

**Indemnity Plan**  
**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 Dept.  
Linden and Monroe Avenue  
Scranton, Pa 18510-4679**

Phone: ( 570) 941-7767

The appropriate Blue Cross and Blue Shield Plan contact is:

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

Customer Service Phone: **1-800-829-8599**

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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## Section I

# Administration of Hospital, Medical-Surgical and Major Medical Plan

*Administration of Hospital, Medical-Surgical and  
Major Medical Plan*

Plan Number

501

**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**

Participants

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

Contributions

The costs for certain coverage for your benefits under the plan are shared by you and your employer, if applicable.

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

Plan Effective Date

2-1-99

This booklet has been prepared to meet the summary Plan description requirements of the 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.

Named Fiduciary

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

Name of Plan

The University of Scranton

Plan Records

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

Employer and Plan Sponsor

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

Plan/Type Administration

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

Plan Administrator

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

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.

Employer Identification Number

24-0795495

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 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, 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.

### Open Enrollment

During the annual open enrollment period, benefit eligible Employees and their Dependents will be able to change 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.

### 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.

### Funding 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 the month following date of hire by completing an application form.

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.

## 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 you 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 directory or the Division of Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, DC 20210.

Agent For Service of  
Legal Process on the Plan

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

## General Information

No physical or oral examination of any subscriber is required as a condition of membership.

However, the subscriber agrees that any person or organization furnishing services or supplies to him is authorized to provide Blue Cross and/or Blue Shield with requested information and records.

## Eligibility: Hospital, Medical-Surgical and Major Medical

You, your spouse and all unmarried dependent children under 19 years of age are eligible for enrollment as participants for the benefits described herein.

Each eligible dependent child is covered from birth until: (a) the end of the calendar year in which he/she reaches their 19<sup>th</sup> birthday, (b) the end of the month in which he/she marries or becomes employed or (c) the end of any period during which he/she is incapable of self-support because of a disabling abnormality or condition of illness or injury. Eligibility for continuation of such disabled children will be determined by Blue Cross and Blue Shield and such determination shall be conclusive.

The term “*dependent child*” means any unmarried child (whether or not adopted) of any enrolled employee or the spouse of an enrolled employee, or any other unmarried child principally supported by or living in a parent/child relationship with such employee.

Unmarried dependent students will be covered to age **23** if they are attending on a full time basis an accredited college, university, technical or specialized school and are pursuing a course of study requiring at least 2 years which will lead to a degree or certificate upon completion.

## Change in Family Status

It is important that the participant notify the Plan Administrator and complete a change form for changes in family status; that is, marriage, marriage of any of the participant’s children,

death, divorce or other change affecting the eligibility of his or her dependents.

**Note: A participant’s newborn child will be considered a dependent under this program for 31 days immediately following birth. If the employee is not enrolled under a family contract and wishes to continue coverage of the newborn beyond that date, application must be made within the 31 day period.**

## Identification Cards (ID)

Blue Cross and Blue Shield will issue identification cards. If an identification card is misplaced, request a new one through your personnel office.

## How To File Your Claim For Hospital And Medical-Surgical Benefits

All claims for benefits covered under your Plan will be submitted directly to Blue Cross or Blue Shield by the Member Hospital and all Participating Providers. Be sure to present your Blue Cross and Blue Shield identification card to the provider or hospital admitting clerk. They will assist you in completing any forms that may be required.

If the hospital is a Blue Cross Member Hospital or the provider is a Blue Shield Participating Provider, payment for benefits will be made directly to the hospital or provider. However, if a Non-Member Hospital or a Non-Participating Provider provides the services, payment may be made to you.

## How to File Your Claim For Major Medical Benefits

Keep a record of expenses covered under the Major Medical Program incurred by you and each of your eligible dependents. Complete a Major Medical statement and submit it, together with itemized bills, to Blue Cross. File your claims throughout the year to expedite processing. Claims for Major Medical benefits must be submitted no later than 24 months after the

incurred date. Payment for covered medical expenses will be made directly to the subscriber. Claim forms may be obtained from your Human Resource Department.

Blue Cross of Northeastern Pennsylvania has contracted with Express Scripts electronic processing system to communicate with and receive Major Medical prescription drug claims from Blue Cross of Northeastern Pennsylvania Member Pharmacies.

When you purchase prescription drugs from a Blue Cross of Northeastern Pennsylvania Member Pharmacy, it is not necessary for you to submit a receipt to our office for these charges. The member pharmacy at the time of dispensing a prescription for you and your dependent(s) will have the ability to verify member eligibility and submit the prescription claim electronically. All you need to do is present your Blue Cross identification card each time a prescription is filled and pay the pharmacy the amount due for the prescription. Blue Cross will electronically receive the prescription drug claim; apply the appropriate Major Medical benefits; determine the applicable deductible and/or co-insurance; calculate the payment due and reimburse you directly.

If you are outside Blue Cross of Northeastern Pennsylvania's service area, you should ask if the pharmacy is a Express Scripts National Member Pharmacy. If the pharmacy is a member of the National Network, the claim will be handled as described above. Should the pharmacy not be a National Member Pharmacy you must submit appropriate receipts along with a Major Medical claim form to our office.

#### What To Do If Your Claim For Benefits Is Denied

Should your claim be denied in whole or in part, you will receive written notification from Blue Cross and/or Blue Shield.

If you have any questions about the payment of your claim, see your personnel or payroll office for further information.

If you disagree with any part of the Blue Cross or Blue Shield decision on your claim, you have the right to appeal. If, in preparing your appeal, you wish to review the documents pertinent to your claim, you should write to:

Blue Cross of Northeastern Pennsylvania  
And Pennsylvania Blue Shield  
70 North Main Street  
Wilkes-Barre, PA 18711

Your appeal letter should be sent within 60 days of the denial. In your appeal, you should clearly state your reasons for believing the claim should be paid, including all pertinent data. You will be sent notification of their final decision within 60 days of your appeal, unless special circumstances require an additional 60 days for processing.

#### Termination and Amendment of Plan

Upon 60 days written notice, the Plan Administrator may terminate this contract or, subject to Blue Cross and Blue Shield approval, may modify, amend or change the benefit provisions, terms and conditions of the contract. No consent of any participant, or any other person referred to on the contract, shall be required to terminate, modify, amend or change the contract.

Plans maintained as a result of collective bargaining Agreements are, of course, subject to change negotiated in the collective bargaining process.

If you are laid off, resign, or retire, all health care benefits described herein for you and for your dependents will cease on the date specified by the plan in writing.

If at the time of termination you are receiving Major Medical benefits for an injury which occurred or an illness which began prior to termination, payments will be made for Covered Medical Expenses incurred for a period not to exceed 12 months from the date of such termination of coverage on account of that particular accident or illness only. This 12 month extension applies only to Major Medical benefits.

If the coverage described in this booklet is terminated because it is being replaced by another carrier, all benefits will cease on the date when such other coverage becomes effective.

After termination of your coverage under this Plan, you may arrange to continue your protection under the type coverage for which you are then eligible by paying the charges for such coverage directly to Blue Cross and Blue Shield.

#### Alternative Benefit Provision

The Managed Care Program provided by Blue Cross directly or through its agent is designed to review a subscriber's benefits associated with a proposed or actual course of treatment and recommend alternative benefits (including benefits not otherwise covered by this Agreement) which maintain the quality of care, maximize the rate of recovery, and reduce cost. **The Managed Care Program only involves the review and recommendation of benefits which may be paid to a participant by Blue Cross. All decisions with respect to a participant's proposed or alternative plan of care shall be the sole responsibility of the participant's physician and shall be approved by the subscriber.**

Notwithstanding anything in the Plan to the contrary, Blue Cross may, in its sole discretion, provide such alternative benefits, in lieu of benefits otherwise payable under the Plan, as it determines to be reasonable and consistent with the plan of care developed by the participant's physician and approved by the participant. Subject to the foregoing, payment of benefits under the Plan is conditioned upon the participant's compliance with all Blue Cross rules and regulations pertaining to the Managed Care Program, including but not limited to authorizing Member Hospitals, physicians, providers, employers, unions, family members and public or private agencies, as necessary and appropriate.

