

**ACCESS CARE II**  
**The University of Scranton**  
Member Handbook

**Your Benefits**  
**And**  
**How to Use Them**

Use this space for information you'll need when asking about your coverage.

The company office or person to contact about coverage is:

Address: **The University of Scranton, Human Resources Department  
Linden and Monroe Avenue  
Scranton, Pennsylvania 18510-4679**

Phone: **(570) 941-7767**

The appropriate Access Care II Plan contact is:

Address: **Blue Cross of Northeastern Pa.  
70 North Main Street  
Wilkes Barre, Pa 18711**

Customer Service Phone: **1-888-338-2211**

Website: [www.bluecares.com](http://www.bluecares.com)

Prescription Drugs: **1-877-603-8399**

The Subscriber Number shown on my Identification Card is:

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The Group Number shown on my Identification Card is:

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The "Effective Date" when my coverage begins is:

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**This booklet describes, in general, the main features of the Plan. Complete terms and conditions are set forth in the Agreement between Blue Cross, Blue Shield and your employer. The Plan is self-funded health plan and the administration is provided through Blue Cross of Northeastern Pennsylvania and Pennsylvania Blue Shield, 70 North Main Street, Wilkes-Barre, PA 18711**

**The funding is derived from the funds of the Employer and contributions made by employees. The plan is not insured.**

This booklet has been prepared to meet the summary Plan description requirements of Employee Retirement Income Security Act of 1974. The benefits provided under the Plan are subject to the terms and conditions of the group insurance contract issued by Blue Cross of Northeastern Pennsylvania and Pennsylvania Blue Shield, 70 North Main Street, Wilkes-Barre, PA 18711.

Name of Plan

The University of Scranton

Employer and Plan Sponsor

The University of Scranton  
Linden and Monroe Ave.  
Scranton, PA 18510-4679  
Phone: (570) 941-7767

Plan Administrator

The University of Scranton  
Linden and Monroe Ave.  
Scranton, PA 189510-4679  
Phone: (570) 941-7767

Employer Identification Number

24-0795495

Plan Number

501

Participants

The benefits in this summary apply to active employees of The University of Scranton.

Contributions

The cost for your benefits under the plan are shared by you and your employer.

Plan Effective Date

2-1-99

Named Fiduciary

The University of Scranton  
Human Resources Department  
Linden and Monroe Ave.  
Scranton, PA 18510-4679  
Phone: (570) 941-7767

Plan Records

The records for the plan are reported on a calendar year basis beginning each January 1 and ending December 31.

Plan/Type Administration

The program described in this booklet is an employee welfare plan providing Medical benefits administered by Blue Cross of Northeastern Pennsylvania and Pennsylvania Blue Shield.

Amending and Terminating the Plan

If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

The benefits provided under this Plan and all statements in this booklet are subject to the terms and conditions of the Agreement between Blue Cross, Blue Shield and The University of Scranton.

#### Clerical Error

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of Covered Person, if it is requested, the amount of overpayment will be deducted from future benefits payable.

#### Responsibilities For Plan Administration

Plan Administrator – The Plan is to be administered by the Plan Administrator in accordance with the Provisions of ERISA. An individual may be appointed by The University of Scranton to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, The University of Scranton shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Services of legal process may be made upon the Plan Administrator.

#### Duties of The Plan Administrator

- 1) To administer the Plan in accordance with its terms.
- 2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- 3) To decide disputes which may arise relative to a Plan Participant's rights.
- 4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- 5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- 6) To appoint a Claims Administrator to pay claims.
- 7) To perform all necessary reporting as required by ERISA.
- 8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
- 9) To delegate to any person or entity such Powers, duties and responsibilities as it deems appropriate.

#### Plan Administrator Compensation

The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

#### Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

#### Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- 1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
- 2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
- 3) in accordance with the Plan documents to the extent that they agree with ERISA.

#### The Named Fiduciary

A “named fiduciary” is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

- 1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- 2) the named fiduciary breached its fiduciary responsibility under Section 405(1) of ERISA.

#### Claims Administrator Is Not A Fiduciary

A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan’s rules as established by the Plan Administrator.

#### Finding The Plan And Payment Of Benefits

The cost of the Plan is funded as follows:

For Employee Coverage: funding is derived solely from the funds of the Employer.

For Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee’s pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

#### Effective Date

Newly hired and rehired full-time employees and their eligible dependents will be eligible for the benefits described in this summary plan description on the first of month following date of hire.

Persons who become eligible dependents of an enrolled employee after the effective date of the employee’s enrollment will be eligible for these benefits upon notification from employee of such additional dependents and payment of applicable contributions.

Each eligible employee must complete an application form.

#### Statement of ERISA Rights

The following statement of rights under ERISA is provided as required by regulation issued by the Department of Labor and is in the form suggested by the Department.

As a participant in your group insurance Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of

1974 (ERISA). ERISA provides all Plan participants shall be entitled to:

Examine, without charge at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining arrangements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in anyway to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefits is denied in whole or part, you must receive a written explanation of the reason for denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are

discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous). If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone director or the Division of Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, DC 20210.

Agent For Service  
Legal Process on the Plan

The University of Scranton  
Human Resources  
Linden and Monroe Ave.  
Scranton, PA 18510-4679  
Phone: (570) 941-7767

## Welcome To The Access Care II Program

Access Care II is a comprehensive health care coverage program which is tailored to meet the needs of a changing environment. Under Access Care II, you will continue to enjoy the freedom of selecting any network provider, while benefiting from managed care elements included in the product structure.

Access Care II provides members with comprehensive coverage through an extensive national network of facilities and physicians. This network structure, called a Preferred Provider Organization (PPO), allows Blue Cross of Northeastern Pennsylvania and Pennsylvania Blue Shield to contract with specific providers and keep quality of care high while holding costs down. This PPO structure extends outside of the Blue Cross of Northeastern Pennsylvania 13-county service area, to all areas of the country. As a result, you can take advantage of PPO discounted rates no matter where you live or travel. Members are welcome to seek care outside the Access Care II network of preferred providers although your out-of-pocket costs will generally be higher. However, in instances where covered services are unavailable from within the preferred provider network, members may be treated outside the network (with proper approval), and coverage will increase to the in-network payment level.

In order to ensure that you are receiving the proper services to which you are entitled, and are not being subjected to additional, unnecessary charges, Access Care II requires that certain diagnoses and procedures be precertified. This means that either you or the provider calls the Plan toll free at 1-888-338-2211 prior to the procedure, in order to receive

authorization.

In emergencies, you should seek care from the nearest available provider. You will be covered at in-network levels, regardless of where you seek care. If the service requires precertification, you are responsible for contacting the Plan within forty-eight hours after the emergency, or as soon as reasonably possible.

This handbook will serve as a summarization of the benefits and main features of Access Care II. However, the complete terms and conditions are set forth in the contract between your employer, University of Scranton and Blue Cross of Northeastern Pennsylvania and Pennsylvania Blue Shield. Final interpretation of any specific provision is governed by reference to those documents.

### **Access Care II Benefits**

Access Care II coverage includes benefits for facility, physician, and other professional provider services for you and your eligible dependents.

Some benefits and services are subject to precertification before qualifying for coverage, and some services require copayment, coinsurance, or satisfaction of a deductible. A brief description of each of these terms is below, followed by an overview of your Access Care II benefits. If you have any questions, you should contact either your group, or call customer service, toll free 1-888-338-2211.

### **Copayments**

A copayment is a specified amount of the Provider's reasonable charge for specific benefits for which you are responsible. You are responsible for a copayment of \$10 for

physician office visits, a \$35 copayment for visits to the emergency room and a \$10 copayment for prescription drugs.

### **Coinsurance**

Coinsurance is a specified percentage of the provider's usual, customary and reasonable charge for covered services of which you are responsible. The coinsurance selected by your group is 0% for preferred providers and 20% coinsurance for non-preferred providers based on applicable usual, customary and reasonable fee schedule. Coinsurance applies to all covered services except emergencies and those services that are subject to a copayment or where specifically prohibited by law.

Payment for covered services performed by Non-Participating Professional Providers will be made to you on the basis of 80% of the applicable UCR fee schedule allowance or the amount charged, whichever is less. Such payment will constitute full discharge of Blue Shield's liability under the program. Non-Participating Professional Providers are not obligated to accept the UCR fee schedule allowance as payment-in-full. You shall be responsible for payment of the remaining charges.

### **Out-of-Pocket Maximum**

The out-of-pocket maximum is the highest amount of coinsurance for which you are responsible each calendar year. This feature is for your protection, to limit the amount of coinsurance expenses for which you are responsible. Your out-of-pocket annual maximum is \$2,000 per individual; \$4,000 per family for non-preferred providers.

### **Lifetime Maximum**

When you use preferred providers you are

not subject to a lifetime maximum. There is a \$1,000,000 lifetime benefit maximum applied to all services performed by non-preferred providers. The lifetime benefit maximum is non-renewable.

### **Deductible**

A deductible is a specified amount of covered services that must be incurred by you before the Plan will assume any liability for all or part of the remaining covered services. The deductible applies to all covered services, except for emergency care and services specifically prohibited by law.

While there is no annual deductible for preferred providers, your group specific annual deductible for non-preferred providers is \$200 per individual; \$400 per family.

## **COVERED SERVICES**

### **Inpatient Care**

Coverage is provided for 365 days per year of hospitalization. Facility charges for special care units, and ancillary services in a preferred hospital are covered in full. Ancillary services include the use of operating, delivery, and treatment rooms and equipment, prescription drugs, meals, blood and blood services, anesthesia, anesthesia supplies and services, medical and surgical dressings, supplies, casts and splints, diagnostic services, therapy services, and nursing services. Also, included is coverage for professional provider visits.

Coverage is provided for concurrent medical care by a provider who is not in charge of the case, but whose particular skills are required. This does not include routine care, standby services or patient observation. Coverage is also provided for consultations by a provider who is not in charge of the care, but requested by the provider in charge of the care when the patient's condition warrants it.

Precertification is required for all out-of-area or non-preferred inpatient admissions and select outpatient procedures. See page 19 of this handbook for a listing of procedures which require Precertification  
Note: in-area Precertification is performed by your local preferred providers.

### **Skilled Nursing Facilities**

Facility charges for 100 inpatient days per calendar year are covered, along with two visits by the physician during the first week of confinement, and one visit per week for each consecutive week thereafter, subject to the coinsurance level selected by your group.

Benefits are not payable when a maximum level of recovery has been reached, for treatment of alcoholism, drug addiction, or mental illness, or when admission is intended for the sole purpose of assisting with daily living activities (custodial care). Precertification is required.

### **Emergency Accident/Emergency Medical Services**

Services and supplies for the initial treatment of traumatic bodily injury or the sudden onset of a medical condition that requires immediate medical treatment and would cause other serious medical consequences if not treated immediately. Unlike most other services, emergency services are not subject to deductibles or out-of-network coinsurance levels; however, there is a \$35 Emergency Room copayment required.

