participating Provider Network, the rendition of medical or **Hospital** benefits or other services provided under this **Certificate** is delayed or rendered impractical, **HMO** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **HMO** on the date such event occurs. **HMO** is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

H. **Confidentiality.** Information contained in the medical records of **Members** and information received from **Physicians**, surgeons, **Hospitals** or other **Health Professionals** incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential in accordance with applicable law. Information may not be disclosed without the consent of the Member except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary by **HMO** in connection with the administration of this **Certificate**, or in the compiling of aggregate statistical data.

I. **Limitation on Services.** Except in cases of a **Medical Emergency**, as provided under the Covered Benefits section of this **Certificate**, services are available only from **Participating Providers**. **HMO** shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a **Member** from any **Physician**, **Hospital**, **Skilled Nursing Facility**, home health care agency, or other person, entity, institution or organization unless prior arrangements are made by **HMO**.

J. **Incontestability.** In the absence of fraud, all statements made by a **Member** shall be considered representations and not warranties, and no statement shall be the basis for voiding coverage or denying a claim after the **Group Agreement** has been in force for 2 years from its effective date, unless the statement was material to the risk and was contained in a written application.

K. This **Certificate** applies to coverage only, and does not restrict a **Member's** ability to receive health care **benefits** that are not, or might not be, **Covered Benefits.**

L. **Contract Holder** hereby makes **HMO** coverage available to persons who are eligible under the Eligibility and Enrollment section of this **Certificate**. However, this **Certificate** shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by the state Department of [Insurance]. This can also be done by mutual written agreement between **HMO** and **Contract Holder** without the consent of **Members**.

M. **HMO** may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **Certificate**.

N. No agent or other person, except an authorized representative of **HMO**, has authority to waive any condition or restriction of this **Certificate**, to extend the time for making a payment, or to bind **HMO** by making any promise or representation or by giving or receiving any information. No change in this **Certificate** shall be valid unless evidenced by an endorsement to it signed by an authorized representative.

O. This **Certificate**, including the Schedule of Benefits, any Riders, and any amendments, endorsements, inserts, or attachments, constitutes the entire **Certificate** between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of this **Certificate** shall be binding unless executed in writing by authorized representatives of the parties.

P. This **Certificate** has been entered into and shall be construed according to applicable state and federal law.

DEFINITIONS

The following words and phrases when used in this **Certificate** shall have, unless the context clearly indicates otherwise, the meaning given to them below:

- **Actively at Work.** The condition where an employee is performing all of the **Subscriber's** regular duties for the **Contract Holder** (the **Subscriber's** employer) on a regularly scheduled work day, at the location where such duties are normally performed, and on a full-time basis. An employee will be considered to be actively at work on a non-scheduled work day only if such person is actively at work on the last regularly scheduled work day immediately preceding such non-scheduled work day.

- **Allowable Expense.** Any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the **Member** for whom claim is made.

- **Behavioral Health Provider.** A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

- **Certificate.** This Certificate of Coverage, including the Schedule of Benefits, and any riders, amendments, or endorsements, which outlines coverage for a **Subscriber** and **Covered Dependents** according to the **Group Agreement.**

- **Contract Holder.** An employer or organization who agrees to remit the **Premiums** for coverage under the **Group Agreement** payable to **HMO**. The **Contract Holder** shall act only as an agent of **HMO Members** in the **Contract Holder's** group, and shall not be the agent of **HMO** for any purpose.

- **Contract Year.** A period of one year commencing on the **Contract Holder's Effective Date of Coverage** and ends at 12:00 midnight on the last day of the one year period.

- **Coordination of Benefits.** A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first. Refer to the Coordination of Benefits section of this **Certificate** for a description of the **Coordination of Benefits** provision.

- **Copayment.** A specified dollar amount or percentage required to be paid by or on behalf of a **Member** in connection with benefits, if any, as set forth in the Schedule of Benefits. **Copayments** may be changed by **HMO** upon 30 days written notice to the **Contract Holder**.

- **Copayment Maximum.** The maximum annual out-of-pocket amount for payment of **Copayments**, if any, to be paid by a **Subscriber** and any **Covered Dependents**, if any.

- **Cosmetic Surgery.** Any non-medically necessary surgery or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function, correct a diseased state, physical appearance, or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. **Cosmetic Surgery** includes, but is not limited to, ear piercing, rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of **Cosmetic Surgery**.

- **Covered Dependent.** Any person in a **Subscriber's** family who meets all the eligibility requirements of the Eligibility and Enrollment section of this **Certificate** and the Dependent Eligibility section of the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements set forth in the Premiums section of the **Group Agreement**.

