Benefits Book

How your vision plan works

Independence

Master Table of Contents

Use your vision benefits

Vision problems are among the most prevalent health issues in the United States. Three out of four adults use some form of vision correction. An eye exam can help detect vision problems, and can also help detect more serious chronic health conditions, such as diabetes, hypertension, and heart disease.

Administered by Davis Vision, your vision plan features a robust network, low out-of-pocket costs, and a variety of value-added services.

Freedom of provider choice

You have access to the national Davis Vision network, which includes more than 160,000 access points for independent eye care professionals and large retail and online providers like Visionworks, Befitting.com, Glasses.com, and 1800Contacts.com.

Low-cost frames and lens options

You have several options to choose from for your eyewear needs:

- Select frames from the Davis Vision Exclusive Collection, which are covered in full or with a minimal copay. An interactive frame try-on tool will allow you to see what the frames look like on before purchasing them.
- Choose from any in-network independent or retail provider's own frame collection and receive an allowance. This includes the following online providers: 1800Contacts.com, Befitting.com, and Glasses.com. You may have an enhanced frame allowance towards the purchase of frames at Visionworks stores. Please refer to your benefits for more information.

With fixed pricing on all lens styles and coatings, including blue light coatings, it's easy to predict your out-of-pocket costs. All frames and lenses provided by Davis Vision providers are warranted against breakage for one year from the original date of dispensing.

View your benefits online

Log in at ibx.com to:

- Check eligibility and plan allowances
- Locate an in-network provider

Coverage for contacts and laser vision correction

You have the option to choose contact lenses instead of eyeglasses using your allowance. You can also use your contact lens benefit allowance at 1800Contacts.com, which features an extensive collection, mail order, and discounted pricing.

If you're eligible and interested in LASIK laser vision correction services, you can receive exclusive discounted pricing and financing options from a national network of credentialed physicians.

Additional value-added services

Through your Davis Vision benefits, you have access to a free hearing exam and exclusive discounts on hearing aids, supplies, and more from Your Hearing Network.

Vision plan administered by DavisVision™

Independence

IBX

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Vision Benefits Program

Benefits underwritten or administered by QCC Ins. Co., a subsidiary of Independence Blue Cross®
Independent Licensees of the Blue Cross and Blue Shield Association.

QCC INSURANCE COMPANY
(Hereafter called "The Health Benefit Plan")

Group (Contractholder)
(Hereafter called "The Contractholder")

VISION CARE PROGRAM

QCC Insurance Company
(Hereafter called "the Health Benefit Plan")

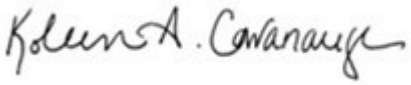
Group Health Benefits
Benefit Booklet

The Health Benefit Plan certifies that Employees/Members in an eligible class of the Contractholder are entitled to the benefits described in this Benefit Booklet, subject to the eligibility and effective date requirements of the Group Contract.

This Benefit Booklet replaces any and all Benefit Booklets previously issued by the Health Benefit Plan providing the types of benefits described in this Benefit Booklet.

The Contract is between the Health Benefit Plan and the Contractholder. This Benefit Booklet is a summary of the Contract provisions that affect your insurance. All benefits and exclusions are subject to the terms of the Group Contract.

QCC INSURANCE COMPANY



Koleen Cavanaugh
SVP and Chief Marketing Officer

ATTEST:

Jonathan Stump
VP Product Services

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Telugu: శ్ర్ద పెట్టం డి: ఒకవేళ మీరు తెలుగు భాష మాట్లా డుతున్న ట్యితే, మీ కొరకు తెలుగు భాషాసహాయక సేవలు ఉచితంగాలభిన్ యి. 1-800-275-2583 (TTY: 711) కు కాల చేయండి.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih koji' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں. کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Taglines as of 11/4/2024

Discrimination is Against the Law

This plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This plan does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

This plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator.

If you believe that this Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: our Civil Rights Coordinator, in person or by mail: 1901 Market Street, Philadelphia, PA 19103, by phone: 1-888-377-3933 (TTY: 711), by fax: 215-761-0245, or by email: civilrightscoordinator@1901market.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

This notice is available at the following website: **https://www.healthinsurancehosting.com/notices**.

VISION CARE COVERAGE

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SECTION 1 - SCHEDULE OF BENEFITS

VISION CARE BENEFITS

Subject to the Exclusions, conditions and Limitations of this Benefit Booklet, a Member is entitled to benefits for Covered Services described in this section during a Benefit Period, and in the amounts as specified in this ***Schedule of Benefits*** section.

Benefit Period	Once per calendar year.
Coinsurance	None

SCHEDULE OF COVERED SERVICES

COVERED SERVICES	AMOUNTS PAYABLE AND LIMITATIONS ON COVERED SERVICES	
	Participating*	**Non-Participating**
Eye examination, including refraction and glaucoma screening and dilation, as professionally indicated.	100% of the Provider's Reasonable Charge, up to a Maximum of $10.	100% of the Provider's Reasonable Charge, up to a Maximum of $45.
Eyeglasses, including Spectacle Lenses and Frames (one pair).		100%, up to a Maximum of $100
Frames - Plan supplied: • Fashion selection • Designer selection • Premier selection OR	100%, with a Copayment of: $0 $0 $0	 Not Covered Not Covered Not Covered
- Doctor supplied:	100%, up to a Maximum of Up to $270 Allowance (plus a 20% discount on overage)	100%, up to a Maximum of $70
OR - Visionworks supplied:	$0	Not Covered
Contact Lenses (in lieu of eyeglasses) including Standard, Specialty and Disposable Lenses and Evaluation and Fitting	100%, up to a Maximum of Up to $250 Allowance; Evaluation: Up to $60 Allowance; (plus a 15% discount on overage)	100%, up to a Maximum of $105
Medically Necessary Elective Contact Lenses (in lieu of eyeglasses or elective contact lenses) including Standard, Specialty and Disposable Lenses (with prior approval)	100%	100%, up to a Maximum of $225

Out-of-pocket expenses incurred by a Member for pediatric Vision Care benefits will be included in the calculation of the Member's overall medical plan out-of-pocket limit.

* The Health Benefit Plan reserves the right to modify the ***Schedule of Covered Services*** from time to time, subject to prior notice to the Group.

SECTION 2 - VISION CARE BENEFITS

COVERED SERVICES

Subject to the Exclusions, conditions, and Limitations set forth in this Benefit Booklet, a Member is entitled to benefits of this benefit section for Covered Services rendered by a Professional Provider or Supplier, unless otherwise indicated, in the amounts specified in the section entitled ***Schedule of Benefits***.

This program allows the Member to maximize the Member's Vision Care benefits by utilizing Participating Providers. When the Member goes to a Participating Provider for an eye examination, the Member is assured of little or no out-of-pocket cost. When the Member purchases vision care hardware, such as frames and spectacle lenses or contact lenses, from a Participating Provider/Supplier, the Member may have no out-of-pocket costs, depending on the Member's choice of hardware. The program requires a Copayment amount for the purchase of some specialty hardware supplies, as shown in the ***Schedule of Benefits***. However, using Participating Providers will lower the Member's out-of-pocket costs and allow the Member to purchase most vision care hardware at fixed, reduced prices. The Member will receive a listing of the Professional Providers that participate in the QCC Insurance Company's Vision Care Program.