### **Ambulance Services**

Coverage is provided for medically necessary transportation services. You are responsible for a 20% coinsurance for ambulance services.

### **Surgery**

The following surgical services and supplies are covered, including inpatient pre-operative

care and normal post-operative care. Precertification is required for selected elective surgical procedures.

**Transplant Surgery** including services performed for the removal of an organ from a donor when the donor is not covered under another health plan.

**Oral Surgery** for treatment of diseases or injuries of the jaw, for fractures or dislocations, for removal of bony impacted teeth, for accidental injury to the jaws, natural teeth, mouth or face or for orthodontic treatment for congenital cleft palates.

**Assistant Surgery** when the Plan determines the condition of the patient or the type of surgery warrants the assistance of another provider.

**Second Surgical Opinions** to determine the medical necessity of elective surgery. The consultation must be performed by a provider other than the consultant who provided the original recommendation for surgery or the provider who performs the surgery.

**Anesthesia** for covered services when administered by a provider other than the surgeon, assistant surgeon or the provider who is performing the service. Local infiltration anesthetic is not covered.

### **Maternity Services**

Benefits are provided for the services associated with a normal pregnancy, complications of pregnancy, interruptions of pregnancy, nursery care, and routine newborn care.

Maternity Services do not include those services rendered to accomplish an elective abortion, but do include services rendered to treat illness or injury resulting from elective abortion, services necessary to avert the death of the woman and services to terminate pregnancies caused by rape or

incest.

### **Outpatient Medical Care**

Medical visits and consultations by a professional provider are unlimited.

### **Diagnostic Services**

Coverage is provided for diagnostic radiology consisting of X-ray, ultrasound and nuclear medicine; diagnostic pathology and laboratory tests performed, billed or ordered by a professional provider; diagnostic medical tests such as a ECG, EEG and other procedures approved by the Plan. Allergy testing is also covered.

### **Preventative Services**

**Routine Pediatric Care** including childhood immunizations.

**Routine Adult Care** including immunizations.

**Mammogram Screening** coverage is provided for one screening per calendar year for all persons 40 years and older. Physician-ordered mammographies are also covered.

**Annual Routine Gynecological Examination and Pap Smear** includes a pelvic examination and clinical breast examination. These services are exempt from deductibles and maximums.

### **Therapy Services**

Benefits are provided for the following therapies:

Radiation therapy, including the cost of the radioactive materials.

Chemotherapy, including the cost of drugs approved by the Food and Drug Administration (FDA) as antineoplastic

agents.

Dialysis treatments.  
Respiratory therapy.

Physical therapy, Speech therapy, and occupational therapy visits are limited to a combined maximum of 36 sessions per calendar year.

Cardiac rehabilitation therapy is limited to 3 sessions per week for 12 weeks per calendar year.

Pulmonary rehabilitation therapy is limited To 36 sessions per calendar year.

### **Spinal Manipulations**

Benefits are provided for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column. Benefits are provided for up to twelve sessions per calendar year.

### **Psychiatric Services**

Benefits are provided for the treatment of mental illness, based on the services provided and reported by the provider. Precertification is required.

Covered services include facility and professional provider charges for outpatient care. Thirty days of inpatient care are covered per calendar year, and these days may be exchanged, on a two for one basis, for partial hospitalization care visits. Thirty outpatient care visits are also covered each calendar year, subject to a 50% coinsurance.

Services include treatments such as: psychiatric visits, consultations, testing, psychotherapy (individual and group), electroconvulsive therapy, psychopharmacologic management, and psychoanalysis.

Benefits do not include: vocational or religious counseling, family counseling, educational activities, treatments not incorporated into commonly accepted repertoire (primal therapy, rolfing or structural integration, bioenergetic therapy, or obesity-control therapy).

### **Substance Abuse Treatment**

Benefits are provided for the treatment of substance abuse, subject to the coinsurance amounts specified by your group. Precertification is required.

#### **Inpatient Substance Abuse**

Inpatient detoxification in a hospital is limited to seven days per admission, and to four confinements per lifetime. Inpatient residential care is covered for 30 days per calendar year, with a maximum of 90 days per lifetime. Physician charges are covered for 30 inpatient days per calendar year.

Covered services include: lodging and dietary services, staff services, diagnostic and laboratory testing, and use of drugs, medicine, supplies and equipment.

#### **Outpatient Substance Abuse**

Thirty outpatient facility visits are covered per calendar year. Members may exchange the thirty outpatient days on a two for one basis for up to 15 additional inpatient rehabilitation days. Physician charges are also covered for the thirty visits per calendar year.

Covered services include: staff services, diagnostic and laboratory testing, and use of drugs, medicine, supplies and equipment.

### **Durable Medical Equipment/Orthotic/Prosthetics**

Benefits are provided for durable medical equipment, orthotics, prosthetics, oxygen and related supplies as follows, limited to \$5,000 maximum per calendar year.

Costs associated with the rental or purchase of durable medical equipment when prescribed for therapeutic use, and determined to be medically necessary by the plan.

Costs associated with orthotics or prosthetics for an illness or injury which occurs after the effective date of coverage. These costs are subject to medical review by the Plan to determine medical necessity.

Covered expenses include: purchase, fitting and adjustments to prosthetics and supplies, orthopedic braces, eyeglasses or contact lenses ( to replace function of the human lens), corneal or scleral lenses, replacement of a prosthetic for a dependent child due to the normal growth process, and oxygen ( and related supplies) for use in a patient's home.

Covered expenses do not include: dental appliances, wigs, or eyeglasses except as specified in the group contract.

### **Home Health Care**

Benefits are provided for services performed by a licensed home health care agency, subject to the coinsurance amounts specified by your group. A visit occurs when you receive home treatment. Precertification is required.

Covered services include services of a RN or LPN, or service from a home health aide who is supervised by a RN or LPN; physical therapy; speech therapy; occupational therapy, oxygen, respiratory therapy, medical social service consultations, and nutritional guidance counseling, when provided by the appropriate licensed Provider; diagnostic, therapeutic radiology and laboratory services; medical and surgical supplies; short term rental of Durable Medical equipment (provided the Agency does not

own the equipment). Services must be prescribed by your Physician and a treatment plan must be submitted for approval of medical necessity.

No benefits will be provided for: food or home delivered meals, professional medical services, custodial care, housekeeper charges, private duty nursing, ambulance services, non-prescription drugs, and services of family members.

### **Home Infusion Therapy**

Benefits are provided for services provided by a home infusion therapy agency as follows. Precertification is required.

Covered services include: total parenteral nutrition, hydration and antibiotic therapy, pain management, chemotherapy, pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies, and nursing services. Benefits are provided only if services are prescribed by your physician, precertification is approved, and a written treatment plan is submitted for review by the Plan. Continued eligibility is dependent on the treatment plans being submitted no less than every 30 days.

### **Hospice Care**

Benefits for supportive services and care to alleviate pain for terminally ill members is covered for a lifetime benefit of 180 days. hospice care is subject to the coinsurance amounts specified by your group. These days are in addition to any other benefits a covered person is entitled to under the Access Care II program.

Covered services include: palliative and supportive services in accordance with a treatment plan (submitted and reviewed by the Plan), services of a RN or LPN, home

health, laboratory, and therapy services (except for dialysis treatment), medical can surgical supplies, durable medical equipment, prescription drugs, oxygen (and administration), medical social service consultations, palliation of pain control and symptom management, respite care in a skilled nursing facility (5 days in a 3 month period), family counseling related to the terminal condition, dietician services, and bereavement counseling (limited to 2 visits).

No benefits are provided for services or supplies for which there is no charge, research studies on treatments to lengthen life, medical care by your private physician, pastoral services, costs for services related to the patient's personal, legal, and financial affairs (will preparation, disposition of property), and care provided by family members, relatives, and friends.

### **Prescription Drugs**

Benefits are available at 100% at a preferred provider subject to a \$10 copayment per prescription. Prescription drugs are not covered when purchased at a Non-Preferred Pharmacy. There is no coverage for the difference between the charge for the brand-name and the Generic Equivalent drug, when the Generic Equivalent Drug is available.

### **Private Duty Nursing**

Benefits are limited to outpatient services not to exceed 240 hours per calendar year. Precertification is required.

### **Diabetes Education Services**

Benefits are provided for diabetes education services.

Covered services include one diabetic self-management education program per lifetime and one consultation following participation and completion of the program.

No benefits are provided if you fail to complete the program, if the program is not certified by the Pennsylvania Department of health of the American diabetes Association, or if the program is not approved by the Plan.

### **Blood**

Benefits are provided for whole blood, blood plasma, administration of blood and blood processing, and blood derivatives.

### **Where Do I Call If I Have Questions On My Coverage?**

Call 1-888-338-2211 toll free for any questions about your coverage. You will be connected to the appropriate department and a representative will be pleased to help you. Follow the instructions that are outlined for you, and select the option which relates to your issue. If you are uncertain which department to select, choose the Customer Service option for assistance.

### **Who Is Eligible?**

Persons eligible for coverage include the participant, their legal spouse, and unmarried dependent children, subject to the limitations and exceptions outlined in the group contract.

Coverage begins on the group's contract date of current employees and their eligible dependents. For new employees, coverage begins on the date specified in the group contract.

Your newborn child will be considered a dependent under this program for thirty-one days immediately following birth. If you are not enrolled under a family contract and wish to continue coverage of the newborn beyond that date, you must apply for coverage within the 31-day period.

Unmarried children are covered until the end of the year in which they reach age 19 as specified by the group contract, or until the end of the month in which they marry or become employed full-time.

Full-time students are covered until the end of the year the student reaches age 23 as specified in the group contract, or until the end of the month in which the student ceases to be a full-time student for any reason, including graduation.

### **COBRA CONTINUATION OPTION**

Federal law gives certain persons the right to continue their health care benefits beyond the date that they might otherwise terminate. The entire cost (plus the administration fee allowed by law) must be paid by the continuing person. Coverage will end if the covered individual fails to make timely payment of contributions or premiums (within a maximum of 45 days during initial premium/contribution and 30 days thereafter). This law is referred to as "COBRA", which stands for the Consolidated Omnibus Budget Reconciliation Act of 1985.

Complete instructions on COBRA will be provided by the Plan Administrator to Covered Persons who become qualified beneficiaries under COBRA.

### **Maximum time Periods**

Continuation will be available for a qualified beneficiary up to the maximum time period shown in item (1), (2) or (3) below. Combined qualifying events will not continue a beneficiary's

coverage for more than 36 months beyond the date of the original qualifying event.

- 1) Up to 18 months for an Employee and his covered Dependent(s) when coverage terminates due to reduction of hours worked, or termination of employment for reasons other than gross misconduct.