In the event Blue Cross determines in accordance with the Plan that further treatment or hospitalization associated with the alternative benefits is no longer medically necessary or cost

effective, such alternative benefits may be terminated and Blue Cross may pay those benefits, if any, which would otherwise be available to the participant under the provisions of the Plan.

Payment of benefits under the Managed Care Program is at all times subject to all other provisions of the Plan except where such other provisions are inconsistent with this Section in which case this Section shall control.

#### Portability

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if you terminate employment and obtain other health insurance coverage which has a pre-existing condition exclusion, you may be entitled to receive credit toward the exclusionary period, provided you have not had a break in coverage of more than 63 days.

At the time you terminate coverage with us, BCNEPA will issue (upon request) a certificate of coverage showing the period of time during which you were covered under this program. This new insurer will reduce its exclusionary period, if any, in accordance with that information.

#### Coordination of Benefits

In order to avoid duplication of payment for covered services received by the participant, payment for benefits under this Plan will be coordinated with other group health Plans.

1. In the event a participant is covered under a Benefit program other than this Plan, which does not contain a provision coordinating its benefits with those of this Plan, such other Plan will be the primary Plan and as such shall determine its benefits before benefits are determined under this Plan. Benefits payable under another Plan include the benefits that would be payable, whether or not claim is made therefore.

Such other Plan may include any company-sponsored Plan, including any group Blue Cross/Blue Shield Plan, franchise

- arrangements, or any company-sponsored Plan to which any employer contributes or makes payroll deductions. Such other Plan will not include blanket student accident coverage.
2. When a participant is covered under another Plan which contains a provision coordinating its benefit with those of this Plan, the following rules will establish order of determining liability of this or any other Plan:
    - a. The Plan covering the participant as a contract Holder is the primary Plan, which shall determine its benefits before benefits are determined under any other Plan.
    - b. Except for situations where the parents of a child are separated or divorced:
      - i. The Plan of the parent whose date of birth (month, day) falls earlier in the calendar year is the primary Plan. If both parents have the same birthday, the Plan which covered the parent longer will be the primary Plan; or
      - ii. If this Plan is coordinating with a Plan which uses a rule based on the gender of the parent, the Plan of the male parent is the primary Plan.
    - c. In those situations where the parents of the child are separated or divorced:
      - i. The Plan covering the child as a dependent of the parent with custody will be the primary Plan;
      - ii. If the parent with custody has remarried, the Plan which covers the child as a dependent of the step-parent with custody will be the primary Plan;
      - iii. Where there is a court decree which establishes financial responsibility for the health care expenses of the dependent child, the plan which covers the child as a dependent of the parent with such financial responsibility will be the primary Plan, as long as the Plan of that parent has actual knowledge of the court decree; or
      - iv. If the specific terms of a 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 paragraph 2.b.
  3. Where the determination cannot be made in accordance with the above, the Plan which has covered the participant for the longer period of time will be considered the primary Plan, except:
    - a. The Plan which covers the participant as an active employee (or a dependent of such a person) is the primary Plan over a Plan that covers a participant as laid-off or retired employee (or dependent of such a person); or
    - b. If either Plan does not have a provision regarding laid-off or retired employees and as a result, the benefits of each Plan are determined after the other, then the provisions of a 3.a. above shall not apply.
  4. Services provided under any governmental Program for which any periodic payment of rate is made by or for the participant shall always be the primary Plan, except where prohibited by law.
  5. Individual Non-Group Health Plans of any kind will not be coordinated when the participant pays the entire cost.
  6. When this Plan is determined to be the Primary Plan, benefits will be paid without regard to coverage under any other Plan. When this Plan is not the primary Plan and there are remaining covered services, this Plan will pay its regular benefit up to the amount of such remaining eligible covered services.
  7. Facility of Payment – Whenever payments

which should have been made under this Plan in accordance with this provision have been made under any other Plan, Blue Cross and Blue Shield will have the right, at their sole discretion, to pay to any organization making such other payments any amounts they determine to be warranted in order to satisfy the intent of this provision and amounts so paid will be considered benefits paid under this Plan and Blue Cross and Blue Shield will be fully discharged from liability.

8. Right of Recovery – Whenever payments Have been made by Blue Cross and Blue Shield in excess of the maximum amount of payment necessary to satisfy the intent of this provision, irrespective of to whom paid, Blue Cross and Blue Shield will have the right to recover such payments to the extent of such excess from among one or more of the following, as Blue Cross and Blue Shield will determine:
- a. Any persons to or for or with respect to whom such payments were made (including the participants covered under this Plan);
  - b. Any insurance companies; and
  - c. Any organization.

Blue Cross and Blue Shield may use such reasonable efforts as deemed suitable to determine the existence of other Plans but will be under no obligation to do so. Blue Cross and Blue Shield shall not be required to determine the existence of any contract or amount of benefits under any Plan except this Plan and the payment of benefits under this Plan shall be affected by the benefits under any and all other Plans only to the extent that Blue Cross and Blue Shield are furnished with information relative to such other Plan by the group or participant or any other organization or person.

When the benefits are reduced under the primary Plan because a participant does not comply with the Plan provisions, the amount of such reduction will not be considered covered services. Examples of such provisions are those related to

second surgical opinions, prior certification of admissions and services and preferred provider arrangements.

This Coordination of Benefits provision does not apply to individual, non-group or group conversion policies.

## Subrogation

### **A. Plan Responsibilities**

Plan represents and warrants that the Summary Plan Description confers on the Plan rights of subrogation and third part recovery. Plan delegates or assigns these subrogation rights and third party recovery rights to Blue Cross of Northeastern Pennsylvania as the Plans agent for purposes of subrogation.

### **B. BCNEPA’s Subrogation Duties**

Blue Cross of Northeastern Pennsylvania shall undertake reasonable steps to identify claims in which the Plan has a subrogation interest and shall manage subrogation cases on behalf of the Plan. Blue Cross of Northeastern Pennsylvania shall be subrogated, and succeed to the rights of recovery of a participant for expenses incurred against any person or organization except insurers or policies of health insurance issued to and in the name of participant. In those instances where the subrogation recovery efforts of the participant’s attorney should, in the opinion of Blue Cross of Northeastern Pennsylvania, be compensated, the Plan delegates to Blue Cross of Northeastern Pennsylvania full authority to act on behalf of the Plan to negotiate reasonable attorney fees not to exceed thirty-three and one-third percent (33 1/3%) for personal injury cases, up to forty percent (40%) for medical malpractice cases and twenty percent (20%) for worker’s compensation cases. Any determination by Blue Cross of Northeastern Pennsylvania with respect to attorney fees shall be final and conclusive, unless overturned under a limited arbitrary and capricious standard of review. Blue Cross of Northeastern Pennsylvania shall

provide the participant's attorney with updated lien amounts, as requested, and shall work with the participant's attorney to recover 100% of the Covered Services paid (unless such amount is compromised as set forth in Section C). Blue Cross of Northeastern Pennsylvania shall credit the plan with the amount recovered, minus, as applicable, a pro-rata share of the costs and the participant's attorney fees.

### C. Authority to Compromise Liens

In those instances where a plan's subrogation lien should, in the opinion of Blue Cross of Northeastern Pennsylvania, be compromised, the plan delegates to Blue Cross of Northeastern Pennsylvania full authority to act on behalf of the plan to compromise the lien. Any determination by Blue Cross of Northeastern Pennsylvania with respect to subrogation liens shall be final and conclusive, unless overturned under a limited arbitrary and capricious standard of review.

### D. Participant's Duties

The participant shall pay to Blue Cross of Northeastern Pennsylvania all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided and paid under the plan less any attorney's fees and expenses. The participant shall take such action, furnish such information and assistance, and execute such papers as Blue Cross of Northeastern Pennsylvania may require to facilitate enforcement of its rights and shall take no Action prejudicing the rights and interest of Blue Cross of Northeastern Pennsylvania.

### E. Prohibited by Law

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

Consolidated Omnibus Budget Reconciliation  
Act of 1985 (COBRA)

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.

### Benefits Affected by COBRA:

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 an 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 ceased 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 or 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.

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 renew ability 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.

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

Complete instruction 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.

If the participant dies, the surviving spouse and child may continue coverage under the direct payment type of subscriber Agreements.