A Member who receives Vision Care services from a Participating Provider can elect to utilize a Non-Participating Provider for related Vision Care services on the recommendation or referral of the Participating Provider, provided that the Participating Provider gives to the Member, prior to recommending, referring, prescribing or ordering any Vision Care services from the Non-Participating Provider, written notice that:

- The Non-Participating Provider is not a Participating Provider.
- The Member has the option of selecting a Participating Provider.
- The Member may have different financial obligations depending on whether the Vision Care Provider is Participating or Non-Participating.

Vision Care services received from a Non-Participating Provider are not covered under this Health Benefit Plan.

The Program also provides benefits if the Member chooses to use Non-Participating Providers and Suppliers. Benefits are payable up to the Benefit Period Maximum amounts shown in the ***Schedule of Benefits*** for eye examinations and vision care hardware provided by Non-Participating Providers.

The Benefit Period Maximum amount shown in the ***Schedule of Benefits*** is applicable to either all Participating Covered Services or all Non-Participating Covered Services per Benefit Period.

Professional Services

- Eye Examination Services
  Such services, performed by a Professional Provider, as defined in the section entitled ***Important Definitions*** shall include, but are not limited to:
  - Case history.
  - Visual acuity, near and far.
  - External examination, including biomicroscopy or other magnified evaluation of the anterior chamber.
  - Objective, subjective and ophthalmoscopic examinations.
  - Binocular measure.
  - Summary, findings, and recommendations.
- Hardware
  - Contact Lens Prescription and Fitting Services
    Such services, performed by a Professional Provider shall include, but are not necessarily limited to:
    - Keratometry, or "K" reading, through the use of a keratometer to determine measurements of the eyes, curvature and base curve.
    - Proper fitting of appropriate contact lenses, including the training of insertion and removal of trial contact lenses to the Member's corneas.
    - Post-dispensing contact lens follow-up care, including correction of any ill-fitting or unsuitable lenses.

    Contact Lens Prescription and Fitting Services must be preceded by Eye Examination Services as described in the "Eye Examination Services" subsection shown above.
  - Post-Refractive Services
    Post-refractive Services consist of the ordering of lenses and frames (facial measurements, lenticular formula and other specifications), cost of the materials, verification of the completed prescription upon return from the laboratory, adjustment of the completed eyeglasses to the Member's face and the subsequent servicing (For Example, refitting, realigning, readjusting, tightening).

Limitations

- In cases involving Covered Services in which the Professional Provider or Supplier and Member elect to utilize photogrey or light sensitive lenses, the program may provide benefits providing the Member qualifies for such benefits. See the ***Schedule of Benefits*** for the benefit allowance, if any.
- Payment for frames, or spectacle lenses and/or contact lenses will be made only if prescribed by a Professional Provider or Supplier.

SECTION 3 - EXCLUSIONS - WHAT IS NOT COVERED

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

- For examinations or materials which are not listed herein as a Covered Service;
- For any lenses which do not require a prescription;
- For an eye examination without a refraction;
- For replacement of lost, stolen, broken or damaged lenses, contact lenses or frames unless the Member would otherwise meet the frequency limitations. However, this does not apply to plan-supplied frames and spectacle lenses obtained from a Participating Provider if breakage occurs during normal use within 365 days of the dispensing date;
- For the cost of any insurance premiums indemnifying the Member against losses for lenses or frames;
- For medical attention or surgical treatment of the eye;
- For diagnostic services, such as diagnosis X-rays, cardiographic, encephalographic examinations and pathological or laboratory tests;
- For drugs or any other medications;
- For procedures, such as but not limited to, orthoptics, vision therapy, subnormal vision aids, and tonography;
- For eye examinations or materials sponsored by the Member's employer without charge to the Member;
- 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 the Worker's Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Member claims the benefits or compensation, unless the Member is an owner or executive officer and claims an exemption permitted by law;
- For which a Member would have no legal obligation to pay;
- Received from a medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
- Incurred prior to the Member's Effective Date;
- Incurred after the date of termination of the Member's coverage except for lenses and frames prescribed prior to such termination and delivered within 30 days from such date;
- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;

- For duplicate and temporary devices, appliances, and services. This exclusion does not apply to disposable contact lenses;

- For which the Member incurs no charge;

- In a facility performed by a Professional Provider or Supplier who in any case is compensated by the facility for similar Covered Services performed for Members;

- 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;

- For any loss sustained or expenses Incurred during military services while on active duty; or as a result of an act of war, whether declared or undeclared;

- Paid or payable by Medicare when Medicare is primary. For purposes of this Program, a service, supply or charge is "payable under Medicare" when the Member is eligible to enroll for Medicare benefits, regardless of whether the Member actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits;

- For low vision aids;

- Other than specifically provided in the section entitled ***Vision Care Benefits*** of this Benefit Booklet.

SECTION 4 - WHO IS COVERED

Eligible Person

- Eligible Person is defined as a Member who is determined by the Contract Holder as eligible to apply for coverage and sign the Application; and
- Eligible Dependents as specified to the Health Benefit Plan by the Contract Holder as eligible for coverage.

Eligible Dependent

Eligible Dependent is defined as:

- The Member's spouse under a legally valid existing marriage between persons of the opposite sex.
- The unmarried children, including newborn children, step-children, children legally placed for adoption, and legally adopted children of the Member or the Member's spouse, or children for whom the Member is a legal guardian or newborns of dependent children covered under the Group Contract. The limiting age for covered, unmarried children is to the first of the month following the month in which they reach age 26; or if a student is enrolled full-time in an Accredited Educational Institution, the limiting age is the first of the month following the month in which they reach age 26.

  In addition, a full-time student will be considered eligible for coverage when they are on a Medically Necessary leave of absence from the Accredited Educational Institution. The Health Benefit Plan must receive certification from the full-time student's physician that the full-time student is suffering from a serious illness or injury that requires a Medically Necessary leave of absence from the Accredited Educational Institution or requires the full-time student to become a part-time student. The Dependent child will be eligible for coverage until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate. The limiting age referenced above will be applicable regardless of the status of the Medically Necessary leave of absence.
- A full-time student who is eligible for coverage under the coverage who is:
  - A member of the Pennsylvania National Guard or any reserve component of the U.S. armed forces and who is called or ordered to active duty, other than active duty for training for a period of 30 or more consecutive days; or
  - A member of the Pennsylvania National Guard who is ordered to active state duty, including duty under Pa. C.S. Ch.76 (relates to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

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

  As proof of eligibility, the Employee must submit a form to the Health Benefit Plan approved by the Department of Military & Veterans Affairs (DMVA):
  - Notifying the Health Benefit Plan that the Dependent has been placed on active duty;
  - Notifying the Health Benefit Plan that the Dependent is no longer on active duty;
  - Showing that the Dependent has re-enrolled as a full-time student in an Accredited Educational Institution for the first term or semester starting 60 or more days after the Dependent's release from active duty.
- Eligibility will be continued past the limiting age for unmarried children, regardless of age,

who are incapable of self-support because of mental retardation or physical handicap, mental illness or developmental disability and who are dependent for support upon a Member covered under the Group Contract. The Health Benefit Plan may require proof of such Member's eligibility from time to time.