Note: A qualified beneficiary who is disabled may have COBRA coverage extended (and an extra fee charged) for himself and the other a qualified beneficiaries in his or her family from 18 months to 29 months provided that:

- a) the individual is determined as being disabled for Social Security purposes on the date of the qualifying event or within the first 60 days of COBRA coverage; and
  - b) the individual notifies the Plan Administrator within 60 days of the Social Security Administration's determination of disability and within the original 18-month COBRA period which applies to the person.
- 2) Up to 36 months for:
    - a) a covered child who ceases to be eligible Dependent;
    - b) a covered Dependent of a deceased Employee;
    - c) a former covered Spouse whose coverage ceases due to divorce or legal separation; or
    - d) a covered dependent when the Employee's coverage ceases due to entitlement for Medicare.
  - 3) There is a special continuation period for Retired Employees and their Dependents when the Employer declares bankruptcy under Title 11 of the United States Code and the Retired Employees and their Dependents lose substantial coverage within one year before or after the date that each bankruptcy proceedings commenced. Coverage will be continued for each person until the date of that person's death. However, the surviving Spouse or children of a deceased Retired

Employee, may continue coverage for up to a maximum of 36 months following the Retired Employee's death. For this item 3, coverage does not terminate when the person becomes eligible for Medicare.

Continued coverage may also cease before the end of the maximum period on the earliest of:

- 1) The date that the Employer ceases to provide a group health Plan to any Employee; or
- 2) The date that the qualified beneficiary first becomes, after the date of election, (a) covered under any other group health Plan (as an Employee or otherwise), or (b) entitled to benefits under Medicare (except as stated in item 3 above). However, a qualified beneficiary who becomes covered under a group health Plan which has a Pre-Existing conditions limit must be allowed to continue COBRA coverage for the length of a Pre-Existing condition or to the COBRA maximum time period, if less. COBRA coverage may be terminated if the qualified beneficiary becomes covered under a group health Plan with a Pre-Existing conditions limit, if the Pre-Existing conditions limit does not apply to (or is satisfied by) the qualified beneficiary by reason of the group health Plan portability, access and renewability requirements of the health Insurance Portability and Accountability Act, or the public Health Services Act.
- 3) The date the cost of continued coverage is not paid by the due date.
- 4) For an individual who has extended COBRA coverage of 29 months due to disability, COBRA coverage will end in the month that begins more than 30 days after a final determination has been made by the Social Security Administration that the individual is no longer disabled.

### **Notice Requirements**

When coverage terminates due to an Employee's death, termination or eligibility for Medicare, the

Employer has 30 days in which to notify the Plan Administrator of the qualifying event.

When coverage terminates due to divorce, legal separation or change of Dependent status, the qualified beneficiary has 60 days from the qualifying event or from the date coverage terminates in which to notify the Plan Administrator that the qualifying event has occurred.

Complete instructions on how to elect continuation will be provided by the Plan Administrator within 14 days of receiving notice of the qualifying event. Covered Persons then have 60 days in which to elect continuation. The 60 day period is measured from the later of the date coverage terminates or the date notice of the right to continue is sent. If continuation is not elected in that 60-day period, then the right to elect continuation ceases.

## **TERMINATION OF COVERAGE**

When coverage under this Plan stops, Covered Persons will receive (upon request) a (HIPAA) Certificate of Coverage that will show the period of coverage under this plan. Please contact the Plan Administrator for further details.

### When Employee Coverage Terminates

Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Option):

1. The date the Plan is terminated
2. The last day of the calendar month in which the coverage Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the COBRA Continuation Option).

3. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

### **Continuation During Period of Employer-Certified Disability, Leave of Absence or Layoff**

A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This occurs only while the Employee is in a compensable status or as required under the provisions of a specific labor contract agreement.

### **Continuation During Family and Medical Leave**

This Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

Leave taken under the Family Medical Leave Act shall be covered under this plan on the same conditions as previously provided, as though the Employee has been continuously employed up to the 12-week leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when the coverage terminated. For example, Pre-Existing conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

### **Rehiring a Terminated Employee**

A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, with the exception of an Employee returning to work directly from COBRA coverage.

conditions apply and how to select it, see the section entitled COBRA Continuation Option):

### **Employees on Military Leave**

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

- 1) The maximum period of coverage of a person under such an election shall be the lesser of:
  - a) The 18 month period beginning on the date on which the person's absence begins; or
  - b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.
- 2) A person who elects to continue health Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- 3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

### **When Dependent Coverage Terminates**

A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what

- 1) The date the Plan or Dependent coverage under the Plan is terminated.
- 2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Option.)
- 3) The date a covered Spouse loses coverage due to a loss of dependency status. (See the COBRA Continuation Option.)
- 4) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Option.)
- 5) The end of the period for which the required contribution as been paid if the charge for the next period is not paid when due.

### **Will I Receive An Identification Card?**

You will be provided with an Access Care II identification card. Your identification card will show important information concerning your health care coverage under the Access Care II program. You can call 1-888-338-2211 for information regarding:

Customer Service	Pharmacy Selection
Precertification	Facility Selection
Claims Inquiries	Physician Selection

### **OPEN ENROLLMENT**

During the annual open enrollment period, benefit eligible Employees and their Dependents will be able to change their health insurance coverage based on which benefits and coverage are right for them.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect unless there is a change in family status during the year (birth, death, marriage, divorce,

adoption) or loss of coverage due to loss of a Spouse's employment.

A Covered Person who fails to make an election during open enrollment will automatically retain his or her present coverage.

Covered Persons will receive detailed information regarding open enrollment from their Employer.

### **What If There Is A Change In My Family Status?**

It is very important that you notify your employer and complete the required form for changes in family status; such as marriage, marriage of any of your children, death, divorce or other changes which affect the eligibility of your dependents.

NOTE: In case of marriage, provisions can be made for adding an eligible spouse on the date of marriage if the required form is received by the Plan prior to the date of marriage.

### **Do I Have To Obtain Care Within The Blue Cross Of Northeastern PA Service Area For Full Benefits?**

Under the Access Care II program, you can obtain care anywhere in the country from a network provider and enjoy the negotiated discounts of a preferred provider organization. Blue Cross and Blue Shield plans in each state have agreed to work together in order to provide care to members, no matter where you are when you seek care. Access Care II offers you a national network of providers, the BlueCard PPO, from which to choose:

Here is how the BlueCard PPO Works:

1. You are outside your Blue Cross and Blue Shield Plan's service area and need health care.
2. Call 1-800-810-BLUE (2583) for information on the nearest PPO doctors and hospitals.
3. You are responsible for precertification/prior authorization from your Blue Cross

and Blue Shield Plan.

4. Visit the PPO physician or hospital and present your membership card that has the "PPO in a suitcase" logo.
5. The doctor or hospital verifies your membership and coverage information.
6. After you receive medical attention, your claim is electronically routed to your Blue Cross and Blue Shield Plan, which processes it and sends you a detailed explanation of Benefits. You are only responsible for meeting your deductible and coinsurance payments, if any.
7. All PPO physicians and hospitals are paid directly, relieving you of any hassle and worry.

### **What Are The "Managed Care Elements" Of Access Care II?**

#### **Selection of Providers – Preferred Provider Networks**

You have the option of choosing where to go and whom to select for covered services. In general, your out-of-pocket costs are lower when you have covered services performed by preferred providers.

#### **Preferred Providers**

A preferred provider (those professional or facility providers with whom Blue Cross or Blue Shield have a contract with respect to payment for covered services) must accept the Blue Cross or Blue Shield allowance as payment-in-full for covered services. You are responsible for any coinsurance, copayments, deductibles and amounts exceeding the maximum or any service not covered by Blue Cross/Blue Shield. The sum of your payment and the Blue Cross/Blue Shield payment will be accepted as payment-in-full.

#### **Non-Preferred Providers**

A non-preferred provider (those professional or facility providers with whom Blue Cross or Blue Shield do not have a contract with respect to payment for covered services) is not required

to accept the Blue Cross or Blue Shield allowance as payment-in-full for covered services. The non-preferred provider may bill for the difference between the charge and the Blue Cross/Blue Shield payment.

### **Medical Necessity**

Blue Cross and Blue Shield only cover services which are determined to be medically necessary. A preferred provider accepts our decision and will not bill you for services which we determine are not

Medically necessary unless, of course, you Consent to such services. A non-preferred provider, however, is not obligated to accept our determinations and may bill you for services which we determine are not medically necessary. You are responsible for these charges when performed by a non-preferred provider. You can avoid these charges simply by choosing a preferred provider for your care.

### **Precertification**

What is precertification? In order to ensure that you are receiving the proper services to which you are entitled, and are not being subjected to additional, unnecessary charges, Access Care II requires that certain diagnoses and procedures be precertified. This means that either you or the provider calls the Plan toll free 1-888-338-2211 prior to the procedure, in order to receive authorization.

### **Precertification Within Our Service Area**

In our thirteen county service area, it is your preferred provider's responsibility to contact the Plan for precertification. If your preferred provider fails to obtain precertification for your procedure, no payment will be made to the Provider. You will not be held responsible for charges associated with a procedure to which the preferred provider did not obtain Precertification.

If you are seeking care from a non-preferred provider within the service area, it is your

responsibility to contact the Plan for precertification. While a provider may obtain precertification for you, it is still your responsibility to ensure that the precertification is obtained.

### **Precertification Outside Our Service Area**

If you are seeking care from a preferred provider or non-preferred provider outside our thirteen county area, it is your responsibility to request that your provider obtain precertification. In the event your provider does not initiate precertification, it is your responsibility to call toll free 1-888-338-2211 in order to avoid unnecessary out-of-pocket expenses. All inpatient out-of-area admissions require precertification. In addition, the following procedures require precertification even if performed as an outpatient: bunionectomy, cataract surgery, cholecystectomy, coronary artery bypass surgery, hemorrhoidectomy, herniorrhaphy, hysterectomy, knee surgery, prostate surgery, spinal and vertebral surgery, submucous resection (deviated septum), tonsillectomy/adenoidectomy, or varicose vein stripping or ligation.

### **How Do I Appeal The Plan's Precertification Decision?**

If you or your provider disagree with the Plan decision on precertification, you can submit a written appeal to the Plan. You must submit this appeal no later than sixty days from the date documented on the notification of the decision. The appeal should include all information supporting your claim. The Plan will review the appeal, make a final decision, and notify you of this decision within sixty days after we receive your appeal. Send your appeal to the following address:

**For Facility Provider Services**  
Precertification Department  
Blue Cross of Northeastern PA  
70 North Main Street  
Wilkes Barre, PA 18711

## **For Professional Provider Services**

Pennsylvania Blue Shield  
Managed Care Department  
1800 Center St  
Camp Hill, PA 17089

## **Care Management**

In some cases, a member will require benefits that would ordinarily not be covered under the Access Care II program. When this occurs, the Plan will make a decision regarding approval of alternative care or alternative treatment for services that would not otherwise be a covered service. The Plan will make this decision based on whether the service is medically necessary and cost effective. The additional service or treatment cannot exceed the total benefits to which you would otherwise be entitled under the Access Care II coverage. If the Plan approves alternative care or treatment in one instance, it is not obligated to provide the same or similar benefits in another instance.