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

### Misrepresentations

### 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.

If a false statement is intentionally made by the subscriber in obtaining coverage or benefits under this Agreement, or if the subscriber cooperates with a provider of service in the making of a false statement with the knowledge that such statement is false, this Agreement will be terminated immediately. Restitution will be sought by Blue Cross for any amounts paid to the subscriber because of any false statement or misrepresentation.

### Conversion

If the subscriber ceases to a participant for this program because of layoff, disability, leave of absence or termination of employment, arrangements may be made to continue both Blue Cross and Blue Shield under the direct payment type of participant Agreements. However, if a participant becomes one of a group having benefits available under a Health Insurance Program other than Blue Cross, he or she is not entitled to this conversion privilege.

## Section II

### Hospital

Covered Services

The following inpatient services will be covered for semi-private bed patients when consistent with the diagnosis and treatment and when administered by an employee of a facility. This coverage is provided for admissions occurring on or after your effective date:

1. Bed and board, including special diets and general nursing care;
2. Intensive Care Unit and Cardiac Unit;
3. Use of operating, delivery, recovery, cystoscopic, treatment and other specialty service rooms, plus equipment and supplies;
4. Casts;
5. Surgical dressings and supplies;
6. Physical Therapy;
7. Radiation Therapy;
8. Oxygen and Oxygen Therapy;
9. Chemotherapy;
10. Administration of blood and blood plasma, including the processing of blood from donors (but excluding the cost of blood and blood plasma);
11. Anesthetic supplies and the use of anesthetic equipment;
12. Anesthesia;
13. All drugs, medications and combinations thereof (including intravenous injections and solutions) for use while in the hospital, which are released for general use and are commercially available to hospitals;
14. Laboratory examinations;
15. X-ray examinations and radiation testing;
16. Cardiographic examinations and electroencephalograms.

The participant pays to the facility \$5 per day for the first 15 days of each inpatient admission during any 12 month period up to a maximum payment of \$75 for all participants under the Plan.

Duration of Benefits

Regular Admissions: You and each of your enrolled dependents will be entitled to 365 days per calendar year of hospital care.

Special Admissions

**Mental and Nervous Disorders:** Up to 30 of the participant's eligible benefit days are available for this care during any consecutive 12 month period.

**Psychiatric Care:** Full coverage is provided for psychiatric care when received in an approved day or night care center, under a program approved by Blue Cross. Each visit will count as ½ day toward the 30 days provided for mental and nervous disorders.

**Alcohol or Drug Abuse Treatment:**

1. Inpatient detoxification when provided either in a participating Hospital or on an inpatient basis in a participating non-hospital facility which is licensed as an approved alcohol and/or drug addiction treatment program and is approved by the Department of Health. The inpatient detoxification treatment is subject to a lifetime limit of 4 admissions and reimbursement per admission is limited to 7 days of treatment. The following services will be covered when administered by an employee of the facility;
  - a. Lodging and dietary services.
  - b. Physician, psychologist, nurse, certified addiction counselors and trained staff services.

- c. Diagnostic X-ray.
  - d. Psychiatric, psychological and medical laboratory testing.
  - e. Drugs, medicines, equipment use and supplies.
2. Non-hospital residential alcohol or other drug abuse services when provided in a participating non-hospital facility which is appropriately licensed by the Department of Health as an alcoholism or drug addiction treatment program. This treatment will be limited to 30 days per year subject to a lifetime maximum of 90 days. In those specialized cases where an approved facility has a contract with BCNEPA which provides for additional treatment, the benefits will not be limited to 30 days per year. The following services will be covered when administered by an employee of the facility:
- a. Lodging and dietary services.
  - b. Physician, psychologist, nurse, certified addiction counselors and trained staff services.
  - c. Rehabilitation Therapy and counseling.
  - d. Family counseling and intervention.
  - e. Psychiatric, psychological and medical laboratory testing.
  - f. Drugs, medicines, equipment use and supplies.
3. Outpatient alcohol or other drug abuse services when provided in a participating facility appropriately licensed by the Department of Health as an alcoholism or drug addiction treatment program. Thirty outpatient, full session visits or equivalent partial visits are available per benefit year and are subject to a lifetime maximum of 120 outpatient, full session visits or equivalent partial visits. The following services will be covered when administered by an employee of the facility.
- a. Physician, psychologist, nurse, certified addiction counselors and trained staff services.
  - b. Rehabilitation Therapy and counseling.
  - c. Family counseling and intervention.
  - d. Psychiatric, psychological and medical laboratory test.
  - e. Drugs, medicines, equipment use and supplies.
4. An additional 30 outpatient, full session visits or equivalent partial visits, which may be exchanged on a two-for-one basis for up to 15 non-hospital, residential alcohol or drug treatment days, shall be available in addition to the benefits in 2. and 3. These additional benefits are subject to the lifetime maximums indicated.
5. If alcohol or other drug abuse services are provided in a non-hospital facility that is located outside of the Service Area and the facility does not have a contract with the Blue Cross Plan servicing the area in which it is located, BCNEPA will pay to the subscriber 70% of the eligible billed charges.
6. All inpatient and outpatient treatment must be pre-certified by BCNEPA. In order to obtain pre-certification, the attending physician must provide evidence prior to ordering such treatment, in a form satisfactory to BCNEPA, that alcohol or drug abuse treatment is medically necessary and appropriate. Prior to admission, the Alcohol or Drug Abuse Facility shall advise the Plan's Medical Review Department by telephone with necessary information. Also, the same procedure is to be followed should the participant's condition require an extension of inpatient or outpatient treatment beyond the approved period.

Determination by BCNEPA as to eligibility for benefits shall be conclusive.

**Skilled Nursing Care Facility:** Following at least 3 days in the hospital, benefits will be provided in a Skilled Nursing Facility if admitted within 14 days following discharge, for continued treatment of the same or related condition which required hospitalization, when certified as medically necessary by a doctor. Three days in a Skilled Nursing Facility will count as 1 day in a hospital against the subscriber's eligible benefit days.

### Pre-Admission Certification (PAC)

When any participant requires treatment on an inpatient basis, benefits for covered services as described in this Section II will be provided only if a licensed physician provides evidence prior to such admission, in a form satisfactory to BCNEPA that the following hospitalization is medically necessary and appropriate:

1. All out-of-area inpatient medical/surgical admissions.
2. All psychiatric and substance abuse inpatient admissions.
3. Skilled Nursing Facility admissions.
4. Home Health services.
5. Private Duty Nursing cases.
6. Complications of same day surgeries requiring inpatient admission.
7. Partial psychiatric hospitalizations.
8. Physical rehabilitation hospitalization.
9. Dental extraction of impacted wisdom teeth as inpatient or same day surgery (not physician office).

Determination by BCNEPA as to eligibility for benefits under 1 through 9 above shall be conclusive;

When a proposed inpatient stay is determined not to be eligible for benefits under this provision, if otherwise medically necessary and appropriate, benefits will be provided for outpatient services as set forth in Section II of this booklet.

Pre-Admission Certification for emergency inpatient admissions is waived. However, the physician must submit an admission notification to Blue Cross within 48 hours or the first regular business day of the emergency admission so that a specific number of inpatient days can be assigned.

### Maternity Admissions

Normal deliveries as opposed to a surgical delivery (Caesarean Section) do not need pre-certification (PAC).

Any Caesarean Section or complications of pregnancy which require greater than three (3) days inpatient hospitalization requires PAC in out-of-area hospitals only.

**Appeal Procedure:** In the event BCNEPA has determined that the participant is not eligible for benefits, the participant may submit an appeal by telephone within 24 hours or in writing to Blue Cross. Such appeal must be submitted not later than 60 days from the date Blue Cross notified the subscriber of its determination and should include specific information in support of the subscriber's eligibility for benefits. Blue Cross will then notify the subscriber of its final decision in writing, not later than 60 days following receipt of the subscriber's appeal.

**Note:** Certification of your admission refers only to the medical necessity of the admission. Once the certified admission takes place, payment of benefits is subject to the patient's eligibility on the admission date.

## Oral Surgery

Full coverage is provided for oral surgery if the participant's doctor certifies that hospitalization is necessary and only if such surgery consists of cutting procedures for the treatment of fractures and dislocations of the jaw, for removal of bone-impacted teeth and for surgery for injuries to the jaw or any structure contiguous to the jaw or dislocation of any facial bone.