- The newborn child(ren) of a Member from the moment of birth to a maximum of 31 days immediately following birth. The coverage of newborn children within such 31 day period shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities and prematurity and services of a doctor rendered as part of nursery care, but not nursery charges. To continue coverage beyond the 31 day period, application for coverage must be made within 31 days of the child's birth and the appropriate premium paid.
- A Domestic Partner, including the child of a Domestic Partner, shall be considered for eligibility under the Program as if they were the child of the Applicant, as long as the domestic partnership exists.

Effective Date
The date the Contract Holder agrees that all Eligible Persons may apply and become covered. If a person becomes an Eligible Person after the Contract Holder's Effective Date, that date becomes the Effective Date.

SECTION 5 - GENERAL INFORMATION

Benefits To Which Members Are Entitled

- The liability of the Health Benefit Plan is limited to the benefits specified in the Group Contract.
- No person other than a Member is entitled to receive benefits under this Program.
- Benefits for Covered Services will be provided only for services and supplies that are rendered by a Professional Provider specified in the ***Important Definitions*** section of this Benefit Booklet.

Termination Of Coverage At Termination Of Employment Or Membership In The Group

When a Member ceases to be an Eligible Employee or Eligible Dependent, or the required contribution is not paid, the Member's coverage will terminate at the end of the last month for which payment was made. However, if benefits under this Program are provided by and/or approved by the Health Benefit Plan before the Health Benefit Plan receives notice of the Member's termination under this Program, the cost of such benefits will be the sole responsibility of the Member. In that circumstance, the Health Benefit Plan will consider the effective date of termination of a Member under this Program to be not more than 30 days before the first day of the month in which the Contract Holder notified the Health Benefit Plan of such termination.

Continuation Of Coverage At Termination Of Employment Or Membership Due To Total Disability

A Member's benefits under this Program may be extended after the date that person ceases to be a Member under the Group Contract because of termination of employment or termination of membership in the group. It will be extended if, on that date, the person is Totally Disabled from an illness or injury. The extension is only for that illness or injury and any related illness or injury. It will be for the time the person remains Totally Disabled from any such illness or injury, but not beyond 12 months if the person ceases to be a Member because the Group Contract ends.

The Health Benefit Plan will provide benefits under the Group Contract during an extension as if the person were still a Member. In addition, the Health Benefit Plan will provide benefits only to the extent that other coverage for the Covered Services is not provided for the by the Contract Holder. Continuation of coverage is subject to payment of the applicable premium.

When The Employee Terminates Employment - Continuation Of Coverage Provisions Consolidated Omnibus Budget Reconciliation Act Of 1985, As Amended (COBRA)
The Employee should contact their Employer for more information about COBRA and the events that may allow the Employee or the Employee's eligible Dependents to temporarily extend health care coverage.

When The Employee Terminates Employment - Continuation Of Coverage Provisions Pennsylvania Act 62 Of 2009 (Mini-COBRA)
This subsection, and the requirements of Mini-COBRA continuation, applies to groups consisting of two to 19 Employees.

For purposes of this subsection, a "qualified beneficiary" means any person who, before any event which would qualify that person for continuation under this subsection, has been covered continuously for benefits under this Program or for similar benefits under any group policy which it replaced, during the entire three-month period ending with such termination as:

- A covered Employee;
- The Employee's spouse; or
- The Employee's Dependent child.

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

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

- If An Employee Terminates Employment or Has a Reduction of Work Hours: If the Employee's group benefits end due to the Employee's termination of employment or reduction of work hours, the Employee may be eligible to continue such benefits for up to nine months, if:
  - The Employee's termination of employment was not due to gross misconduct;
  - The Employee is not eligible for coverage under Medicare;
  - The Employee verifies that the Employee is not eligible for group health benefits as an eligible dependent; and
  - The Employee is not eligible for group health benefits with any other carrier.

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

- The Employer's Responsibilities: The Employee's employer must notify the Employee, the plan administrator, and the Health Benefit Plan, in writing, of:
  - The Employee's termination of employment (for reasons other than gross misconduct) or reduction of work hours;

- The Employee's death;
- The Employee's divorce or legal separation from an eligible dependent;
- The Employee becomes eligible for benefits under Social Security;
- The Employee's dependent child ceases to be a dependent child pursuant to the terms of the group health benefits Benefit Booklet;
- Commencement of Employer's bankruptcy proceedings.

The notice must be given to the Employee, the plan administrator and the Health Benefit Plan no later than 30 days of any of these events.

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

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

  Upon receipt of the Employee's, or the Employee's eligible dependent's election of continuation coverage, the administrator, or its designee, shall notify the Health Benefit Plan of the election within 14 days.

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

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

- If a Dependent Loses Eligibility: If the Employee's Dependent child's group health benefits end due to the Dependent's loss of dependent eligibility as defined in this Benefit Booklet, other than the Employee's coverage ending, the Dependent may elect to continue such benefits. However, such Dependent child must be a qualified beneficiary. The continuation can last for up to nine months, subject to the "When Continuation Ends" paragraph of this subsection.

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

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

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified beneficiary stayed insured under this benefit plan on a regular basis. It includes any amount that would have been paid by the employer. An additional administrative charge of up to 5% of the total premium charge may also be required by the Health Benefit Plan.

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

- When Continuation Ends: A qualified beneficiary's continued group health benefits under this Program ends on the first to occur of the following:
  - With respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the nine month period which starts on the date the group health benefits would otherwise end;
  - With respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of the Employee's covered Dependent's eligibility, the end of the nine month period which starts on the date the group health benefits would otherwise end;
  - With respect to the Employee's Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the nine month period which starts on the date the group health benefits would otherwise end;
  - The date coverage under this Program ends;
  - The end of the period for which the last premium payment is made;
  - The date the qualified beneficiary becomes covered under any other group health plan (as an employee or otherwise) which contains no limitation or exclusion with respect to any pre-existing condition of the qualified beneficiary other than a pre-existing condition exclusion or limitation which the qualified beneficiary satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;
  - The date the Employee and/or eligible dependent become eligible for Medicare.

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

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

Continuation Of Incapacitated Child

If the Member's unmarried child is incapable of self-support because of mental or physical incapacity and is dependent on the Member for over half of their support, the Member may apply to the Health Benefit Plan to continue coverage of such child under this Program upon such terms and conditions as the Health Benefit Plan may determine. Coverage of such Dependent child shall terminate upon the child's marriage. Continuation of benefits under this provision will only apply if the child was eligible as a Dependent and mental or physical incapacity commenced prior to age 19.

The disability must be certified by the attending physician; furthermore, the disability is subject to annual medical review. In a case where a handicapped child is over the limiting age and joining the Health Benefit Plan for the first time, the handicapped child must have been covered under the prior Health Benefit Plan and submit proof from the prior Health Benefit Plan that the child was covered as a handicapped person.

Timely Filing
The Health Benefit Plan will not be liable under this Program unless proper notice is furnished to the Health Benefit Plan that Covered Services have been rendered to a Member. Written notice must be given within 20 days after completion of the Covered Services. The notice must include the date and information required by the Health Benefit Plan to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

The Member's failure to give notice to the Health Benefit Plan within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will the Health Benefit Plan be required to accept notice more than two years after the end of the Benefit Period in which the Covered Services are rendered.