Case management activities may also include disease management monitoring during episodes of care of long term illnesses.

## **Experimental Treatments**

Blue Cross and Blue Shield do not cover services which they determine to be experimental or investigative because such services are not accepted by the broad medical community as effective treatments. However, we realize that situations exist when a patient and his or her provider agree to pursue an experimental treatment. If your provider performs an experimental procedure, or if you receive experimental or investigative services, you are responsible for all charges. You or your provider may contact the Plan to determine whether a service is considered experimental or investigative.

## **Am I Responsible For Filing My Claims?**

### **Preferred Provider Services**

Present your Access Care II identification card at the time services are rendered by a preferred provider. The provider will submit a claim form directly to Blue Cross or Blue Shield on your behalf. Payment will be sent to the provider and Blue Cross or Blue Shield will notify you of the final disposition of the claim.

NOTE: Blue Shield's payment to the preferred professional provider will be considered payment in full, as long as your portion of the payment is received by the preferred professional provider within sixty days of notification. Otherwise, the preferred professional provider may bill you the difference between the charge and the Blue Shield payment.

### **Non-Preferred Provider Services**

Present your Access Care II identification card at the time services are rendered by a non-preferred provider. Non-preferred providers include Blue Shield professional providers that have not signed a PremierBlue preferred professional provider agreement with the Plan. A non-preferred provider, in most cases, will submit a claim on your behalf. If you need to submit a claim, request an itemized bill which shows:

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

Add your name, group, and identification number (as shown on your identification card), and the patient's date of birth. If you need assistance, contact customer service by calling the number on your identification card. Send your bill to:

### **For Facility Provider Billing**

Attention: Claims Department  
Blue Cross of Northeastern PA  
70 North Main Street  
Wilkes Barre, PA 18711

### **For Professional Provider billing**

Attention: Medical-Surgical Claims  
Pennsylvania Blue Shield  
PO Box 890062

### **Appeals: What To Do If Your Claim Is Denied**

In the event that you disagree with the Plan decision on claims payment of benefit issues, you can submit a written appeal no later than sixty days from the date that you receive notification of the decision. The appeal should include all information supporting your claim. The Plan will review the appeal, make a final decision, and notify you of this decision within sixty days after we receive your appeal. Send your appeal to the following address:

#### **For Facility Provider Services**

Blue Cross of Northeastern PA  
Attention: Customer Information Center  
70 North Main Street  
Wilkes Barre, PA 18711

#### **For Professional Provider Services**

Pennsylvania Blue Shield  
Medical-Surgical Claims  
PO Box 890062  
Camp Hill, PA 17089-0062

### **Definitions**

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

1. **Alcohol and/or Drug Abuse** – Any use of Alcohol or other 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. Drugs shall be defined as addictive drugs and drugs of abuse listed as scheduled drugs in “The Controlled Substance, Drug, Device and Cosmetic Act,” (35 P.S § 780.101 et seq.).
2. **Ambulatory Surgical Facility** – A facility Provider, with an organized staff of Physicians, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health Care, Inc. or by the Plan, which:
  - a. has permanent facilities and equipment for the purposes of performing surgical procedures on an Outpatient basis;
  - b. provides nursing services and treatment by or under the supervision of Physicians whenever the patient is in the facility;
  - c. does not provide Inpatient accommodations; and
  - d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician or Dentist.
3. **Applicant – Participant** – The Eligible Person who applies for coverage and is enrolled under the contract.
4. **Benefit Period** – The specified period of time during which charges for Covered services must be incurred in order to be eligible for payment by the Plan. A charge for a Covered service shall be considered incurred on the date the service or supply was provided to a Participant.
5. **Birthing Facility** – A Facility Provider, licensed or approved by the appropriate government agency and approved by the Plan, which is primarily organized and staffed to provide maternity care by Nurse Midwives.
6. **BlueCard PPO Network** – A Network of Providers who have a Preferred Provider Contract with their local Blue Cross and/or Blue Shield Plan.
7. **Blue Cross or BCNEPA** – Blue Cross of Northeastern Pennsylvania, unless the context clearly indicates otherwise.
8. **Blue Shield** – Pennsylvania Blue Shield, unless the context clearly indicates otherwise.
9. **Calendar Year** – A one-year period which begins on January 1 and ends on December 31.

10. **Certified Registered Nurse** – A certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the State Board of Nursing, or a national nursing organization recognized by the State Board of Nursing. This excludes any non-certified registered professional nurses employees by a health care facility, as defined in the Health Care Facilities Act, or by an anesthesiology group.
11. **Coinsurance** – A specific percentage amount of the Provider’s Reasonable Charge for Covered Services for which the Participant is responsible.
12. **Contract** – The agreement including the Group Application, any amendatory riders and the individual applications of the Participants, are referred to as the Contract or Group Contract.
13. **Contract Date** – The date, specified on the Acceptance page of the Contract, on which coverage under the Contract commences for the Group.
14. **Copayment** – A specified amount of the Provider’s Reasonable Charge for Covered Services, expressed in dollars, that is the responsibility of the Participant.
15. **Covered Services** – A service or supply specified in this Contract for which benefits will be provided pursuant to the terms of the Contract.
16. **Custodial Care** – Care provided primarily for maintenance of the Participant or which is designed essentially to assist the Participant in meeting the activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial care includes but is not limited to help in walking, bathing, dressing, feeding, preparation of special diets, supervision over self-administration or medications, and other services that can be provided by non-medical personnel.
17. **Deductible** - A specified amount of Covered Services, expressed in dollars, that must be incurred by a Participant before the Plan will assume any liability for all or part of the remaining Covered Services.
18. **Dependent** – A Participant other than the Applicant-Participant as specified in the Schedule of Eligibility.
19. **Detoxification** – The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other drug, alcohol or other drug dependency factors or alcohol in combination with drugs as determined by a Physician, while keeping the physiological risk to the patient at a minimum.
20. **Diagnostic Services** – The following procedures ordered by a Physician because of specific symptoms to determine a definite condition or disease. Diagnostic Services are covered to the extent specified in the Benefits section and include but are not limited to:
- a. diagnostic radiology, consisting of x-ray, ultrasound and nuclear medicine;
  - b. diagnostic pathology, consisting of laboratory and pathology tests;
  - c. diagnostic medical procedures, consisting of ECG, EEG, and other diagnostic medical procedures approved by the Plan; and
  - d. allergy testing consisting of percutaneous, intracutaneous and patch tests.

21. **Durable Medical Equipment** – Items which meet all of the following criteria:
- a. primarily used to serve a medical purpose;
  - b. primarily purchased from a medical supplier;
  - c. generally not useful to a person in the absence of illness, injury, or disease;
  - d. appropriate for use in the patient’s home; and
  - e. can withstand repeated use.
22. **Effective Date** – According to the Schedule of Eligibility, the date on which coverage for a Participant begins under the Contract.
23. **Eligible Person** – A person entitled to be a Participant.
24. **Emergency Care** – The initial treatment of a sudden, unexpected onset of a medical condition or traumatic injury. This shall not include treatment for an occupational injury for which benefits are provided under any Workers’ Compensation Law or any similar Occupational Disease Law. The symptoms or injury must be of sufficient severity to warrant immediate attention.
- a. Emergency Accident Services – the initial treatment of traumatic bodily injuries resulting from an accident.
  - b. Emergency Medical Services – the initial treatment of sudden onset of a medical condition with acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:
    1. permanently placing the Participant’s health in jeopardy;
    2. causing other serious medical consequences;
    3. causing serious impairment to bodily functions; or
    4. causing serious and permanent dysfunction of any bodily organ or part.

The Plan shall determine whether an emergency condition existed. However, the

Participant shall have the right to appeal such determination as set forth in the General Provisions section.

25. **Employee**- A person who performs services in the regular course of the business of the Group on a full-time basis, and for which such person is paid a salary or wages, and is reported on Federal and/or State payroll tax. Employee may also be defined as a person who works less than full-time but not less than twenty (20) hours per week.
26. **Family Coverage** – Coverage for the Applicant-Participant and one or more of the Applicant-Participant’s Dependents.
27. **Freestanding Dialysis Facility** - A facility provider, approved by the Plan, which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.
28. **Freestanding Outpatient Facility** – A facility provider, approved by the Plan, which is primarily engaged in providing Outpatient Diagnostic and/or therapeutic services by or under the direction of Physicians.
29. **Home Health Care Agency** – A facility provider, approved by the Plan, which:
  - a. provides skilled nursing and other services on a visiting basis in the Participant’s home; and
  - b. is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
30. **Home Infusion Therapy** – The administration of intravenous solutions which are provided in the home setting.
31. **Home Infusion Therapy Agency** – A Facility Provider, approved by the Plan, which:
  - a. provides Home Infusion Therapy services in the Participant’s home; and

- b. is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by attending Physician.
32. **Hospice** – A Facility Provider, approved by the Plan, which is primarily engaged in providing palliative care to terminally ill individuals.
33. **Hospital** – A Facility Provider, that is a short term, acute care, general hospital, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations or by the American Osteopathic Hospital Association or by the Plan, and which:
- a. is a duly licensed institution;
  - b. is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians;
  - c. has organized departments of medicine and/or major Surgery;
  - d. provides 24-hour nursing services by or under the supervision of Registered Nurses; and
  - e. is not other than incidentally a:
    - 1) Skilled Nursing Facility,
    - 2) nursing home,
    - 3) custodial care home,
    - 4) health resort,
    - 5) spa or sanitarium,
    - 6) place for rest,
    - 7) place for the aged,
    - 8) place for the treatment of Mental Illness,
    - 9) place for the treatment of alcoholism or drug abuse,
    - 10) place for the provision of hospice care,
    - 11) place for the provision of rehabilitation care.
34. **Immediate Family** – The Applicant – Participant’s spouse, parent, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law, child or step-child.
35. **Incurred** – A charge shall be considered incurred on the date a Participant receives the service or supply for which the charge is made.
36. **Inpatient** – A Participant who is treated as a registered bed patient in a Hospital or Facility Provider, who is expected to stay overnight and for whom a room and board charge is made.
37. **Inpatient Non-Hospital Residential Care** – The provision of acute medical, nursing, counseling or therapeutic services to patients suffering from Alcohol and/or Drug Abuse or dependency in a residential environment, according to individualized treatment plans.
38. **Inpatient Non-Hospital Residential Facility** – A Facility Provider licensed by the Department of Health to render an Alcohol and/or Drug Abuse treatment program designed to provide Inpatient Non-Hospital Residential Care.
39. **Licensed Practical Nurse (LPN)** – A nurse who has graduated from a formal practical nursing education program and is licensed by appropriate state authority.
40. **Long-Term Residential Care** – The provision of long-term diagnostic or therapeutic services (ie: assistance or supervision in managing basic day to day activities and responsibilities) to patients suffering from Alcohol and/or Drug Abuse or dependency. This care is provided in a long-term residential environment known as a Transitional Living Facility, on an individual, group, and/or family basis, with a program duration greater than sixty (60) days. Long-Term Residential Care is not Inpatient Non-Hospital Residential Care.
41. **Maximum** – The greatest benefit amount payable by the Plan for Covered Services. This could be expressed in dollars, number

of days, or number of services for a specified period of time.