## Transplant Services

Full coverage is provided for eligible human transplant services, including services performed for the removal of an organ from a donor when the donor is not a participant and not covered under another health care Plan. The services must be directly and specifically related to the transplantation to be eligible.

If an organ or tissue is sold rather than donated to the participant, no benefits will be payable for the purchase price of such organ or tissue.

## Maternity Care

Maternity benefits for all female participants who are enrolled under the Plan will be provided in the same manner as for any other medical condition. This coverage includes medically necessary diagnostic services in connection with pregnancy as well as the services of a State approved Birthing Center.

## Newborn Care

Nursery care of the newborn child also will be covered for this same period while the mother is hospitalized.

## Private Room

If you use a private room, you will be expected to pay the difference between the private room charge and the average charge made by the hospital for its regular semi-private accommodations. You will receive full allowance for all other services previously described.

If, due to overcrowded conditions, semi-private accommodations are not available and you or your covered dependent must use a private room or other accommodations, BCNEPA will arrange with the hospital that during the time the semi-private accommodations are not available, such other accommodations be provided on a basis which will involve no charge therefore to you. However, if you are hospitalized in an institution where only private room accommodations are available, BCNEPA will pay to the hospital an amount equal to the average semi-private charges being made in that general area. You will be expected to pay the difference between the private room charges and this amount.

## Outpatient Care

**Accidental Injury:** Full service benefits will be provided for hospital treatment rendered within 72 hours of an accident.

**Emergency Medical Care:** Full service benefits will be provided for emergency medical care (initial visit only, not follow-up care) rendered within 72 hours of the onset of the medical emergency. This includes heart attacks, strokes, convulsions, diabetic coma, etc.

**Note:** If you should require outpatient services Outside Northeastern Pennsylvania, pay the bill and submit your itemized receipt to Blue Cross of Northeastern Pennsylvania. Write your Agreement number and Plan number on the receipt. If the reason for which treatment was given is not indicate, attach a brief note explaining the circumstances.

## Diagnostic Services

All accepted, medically necessary diagnostic testing is covered when ordered by a doctor.

Outpatient diagnostic services are not provided for care of teeth, research studies, screening, routine physical examinations or checkups, premarital examinations and audiometric testing or eye refraction examinations.

## Routine Gynecological Examination And Routine Papanicolaou Smear

Benefits are provided for one (1) routine Gynecological Examination, including a pelvic examination and clinical breast examination and one (1) routine Papanicolaou Smear per calendar year for all female participants. Benefits are exempt from all deductibles and maximums.

## Mammography Screening

One mammography screening per calendar year is covered for all participants age 40 and over whether or not directed toward a definite condition of disease or injury. Mammographs which are recommended by a physician are covered for all subscribers.

Benefits for mammography screening are payable only if performed by a mammography service provider who is properly certified by the Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

## Diabetes Education Services

Covered services include participation in one diabetes self-management education program per member per lifetime and one consultation in each year following participation in and completion of the diabetes education program.

**Limitation:** Benefits will only be provided if the member completes the diabetes education program. Services must be provided by a Participating Hospital. Services must be performed in conjunction with a program certified by the Pennsylvania Department of Health or the American Diabetes Association and recognized by Blue Cross of Northeastern Pennsylvania.

## Pediatric Immunizations

Benefits are provided for those pediatric immunizations, including the immunizing agents, which as determined by the Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control of the U.S.

Department of Health and Human Services. Benefits are limited to dependent children and are exempt from deductibles or maximums.

## Outpatient Surgery

Full service benefits will be provided for outpatient surgery. This includes necessary follow-up care received within 72 hours of the initial surgery, except for application or reapplication of casts, in which case there is no time limit.

## Radiation Therapy

Outpatient Radiation Therapy is covered when received in the outpatient department of a hospital and billed for by the hospital.

## Chemotherapy

Outpatient Chemotherapy is covered when received in the outpatient department of a hospital and billed for by the hospital. This includes related hospital charges incurred the same day that treatment is given.

## Respiratory and Physical Therapy

Outpatient Respiratory and Physical Therapy are covered, following an illness or injury for which the participant was hospitalized, during the 90 day period following discharge. Speech and Occupational Therapy are not covered.

## Home Health Care

Following an inpatient admission or where medically feasible in place of hospitalization, the participant will be eligible for up to 100 Skilled Home Care visits in a period of 12 consecutive months following the date of the first visit.

Benefits will be available if the participant is essentially homebound and the attending physician has: (1) ordered Home Health Care, (2) received Pre-Certification approval from BCNEPA, and (3) furnished, in consultation with the Member Home Health Agency's professional personnel prior to the first visit, a

written plan of treatment stating that the services ordered are medically necessary. Continuing eligibility requires that the attending physician provide such a plan of treatment at intervals of no less than every 30 days.

Covered services include drugs that under Federal law may be dispensed only by written prescription and are approved for general use by the Food and Drug Administration.

BCNEPA will issue a Prescription Drug identification card for the participant to the Participating Home Health Agency. The Agency will distribute the card to the participant and obtain it at the time of a discharge, or when benefits are exhausted or terminated by Blue Cross. The Prescription Drug identification card is only eligible for the covered Benefit Period as determined by the Blue Cross Pre-Certification process. Each prescription is limited to a 15 day supply.

In addition, the following Home Health Care services are covered when provided by qualified health care professionals: Registered or Licensed Practical Nurse Services, but not including special duty nurses; home health aide services as assigned and supervised by a registered nurse; physical therapy treatments; speech pathology services; occupational Therapy treatments; a medial social service consultation; nutritional guidance counseling; diagnostic and therapeutic radiology services; laboratory services; machine diagnostic testing; oxygen and inhalation therapy; medical-surgical supplies, including bandages, dressings and casts; the rental of durable medical equipment on a short term basis only (if not Agency owned); and other services necessary for intermittent skilled services which are approved by the Plan.

Only benefits provided by a Participating Home Health Agency of a Blue Cross Plan will be eligible. Home care does not cover the following: meals; professional medical services of housekeepers; private duty nursing; ambulance service; drugs other than prescription drugs and such other non-legend drugs not specifically designated by Blue Cross; or

services of immediate relatives or members of the participant's household.

#### **Pre-Certification of Home Health Care:**

When any participant requires Home Health Care, benefits for covered services will be provided as follows:

1. The attending physician must provide evidence prior to ordering such treatment, in a form satisfactory to BCNEPA, that Home Health Care is medically necessary and appropriate;
2. For each admission the Participating Home Health Agency shall advise the Plan's Medical Review Department by telephone with necessary information. Also, the same process is required should the participant's condition require an extension of skilled home health care visits beyond the approved period.
3. Determination by BCNEPA as to eligibility for benefits under 1 and 2 above shall be conclusive.

#### Hospice Care

Hospice care benefits are available if the attending physician has certified that the patient is terminally ill with a prognosis of 6 months or less to live and has received approval by Blue Cross prior to referring the patient to a Blue Cross Participating Hospice Organization. In addition, the participant must reside within a reasonable distance of a Participating Hospice Organization.

Eligible Hospice Care Services include the following:

1. Professional nursing services;
2. Home health aid services;
3. Laboratory services;
4. Therapy services (except for dialysis treatments);

5. Medical-Surgical supplies and durable medical equipment;
6. Prescribed drugs;
7. Oxygen and its administration;
8. Medical social services;
9. Palliation for pain control and symptom management;
10. Respite care in a member Blue Cross Skilled Nursing Facility (limited to 5 days in a 3 month period);
11. Family counseling related to the patient's terminal condition;
12. Dietitian services;
13. Hospice inpatient room, board and general nursing services for acute pain management (payable under the basic hospital benefit); and
14. Bereavement counseling (limited to 2 visits).

The maximum hospice benefit payment by Blue Cross will be \$8,000. No benefits will be provided for services provided by a Non-Participating Hospice Organization.

#### Pre-Admission Testing (PAT)

Outpatient benefits will be provided for services ordinarily received on an inpatient basis for the participant who, when scheduled for admission to a Participating Hospital, receives, prior to actual admission as an inpatient, the usual and specific diagnostic services ordinarily associated with the condition requiring hospitalization.