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

The Health Benefit Plan may also furnish membership and/or coverage information for the purpose of claims processing or facilitating patient care.

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

Claim Forms
The Health Benefit Plan will furnish to the Member making the claim, or to the Contract Holder, for delivery to such Member, such forms as are required for filing proof of loss.

Time Of Payment Of Claims
All benefits payable under this Program will be payable not more than 60 days after receipt of proof.

Right To Recover Payments In Error
If the Health Benefit Plan should pay for any contractually excluded services through inadvertence or error, the Health Benefit Plan maintains the right to seek recovery of such payment from the Professional Provider, Supplier or Member to whom such payment was made.

Limitation Of Actions
No legal action may be taken to recover benefits prior to 60 days after notice of claim has been given as specified above, and no such action may be taken later than two years after the date services are rendered.

Member/Provider Relationship
- The choice of a provider is solely the Member's.
- The Health Benefit Plan does not furnish Covered Services but only makes payment for Covered Services received by Members. The Health Benefit Plan is not liable for any act or omission of any Professional Provider or Supplier. The Health Benefit Plan has no responsibility for a Professional Provider's or Supplier's failure or refusal to render Covered Services to a Member.

Agency Relationships
The Contract Holder is the agent of the Member, not the Health Benefit Plan.

Identification Cards And Benefit Booklets
The Health Benefit Plan will provide the Identification Cards to Members or to the Contract Holder, depending on the direction of the Contract Holder. The Health Benefit Plan will also provide to each Member of an enrolled group a Benefit Booklet describing the benefits provided under the Group Contract.

Member Rights
A Member shall have no rights or privileges as to the benefits provided under this Program except as specifically provided herein.

Notice
Any notice required under the Group Contract must be in writing. Notice given to a Member will be given to the Member in care of the Contract Holder, or sent to the Member's last address furnished to the Health Benefit Plan by the Contract Holder. The Contract Holder, the Health Benefit Plan, or a Member may, by written notice, indicate a new address for giving notice.

Subrogation and Reimbursement Rights
The Employee Retirement Income Security Act (ERISA) applies to many health benefit plans and, to comply with legal requirements that relate specifically to ERISA-governed plans, this Benefit Booklet describes "Subrogation and Reimbursement Rights" in two sections:
- Subrogation and Reimbursement Rights When The Program Is Governed By ERISA; and
- Subrogation and Reimbursement Rights When The Program Is Not Governed By ERISA.

However, the fact that these Rights are described in separate sections using different language does not mean or imply that the Rights are substantively different or that the Rights described in one section are greater or lesser than the Rights described in the other section. Under both sections, the Health Benefit Plan reserves right the pursue subrogation recoveries and the Member has an obligation to fully reimburse the Health Benefit Plan to the fullest extent permitted by law.

- **Subrogation and Reimbursement Rights When The Program Is Governed By ERISA**

  By accepting benefits for Covered Services, the Member agrees that the Health Benefit Plan has the right to enforce subrogation and reimbursement rights. This section explains these rights and the responsibilities of each Member pertaining to subrogation and reimbursement. The term Member includes Eligible Dependents. The term Responsible Third Party refers to any person or entity, including any insurance company, health benefits plan or other third party, that has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to the Member for an injury or illness.

  The Health Benefit Plan or the Plan Administrator, as applicable, retains full discretionary authority to interpret and apply these subrogation and reimbursement rights based on the facts presented. The right of subrogation or reimbursement is not enforceable if prohibited by statute or regulation.

  Subrogation Rights
  Subrogation rights arise when the Health Benefit Plan pays benefits on behalf of a Member and the Member has a right to receive damages, compensation, benefits or payments of any kind (whether by a court judgment, settlement or otherwise) from a Responsible Third Party. The Health Benefit Plan is subrogated to the Member's right to recover from the Responsible Third Party. This means that the Health Benefit Plan "stands in your shoes" - and assumes the Member's right to pursue and receive the damages, compensation, benefits or payments from the Responsible Third Party to the full extent that the Health Benefit Plan has reimbursed the Member for medical expenses or paid medical expenses on the Member's behalf, plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights. The right to pursue a subrogation claim is not contingent upon whether or not the Member pursues the Responsible Third Party for any recovery.

  Reimbursement Rights
  If a Member obtains any recovery - regardless of how it's described or structured - from a Responsible Third Party, the Member must fully reimburse the Health Benefit Plan for all medical expenses that were paid to the Member or on the Member's behalf, plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights. The Health Benefit Plan has a right to full reimbursement.

Lien
By accepting benefits for Covered Services from the Health Benefit Plan, the Member agrees to a first priority equitable lien by agreement on any payment, reimbursement, settlement or judgment received by the Member, or anyone acting on the Member's behalf, from any Responsible Third Party. As a result, the Member must repay to the Health Benefit Plan the full amount of the medical expenses that were paid to the Member or on the Member's behalf out of the amounts recovered from the Responsible Third Party (plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights) first, before funds are allotted toward any other form of damages, whether or not there is an admission of fault or liability by the Responsible Third Party. The Health Benefit Plan has a lien on any amounts recovered by the Member from a Responsible Third Party, regardless of whether or not the amount is designated as payment for medical expenses. This lien will remain in effect until the Health Benefit Plan is reimbursed in full.

Constructive Trust
If the Member (or anyone acting on the Member's behalf) receive damages, compensation, benefits or payments of any type from a Responsible Third Party (whether by a court judgment, settlement or otherwise), the Member agrees to maintain the funds in a separate, identifiable account and that the Health Benefit Plan has a lien on the monies. In addition the Member agrees to serve as the trustee over the monies for the benefit of Health Benefit Plan to the full extent that the Health Benefit Plan has reimbursed the Member for medical expenses or paid medical expenses on the member's behalf, plus the attorney's fees and the costs of collection incurred by the Health Benefit Plan.

- These subrogation and reimbursement rights apply regardless of whether money is received through a court decision, settlement, or any other type of resolution.
- These subrogation and reimbursement rights apply even if the recovery is designated or described as covering damages other than medical expenses (such as property damage or pain and suffering).
- These subrogation and reimbursement rights apply with respect to any recoveries made by the Member, including amounts recovered under an uninsured or underinsured motorist policy.
- The Health Benefit Plan is entitled to recover the full amount of the benefits paid to the Member or on the Member's behalf plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights without regard to whether the Member has been made whole or received full compensation for other damages (including property damage or pain and suffering). The recovery rights of the Health Benefit Plan will not be reduced by the "made whole" doctrine or "double recovery" doctrine.
- The Health Benefit Plan will not pay, offset any recovery, or in any way be responsible for attorneys' fees or costs associated with pursuing a claim against a Responsible Third Party unless the Health Benefit Plan agrees to do so in writing. The recovery rights of the Health Benefit Plan will not be reduced by the "common fund" doctrine.
- In addition to any Coordination of Benefits rules described in this Benefit Booklet, the benefits paid by the Health Benefit Plan will be secondary to any no-fault auto insurance benefits and to any worker's compensation benefits (no matter how any settlement or award is characterized) to the fullest extent permitted by law.
- These subrogation and reimbursement rights apply and will not be decreased, restricted, or eliminated in any way if the Member receives or has the right to recover no-fault insurance benefits.
- All rights under this section are enforceable against the heirs, estate, legal guardians or legal representatives of the Member.