- a. **Benefit Maximum** – the greatest benefit amount payable by the Plan for a specific Covered Service, per Benefit Period.
- b. **Lifetime Benefit Maximum** – the greatest benefit amount payable by the Plan for a specific Covered Service, in the Participant’s lifetime.

42. **Medical Care** – Services rendered by a Professional Provider for the diagnosis and treatment of an illness or injury.

43. **Medically Necessary (or Medical Necessity)** – Services or supplies provided by a Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Participant’s condition, illness, disease, or injury;
- b. provided for the diagnosis or the direct care and treatment of the Participant’s condition, illness, disease, or injury;
- c. in accordance with the standards of good medical practice;
- d. not primarily for the convenience of a Participant or the Provider; and
- e. the most appropriate supply or level of service that can safely be provided to the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant’s condition, and the Participant cannot receive safe or adequate care as an Outpatient or in another less costly setting.

44. **Medicare** – The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

45. **Mental Illness** – An emotional or mental disorder characterized by an abnormal functioning of the mind or emotions and in which psychological, emotional or

behavioral disturbances are the dominating feature.

46. **Non-hospital Alcohol or Drug Abuse Facility** – A facility, licensed by the Department of Health, for the care or treatment of alcohol or other drug dependent persons, except for Transitional Living Facilities.

47. **Orthotic** – A rigid or semi-rigid appliance used for the purpose of supporting a weak or deformed body part or for restricting or eliminating motion in a diseased or injured part of the body.

48. **Out-of-pocket Maximum** – A specified dollar amount of Coinsurance incurred by a Participant as set forth in the Schedule of Benefits, for Covered Services in a calendar year. The Out-of-Pocket Maximum does not include penalties for failure to obtain Pre-Certification, Deductibles, Copayments, amounts in excess of Provider’s Reasonable Charge, charges for non-Covered Services and charges after Covered Services have been exhausted.

49. **Outpatient** – A Participant who receives services or supplies while not an Inpatient.

50. **Partial Hospitalization Psychiatric Care Services** – The provision of diagnostic and therapeutic services for the treatment of Mental Illness on an Outpatient basis only during the day or night through a Hospital or Psychiatric Hospital based program which is approved by the Joint Commission on the Accreditation of Healthcare Organizations.

51. **Partial Hospitalization Substance Abuse Services** – The provision of medical, nursing, counseling, or therapeutic services on a planned and regularly scheduled basis in a Hospital or non-Hospital facility licensed by the Department of Health to provide an Alcohol and/or Drug Abuse treatment program 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.

52. **Participant** – An Eligible Person who has satisfied the specifications of the Schedule of Eligibility and is enrolled for coverage.
53. **Participating Facility Provider Agreement** – An agreement between a Provider and the Plan or any other Blue Cross Plan pursuant to which negotiated rates are established for payment of Covered Services rendered to a Participant.
54. **Physician** – A person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed and legally entitled to practice medicine in all its branches, perform Surgery and dispense drugs.
55. **Plan Service Area** – The following thirteen Pennsylvania counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming.
56. **Pre-certification** – The review by the Plan of evidence provided by a Provider or Participant prior to a Participant receiving Covered Services to determine Medical Necessity for benefits.
57. **Preferred Professional Provider Allowance** – A schedule of allowances or payment methodology as approved by the Insurance Department of the Commonwealth of Pennsylvania. The Preferred Professional Provider Allowance is that approved for use with the PremierBlue Preferred provider Program.
58. **Prosthetic** – An artificial body part which replaces all or part of a body organ or which replaces all or part of the function of a permanently inoperative or malfunctioning body part.
59. **Provider** – A Facility Provider, Professional Provider, Other Provider or Supplier licensed where required and performing services within the scope of such license.
- a. **PROVIDERS include:**
- 1) **Facility Providers:**
    - Birthing Facility
    - Freestanding Dialysis Facility
    - Home Health Care Agency
    - Home Infusion Therapy Agency
    - Hospice
    - Hospital
    - Inpatient Non-Hospital Residential Facility
    - Psychiatric Hospital
    - Rehabilitation Hospital
    - Skilled Nursing Facility
    - Substance Abuse Treatment Facility
    - Supplier
  - 2) **Professional Providers:**
    - Audiologist
    - Certified Registered Nurse
    - Chiropractor
    - Clinical Laboratory
    - Dentist
    - Doctor of Medicine
    - Nurse Midwife
    - Optometrist
    - Physical Therapist
    - Podiatrist
    - Psychologist
    - Speech
    - Language Pathologist
    - Teacher of the Hearing Impaired
  - 3) **Other Providers**
    - Licensed Practical Nurse
    - Occupational Therapist
    - Registered Nurse
    - Respiratory Therapist

- b. **Preferred Facility Provider** – A Facility Provider that has an agreement with Blue Cross pertaining to payment for Covered Services rendered to a Participant as a member of the Access Care II Network or a member of the BlueCard PPO Network is used by Participants, coverage will be provided at the Preferred Provider level.
- c. **Preferred Professional Provider** – A Professional Provider who has an agreement with Blue Shield pertaining to payment for Covered Services rendered to a Participant in PremierBlue Managed Care Programs and who has the required admitting privileges at a Preferred Facility Provider or a Professional Provider who is a member of the BlueCard PPO Network.
- d. **Non-preferred Member Facility Provider** – A Facility Provider that is not in the Access Care II network or the BlueCard PPO network, but does have a member contract with its local Blue Cross Plan.
- e. **Non-preferred Non-member Facility Provider** – A Facility Provider that is not in the Access Care II network or the BlueCard PPO network and does not have a member contract with its local Blue Cross Plan.
- f. **Non-preferred Professional Provider** – A Professional Provider that does not have an agreement with Blue Shield pertaining to payment for Covered Services under this Contract and which does not participate in the BlueCard PPO Network.
- g. **Medicare Participating Provider** – A Provider which has been certified by the Department of Health and Human Services of the United States for participation in the Medicare Program.

60. **Provider's Reasonable Charge** – The charge that the Plan determines is reasonable

for Covered Services provided to a Participant. In the case of a Preferred Facility Provider and a Non-Preferred Member Facility Provider, the Provider's Reasonable Charge is established by a Participating Facility Provider Agreement between the Plan and the Provider and will be accepted by the Provider as payment in full for Covered Services. In the case of a Non-Preferred Non-Member Facility Provider, the Provider's Reasonable Charge is the actual charge billed by the Provider, unless the actual charge is greater than twice the Medicare allowance, then the Provider's Reasonable Charge will be twice the Medicare allowance. The Participant will be responsible for any difference between the Non-Preferred Non-Member Facility Provider's actual charge and the payment by the Plan.

For Preferred and Non-Preferred Professional Providers in Pennsylvania, the Provider's Reasonable Charge is based upon the Preferred Professional Provider Allowance as defined in this Contract or the charge, whichever is lower. For Preferred Professional Providers who are members of the BlueCard PPO Network, the Provider's Reasonable Charge will be determined by the contract between the Plan and the Professional Provider and will be accepted by the Professional Provider as payment-in-full for Covered Services. For covered services performed out-of-state by Non-Preferred Professional Providers, the Provider's Reasonable Charge will be based on the 90<sup>th</sup> percentile of actual charge data that the Plan has accumulated for the state in which the services were performed. Payment is based upon the Provider's Reasonable Charge or the charge, whichever is lower. The Participant is liable for charges that exceed the Provider's Reasonable Charge.

61. **Psychiatric Hospital** – A Facility Provider, approved by the Joint Commission on the Accreditation of Healthcare Organizations or by the Plan, which is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness. Such services are provided

by or under the supervision of an organized staff of Physicians, Continuous nursing services are provided by or under the supervision of a Registered Nurse.

62. **Psychologist** – A licensed clinical Psychologist. When there is no licensure law, the psychologist must be certified by the appropriate professional body.
63. **Registered Nurse (RN)** – A nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by appropriate state authority.
64. **Rehabilitation Hospital** – A Facility Provider, approved by the appropriate accrediting agency or by the Plan, which is primarily engaged in providing rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided by or under the supervision of a Registered Nurse.
65. **Semi-private Room** – The bed, board and nursing care regularly provided to patients in a room which is designated as semi-private by the Provider of care and which contains more than one bed.
66. **Skilled Nursing Facility** – A Facility Provider, approved by the Plan, which is primarily engaged in providing skilled nursing and related services on an Inpatient basis to patients requiring 24-hour skilled nursing services but not requiring confinement in a Hospital. Such care is rendered by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:
- minimal care, Custodial Care, ambulatory care, or part-time care services;

- care or treatment of Mental Illness, alcoholism, drug abuse or pulmonary tuberculosis; or
- care or treatment for the blind, the deaf or the mentally deficient or retarded.

67. **Substance Abuse Treatment Facility** – A Facility Provider, approved by the Department of Health, which is primarily engaged in Detoxification and/or Rehabilitation treatment for Alcohol and/or Drug Abuse.
68. **Supplier** – An individual or entity that is in the business of leasing and selling Durable Medical Equipment and supplies.
69. **Surgery**
- The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures;
  - The correction of fractures and dislocations; and
  - Usual and related pre-operative and post-operative care.
70. **Therapy Services** – The following services or supplies ordered by a Physician and used for the treatment of an illness or injury to promote the recovery of the Participant. Therapy Services are covered to the extent specified in the benefit section.
- Radiation Therapy** – The treatment of disease by X-ray, radium, or radioactive isotopes.
  - Chemotherapy** – The treatment of malignant disease by chemical or biological antineoplastic agents.
  - Dialysis Treatment** – The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis.
  - Cardiac Rehabilitation Therapy** – Medically supervised rehabilitation program designed to improve a patient's

tolerance for physical activity or exercise.

- e. **Physical Therapy** – The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.
- f. **Respiratory Therapy** – Introduction of dry or moist gases into the lungs for treatment purposes.
- g. **Occupational Therapy** – Treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person’s ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person’s particular occupational role.
- h. **Speech Therapy** – Treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic process.
- i. **Pulmonary Rehabilitation Therapy** – Multidisciplinary treatment which combines Physical Therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.