If the condition to which PAT is related would not be covered under this program if the participant were admitted as an inpatient, PAT benefits will not be available.

#### Benefits In Non-Participating Hospitals

##### **1. Inside United States:**

- a. Outpatient treatment for accidental injury within 72 hours and for outpatient surgery, the program will pay up to \$50 or 70% of billed charges, whichever is greater. Payment to school infirmaries will be up to \$12 per day.
- b. For outpatient x-ray and laboratory tests, up to \$100 or 70% of billed charges, whichever is greater.
- c. For all other medically necessary eligible services as set forth herein, the program will pay 70% of billed charges.

##### **2. Outside United States:**

- a. Outpatient treatment for accidental injury within 72 hours and for outpatient surgery, the program will pay up to \$50 or 80% of billed charges, whichever is greater.
- b. For outpatient x-ray and laboratory tests, up to \$100 or 80% of billed charges, whichever is greater.
- c. For all other medically necessary eligible services as set forth herein, the program will pay 80% of billed charges.

##### **3. Admissions for Mental or Nervous Disorders:**

- a. Blue Cross will pay the billed amount for hospital services provided for mental and nervous disorders up to \$10 per day for a maximum period of 30 days in any consecutive 12 month period.

#### Benefits in Non-Participating Skilled Nursing Facilities

In a Non-Participating Skilled Nursing Facility, Blue Cross will pay to the participant 70% of billed charges made by the Skilled Nursing Facility for the services described in this section.

## Exclusions

Unnecessary inpatient admission for treatment, diagnosis, diagnostic study or medical observation when care could be provided on an outpatient basis and the condition of the participant or the nature of the procedure does not medically necessitate the participant's being hospitalized as an inpatient. However, benefits will be provided for diagnostic procedures which would have been eligible for coverage if received on an outpatient basis.

### **Inpatient or Outpatient Hospital Care for:**

1. Dental Care, even if medically necessary, except when provided under Oral Surgery in the Plan.
2. Custodial care; research studies; screening examinations; checkups; rest cures; convalescent care; weight reduction; routine physical or pre-marital examinations; hearing test; and eye refraction examinations.
3. Cosmetic surgery or treatment, unless required for correction of damage caused by accidental injury sustained while the participant is covered under the Plan.

### **Services, Facilities and Supplies when:**

1. The expenses are paid or which the participant is entitled to have paid or obtain without cost in accordance with law or the regulations of Medicare, CHAMPUS-CHAMPVA, the Department of Defense for Active Personnel, the Veterans' Administration, the National Health Service of the Bureau of Vocational Rehabilitation;
2. Furnished in federal Institution;
3. Furnished in connection with a disease contracted or injury sustained during military service or war;
4. Furnished for an occupational condition, ailment or injury arising out of and in the course of employment, for which

hospitalization coverage is or was available in full or in part under Worker's Compensation laws or similar state or federal legislation, even though the participant's rights have been waived or expired;

5. Charges for them 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 subscriber;
6. Furnished without charge to the participant;
7. Treatment for alcohol or drug abuse is rendered in a facility located within the Plan's Service Area which does not have a contract with Blue Cross of Northeastern Pennsylvania.

Services covered under the other subscriber Agreements issued by any Blue Cross Plan, provided, however, that this provision will not operate to deny such coverage by both/all Plans.

Charges for blood donor; cost of blood, blood plasma or derivative.

Services of attending or emergency room doctors, surgeons, other specialists; charges for services or board of private duty nurses.

Home Care Services for: meals; professional medical services billed for by a doctor; custodial care; services of housekeepers; prescription and non-prescription drugs and biologicals; Occupational Therapy; services of immediate relatives or members of the participant's household.

Services, supplies, or charges which are Experimental/Investigative in nature.

Inpatient admissions not certified as eligible under the Pre-Admission Certification provision.

Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a Plan or

policy of motor vehicle insurance, including a certified self-insured Plan, or payable under the Catastrophic Loss Trust Fund established under the Pennsylvania Motor Vehicle Financial Responsibility law.

Sexual dysfunction not related to organic disease.

Treatment in connection with transsexual surgery, artificial insemination, in-vitro fertilization.

For elective abortions, 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.

Services other than described herein.

## Member Hospitals in Northeastern Pennsylvania

### LOCATION

### HOSPITAL

Berwick	Berwick Hospital
Carbondale	Marian Community Hospital
Coaldale	Miners Memorial Medical Center
East Stroudsburg	Pocono Medical Center
Hazleton	Hazleton St. Joseph Medical Center
Hazleton	Hazleton General Hospital
Honesdale	Wayne Memorial Hospital
Jersey Shore	Jersey Shore Hospital
Kingston	Wyoming Valley Health Care System, Inc. – Nesbitt Memorial Hospital Campus
Lehighton	Gnaden Huetten Memorial Hospital
Lock Haven	Lock Haven Hospital
Montrose	Montrose General Hospital
Muncy	Muncy Valley Hospital
Nanticoke	Mercy Hospital
Palmerton	The Palmerton Hospital
Peckville	Mid-Valley Hospital
Renovo	Bucktail Medical Center
Sayre	Robert Packer Hospital
Scranton	Allied Services for the Handicapped, Inc.
Scranton	Community Medical Center
Scranton	Moses Taylor Hospital
Scranton	Mercy Hospital
Susquehanna	Barnes-Kasson Hospital
Towanda	Troy Community Hospital, Inc.
Tunkhannock	Tyler Memorial Hospital
Waverly, NY	Tioga General Hospital
Wellsboro	Soldiers & Sailors Memorial Hospital
Wilkes-Barre	Wyoming Valley Health Care System, Inc. – Wilkes-Barre General Hospital Campus
Wilkes-Barre	Geisinger-Wyoming Valley Medical Center
Wilkes-Barre	Mercy Hospital
Williamsport	The Williamsport Hospital
Williamsport	Divine Providence Hospital

## Section III

### Medical-Surgical Benefits

## Basic Benefits For Your Medical-Surgical Care

When you are ill or injured, your coverage helps pay for covered services by a Professional Provider. These Professional Providers are:

Clinical Laboratory	Optometrist
Dentist	Osteopath
Doctor of Medicine	Podiatrist
Nurse Midwife	Psychologist
Chiropractor	Physical Therapist

- Certified Clinical Nurse Specialist
- Certified Community Health Nurse
- Certified Enterostomal Therapy Nurse
- Certified Psychiatric Mental Health Nurse
- Certified Registered Nurse Anesthetist
- Certified Registered Nurse Practitioner
  - Excluded from eligibility are registered professional nurses employed by a health care facility or by an anesthesiology group.

### Payment of Benefits

Usual, Customary and Reasonable (UCR) Method

The **usual** fee is that which an individual Professional Provider most frequently charges the majority of patients for the procedure performed. The **customary** fee is the fee determined by Blue Shield based on charges made by most Professional Providers of the same specialty in comparable geographic/economic areas for the procedure performed. The **reasonable** fee (which may differ from the **usual** or **customary** fee) is the fee determined by Pennsylvania Blue Shield by considering usual clinical circumstances; the degree of Professional involvement; or the actual cost of equipment and facilities involved in providing the service.

Payment for covered services performed by Pennsylvania Blue Shield Participating

Professional Providers (those Professional Providers with whom Pennsylvania Blue Shield has a contract with respect to payment for services) will be made to the Professional Provider on the basis of 100% of the UCR allowance or the amount charged, whichever is less.

A Participating Professional Provider must accept Blue Shield's allowance as payment in full for covered services. You are responsible for any deductibles and amounts exceeding the maximum (if applicable under your program) or any service not covered by Blue Shield.

Payment for covered services performed by Non-Participating Professional Providers will be made to you on the basis of 100% of the UCR 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 allowance as payment-in-full. You shall be responsible for payment of the remaining charges.

### Service Benefits

If you had services performed by a Pennsylvania Blue Shield Participating Professional Provider and the Provider should bill you for other than the deductible, co-insurance, amounts exceeding the maximum or ineligible services, do the following:

Discuss the situation with the Provider.

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

1. Contact Pennsylvania Blue Shield at:

**Medical-Surgical: 1-800-345-3806**

Blue Shield will review the situation to resolve the disagreement. The decision by Blue Shield shall be final.