- The Health Benefit Plan is entitled to recover the full amount of the medical benefits paid without regard to any claim of fault on the Member's part.

Obligations of Member

- Immediately notify the Health Benefit Plan or its designee in writing if the Member asserts a claim against a Responsible Third Party, whether informally or through judicial or administrative proceedings.
- Immediately notify the Health Benefit Plan or its designee in writing whenever a Responsible Third Party contacts the Member or the Member's representative - or the Member or the Member's representative contact a Responsible Third Party - to discuss a potential settlement or resolution.
- Refuse any offer to settle, adjust or resolve a claim for damages, benefits or compensation that involves an injury, illness or medical expenses in any way, unless and until the Member receives written authorization from the Health Benefit Plan or its delegated representative.
- Fully cooperate with the Health Benefit Plan and its designated representative, as needed, to allow for the enforcement of these subrogation and reimbursement rights and promptly supply information/documentation when requested and promptly execute any and all forms/documents that may be needed.
- Avoid taking any action that may prejudice or harm the Health Benefit Plan's ability to enforce these subrogation and reimbursement rights to the fullest extent possible.
- Fully reimburse the Health Benefit Plan or its designated representative immediately upon receiving compensation of any kind (whether by court judgment, settlement or otherwise) from a Responsible Third Party.
- Serve as trustee for any and all monies paid to (or payable to) the Member or for the Member's benefit by any Responsible Third Party to the full extent the Health Benefit Plan paid benefits for an injury or illness.
- All of these Obligations apply to the heirs, estate, legal guardians or legal representatives of the Member.

- **Subrogation and Reimbursement Rights When The Program Is Not Governed By ERISA**

By accepting benefits for Allowable Charges, the Member agrees that the Health Benefit Plan has the right to enforce subrogation and reimbursement rights to the extent permitted by law. This section explains these rights and the responsibilities of each Member pertaining to subrogation and reimbursement. The term Member includes Eligible Dependents. The term Responsible Third Party refers to any person or entity, including any insurance company, health benefits plan or other third party, that has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to the Member for an injury or illness.

The Health Benefit Plan or the Plan Administrator, as applicable, retains full discretionary authority to interpret and apply these subrogation and reimbursement rights based on the facts presented The right of subrogation or reimbursement is not enforceable if prohibited by statute or regulation..

Subrogation Rights

Subrogation rights arise when the Health Benefit Plan pays benefits on behalf of a Member and the Member has a right to receive damages, compensation, benefits or payments of any

kind (whether by a court judgment, settlement or otherwise) from a Responsible Third Party. The Health Benefit Plan is subrogated to the Member's right to recover from the Responsible Third Party. This means that the Health Benefit Plan "stands in your shoes" - and assumes the Member's right to pursue and receive the damages, compensation, benefits or payments from the Responsible Third Party to the full extent that the Health Benefit Plan has reimbursed the Member for medical expenses or paid medical expenses on the Member's behalf, plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights. The right to pursue a subrogation claim is not contingent upon whether or not the Member pursues the Responsible Third Party for any recovery.

Reimbursement Rights

If a Member obtains any recovery - regardless of how it's described or structured - from a Responsible Third Party, the Member must fully reimburse the Health Benefit Plan for all medical expenses that were paid to the Member or on the Member's behalf, to the extent permitted by law.

- These subrogation and reimbursement rights apply regardless of whether money is received through a court decision, settlement, or any other type of resolution.
- These subrogation and reimbursement rights apply even if the recovery is designated or described as covering damages other than medical expenses (such as property damage or pain and suffering).
- These subrogation and reimbursement rights apply with respect to any recoveries made by the Member, including amounts recovered under an uninsured or underinsured motorist policy.
- The Health Benefit Plan will not pay, offset any recovery, or in any way be responsible for attorneys' fees or costs associated with pursuing a claim against a Responsible Third Party unless the Health Benefit Plan agrees to do so in writing.
- In addition to any Coordination of Benefits rules described in this Benefit Booklet, the benefits paid by the Health Benefit Plan will be secondary to any no-fault auto insurance benefits and to any worker's compensation benefits (no matter how any settlement or award is characterized) to the fullest extent permitted by law.
- These subrogation and reimbursement rights apply and will not be decreased, restricted, or eliminated in any way if the Member receives or has the right to recover no-fault insurance benefits.
- All rights under this section are enforceable against the heirs, estate, legal guardians or legal representatives of the Member.
- The Health Benefit Plan is entitled to recover the full amount of the medical benefits paid without regard to any claim of fault on the Member's part.

Obligations of Member

- Immediately notify the Health Benefit Plan or its designee in writing if the Member asserts a claim against a Responsible Third Party, whether informally or through judicial or administrative proceedings.
- Immediately notify the Health Benefit Plan or its designee in writing whenever a Responsible Third Party contacts the Member or the Member's representative - or the Member or the Member's representative contact a Responsible Third Party - to discuss a potential settlement or resolution.
- Refuse any offer to settle, adjust or resolve a claim for damages, benefits or compensation that involves an injury, illness or medical expenses in any way, unless and until the Member receives written authorization from the Health Benefit Plan or its delegated representative.
- Fully cooperate with the Health Benefit Plan and its designated representative, as needed, to allow for the enforcement of these subrogation and reimbursement rights and promptly supply information/documentation when requested and promptly execute any and all forms/documents that may be needed.
- Avoid taking any action that may prejudice or harm the Health Benefit Plan‘s ability to enforce these subrogation and reimbursement rights to the fullest extent possible.
- Fully reimburse the Health Benefit Plan or its designated representative immediately upon receiving compensation of any kind (whether by court judgment, settlement or otherwise) from a Responsible Third Party.
- All of these Obligations apply to the heirs, estate, legal guardians or legal representatives of the Member.

Special Circumstances

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

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

Special Circumstances, as recognized in the community, and by the Health Benefit Plan and appropriate regulatory authority, are extraordinary circumstances not within the control of the Health Benefit Plan, including but not limited to:

- Major disaster;
- Epidemic;
- Pandemic;
- The complete or partial destruction of facilities;
- Riot;
- Civil insurrection; or
- Public health emergency.

Regarding Non-Discrimination Rights

The Member has the right to receive health care services without discrimination:

- Based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, source of payment, sexual orientation, or sex, including stereotypes and gender identity, pre-existing conditions, health status, and marital status;
- For Medically Necessary health services made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender;
- Based on an individual's sex assigned at birth, gender identity, or recorded gender, if it is different from the one to which such health service is ordinarily available;
- Related to gender transition if such denial or limitation results in discriminating against a transgender individual.

SECTION 6 - RESOLVING PROBLEMS

(APPEAL OF AN ADMINISTRATIVE DENIAL AND MEDICAL NECESSITY APPEAL PROCESS)

Informal Member Complaint Process
The Health Benefit Plan has a process for Members to request an informal Complaint. To register an informal Complaint, Members should call the Member Services Department at the telephone number on the back of their Identification Card or write to the Health Benefit Plan at the following address:

General Correspondence
1901 Market Street
Philadelphia, PA 19103

Most Member concerns are resolved informally at this stage. If the Health Benefit Plan cannot immediately resolve the Member's concern, the Health Benefit Plan will acknowledge it in writing within **five business days** of receiving the request. The Member will receive a response within 30 calendar days. If the Member is not satisfied with the response to their concern from the Health Benefit Plan, the Member has the right to file a formal appeal through the Member's Appeal of an Administrative Denial process described below.