71. **Transitional Living Facility** – A facility that renders Long-Term Residential Care. This type of facility can be licensed, when appropriate, by the Department of Health. However, a facility providing Long-Term Residential Care is not to be considered an Inpatient Non-Hospital Residential Facility rendering inpatient Non-Hospital Residential Care. Specific Transitional Living Facilities include half-way houses, group homes or supervised apartment settings.

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

1. which are not prescribed by or performed by or under the direction of a Physician or Professional Provider within the scope of licensure;
2. which are not Medically Necessary as determined by the Plan;
3. which are not listed as Covered Services;
4. which the Plan determines, in its sole discretion, are Experimental or Investigative in nature or for the Covered Services related to them; the Plan’s procedure in determining whether the use of any treatment, procedure, Provider, equipment, drug, drug usage, device or supply is Experimental or Investigative is set forth in the General Provisions section;
5. for any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of workers’ compensation, occupational disease or similar type legislation. This exclusion applies whether or not the Participant claims the benefits or compensation;
6. for care for any illness or injury suffered after the Participant’s Effective Date of coverage as a result of any act of war;
7. for which a Participant would have no legal obligation to pay;
8. received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
9. to the extent benefits are provided for active military personnel by the Veteran’s Administration or by the Department of Defense;
10. for operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in

### **Exclusions**

physiologic function can be expected. However, benefits are payable to correct a condition resulting from an accident which occurs while a Participant is covered by the Plan. The Participant must be enrolled without interruption from the date of the accident to the date of the operation in order to be eligible for cosmetic Surgery. Benefits are also payable to correct functional impairment which results from a covered disease, injury, or congenital birth defect;

11. incurred prior to the Participant's Effective Date or during an Inpatient admission that commenced prior to the Participant's Effective Date except, however, benefits for Covered Services shall be provided during the Inpatient admission for a condition that commenced on or after the Effective Date of coverage;
12. incurred after the date of termination of the Participant's coverage, except as provided for in the General Provisions Section;
13. for personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, whether or not prescribed by a Physician;
14. for telephone consultations between a Provider and the Participant, charges for failure to keep a scheduled visit with a Provider, or charges for completion of a Provider's claim form;
15. for Inpatient admissions which are primarily for Diagnostic Services which could have been performed on an Outpatient basis;
16. for Long-Term Residential Care;
17. for Inpatient admissions which are primarily for Therapy Services which could have been provided on an Outpatient basis;
18. for Chronic Alcohol and/or Drug Abuse treatment, except as provided for in the Benefits Description section, Treatment of Alcohol and/or Drug Abuse and Dependency;
19. for Custodial Care, domiciliary care or rest cures;
20. for palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
21. for screening examinations except as specifically provided for in the Benefits section;
22. directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease; except orthodontic treatment for congenital cleft palates as specifically provided for and defined in Section D.B., Description of Benefits, Subsection E. Surgery;
23. for hearing aids or examinations for the prescription or fitting of hearing aids;
24. for the correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileosis, keratophakia and radial keratotomy and all related services;
25. for any treatment leading to or in connection with transsexual Surgery, except for sickness or injury resulting from such Surgery;
26. for treatment of obesity, except for medical and surgical treatment of morbid obesity when weight is at least twice the ideal weight specified for frame, age, height, and sex;
27. to the extent payment has been made under Medicare or would have been made if the

Participant had applied for Medicare and claimed Medicare benefits; however, this exclusion shall not apply when the Group is obligated by law to offer the Participant all the benefits of this Contract and the Participant so elects this coverage as primary;

28. for treatment of sexual dysfunction not related to organic disease or injury;
29. for assisted fertilization techniques such as, but not limited to, artificial insemination, in-vitro fertilization (IVF), gamete intra fallopian transfer (GIFT), and zygote intra fallopian transfer (ZIFT);
30. for injuries resulting from the use or maintenance of a motor vehicle if such services are paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable by the Catastrophic Loss Trust Fund established under the Pennsylvania Motor Vehicle Financial Responsibility Law;
31. for admissions or treatment not certified as eligible under the Pre-Certification provision of this Contract when such certification is required by the Participant;
32. for routine neonatal circumcision;
33. which are recoverable by or on behalf of the Participant in any action at law or in compromise or settlement of a claim against a party, other than an insurer of the Participant, unless the Participant furnished such information as the Plan may require to facilitate enforcement of its rights;
34. which exceed the Provider's Reasonable Charge;
35. for treatment of temporomandibular disorders (TMD), also known as craniomandibular disorders (CMD), with intra-oral devices, or any other method to alter vertical dimension;
36. for equipment costs related to services performed on high cost technological equipment as defined by Blue Shield, such as

but not limited to computed tomography (CT) scanners, magnetic resonance imagers (MRI) and extracorporeal shock wave lithotripters, unless the acquisition of such equipment by a Professional Provider was approved through the Certificate of Need (CON) process and/or by Blue Shield;

37. for local infiltration anesthetic;
38. performed in a facility by a Professional Provider who in any case is compensated by the facility for similar services performed for patients;
39. for drugs dispensed in a Physician's office;
40. performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training;
41. for eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses; including related diagnostic tests, such as, but not limited to, visual fields testing, except as specifically provided in Benefits description sections;
42. which are submitted by a Certified Registered Nurse and another Professional Provider for the same services performed on the same date for the same patient;
43. for elective abortion, except however, services rendered to treat illness or injury resulting from an elective abortion, services which are necessary to avert the death of the woman and services to terminate pregnancies caused by rape or incest will be covered.

## **General Provisions**

### **A. Entire Contract; Changes**

The Contract with the Group Application, any riders and/or endorsements and the individual applications of the Participants, is the entire Contract between the Group and the Plan. No change in the Contract will be effective until approved by an

authorized Plan officer. This approval must be noted on or attached to the Contract. No agent or representative of the Plan, other than a Plan officer, may change the Contract or waive any of its provisions. All statements made by the Group or by any individual Participant shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall be used in the defense to a claim under the Contract, unless it is contained in a written application.

#### **B. Relationship to Blue Cross and Blue Shield Plans**

The Contract is between the Group, on behalf of itself and the Participants and Blue Cross of Northeastern Pennsylvania and Pennsylvania Blue Shield only. Blue Cross of Northeastern Pennsylvania and Pennsylvania Blue Shield are independent corporations operating under licenses from the 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 Blue Cross of Northeastern Pennsylvania and Pennsylvania Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Blue Cross of Northeastern Pennsylvania and Pennsylvania Blue Shield, who are entering into the Contract, are not contracting as an agent of the Association. Only Blue Cross of Northeastern Pennsylvania and Pennsylvania Blue Shield shall be liable to the Group, on behalf of itself and the Participants, for any of the Plan’s obligations under the Contract. The paragraph does not add any obligations to the Contract.

#### **C. Benefits to Which Participants Are Entitled**

1. The Plan’s liability for benefits is limited to the benefits specified in the Contract.
2. No person other than a Participant is entitled to receive benefits under the Contract, except, however, a transplant donor as provided for in the Contract and a newborn child of the Participant as provided for in the Contract.
3. Benefits for Covered Services specified in the Contract will be provided only for services and supplies that are rendered by a Provider as defined in the Contract and regularly included in such Provider’s charges.

#### **D. Records of Participant Eligibility and Changes in Participant Eligibility**

1. The Plan reserves the right to require the Group to certify from time to time that the Group’s Employees meet all eligibility requirements set forth under the Contract. To substantiate enrollment eligibility, the Group must maintain and shall make available to the Plan, upon request, applicable business records, tax returns, payroll and personnel records in accordance with state and federal laws and regulations.
2. The Group must furnish the Plan with any data required by the Plan for coverage of Participants under the Contract. In addition, the Group must provide prompt notification to the Plan of the Effective Date of any changes in a Participant’s coverage status under the Contract.
3. All notification by the Group to the Plan must be furnished on forms approved by the Plan. The notification must include all information reasonably required by the Plan to effect changes.
4. Clerical errors or delays in recording or reporting dates will not invalidate coverage which would otherwise be in force or continue coverage which would otherwise terminate. Upon discovery of errors or delays, an

equitable adjustment of charges and benefits will be made.

5. The Group is liable for the premium payment when benefits are provided for Covered Services rendered to a terminated Participant because of the Group's failure to notify BCNEPA of such Participant's termination on or before the termination date. The Group's experience shall include claims paid for the Participant during this period.

#### **E. Termination of the Group Contract**

1. Either the Group or the Plan may cancel the Contract on any Contract anniversary by giving written notice to the other party at least thirty days in advance.
2. The Contract will be terminated, at the Plan's option, for the Group's non-payment of the appropriate payment when due, for the Group's failure to perform any material obligation required by the Contract or in the event the Group makes a false statement for the purpose of obtaining coverage for a person who does not meet the eligibility requirements for coverage in the Group. The Plan agrees to notify the Group of its failure to perform a material obligation, including the failure to make payment when due, to give the Group ten (10) days advance written notice prior to termination of the Contract, and to allow the Group to cure its failure to perform during the ten (10) day period. Should the Group fail to perform its obligation or fail to make the appropriate payment, the Contract shall be terminated at the end of the ten (10) day period, and the Plan shall not be required to give any further notice to the Group.

#### **F. Termination of a Participant's Coverage under the Group Contract**

1. When a Participant ceases to be an Eligible Person under the Contract or

the required subscription rate is not paid, the Participant's coverage will terminate at the end of the last month for which payment was made.

2. In the event a Participant fails to pay or have paid on the Participant's behalf, any amount due to the Plan for Coinsurance, Copayments and/or penalties after the Plan has provided in writing a thirty (30) day cancellation notice to the Participant, coverage for the Participant and any Dependents will be canceled upon the expiration of the thirty (30) day period, unless payment has been received by the Plan within the thirty (30) day period. The Plan's collection procedure will be on file with and approved by the Pennsylvania Insurance Department.
3. Termination of the Group Contract automatically terminates all the Participant's coverage. It is the responsibility of the Group to notify all the Participants of the termination of the coverage. However, coverage will be terminated regardless of whether the notice is given.
4. If the Group is obligated by law (as set forth in Section SE Subsection E. COBRA) to continue a Participant under the Contract who would otherwise be terminated, then coverage will continue upon receipt by the Plan of notice of the Participant's election to continue coverage.
5. If it is proven that the Participant committed fraud in the application for coverage under the Contract or if the Participant makes a material misrepresentation in the application for coverage under the Contract and such material misrepresentation is discovered by the Plan within three (3) years of the Effective Date of coverage, the Participant's coverage under the Contract will be terminated.
6. If it is proven that the Participant obtained or attempted to obtain benefits or payment of benefits through fraud and/or material misrepresentation, the Plan may

terminate the Participant's coverage under the Contract. If benefits were provided under such circumstances, the Plan may pursue legal action in order to obtain reimbursement from the Participant.

### **G. Benefits after Termination of Coverage**

If the Participant is an Inpatient on the date coverage terminates, the benefits of the Contract for Inpatient Covered Services shall be provided:

1. Until the maximum amount of benefits has been paid; or
2. until the Inpatient stay ends; or
3. until the Participant becomes covered without limitation as to the condition for which he is receiving Inpatient care under any other group coverage; whichever occurs first.