- **Covered Benefits.** Those **Medically Necessary Services** and supplies set forth in this **Certificate**, which are covered subject to all of the terms and conditions of the **Group Agreement** and **Certificate**.

- **Custodial Care.** Care, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital **Skilled Nursing Facility** care; or c) is a level such that the **Member** has reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. **Custodial Care** includes, but is not limited to, any type of care where the primary purpose of the type of care provided is to attend to the **Member's** daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this includes, but is not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non infected, post operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the **Member**, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of **HMO**, based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest cures, convalescent care

- **Detoxification.** The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent 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.** Equipment, as determined by **HMO**, which is a) made to withstand prolonged use; b) made for and mainly used in the treatment of a disease or injury; c) suited for use while not confined as an inpatient in the **Hospital**; d) not normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; and f) not for exercise or training.

- **Effective Date of Coverage.** The commencement date of coverage under this **Certificate** as shown on the records of **HMO**.

- **Emergency Service.** Professional health services that are provided to treat a **Medical Emergency**. Emergency transportation and related **Emergency Service** provided by a licensed ambulance service shall constitute an **Emergency Service**.

- **Experimental or Investigational Procedures.** Services or supplies that are, as determined by **HMO**, experimental. A drug, device, procedure or treatment will be determined to be experimental if:

  1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

  2. required FDA approval has not been granted for marketing; or

  3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or

4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or

5. it is not of proven benefit for the specific diagnosis or treatment of a **Member's** particular condition; or

6. it is not generally recognized by the **Medical Community** as effective or appropriate for the specific diagnosis or treatment of a **Member's** particular condition; or

7. it is provided or performed in special settings for research purposes.

- **Group Agreement.** The **Group Agreement** between **HMO** and the **Contract Holder**, including the Group Application, Cover Sheet, this **Certificate**, the Schedule of Benefits, any Riders, any amendments, any endorsements, and any attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority.

- **Health Professionals.** A **Physician** or other professional who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.

- **HMO.** [United States Health Care Systems of Pennsylvania, Inc. d/b/a The Health Maintenance Organization of Pennsylvania, Inc. d/b/a U.S. Healthcare [d/b/a Aetna U.S. Healthcare]], a Pennsylvania corporation licensed by the Pennsylvania Department of Insurance as a Health Maintenance Organization.

- **Homebound Member.** A **Member** who is confined to the home due to an illness or injury which makes leaving the home medically contraindicated or which restricts the **Member's** ability to leave the **Member's** place of residence except with the aid of supportive devices, the use of special transportation, or the assistance of another person.

- **Home Health Services.** Those items and services provided by **Participating Providers** as an alternative to hospitalization, and approved and coordinated in advance by **HMO**.

- **Hospice Care.** A program of care that is provided by a **Hospital**, **Skilled Nursing Facility**, hospice, or a duly licensed Hospice Care agency, and is approved by **HMO**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 6 months to live.

- **Hospital.** An institution rendering inpatient and outpatient services, accredited as a **Hospital** by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO** as meeting reasonable standards. A **Hospital** may be a general, acute care, rehabilitation or specialty institution.

- **Infertile or Infertility.** The condition of a presumably healthy **Member** who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual sexual intercourse. This does not include conditions for male **Members** when the cause is a vasectomy or orchiectomy or for female **Members** when the cause is a tubal ligation or hysterectomy.

- **Medical Community.** A majority of **Physicians** who are Board Certified in the appropriate specialty.

- **Medical Emergency.** Any health care service provided to a **Member** after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the

absence of immediate medical attention to result in:

1. placing the health of the **Member**, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

2. serious impairment to bodily functions; or

3. serious dysfunction of any bodily organ or part.

Some examples of **Medical Emergencies** include heart attacks, convulsions, serious burns, poisoning, and loss of consciousness.

- **Medical Services.** The professional services of **Health Professionals,** including medical, surgical, diagnostic, therapeutic, preventive care and birthing facility services.

- **Medically Necessary, Medically Necessary Services, or Medical Necessity.** Services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards as described in the Covered Benefits section of this **Certificate. Medical Necessity**, when used in relation to services, shall have the same meaning as **Medically Necessary Services**. This definition applies only to the determination by **HMO** of whether health care services are **Covered Benefits** under this **Certificate.**

- **Member.** A **Subscriber** or **Covered Dependent** as defined in this **Certificate.**

- **Mental or Behavioral Condition.** A condition which manifests signs and/or symptoms which are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication. Mental or behavioral disorders and conditions include, but are not limited to, psychosis, affective disorders, anxiety disorders, personality disorders, obsessive-compulsive disorders, attention disorders with or without hyperactivity, and other psychological, emotional, nervous, behavioral, or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition. This definition does not include mental, nervous, or emotional disorders with demonstrable organic origins.