Authorizing Someone to Represent the Member
At any time, the Member may choose a third party to be their representative in their Member appeal such as a provider, lawyer, relative, friend, another individual, or a person who is part of an organization. The law states that the Member's written authorization or consent is required in order for this third party called an "authorized representative" to pursue an appeal on the Member's behalf. An authorized representative may make all decisions regarding the Member's appeal, provide and obtain correspondence, and authorize the release of medical records and any other information related to their appeal. In addition, if the Member chooses to authorize an appeal representative, the Member has the right to limit their authority to release and receive the Member's medical records or other appeal information in any other way the Member identifies.

To authorize someone to be the Member's authorized representative, the Member must complete valid authorization forms. The required forms are sent to adult Members or to the parents, guardians, or other legal representatives of minor or incompetent Members who appeal and indicate that they want an authorized representative to appeal on their behalf. Authorized representative forms can be obtained by calling or writing to the address listed below:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA, 19101-1820
Toll Free: 1-888-671-5276
Fax: 1-888-671-5274

Except in the case of an expedited appeal, the Health Benefit Plan must receive completed, valid authorization forms before the Member's appeal can be processed. (For information on expedited appeals, see the definition below and the references in the Appeal of an Administrative Denial Process and the Medical Necessity Appeal Process sections below.) The

Member has the right to withdraw or rescind authorization of an authorized representative at any time during the process.

If the Member's provider files an appeal on the Member's behalf, the Health Benefit Plan will verify that the provider is acting as the Member's authorized representative with their permission by obtaining valid authorization forms. A Member who authorizes the filing of an appeal by a provider cannot file a separate appeal.

Information for the Appeal Review:

How to File and Get Assistance
Appeals may be submitted by the Member or their authorized representative with the Member's authorization by following the steps outlined below in the descriptions of the Appeal of an Administrative Denial and the Medical Necessity Appeal Process. At any time during these appeal processes, the Member may request the help of a Health Benefit Plan employee in preparing or presenting their appeal; this assistance will be available at no charge. Please note that the Health Benefit Plan employee designated to assist the Member will not have participated in the previous decision to deny coverage for the issue in dispute and will not be a subordinate of the original reviewer.

Full and Fair Review
The Member or authorized representative is entitled to a full and fair review. Specifically, at all appeal levels the Member or authorized representative may submit additional written comments, records or other information pertaining to the case, to the Health Benefit Plan. The Health Benefit Plan takes into account all information submitted by the Member, whether such information was submitted or considered during the initial Adverse Benefit Determination or prior level of review. The Health Benefit Plan documents when the Member fails to submit relevant information by the specified deadline. The Member or authorized representative may specify the remedy or corrective action being sought. At the Member’s or authorized representative’s request, the Health Benefit Plan will provide access to and copies of all relevant documents, records, and other information (excluding the Health Benefit Plan’s confidential, proprietary, or privileged information). The Health Benefit Plan will automatically provide the Member or authorized representative with any new or additional evidence considered, relied upon, or generated by the Health Benefit Plan in connection with the appeal, which is used to formulate the rationale. Such evidence is provided as soon as possible and in advance of the date the adverse notification is issued. This information is provided to the Member or authorized representative at no charge.

Advance Notice
The Health Benefit Plan will not terminate or reduce an-ongoing course of treatment without providing the Member or authorized representative with advance notice and the opportunity for advanced review.

Urgent Care
In the appeal context, urgent care is medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. Members with urgent care conditions or who are receiving an on-going course of treatment may request an internal expedited appeal and also proceed with an expedited external review at the same time.

Changes in Member Appeals Processes
Please note that the Member appeals processes described here may change at any time due to changes in the applicable state and federal laws and regulations and/or accreditation standards, to improve or facilitate the Member appeals processes, or to reflect other decisions regarding the administration of Member appeals processes for this Program.

Appeal Decision Letters
The determination letter states the reason(s) for the decision. If a benefit provision, internal rule, guideline, protocol, or other similar criterion is used in making the determination, the Member or authorized representative may request copies of this information at no charge. If the decision is to uphold the denial, there is an explanation of the scientific or clinical judgment for the determination. The letter also indicates the qualifications of the individual/individuals who decided the appeal and their understanding of the nature of the appeal. The Member or authorized representative may request in writing, at no charge, the name of the individual/individuals who participated in the decision to uphold the denial.

Appeal Classifications
Appeals of an Administrative Denial and Medical Necessity Appeals, established by Pennsylvania state laws and regulations, are described in detail in separate sections below.

An Appeal of an Administrative Denial may be filed to challenge a denial based on a contract limitation, prior authorization, coverage or payment based on a lack of eligibility, failure to submit complete information or other failure to comply with an administrative policy, certain surprise medical bills received by a Member from an out-of-network provider, rescissions of coverage (except for failure to pay premiums or coverage contributions) or to complain about other aspects of health plan policies or operations that has not been resolved by the Health Benefit Plan and has been filed with the Pennsylvania Insurance Department (PID).

A Medical Necessity Appeal may be filed when the denial of a covered service is based primarily on Medical Necessity, experimental/investigative exclusions, or cosmetic exclusions.

You may question the classification of your appeal as an Appeal of an Administrative Denial or Medical Necessity Appeal by contacting the Health Benefit Plan's Member Appeals Department or your assigned appeals specialist at the address and telephone number shown above or by contacting the Pennsylvania Insurance Department at:

Pennsylvania Insurance Department
Bureau of Health Care Access,
Administration, and Appeals (HCA3)
1311 Strawberry Square
Harrisburg, PA. 17120
Toll Free: 1-888-466-2787
Fax: 1-717-787-8555
E-Mail:RA-lNHCA3@pa.gov.

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388
Fax: 1-717-787-8585

Appeals are also subject to the following classifications:

A **pre-service appeal** is any appeal for benefits with a coverage requirement that preapproval or precertification by the Health Benefit Plan must be obtained before medical care and services are received.

A **post-service appeal** includes any appeal regarding benefits for medical care or services that a Member has already received or any appeal for a service that does not require preapproval or precertification by the Health Benefit Plan.

Internal Standard Appeal of an Administrative Denial
The Member or authorized representative may file an Appeal of an Administrative Denial for an unresolved dispute or objection. The Appeal of an Administrative Denial process consists of two internal levels of review by the Health Benefit Plan, and one external level of review by the Pennsylvania Insurance Department.

Internal Standard First Level Appeal of an Administrative Denial-
The Member or authorized representative may file an internal standard first level Appeal of an Administrative Denial **within 180 calendar days** from either their receipt of the original notice or the completion of the **Informal Member Complaint Process** described above. To file an internal standard first level Appeal of an Administrative Denial, call Customer Service toll free at the telephone number listed on the Member's ID card, or call, write or fax the Member Appeals Department as follows:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820
Toll Free: 1-888-671-5276
Fax: 1-888-671-5274

The Member or authorized representative may submit an oral or written appeal. Additionally, The Member or authorized representative may submit written data or other information to the Health Benefit Plan for consideration regarding the appeal. The Health Benefit Plan will acknowledge receipt of the Member's Appeal of an Administrative Denial in writing.