### **H. Conversion Privilege**

1. If an individual ceases to be a Participant under the Contract, the individual is eligible for coverage under an individual conversion contract then available from the Plan. The coverage may be different from the coverage provided under the Contract. If the Participant moves outside the Plan Service Area, the coverage may be transferred to a contract with the Blue Cross Plan in that area.
2. Direct payment for coverage under the conversion contract must be made from the date the person ceases to be a Participant under the Contract.
3. The conversion contract will be effective on the date of termination of the Participant's coverage under the Contract.
4. Written application for the conversion contract must be made to the Plan no later than either:

- a. Thirty-one (31) days after termination of membership under the Contract; or
  - b. Fifteen (15) days after the Participant has been given written notice of the existence of the conversion privilege;
  - c. But in no event later than sixty (60) days after termination as a Participant under the Contract.
5. If the Participant is eligible for another health care program which is available in the Group where the Participant is employed or with which the Participant is affiliated, a conversion contract shall not be available.
  6. The conversion contract shall not be available to any Participant where the Group terminates the Contract in favor of group coverage by another organization or where the Group terminates the Participant in anticipation of terminating the Contract in favor of group coverage by another organization.

### **I. Notice of Claims**

1. The Plan will not be liable under the Contract unless proper notice is furnished to the Plan that Covered Services have been rendered to a Participant. Providers who have participating agreements with the Plan will be responsible for providing written notice to the Plan. Should such a Provider fail to provide notice, the Participant will not be liable for payment to the Provider for the Covered Services. The Participant will be responsible for providing written notice within sixty (60) days after completion of Covered Services by Providers who do not have participating agreements with the Plan. The notice must include the data necessary for the Plan to determine benefits. An expense will be

considered incurred on the date the service or supply was rendered.

2. Failure to give notice to the Plan within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will the Plan be required to accept notice more than twelve (12) months after Covered Services are rendered.

#### **J. Release of Information**

Each Participant agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under the Contract may furnish it to the Plan (including copies of records). In addition, the Plan may furnish such information to other entities providing similar benefits at their request. The Plan shall provide to the Group at the Group's request any and all information regarding claims and charges submitted to the Plan by Providers. The parties understand that any information provided to the Group will be adjusted by the Plan to prevent the disclosure of identity of any Participant or other patient treated by said Providers. The Group shall reimburse the Plan for the actual costs of preparing and providing said information. The Plan shall provide the Group with such cost figure and obtain the Group's approval of such expense prior to incurring such costs.

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

#### **K. Limitations of Plan Liability**

The Plan shall not be liable for injuries or damage resulting from acts or omissions of any Plan officer or employee or of any Provider or other person furnishing services or supplies to the Participant; nor shall the Plan be liable for injuries or

damage resulting from the dissemination of information for the purpose of claims processing or facilitating patient care.

#### **L. Limitation of Actions**

No legal action may be taken to recover benefits within sixty (60) days after Notice of Claim has been given as specified above, and no such action shall be maintained against the Plan for any benefits hereunder unless brought within two (2) years after the rendering of the services upon which such claim is based.

#### **M. Payment of Benefits**

1. The Plan will make payments directly to Preferred Providers furnishing Covered Services under the Contract. However, the Plan reserves the right to make payments directly to the Participant.
2. The right of a Participant to receive payment directly from the Plan is not assignable, except however, as required by law. In addition, the right to receive benefits for Covered Services may not be transferred by a Participant.
3. Once Covered Services are rendered by a Provider, the Plan will not honor Participant requests not to pay the claims submitted by the Provider. The Plan will have no liability to any person because of its rejection of the request.
4. For Covered Services rendered by a Preferred Professional Provider and paid at less than 100% of the Preferred Professional Provider Allowance, the Participant is responsible for payment of the difference between 100% of the Preferred Professional Provider Allowance and the Plan's payment. If such payment or arrangements to pay is made within sixty (60) days, there will be no additional charge to the Participant.

## **N. Participant/Provider Relationship**

1. The choice of a Provider is solely the Participant's.
2. The Plan does not furnish Covered Services but only makes payment for Covered Services received by Participants. The Plan is not liable for any act or omission of any Provider. The Plan has no responsibility for a Provider's failure or refusal to render Covered Services to a Participant.
3. The use of non-use of an adjective such as Preferred, Non-Preferred or Participating in modifying any Provider is not a statement as to the ability of the Provider.

## **O. Agency Relationship**

The Group is the agent of the Participants, not the Plan.

## **P. Booklets**

The Plan Administrator will provide the participants with booklets that describe the Contract's benefits and provide claims filing instructions. In the event of a conflict between the Contract and booklet, the Contract shall prevail.

## **Q. Identification Cards**

The Third Party Administrator will provide the Group with identification cards for delivery to Participants.

## **R. Participating Plan**

1. The Plan may make an agreement with any other Blue Cross or Blue Shield Plan (referred to as a Participating Plan) to provide, in whole or in part, benefits for Covered Services to Participants.
2. Wherever Plan is used in the Contract, it includes Participating Plan(2) unless the context clearly indicates to the contrary.

## **S. Applicable Law**

The Contract is entered into in and is subject to the laws of the Commonwealth of Pennsylvania.

## **T. Participant Rights**

A Participant shall have no rights of privileges as to the benefits provided under the Contract, except as specifically provided herein.

## **U. Notice**

Any notice required under the Contract or a booklet must be in writing. Notice given to the Group will be sent to the Group's address stated in the Group Application. Notice given to the Plan will be sent to the Plan's address stated in the Group Application. Notice given to a Participant will be sent to the Participant's address as it appears on the records of the Plan or in care of the Group. The Group, the Plan or a Participant may, by written notice, indicate a new address for giving notice.

## **V. Coordination of Benefits with Other Group Health Plans**

All benefits provided under the Contract are subject to this provision, and will not be increased by virtue of this provision.

### **2. Definitions**

In addition to the Definitions of the Contract, the following definitions only apply to this provision:

- a. **Plan** means any group arrangement providing health care benefits or Covered Services through:
  - 1) group, blanket or franchise insurance coverage. Such other Plan will not include group or group-type hospital indemnity benefits of \$100 per day or less, or student accident coverage;
  - 2) Blue Cross, Blue Shield, health maintenance organization and other prepayment coverage;

- 3) Coverage under labor management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
- 4) Coverage under any tax supported or government program to the extent permitted by law.

- b. **Dependent** means, for any Plan, any person who qualifies as a Dependent under that Plan.
- c. **Allowable Benefits** means the charge for Covered Services.
- d. **Benefits Paid or Payable** means the amounts actually paid for Covered Services.

### 3. Effect on Benefits

- a. This provision shall apply in determining the benefits of the Contract if, for Covered Services received, the sum of the Benefits Payable under the Contract and the Benefits Payable under other Plans would exceed the Allowable Benefits.
- b. Except as provided in item c. of this Section, the Benefits Payable under the Contract for Covered Services will be reduced so that the sum of the reduced benefits and the Benefits Payable for Covered Services under other Plans does not exceed the total of Allowable Benefits.
- c. If,
  - 1) the other Plan contains a provision coordinating its benefits with those of the Contract, and its rules require the benefits of the Contract to be determined first, and
  - 2) the rules set forth in item e. of this Section require the benefits of the Contract to be determined first, then the benefits of the other Plan will

be ignored in determining the benefits under the Contract.

- d. If the other Plan does not include a Coordination of Benefits provision, such Plan will be primary.
- e. If the other Plan does include a Coordination of Benefits provision, such Plan will be primary.
  - 1) The Plan covering the patient other than as a Dependent will be primary.
  - 2) Where both Plans cover the patient as a Dependent child, the Plan covering the patient as a Dependent child of a parent whose date of birth, excluding year of birth, occurs earlier in a calendar year shall be the primary Plan. But, if both parents have the same birthday, the Plan which covered the parent longer will be the primary Plan. If the parents are separated or divorced, the following will apply:
    - a.) The Plan which covers the child as a Dependent of the parent with custody will be the primary Plan.
    - b.) If the parent with custody has remarried, the Plan which covers the child as a Dependent of the stepparent with custody will determine its benefits before the Plan covering the child as a Dependent of the parent without custody.
    - c.) Where there is a court decree which established 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 as long as the Plan of that parent

- has actual knowledge of the court decree.
- d.) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in the first paragraph of 2.e.2).

In the event the Contract is coordinating with a Plan that uses the male/female rule regarding dependent children, the first paragraph of Section W. Coordination of Benefits with Other Group Health Plans, Effects of Benefits, 2.e.2), defaults to the following:

Where both Plans cover the patient as a dependent child, the Plan covering the patient as a dependent child of a male will be the primary Plan, except that if the parents are separated or divorced, the following will apply:

- 3) Where the determination cannot be made in accordance with e.1) or 2) above, the Plan which has covered the patient for the longer period of time will be the primary plan; provided that,
- a) the benefits of a plan covering the person as an Employee or Participant other than a laid-off or retired Employee or Participant or as the Dependent of such a person shall be determined before the benefits of a plan covering the person as a laid-off or retired Employee of

- Participant or as a Dependent of such a person; and
- b) if the other plan does not have a provision and if, as a result, the plans do not agree on the order of benefits, this provision 3)a) shall be ignored.

- f. Services provided under any governmental program for which periodic payment of rate is made by the Participant shall always be the primary plan, except when prohibited by law.

#### 4. Facility of Payment

Whenever payments should have been made under the Contract in accordance with this provision, but the payments have been made under any other plan, this Plan has the right to pay to any organization that has made such payment any amount it determines to be warranted to satisfy the intent of this provision. Amounts so paid shall be deemed to be Benefits Paid under the Contract and to the extent of the payments for Covered Services, the Plan shall be fully discharged from liability under the Contract.

#### 5. Right of Recovery

- a. Whenever payments have been made by this Plan for Covered Services in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, this Plan shall have the right to recover the excess from among the following, as the Plan shall determine: any person to or for whom such payments were made, any insurance company or any other organization.
- b. The Participant, personally and on behalf of family members shall, upon request, execute and deliver such documents as may

be required and do whatever else is reasonably necessary to secure the Plan's rights to recover the excess payments.

6. The Plan shall not be required to determine the existence of any Plan or amount of Benefits Payable under any Plan except the Contract, and the payment of benefits under the Contract shall be affected by the Benefits Payable under any and all other Plans only to the extent that this Plan is furnished with information relative to such other Plans by the Employer or Employee or any other insurance company or organization or person.

When the benefits are reduced under the Primary Plan because a Participant does not comply with the plan provisions, or does not maximize benefits available under the Primary Plan, the amount of such reduction will not be considered an Allowable Benefit. Examples of such provisions are those related to second surgical opinions, Pre-certification of admissions and services, and preferred provider arrangements.