## How Benefits are Obtained

### **Participating Professional Provider**

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

### **Non Participating Professional Provider**

A Non-Participating Professional Provider in most cases will also submit a claim to Blue Shield on your behalf. If you would like to submit a claim yourself, you must do so within 1 year from the date of service. Request an itemized bill which shows:

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

Then add the employee/subscriber's name, group and agreement numbers (as shown on your identification card) and the patient's birthdate. If you need assistance, either contact your nearest Blue Cross and Blue Shield office or call Pennsylvania Blue Shield. If you do not need assistance, please send your receipt to:

**Medical-Surgical:** Pennsylvania Blue Shield  
P.O. Box 890062  
Camp Hill, PA 17089-0062  
**Telephone #:** 1-800-345-3806

**Dental:** Pennsylvania Blue Shield  
P.O. Box 890400  
Camp Hill, PA 17089-0400  
**Telephone #:** 1-800-332-0366

When services are performed by non-participating Professional Providers, the payment is made directly to you.

### Covered Services

You are entitled to payment for the following covered services provided that Blue Shield deems them medically necessary. This professional care can be performed anywhere unless otherwise stated.

### Surgery

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

If more than one surgical procedure is performed by the same Professional Provider during the same operative session, Blue Shield shall pay 100% of the UCR allowance for the highest paying procedure and no allowance for additional procedures except where Blue Shield deems that an additional allowance is warranted.

### Oral Surgery

Oral Surgery for surgical removal of partial and full bony impactions.

Oral Surgical services not covered are described in the section "EXCLUSIONS".

### Assistant Surgery

Services of an assistant surgeon who actively assists the operating surgeon when the condition of the patient or the type of surgery performed requires assistance. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

## Maternity Services

Maternity services including pre-and post-natal care, performed by a Professional Provider for all females.

## Routine Newborn Care

Professional visits to examine the newborn while the mother is an inpatient in a hospital or Birthing Center. Routine neonatal circumcision is covered.

## Anesthesia

Administration of anesthesia in connection with covered services when rendered by or under the direct supervision of a Professional Provider other than the surgeon or assistant surgeon. Anesthesia services administered by a nurse anesthetist not employed by a Professional Provider will be paid at 50% of the UCR allowance.

## Therapy Services

**Radiation Therapy:** The cost of the radioactive material is covered.

**Chemotherapy:** Including the cost of the drugs approved by the Food and Drug Administration (FDA) as antineoplastic agents.

### **Dialysis Treatment**

**Physical Therapy:** To a participant who is an inpatient.

## Diagnostic Services

Diagnostic services required to determine a definite condition or disease.

1. Diagnostic radiology, consisting of x-ray, Ultrasound and nuclear medicine. One screening mammography per calendar year is covered for females 40 years of age and older. For females under 40 all physician recommended mammograms are covered. Benefits for mammography screening are payable only if performed by a mammography service provider who is properly certified by the Department of Health in accordance with

the Mammography Quality Assurance Act of 1992.

2. Diagnostic medical, consisting of ECG, EEG and other diagnostic medical procedures approved by Blue Shield.
3. Diagnostic laboratory consisting of pathology tests performed, billed for, or ordered by a Professional Provider.
4. Allergy testing.
5. Benefits are provided for one (1) routine gynecological examination, including a pelvic examination and clinical breast examination and one (1) routine Papanicolaou smear per calendar year for all female Subscribers. Benefits are exempt from all deductibles and maximums.

## Convulsive Therapy

Convulsive therapy including anesthesia for electroshock therapy.

## Emergency Care

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

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

1. Permanently placing the patient's health in jeopardy,
2. Causing other serious medical consequences,
3. Causing serious impairment to bodily functions.
4. Causing serious and permanent dysfunction of any body part.

These benefits will not be provided if any other benefit of this program is payable. For example: If the accident services are classified as surgery

(suturing, burn care, fracture care, etc.), payment will be made as a surgical benefit.

nursing facility within 14 days following discharge from an accredited hospital.

### Transplant Services

Benefits are provided for eligible human organ transplant services, including the covered services for the removal of an organ from a donor when the donor is not a participant and not covered under another health care Plan.

These services in a skilled nursing facility are limited to two visits during the first week of confinement and one visit a week for each consecutive week of confinement thereafter. Each day of confinement in a skilled nursing facility counts as one-half day against the total 365 days available for inpatient medical services.

### Medical Care

Medical care by the Professional Provider in charge of the case to a participant who is an inpatient in a hospital or a skilled nursing facility for a condition not related to surgery, maternity services, radiation therapy or psychiatric care. These covered services are available for a total of 365 days for each period of hospitalization. At least 90 consecutive days must elapse between discharge from a subsequent admission to a hospital or a skilled nursing facility before inpatient stays will be considered a new period of hospitalization.

### Concurrent Care

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

### Psychiatric Care

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

### Consultation

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

### Second Surgical Opinion

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

### Skilled Nursing Care

Medical Care in a Skilled Nursing Facility. The participant shall be eligible if:

1. The subscriber's illness or injury requires at least 3 days of hospitalization;
2. The participant's condition requires skilled nursing care for continued treatment and;
3. The participant is admitted to the skilled

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

## Pediatric Immunizations

Benefits are provided for those pediatric immunizations, including the immunizing agents, which as determined by the Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control of the U.S. Department of Health and Human Services. Benefits are limited to dependent children and are exempt from deductibles or maximums.

## Exclusions

Except as specifically provided in this booklet, you are not covered for the following:

- Services which are not prescribed by or performed by or billed by a Professional Provider.
- Services which are not medically necessary as determined by Blue Shield.
- Services, supplies or charges that are experimental or investigational in nature.
- Services performed in a facility by a Professional Provider who in any case is compensated by the facility for similar services performed for patients.
- Services performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program.
- Services which are paid, or payable, in whole or in part, by a Blue Cross Plan.
- Services which are incurred prior to your effective date or during an inpatient admission that commenced prior to your effective date.
- Services which are incurred after the date of termination of your coverage unless otherwise indicated.
- Services for any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in

whole or in part, under the provisions of any legislation of any governmental unit. This exclusion applies whether or not you claim the benefits or compensation.

- Services for any illness or injury 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.
- Services for any illness or injury suffered after your effective date as a result of an act of war.
- Service which you have no legal obligation to pay in the absence of this or similar coverage.
- Services provided by any governmental unit.
- Services which are provided by the Veteran's Administration or by the Department of Defense for active military personnel for which you are eligible even if you have not taken the necessary action to obtain such benefits.
- 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 Imaging (MRI) and extracorporeal shock wave lithotriptors unless the acquisition of such equipment by a Professional Provider was approved through a Certificate of Need (CON) process and/or Blue Shield.
- Payment made under Medicare when Medicare is primary, or would have been made if you had enrolled for Medicare and claimed Medicare benefits. However, this exclusion shall not apply when the group is obligated by law to offer the subscriber all the benefits of this contract and the subscriber so elects this coverage as primary.

- Services 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 (surgical removal of the end of a root), root canal treatment, soft tissue impaction, alveolectomy and treatment of periodontal disease.
- Treatment of temporomandibular joint syndrome with intraoral devices, or any other method to alter vertical dimension.
- For the correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia and radial keratotomy and all related services.
- Treatment of obesity, except for surgical treatment of morbid obesity when weight is at least twice the ideal weight specified for frame, age, height and sex.
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance Plan, or payable under the Catastrophic Loss Trust Fund established under the Pennsylvania Motor Vehicle Financial Responsibility Law.
- Personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, whether or not recommended by a Professional Provider.
- Telephone consultations, charges for failure to keep a scheduled appointment, or charges for completion of a claim form.
- Custodial care, domiciliary care or rest cures.
- Palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions, (except by capsular or bone surgery), calluses, toenails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet.
- Routine or periodical physical examinations.
- Screening examinations.
- The detection and correction by manual or mechanical means of structural imbalance or subluxation for the purpose of removing nerve interference resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.
- Well-baby care and adult immunizations.
- For operations for cosmetic purposes except for those performed to correct a condition resulting from an accident which occurs while the participant is covered by Blue Shield. 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.
- Hearing aids or examinations for the prescription of fitting of hearing aids.
- For treatment in connection with sexual dysfunction not related to organic disease, transsexual surgery, artificial insemination and for assisted fertilization techniques such as, but not limited to, In-Vitro Fertilization (IVF), Gamete Intra-Fallopian Transfer (GIFT), and Zygote Intra-Fallopian Transfer (ZIFT).
- Local infiltration anesthetic.
- Clinical pathology services for which a hospital or other facility bills for the technical component of the service and the Professional Provider bills for the professional component of the service.
- Charges for services 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.