- **Non-Hospital Facility.** A facility, licensed by the appropriate regulatory authority, for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities.

- **Open Enrollment Period.** A period of not less than ten (10) consecutive working days, each calendar year, when eligible enrollees of the **Contract Holder** may enroll in **HMO** without a waiting period or exclusion or limitation based on health status or, if already enrolled in **HMO**, may transfer to an alternative health plan offered by the **Contract Holder**.

- **Partial Hospitalization.** The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a **Hospital** or **Non-Hospital Facility** which is licensed as an alcohol or drug abuse or mental illness treatment program by the appropriate regulatory authority, and which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care.

- **Participating.** A description of a **Provider** that has entered into a contractual agreement with **HMO** for the provision of services to **Members.**

- **Physician.** A duly licensed member of a medical profession, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.

- **Premium.** The amount the **Contract Holder** or **Member** is required to pay to **HMO** to continue coverage.

- **Primary Care Physician.** A **Participating Physician** who supervises, coordinates and provides initial care and basic **Medical Services** as a general or family care practitioner, or in some cases, as an internist or a pediatrician to **Members**, initiates their **Referral** for **Specialist** care, and maintains continuity of patient care.

- **Provider.** A **Physician, Health Professional, Hospital, Skilled Nursing Facility**, home health agency or other recognized entity or person licensed to provide **Hospital** or **Medical Services** to **Members**.

- **Reasonable Charge.** The charge for a **Covered Benefit** which is determined by the **HMO** to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. **HMO** may take into account factors such as the complexity, degree of skill needed, type or specialty of the **Provider**, range of services provided by a facility, and the prevailing charge in other areas in determining the **Reasonable Charge** for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.

- **Referral.** Specific directions or instructions from a **Member's PCP**, in conformance with **HMO's** policies and procedures, that direct a **Member** to a **Participating Provider** for **Medically Necessary** care.

- **Respite Care.** Care furnished during a period of time when the **Member's** family or usual caretaker cannot, or will not, attend to the **Member's** needs.

- **Service Area.** The geographic area, established by **HMO** and approved by the appropriate regulatory authority.

- **Skilled Care.** Medical care that requires the skills of technical or professional personnel.

- **Skilled Nursing Facility.** An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a **Skilled Nursing Facility**, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO** to meet the reasonable standards applied by any of the aforesaid authorities.

- **Specialist.** A **Physician** who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

- **Subscriber.** A person who meets all applicable eligibility requirements as described in this **Certificate** and on the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements as set forth in the Premiums section of the **Group Agreement**.

- **Substance Abuse.** Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

- **Substance Abuse Rehabilitation.** Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individualized treatment plans.

- **Totally Disabled or Total Disability.** A **Member** shall be considered **Totally Disabled** if:

1. the **Member** is a **Subscriber** and is prevented, because of injury or disease, from performing any occupation for which the **Member** is reasonably fitted by training, experience, and accomplishments, and is not performing work of any kind for wage or profit; or

2. the **Member** is a **Covered Dependent** and is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

- **Urgent Care. Covered Benefits** required in order to prevent serious deterioration of a **Member's** health that results from an unforeseen illness or injury if the **Member** is temporarily absent from the **HMO Service Area** and receipt of the health care service cannot be delayed until the **Member's** return to the **Service Area**.

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
Office of Rate and Policy Regulation
1311 Strawberry Square
Harrisburg, PA 17120
Fax (717) 787-8555 Telephone (717) 787-0684

October 26, 1999

Fiona E. Wilmarth
Regulatory Analyst
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

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COPIES: Harris
Jewett
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Smith
Wilmarth
Sandusky
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Re: Act 68 Compliance – Managed Care Plan Documents

Dear Ms. Wilmarth:

At our meeting on October 14 regarding Act 68, you requested copies of several Act 68 compliance filings submitted to the Department for review by managed care plans. Attached is information from Act 68 compliance filings submitted by Aetna US Healthcare and Keystone Health Plan East.

Enclosed please find the following plan documents: filing correspondences, certificates of coverage, subscriber agreements, and riders to certificates of coverage or handbooks.

Due to the considerable size of Act 68 filings, we did not enclose in this packet copies of all related plan documents. However, we trust that the selected documents will effectively illustrate the scope of the Department's review process.

If you would like any additional information or have any questions on these filings, we can make arrangements for you to meet with a Policy Examiner from the Department. Please contact me at (717) 787-4192 if I can be of further assistance in this matter.

Sincerely,

Geoffrey Dunaway
Director, Accident and Health Bureau

HMO Plan Member Handbook Pennsylvania Addendum

Emergency Care--Guidelines

Your Certificate of Coverage defines an "emergency" as follows: Any health care service provided to a member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the member, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an emergency service.