#### **W. Subrogation**

1. To the extent that benefits for Covered Services are provided or paid under the Contract, the Plan shall be subrogated and succeed to any rights of recovery of a Participant for expenses incurred against any person or organization except insurers on policies of health insurance issued to and in the name of the Participant.
2. The Participant shall pay the Plan all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided or paid under the Contract, and to the extent permitted by law.
3. The Participant shall take such action, furnish such information and assistance, and execute such papers as the Plan may reasonably require to facilitate enforcement of its rights, and shall take

no action prejudicing the rights and interests of the Plan under the Contract.

4. These provisions shall not apply where subrogation is specifically prohibited by law.

#### **X. Experimental or Investigative Services**

The Plan shall determine, in its sole discretion, whether the use of any treatment, procedure, Provider, equipment, drug, device, or supply (each of which is hereafter called a "Service") is Experimental or Investigative

2. If, in making that determination, the Plan finds that the service, for which a claim for benefits is made, is either: (1) the subject of a written investigational or research protocol used by the treating Provider or of a written investigational or research protocol of another Provider studying substantially the same service; or (2) the subject of a written informed consent used by the treating Provider which refers to the service as Experimental, Investigative, educational, or research; or (3) the subject of an on-going phase I, II or III clinical trial, the service shall be deemed to be Experimental or Investigative.
3. If, in making that determination, the Plan finds that neither a protocol, an informed consent, nor an on-going clinical trial, as described above, exist, then the Plan may require that demonstrated evidence exists, as reflected in the published Peer Reviewed Medical Literature:
  - a. that the service is recognized by a majority of those practicing the appropriate medical specialty as being safe and effective for use in the treatment of the particular condition in question; and
  - b. that the service has a definite positive effect on health outcomes; such evidence must include well designed investigations that have been reproduced by non-affiliated authoritative sources with measurable results supported by the

- c. positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale; and
- c. that, overtime, the service leads to improvements in health outcomes; i.e., the beneficial effects outweigh any harmful effects; and
- d. that the service is at least as effective in improving health outcomes as established technology or is useable in appropriate clinical contexts in which established technology is not employable; and
- e. that improvement in health outcomes is possible in standard conditions of medical practice outside clinical investigatory settings.

**PEER REVIEWED MEDICAL LITERATURE** means two (2) or more U.S. scientific publications which require that manuscripts be submitted to acknowledged experts inside or outside the editorial office for their considered opinions or recommendations regarding publication of the manuscript.

Additionally, in order to qualify as Peer Reviewed Medical Literature, the manuscript must actually have been reviewed by acknowledged experts before publication.

- 4. If, in making the determination, the Plan finds that a drug, a device, a supply, or equipment has not received marketing approval (permission for commercial distribution) by the United States Food and Drug Administration: (1) at the time the service is rendered; and (2) for the purpose for which it is rendered; and (3) for the manner in which it is rendered, the drug, device, supply or equipment shall be deemed to be Experimental or Investigative.

## Y. Facility Provider Reimbursement

### 2. Preferred Facility Providers

A Preferred Facility Provider is either a Member of the Access Care Preferred

Provider Network which has a contractual arrangement with Blue Cross for the provision of services to Participants or is a member of the BlueCard PPO Network and has arrangements with its local Blue Cross Plan for the provision of services to Participants in Preferred Provider programs of other Blue Cross Plans. Benefits will be provided at the Preferred Provider level as specified in the Schedule of Benefits. The Participant's Deductible, Coinsurance, benefit Maximums and benefits for services rendered will be based on the contractual payment to the Provider. Interim payments may be subject to final settlements and/or adjustments between the Plan and the Provider. Any such settlements or adjustments will not be considered in calculating the Participant's Deductible, Coinsurance or benefit Maximums.

### 3. Non-Preferred Facility Providers

- a. **Non-Preferred Member Facility Providers** – A Provider that is not part of the Access Care Preferred Provider Network nor a part of the BlueCard PPO Network. Such Providers may have a contractual arrangement with Blue Cross or with their local Blue Cross Plan. A Non-Preferred Member Facility Provider will be compensated in accordance with contracts entered into between such providers and the Plan. Benefits will be provided at the Non-Preferred Provider level as specified in the Schedule of Benefits. The Participant's Deductibles, Coinsurance, benefit Maximums and benefits for services rendered will be based on the payment to the Provider. Interim payments may be subject to final settlement and/or adjustments between the Plan and the Provider. Any such settlements or adjustments will not be

considered in calculating the Participant's Deductible. Coinsurance or benefit Maximums.

- b. **Non-Preferred Non-Member Facility Providers** – A Provider which has neither a Preferred Provider Contract nor any contract with any Blue Cross Plan. Benefits will be provided at the Non-Preferred Provider level as specified in the Schedule of Benefits. The Participant's Deductibles, Coinsurance, benefit Maximums and benefits for services rendered will be based on the lesser of the Provider's charge for Covered Services or the Providers Reasonable Charge as determined by the Plan. In the event Covered Services cannot be rendered by a Preferred Facility Provider, and Blue Cross determines through Pre-Certification that, as a result, a Participant is required to obtain services from a Non-Preferred Facility Provider, the Participant will not be subject to the financial penalty ordinarily applicable to the Covered Services of Non-Preferred Facility Providers.

**Z. Preferred and Non-Preferred Professional Provider Reimbursement**

Benefit amounts, as specified in the Schedule of Benefits, refer to Covered Services rendered by a Preferred Professional Provider which are regularly included in such Professional Provider's charges and are billed by a payable to such Professional Provider.

The allowance for Covered Services rendered by a Non-Preferred Professional Provider which are regularly included in such Provider's charges and are billed by and payable to such provider is the same as for a Preferred Professional Provider.

When Covered Services are performed by a Non-Preferred Professional Provider, the Plan reserves the right to make payment to

the Participant. Any difference between the Non-Preferred Professional Provider's charge and the Plan payment shall be the personal responsibility of the Participant.

When Covered Services rendered outside Pennsylvania, by Professional Providers who are considered to be Preferred Providers by the Participating Blue Shield Plan, the Participating Blue Shield Plan will determine the Provider's Reasonable Charge. In cases where the Provider is not a Preferred Provider, payment is based on the lower of the Provider's Reasonable Charge or the Provider's charge and payable to the Participant. The participant is liable for charges that exceed the Provider's Reasonable Charge.

In the event no Preferred Professional Providers of a needed specialty are included in the network, and Pennsylvania Blue Shield determines through Pre-Certification that, as a result, a Participant is required to obtain care from a Non-Preferred Professional Provider, the Participant will not be subject to the financial penalty ordinarily applicable to the Covered Services of Non-Preferred Professional Providers.

**AA. Service Benefits Provisions**

Service Benefits apply to Participants who utilize Preferred Professional Providers. Preferred Professional Providers have agreed to accept the Provider's Reasonable Charge as payment in full for Covered Services. Preferred Professional Providers will make no additional charge to Service Benefit Participants for Covered Services except in the case of certain Deductibles, Coinsurance, Copayment or amounts exceeding Maximums referred to in the Contract. Such Deductibles and Coinsurance or amounts must be paid, or arrangements to pay must be made, to the Preferred Professional Provider by the Participant within sixty (60) days of the date in which Blue Shield finalizes such services.

Any dispute between the Preferred Professional Provider and a Participant with respect to balance billing shall be submitted

to Blue Shield for determination. The decision by Blue Shield shall be final.

## **BB. Appeal/Grievance Procedures**

The Plan maintains both formal and informal procedures to resolve Participant complaints and grievances. These procedures are designed to ensure that a Participant's questions, concerns and grievances are resolved in a timely and equitable manner.

The Participant is notified of the grievance procedure initially through the Participant handbook and subsequently on an annual

basis. All complaints and/or grievances may be handled at three levels:

### **1. Informal Complaint Process**

The majority of Participant complaints or inquiries will be resolved at this level. A Participant's inquiry is directed to the Customer Service Department. Dependent on the reason for the inquiry, it will either be resolved by the Customer Service Department or transferred to the appropriate departmental area. The designated department representative will review, research and resolve all Participant inquiries as quickly as possible. If a Participant is dissatisfied with the response to the inquiry, he/she may appeal the initial decision by submitting a written appeal to the initial Grievance Committee within sixty (60) days. Receipt of the written appeal initiates the formal grievance process.

### **2. Initial Grievance Committee**

This Committee is comprised of various members of the Plan's departmental staff. The Initial Grievance Committee reviews the grievance submitted by the Participant. The Committee may refer the matter (depending on the nature of

the grievance) to the Medical Director for an opinion prior to rendering a final decision. The Participant is informed in writing of the action and determination of the Initial Grievance committee within thirty (30) days of the receipt of the grievance. If additional time is needed, the Participant is notified of the reason for the delay. The written notification will state that the decision of the Initial Grievance Committee is binding, unless the Participant chooses to appeal that decision to the Second Level Grievance committee within thirty (30) days of receipt of the decision.

### **3. Second Level Grievance Committee**

This Committee is comprised of members of the Plan's departmental staff other than those serving as members of the Initial Grievance Committee. Members of the Second Level Grievance Committee must be approved at the vice-presidential level. The Second Level Grievance Committee will schedule a hearing to consider the Participant grievance. The Participant will be notified in writing of the hearing procedures, and the rights to such a hearing.

The Participant has a right, but is not required to attend. The hearing will be held within thirty (30) days of the appeal request. The Second Level Grievance Committee will forward their recommended decision on the grievance to the Plan's Vice-President of Operations for final determination. A formal decision will be issued within days of the hearing. If additional time is needed, the Participant is notified of the reason for the delay. The written decision will specify the reason for the committee decision and is binding.

In cases of a grievance in which the Participant believes that serious medical consequences will arise within ten (10) days from a failure to provide needed Medically Necessary covered health

services, the Participant should identify the particular need for an expedited review to the Plan. That grievance will be reviewed by the Medical Director within forty-eight (48) hours and the Participant will be informed of the decision in writing. If the Medical Director's decision is adverse to the Participant, the Participant may appeal the decision immediately to the Second Level Grievance review Committee.

If the appeal concerns services of a Facility Provider, it shall be sent to Blue Cross of Northeastern Pennsylvania, 70 North Main Street, Wilkes-Barre, Pennsylvania 18711.

If the appeal concerns services of a Professional Provider, it shall be sent to Pennsylvania Blue Shield, Managed Care Center, 1800 Center Street, Camp Hill, PA 17089

**CC. Payment of Rates**

The Plan shall not be liable for any expenses incurred by a participant beyond the period for which participant rates shall have been paid, except as provided in Subsections E 2 and G and the Plan shall be entitled to indemnification by the Group for any premiums payable to the Plan under such circumstances.

**DD. Cancellation of Existing Contracts**

The Contract supersedes all prior contracts existing between the parties which the Contract is intended to replace.