- Routine neonatal circumcision.
- For elective abortions, 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.
- Any other medical or dental service or treatment except as provided in this booklet.

## Section IV

### Major Medical Benefits

## Major Medical Benefits

During each calendar year, you are required to pay the first \$100 of Covered Medical Expenses in excess of hospital and medical-surgical benefits. This amount is called the deductible.

Since you and each of your enrolled dependents are entitled to full and separate Major Medical benefits, a separate \$100 deductible is applicable to you and to each of your enrolled dependents with these exceptions:

1. When family members are injured in the same accident, only one deductible is applied toward the Covered Medical Expenses arising out of that accident.
2. Your family will not be required to pay more than 3 deductibles in any calendar year.

A separate deductible is payable during each calendar year in which Covered Medical Expenses are incurred. However, if you or an enrolled dependent incur Covered Medical Expenses during the last 3 months of a year, the amount required to satisfy the deductible may be credited toward the deductible payable by you (or one of your dependents) in the following calendar year Benefit Period.

## Co-Insurance

After the calendar year deductible has been met, Major Medical pays 80% of Covered Medical Expenses and you (or your enrolled dependent) pay 20% of these expenses until you incur Covered Medical Expenses during a calendar year in the amount of \$2,000. Once these incurred expenses have reached this amount during a calendar year, the Major Medical program will pay 100% up to the \$2,000,000 lifetime maximum. Each year the co-insurance reverts to 80% until \$2,000 in Covered Medical Expenses has been incurred.

However, in the case of mental care, Major Medical pays 50% of the Covered Medical Expenses and you (or your enrolled dependent) pay 50% of these expenses.

The remaining expenses are paid by you.

## General Information

If any eligible person is not enrolled in the group's **designated** hospital and medical-surgical program, coverage available thereunder will be used in determining benefits payable under this Major Medical Expense Program. For subscribers enrolled in Medicare, when Medicare is primary, the **designated coverage** will be Part "A" and Part "B" of Medicare together with 65-Special Blue Cross and 65-Special Blue Shield.

## Major Medical Benefits

Major Medical benefits supplement, but do not replace, hospital and medical-surgical coverage. Major Medical is **designated** to cover the extraordinary expenses that occur during very serious, prolonged or unusual illness or injury. The program covers the reasonable and necessary charges for hospital and medical services (Covered Medical Expense) subject to the provisions relating to the Benefit Period, the deductible, co-insurance, maximum amounts and exclusions.

You need not be hospitalized to qualify for Major Medical benefits, nor do you have to receive care under the hospital and medical-surgical programs before the Major Medical program takes effect. Major Medical benefits may be used without the use of, along with the use of, or before or after the use of hospital and medical-surgical benefits. However, payment will not be made for claims submitted later than 24 months after the incurred date.

## How Major Medical Works

### Benefit Period

Your Major Medical Benefit Period is a calendar year. You and each of your enrolled dependents are entitled to separate Major Medical benefits. Family expenses will not be combined.

## Maximum Amount

Major Medical pays up to lifetime maximum of \$1,000,000 for you and for each of your enrolled dependents. The maximum limits may be reinstated, by request, by submission of evidence of insurability satisfactory to Blue Cross and Blue Shield. For the employee, return to active full-time employment for 13 consecutive weeks will be accepted as evidence of good health.

## Covered Medical Expense

When you or an enrolled dependent require hospital or medical services of the type set forth herein and the services are performed or prescribed by a provider, the following services will be covered when they are medically necessary and appropriate for the proper treatment.

1. Hospital charges for room and board accommodations not covered by hospital benefits, up to an average semi-private room charge plus \$10.
2. Hospital services required for medical-surgical care or treatment, such as operating room drugs, dressings, medicines, blood transfusions (including blood or blood plasma to the extent it is not donated or otherwise replaced), oxygen and administration thereof, anesthesia and administration thereof and diagnostic X-ray and laboratory examinations.

**Note:** Eligible charges for the services listed in 1. and 2. above, when rendered in a nonmember hospital located within the Plan's service area, will be determined by the level of basic benefits in effect at the time of the service.

3. Services of a State approved Birthing Center.
4. Services of a licensed Professional Provider.

5. Expenses in or outside the hospital for the services of a Registered graduate Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.). Nursing services must be provided by a nurse who does not ordinarily reside in the subscriber's home or who is not a member of the subscriber's immediate family and such services must be deemed as medically necessary by Blue Cross of Northeastern Pennsylvania.

All private duty nursing services in excess of 240 hours per Benefit Period will require pre-certification prior to the services being rendered. The participant will be responsible for all charges incurred if pre-certification is not obtained.

### Pre-Certification

When any participant requires private duty nursing services in excess of 240 hours in a Benefit Period, benefits for covered services as described in this Section IV will be provided as follows:

1. Private duty nursing services are provided only if the provider in charge of the case provides evidence, in a form satisfactory to Blue Cross, that private duty nursing is medically necessary and appropriate.
2. Determination by Blue Cross as to eligibility for benefits under 1. Above shall be conclusive.
3. When proposed private duty nursing services are determined not to be eligible for benefits under this provision, if otherwise medically necessary and appropriate, benefits will be provided for alternative care as set forth in this booklet.

**Appeal Procedure:** In the event Blue Cross has determined that the participant is not eligible for private duty nursing services benefits, the participant may submit an appeal in writing to Blue Cross. Such an appeal must be submitted not later than 60 days from the date Blue Cross notified the participant of its determination and should include specific information in support of the participant's claim for private duty nursing

services benefits. Blue Cross will review this information and make a final decision concerning the participant's eligibility for private duty nursing services benefits. Blue Cross will then notify the participant of its final decision in writing, not later than 60 days following receipt of the participant's appeal.

6. The following services and supplies when not furnished by the hospital:

- a. Drugs and medicines requiring a provider's prescription and dispensed by a licensed pharmacist, including eligible surgical supplies;
- b. Diagnostic X-ray and laboratory examinations;
- c. X-ray Therapy;
- d. Anesthesia, oxygen and administration thereof;
- e. Blood and blood plasma to the extent it is not donated or otherwise replaced;
- f. Rental or purchase of durable medical equipment: the decision whether to pay the rental or purchase price of an item resides with Blue Cross and Blue Shield (durable medical equipment is equipment that (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) generally is not useful to a person in the absence of an illness or injury and (4) is appropriate for use in the home).

Claims for equipment containing features of an aesthetic nature or features of a medical nature which are not required by the patient's condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished,

Will be based on the reasonable charge for the equipment which meets the patient's medical needs;

- g. Prosthetic Devices (braces, artificial limbs and eyes, etc.), but not replacements except when certified as medically necessary for children;
  - h. Physical Therapy prescribed by a provider as to type and duration when performed by a licensed physical therapist.
7. Professional ambulance service to transport a participant from a place where injured or stricken to the first hospital where treatment might be given. If the first hospital to which the participant is transported is not equipped to care for such patient, then transportation of such patient to another hospital will be eligible.

Local professional ambulance services to or from a hospital for needed medical care.

Air ambulance services are eligible for benefits only if the patient's condition and the distance to the nearest facility equipped to treat the patient's condition justify the use of air transportation.

It is not the intent of the Plan to cover ambulance transportation when it is used primarily for the convenience of the patient. Medical necessity will be determined by Blue Cross of Northeastern Pennsylvania.

### Exclusions

The following are not Covered Medical Expenses:

- Services provided to you or a dependent before coverage under this program becomes effective for you or the dependent.
- Care required as a result of war, declared or undeclared.