You are covered for emergency services 24 hours a day, anywhere in the world, provided the service is a covered benefit and is medically necessary. In an emergency, it is not necessary to call your primary care physician (PCP) or Aetna U.S. Healthcare before receiving care. Aetna U.S. Healthcare covers emergency care screening and stabilization for conditions that reasonably appear to constitute an emergency, based on your presenting symptoms. Also covered is emergency transportation and related emergency services provided by a licensed ambulance service. Prior authorization is not required for emergency medical care.

Emergency room copayments are waived if you are referred by your PCP for services that should have been rendered in the PCP's office, or if you are admitted to the facility.

You will be reimbursed for the cost of emergency services given by a non-participating provider located either within or outside your Aetna U.S. Healthcare service area, less applicable copayments, up to the time that you are medically able to travel or transported to a participating provider. This determination is made by Aetna U.S. Healthcare and the attending physician at the non-participating facility. In the event that transportation is medically necessary, you will be reimbursed for the cost as determined by Aetna U.S. Healthcare, minus applicable copayments. Reimbursement may be subject to payment of all copayments that would have been required if similar benefits been provided during office hours and upon prior referral to a participating provider.

Diabetic Coverage

Aetna U.S. Healthcare covers diabetic equipment and supplies and medically necessary physician visits, as well as outpatient self-management and training, including information on proper diet and nutrition, supervised by a licensed health care professional. Covered equipment includes blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar, and orthotics. Diabetic self-management and training coverage

includes medically necessary physician visits upon the diagnosis of diabetes, visits when a physician identifies a change in the member's self-management regimen, and new medications or therapies that the physician considers medically necessary. Applicable physician copayments apply.

Our network is not restricted and members continue to have access to many other facilities that participate with Aetna U.S. Healthcare.

Continuity of Care Issues

If your health care provider stops participation with Aetna U.S. Healthcare for reasons other than imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, Aetna U.S. Healthcare will continue your coverage for an ongoing course of treatment with your current health care provider during a transitional period.

Continuity of coverage shall continue for up to ninety (90) days from the date Aetna U.S. Healthcare sends notification of the provider's termination of participation with Aetna U.S. Healthcare, or if the member has entered the second trimester of pregnancy, for a transitional period that includes the provision of postpartum care directly related to the delivery. The coverage will be authorized by Aetna U.S. Healthcare for the transitional period only if the health care provider agrees to accept reimbursement at the rates applicable prior to the start of transitional period as payment in full; to adhere to quality standards and to provide medical information related to such care; and to adhere to Aetna U.S. Healthcare's policies and procedures. This paragraph shall not be construed to require Aetna U.S. Healthcare to provide coverage for benefits not otherwise covered.

For new members of Aetna U.S. Healthcare, coverage will be provided to continue an ongoing course of treatment with member's current health care provider for a transitional period of up to sixty (60) days from the effective date of enrollment. If the member has entered the second trimester of pregnancy as of the effective date of enrollment, the transitional period shall include the provision of postpartum care directly related to the delivery. The coverage will be authorized by Aetna U.S. Healthcare for the transitional period only if the health care provider agrees to accept reimbursement rates established by Aetna U.S. Healthcare as payment in full; to adhere to Aetna U.S. Healthcare's quality standards and to provide medical information related to such care; and to adhere to Aetna U.S. Healthcare's policies and procedures. This paragraph shall not be construed to require Aetna U.S. Healthcare to provide coverage for benefits not otherwise covered.

This managed care plan may not cover all your health care expenses. Read your plan documents carefully to determine which health care services are covered. If you have questions, call 800-323-9930.

980 Jolly Road
P.O. Box 1109
Blue Bell, PA 19422

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October 26, 1999

Fiona E. Wilmarth
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Sincerely,

Geoffrey Dunaway
Director, Accident and Health Bureau

HMO CORRECT.

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May 11, 1999

Katherine H. Frear
Aetna U.S. Healthcare
Law Department-U19A
Core Product Support
980 Jolly Road
Blue Bell, PA 19422

RE: Department Filing ID **#A26634001 & A26763001**
(Reference this number in all correspondence)
Act 68 Forms Filing
Your 4/29/99 letter, received 4/30/99

Dear Ms. Frear:

Thank you for the resubmission of the above captioned forms. The changes that you have made, now comply with Pennsylvania Insurance Laws and Regulations.

Enclosed, please find a copy of the above forms bearing the Department's stamp showing approval.

Thank you for your cooperation in this matter.

Sincerely,

JVR 5/11/99
Jeffrey V. Russell, MHP
Policy Examiner
Accident & Health Bureau