The internal standard first level Appeal of an Administrative Denial is decided by a Health

Benefit Plan employee who has no previous involvement with the case and who is not the subordinate of anyone previously involved with the case. The decision notification is sent to the Member or authorized representative within:

- **15 calendar days** from receipt of a pre-service appeal; and
- **30 calendar days** from receipt of a post-service appeal.

If the Member's appeal is denied, the decision letter states:

- The specific reason for the decision;
- This Health Benefit Plan's provision on which the decision is made and instructions on how to access the provision; and,
- How to appeal to the next level if the Member is not satisfied with the decision.

Internal Standard Second Level Appeal of an Administrative Denial

If the Member or authorized representative is not satisfied with the decision from their first level Appeal of an Administrative Denial, they may file an internal standard second level appeal to the Second Level Appeal of an Administrative Denial Committee **within 60 calendar days** of their receipt of the First Level Committee's decision from the Health Benefit Plan. To file a second level appeal, call Customer Service toll free at the telephone number listed on the Member's ID card, or call, write or fax the Member Appeals Department as follows:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820
Toll Free: 1-888-671-5276
Fax: 1-888-671-5274

Upon receipt of the Member's appeal, the Member or authorized representative will be notified in writing in advance of a date and time scheduled for the Internal Standard Second Level Appeal of an Administrative Denial Committee meeting. The Member or authorized representative may request a change in the meeting schedule. The Health Benefit Plan will do its best to accommodate their request while remaining within the established timeframes. If the Member or authorized representative does not participate in the meeting, the Second Level Committee will review their Appeal of an Administration Denial and make its decision based on all available information.

The Second Level Appeal of an Administrative Denial Committee meets and renders a decision on the Member's standard appeal and notifies the Member or authorized representative within:

- **15 calendar days** from receipt of a pre-service appeal; and
- **30 calendar days** from receipt of a post-service appeal.

The Internal Standard Second Level Appeal of an Administrative Denial Committee is composed of at least three persons who have had no previous involvement with the Member's case and who are not subordinates of the person who made the original determination. The Second Level Appeal of an Administrative Denial Committee members will include the Health Benefit Plan's staff, with one third of the Committee being other persons who are not employed by the Health Benefit Plan. The Member or authorized representative may submit supporting materials both before and at the appeal meeting. Additionally, the Member or authorized representative has the right to review all information considered by the Committee that is not the Health Benefit Plan's confidential, or privileged information.

The Internal Standard Second Level Appeal of an Administrative Denial Committee meeting is a forum where Members have an opportunity to present their issues via a video conference or conference call in an informal setting that is not open to the public. Members of the press may only participate in their personal capacity as the Member's authorized representative or to provide general, personal assistance. Members, authorized representatives, and others assisting the Member may not audiotape or videotape the Committee proceedings.

The Member/authorized representative will be sent the decision letter of the Internal Standard Second Level Appeal of an Administrative Denial Committee on their appeal **within five business days** of the date the decision is made. The notice will include the basis for the denial and the procedure for appealing the decision to the Pennsylvania Insurance Department's Bureau of Health Care Access, Administration and Appeals (HCA3) or the Bureau of Consumer Affairs. The Member may be represented by an attorney or other individual in the state review. The decision is final unless the Member chooses to appeal to the Pennsylvania Insurance Department as described in the decision letter. (See also **External Appeal of an Administrative Denial** below.)

Pennsylvania Insurance Department's
Bureau of Health Care Access,
Administration and Appeals (HCA3)
1311 Strawberry Square
Harrisburg, PA. 17120
Toll Free: 1-888-466-2787
Fax: 1-717-787-8555
E-Mail: RA-INHCA3@pa.gov.

Pennsylvania Insurance Department's
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA. 17120
1-877-881-6388
Fax: 1-717-787-8585

The Member's request for external review of an Appeal of an Administrative Denial should include the Member's name, address, daytime telephone number, the name of the Health Benefit Plan as their health care plan, the group number, the Member's Health Benefit Plan ID number and a brief description of the issue being appealed. Also include a copy of the Member's original request for an internal second level standard appeal review to the Health Benefit Plan and copies of any correspondence and decision letters from the Health Benefit Plan.

When an external Appeal of an Administrative Denial request is submitted to the Pennsylvania Insurance Department‘s HCA3 or Bureau of Consumer Services, the original submission date of the request is considered the date of receipt. The regulatory agency that receives the request will review it and transfer it to the other agency if this is found to be appropriate. The regulatory agency that handles the Member's external appeal will provide the Member and the Health Benefit Plan with a copy of the final determination of its decision.

All records from the internal Appeal of an Administrative Denial process are transmitted by the HMO to the HCA3 via the HCA3 Portal.

Internal Standard Medical Necessity Appeal Process

Member Appeal Process for Decisions Based on Medical Necessity
Members/authorized representatives may file a formal Medical Necessity Appeal of a decision by the Health Benefit Plan regarding a Covered Drug that was denied or limited based primarily on Medical Necessity, the cosmetic or experimental/investigative exclusions, or other grounds that rely on a medical or clinical judgment (including appropriateness, health care setting and level of care or effectiveness).

The appeal process consists of one internal review by the Health Benefit Plan and if appealed further, an external review conducted by an accredited private Independent Review Organization (IRO). The external review is coordinated by the Pennsylvania Insurance Department’s HCA3. There is also an internal and external expedited Medical Necessity Appeal process in the event the Member's condition involves an urgent issue.

The Member or authorized representative may file an internal standard Medical Necessity Appeal **within 180 calendar days** from the date of receipt of the original denial by the Health Benefit Plan. To do so, call Customer Service at the toll-free telephone number listed on their ID Card, or call, write or fax the Member Appeals Department as follows:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820
Toll Free: 1-888-671-5276
Fax: 1-888-671-5274

The Health Benefit Plan will acknowledge receipt of the Member's Medical Necessity Appeal in writing. This confirmation advises that the Health Benefit Plan considers the matter to be a Medical Necessity Appeal and that the Member or authorized representative may question the classification by contacting the HCA3. or the Bureau of Consumer Services at the information listed above.

The Member's one level of internal appeal is reviewed by a Health Benefit Plan Medical

Director, who is the decision-maker. This individual holds an active unrestricted license to practice medicine, has had no previous involvement in the case, and is not a subordinate of the person who made the original determination. Additionally, the Health Benefit Plan Medical Director is a same or similar specialist, or the decision-maker receives input from an independent consultant who is a same or similar specialist. A same or similar specialist or "same or similar specialty Physician" is a licensed Physician or psychologist who is in the same or similar specialty as typically manages the case under review. Additionally, the physician consultant:

- Has had no previous involvement in the case;
- Is not a subordinate of the person who makes the original determination;
- Is not a subordinate of anyone previously involved with the case.