- Charges for appliances such as air conditioners and humidifiers, whether or not prescribed by a Provider.
- 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 Worker's Compensation, occupational disease or similar type legislation. This exclusion applies whether or not the subscriber claims the benefits or compensation.
- Vitamins, except those which by law require a prescription order and are prescribed for a specific illness or injury.
- Services furnished by or at the expense of any government or its agencies.
- Eyeglasses, contact lenses and hearing aids or examinations for their prescription or fitting. However, following operations for cataracts, charges for initial replacement of eye lens either by contact lenses or by lenses in frames will be considered a Covered Medical Expense, but not charges for cataract sunglasses.
- Dental treatment or cosmetic surgery for purposes other than correction of damage caused by accidental injury sustained while this coverage is in effect.
- Personal convenience items.
- Expenses for travel, convalescent, custodial or sanitarium care or rest cures.
- Charges for music therapy, counseling with members of the family other than the patient.
- Outpatient Speech and Occupational Therapy, except when performed in the outpatient department of a hospital and billed for by the hospital.
- Treatment of bunions (except by capsular or bone surgery), toe nails (except surgery for ingrown nails), corns, calluses, fallen arches, flat feet, weak feet, chronic foot strain or symptomatic conditions of the feet (except when surgery is performed).
- Medical observation or diagnostic study for hospital inpatients when no disease or injury is revealed; charges in excess of the regular and customary charge for any services or supplies not certified by a provider as required; or services customarily furnished by a person or institution without payment by the patient.
- Donations to organizations providing ambulance service.
- Treatment of temporomandibular joint syndrome with intraoral prosthetic devices, or any other method to alter vertical dimension.
- Routine examinations and procedures, or any service which is not medically necessary for diagnosis or treatment of a sickness or injury.
- Charges for completion of any insurance forms.
- Services performed for a participant by a spouse, parent, or child of that participant.
- Procedures, facilities, treatments, drugs, equipment, devices and supplies that are experimental or investigational in nature (not recognized as accepted medical practice by the general medical community, or by Blue Cross and Blue Shield).
- Charges for inpatient admissions which have been disallowed by Blue Cross under the Pre-Admission Certification provision of the Basic Hospital Program.
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a Plan or policy of motor vehicle insurance, including a certified self-insurance Plan, or payable under the Catastrophic Loss Trust Fund Established

under the Pennsylvania Motor Vehicle Financial Responsibility Law.

pregnancies caused by rape or incest will be covered.

- For the correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia and radial keratotomy and all related services.
- For Home Health Care services except when Home Health Care benefits have been exhausted under the basic Plan and such services are provided by a Member Home Health Agency of any Blue Cross Plan.
- Assisted fertilization techniques, such as, but not limited to, Artificial Insemination, invitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), and zygote intra-fallopian transfer (ZIFT).
- Routine neonatal circumcision.
- The participant's Non-Member Hospital co-insurance liability under the hospitalization program.
- Services or treatment for alcohol and/or drug abuse or rehabilitation.
- Any medical or dental service of treatment except as provided herein.
- Benefits payable under any other group Plan will not be duplicated.
- Charges in excess of the reasonable charge for a covered service, as determined by the Corporations (Blue Cross of Northeastern Pennsylvania or Pennsylvania Blue Shield).
- Cooperative payments under the basic plans are the responsibility of the eligible employee and his dependents and will not be considered Covered Medical Expenses under the Major Medical Program.
- 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

## Definitions

For the purpose 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 purpose 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 Subscriber.
5. **Birth 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. **Blue Cross or BCNEPA** – Blue Cross of Northeastern Pennsylvania, unless the context clearly indicates otherwise.
7. **Blue Shield** - Pennsylvania Blue Shield, unless the context clearly indicates otherwise.
8. **Calendar Year** – A one-year period which begins on January 1 and ends on December 31.
9. **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 employed by a health care facility, as defined in the Health Care Facilities Act, or by an anesthesiology group.
10. **Coinsurance** – A specific percentage amount of the Provider’s Reasonable Charge for Covered Services for which the Participant is responsible.
11. **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.
12. **Contract Date** – The date, specified on the Acceptance page of the Contract, on which coverage under the Contract commences for the Group.

- 13. Covered Service** – A service or supply specified in this Contract for which benefits will be provided pursuant to the terms of the Contract.
- 14. Custodial Care** – Care provided primarily for maintenance of the Subscriber or which is designed essentially to assist the Participant in meeting the activities of daily living in 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 of medications, and other services that can be provided by non-medical personnel.
- 15. Deductible** – A specified amount of Covered Services, expressed in dollars, that must be incurred by a Subscriber before the Plan will assume any liability for all or part of the remaining Covered Services.
- 16. Dependent** – A Participant other than the Applicant-Participant as specified in the Schedule of Eligibility.
- 17. 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 drugs, 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.
- 18. 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.
- 19. 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.
- 20. Effective Date** – According to the Schedule of Eligibility, the date on which coverage for a Participant begins under the Contract.
- 21. Eligible Person** – A person entitled to be a Participant.
- 22. Emergency Care** – The initial treatment of a sudden, unexpected onset of a medical condition or traumatic injury. This shall not include treatment for an occupational injury for which benefits are provided under any Worker's Compensation Law or any similar Occupational Disease Law. The symptoms or injury must be of sufficient severity to warrant immediate attention.
- a. Emergency Accident Services – the initial treatment of traumatic bodily injuries resulting from an accident.
  - b. Emergency Medical Services – the initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:

1. permanently placing the 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 Provision section.

23. **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.
24. **Family Coverage** – Coverage for the Applicant-Participant and one or more of the Applicant-Participant's Dependents.
25. **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.
26. **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.
27. **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.

28. **Home Infusion Therapy** – The administration of intravenous solutions which are provided in the home setting.
29. **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 the attending Physician.
30. **Hospice** – A Facility Provider, approved by the Plan, which is primarily engaged in providing palliative care to terminally ill individuals.
31. **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.
32. **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.
  33. **Incurred** – A charge shall be considered incurred on the date a Participant receives the service or supply for which the charge is made.
  34. **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.
  35. **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.
  36. **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.
  37. **Licensed Practical Nurse (LPN)** – A nurse who has graduated from a formal practical nursing education program and is licensed by appropriate state authority.
  38. **Long-Term Residential Care** – The Provision of long-term diagnostic or therapeutic services (i.e.: 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.
  39. **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.
  40. **Medical Care** – Services rendered by a Professional Provider for the diagnosis and treatment of an illness or injury.
  41. **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 Subscriber’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.

42. **Medicare** – The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.
43. **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.
44. **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.
45. **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.
46. **Out-of-pocket Maximum** – A specified dollar amount of Coinsurance incurred by a Participant as set forth in the Schedule of Benefits, for a 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.
47. **Outpatient** – A Participant who receives services or supplies while not an Inpatient.
48. **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.

49. **Partial Hospitalization Substance Abuse Services** -The provision or 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.
50. **Participant** – An Eligible Person who has satisfied the specifications of the Schedule of Eligibility and is enrolled for coverage.
51. **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.
52. **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.
53. **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.
54. **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.
55. **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:**

- Ambulatory Surgical Facility
- Birthing Facility
- Freestanding Dialysis Facility
- Freestanding Outpatient 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
- Doctor of Osteopathy
- 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. Blue Cross Plan.

56. **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.

57. **Psychologist** – A licensed clinical Psychologist. When there is no licensure law, the psychologist must be certified by the appropriate professional body.
58. **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.
59. **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.
60. **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.
61. **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:
- a. minimal care, Custodial Care, ambulatory care, or part-time care services;
  - b. care or treatment of Mental Illness, alcoholism, drug abuse or pulmonary tuberculosis; or
  - c. care or treatment for the blind, the deaf or the mentally deficient or retarded.
62. **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.
63. **Supplier** – An individual or entity that is in the business of leasing and selling Durable Medical Equipment and supplies.
64. **Surgery**
- a. The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures;
  - b. the correction of fractures and dislocations; and
  - c. usual and related pre-operative and post-operative care.
65. **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.
- a. **Radiation Therapy** – The treatment of disease by x-ray, radium, or radioactive isotopes.
  - b. **Chemotherapy** – The treatment of malignant disease by chemical or biological antineoplastic agents.
  - c. **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.
  - d. **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 processes.
  - i. **Pulmonary Rehabilitation Therapy** – Multidisciplinary treatment which combines Physical Therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.

- j. **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.