If the same or similar specialist Physician is a consultant, their opinion on the Medical Necessity Appeal issues will be reported to the Health Benefit Plan in writing for consideration. The Member or authorized representative may request a copy of the same or similar specialist's opinion in writing, and it will be provided to the Member or authorized representative prior to the date of review by the Health Benefit Plan Medical Director. The same or similar specialist's report includes their credentials as a licensed Physician or psychologist such as board certification.

The Health Benefit Plan Medical Director completes the review of the Member's standard appeal and sends notification to the Member or authorized representative within:

- **30 calendar days** from receipt of a pre-service appeal; and
- **30 calendar days** from receipt of a post-service appeal;
- **72 hours** from receipt of a standard non-formulary exception appeal request.

The Member or authorized representative will be sent the decision on their internal appeal in writing **within five business days** of the determination. If the Member's Medical Necessity Appeal is denied, the decision letter states:

- The specific reason for the denial;
- The Health Benefit Plan's provision on which the decision is made and instructions on how to access the provision; and,
- How to request an external review if the Member is not satisfied with the decision.

Internal Expedited Medical Necessity Appeals

If the Member's case involves an urgent care condition, then the Member or their Physician (or authorized representative) may ask to have the Member's case reviewed in a faster manner, as an Expedited Medical Necessity Appeal. The Health Benefit Plan also grants an expedited Medical Necessity Appeal review for all requests concerning admissions, continued stay or other health care services for a Member who has received Emergency services but has not been discharged from a facility. There is one internal level of appeal review for an Expedited Medical Necessity appeal.

Members with Urgent Care conditions or who are receiving an on-going course of treatment may proceed with an expedited external review at the same time as the internal expedited appeals process.

To request an Internal Expedited Medical Necessity Appeal review by the Health Benefit Plan, call Customer Service at the toll-free telephone number listed on the Member's ID card, or call, or fax the Member Appeals Department at the telephone numbers listed above. The Health Benefit Plan will promptly inform the Member whether their appeal request qualifies for

expedited review or instead will be processed as a standard Medical Necessity Appeal.

The decision process for an Internal Expedited Medical Necessity Appeal mirrors the one described above for the Internal Standard Medical Necessity Appeal.

The Internal Expedited Medical Necessity Appeal review is completed promptly based on the Member's health condition. The Health Benefit Plan conducts an expedited internal review and issues a decision to the Member, authorized representative, and practitioner/provider **within 72 hours** of the date the Health Benefit Plan receives the appeal. For non-formulary exception requests, the appeal is decided, and notification sent **within 24 hours** of receipt of the request. The notification includes the basis for the decision, including any clinical rationale, and the procedure for obtaining an expedited external review.

EXTERNAL REVIEW INDEPENDENT REVIEW ORGANIZATION (IRO) PROCESS

External Appeal Process For Decisions Based On Medical Necessity, Experimental/Investigative Treatment, Cosmetic Issues, Certain Surprise Medical Bills Received by Members From Out-of-Network Providers, and Recissions of Coverage (except for non-payment of premiums or coverage contributions).

The Member or authorized representative may file a written request for an external appeal with the HCA3 **within four months** of the receipt of the Health Benefit Plan's Adverse Benefit Determination or final Adverse Benefit Determination for an internal Medical Necessity Appeal. The HCA3 contracts directly with the IRO and notifies the Health Benefit Plan of the assignment for each case file. The HCA3 is also responsible for keeping IRO pricing at a reasonable level. The Member or authorized representative does not pay any of the cost for an external review.

Please refer to the final internal appeal Adverse Benefit Determination letter for specific instructions on how to file the appeal with the HCA3.

A Member/authorized representative may only request an external review after exhausting the Health Benefit Plan's internal appeal process. The Member/authorized representative shall be deemed to have exhausted the Health Benefit Plan's internal appeal process in the following circumstances:

- The Member/authorized representative has filed a Medical Necessity Appeal.
- Except to the extent the Member or their authorized representative has requested or agreed to a delay, the Health Benefit Plan has not issued a decision to the Member or authorized representative **within 30 calendar days** of when the Member filed the appeal with the Health Benefit Plan.
- The Health Benefit Plan waives its requirement that the Member/authorized representative must exhaust the internal claim and appeal process prior to filing a request for an external review or expedited external review.
- The Health Benefit Plan has failed to comply with the requirements of the internal claims, utilization review and/or appeals process unless the failure or failures are based on de minimis violations that do not cause and are not likely to cause prejudice or harm to the Member/authorized representative.

Preliminary Review of an External Review Request

The HCA3 will send a copy of the external review request to the Health Benefit Plan **within one business day** of receipt of the request. **Within five business days** of the Health Benefit Plan's receipt of this copy, the Health Benefit Plan will perform a preliminary review to determine whether:

- The individual is or was a Member under the health insurance policy at the time the health care service was requested, or in the case of a retrospective utilization review, at the time the health care service was provided.
- The health care service that is the subject of the external review request is covered under the Member's health insurance policy, except for determinations by the Health Benefit Plan that a health care service is not covered because it does not meet the Health Benefit Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.
- The Member has exhausted the Health Benefit Plan's internal Medical Necessity Appeal process.
- The Member has not provided all required information and forms to process an external review.

For an external review of denial of coverage of an experimental/investigative treatment, the Health Benefit Plan's preliminary review will also include a determination of whether:

- The health care service is covered under the Member's health insurance policy, except for the Health Benefit Plan's determination that the health care service is experimental/investigative for a particular condition.
- The health care service is not explicitly listed as an excluded benefit under the Member's health insurance policy.
- The Member's treating health care provider has certified that one of the following situations is applicable:
  - Standard health care services have not been effective in improving the condition of the Member.
  - Standard health care services are not medically appropriate for the Member.
- There are no available standard health care services under the health insurance policy that are more beneficial than the recommended or requested health care services described in the next paragraph.
- The Member's treating health care provider either:
  - Has recommended health care services that the health care provider certifies, in writing, are more likely to be beneficial to the Member, in the health care provider's opinion, than available standard health care services.
  - Has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care services requested by the Member who is the subject of the Adverse Benefit Determination or final Adverse Benefit Determination, are likely to be more beneficial to the Member than any available standard health care services, when the treating health care provider is a licensed, board-certified or board-eligible Physician qualified to practice in the area of medicine appropriate to treat the Member's condition.

External Review Process

Within one business day of completion of the preliminary review, the Health Benefit Plan notifies the HCA3, the Member/authorized representative in writing whether the request is complete and eligible for external review.

- If the request is not complete, the Health Benefit Plan notifies the Member/authorized representative and HCA3 in writing, including what information or materials are needed to make the request complete.
- If the request is not eligible for an external review, the Health Benefit Plan informs the Member/authorized representative and the HCA3 in writing, including the reason(s) why the request is not eligible.
  - The Member/authorized representative may appeal the Health Benefit Plan's initial determination that the external review request is ineligible for review to the HCA3.
  - Despite the Health Benefit Plan's initial determination, the HCA3 may determine, based upon the terms of the Member's health insurance policy, that a request is eligible for external review. This determination will be binding on the Health Benefit Plan and the Member and may be appealed to the PID Commissioner. Consideration of this appeal may not delay or terminate the external review.

Within one business day of the HCA3's receipt of the Health Benefit Plan's notification that the external review is eligible based on the Health Benefit Plan's preliminary review, the HCA3 assigns an IRO to review the case file and notifies the Health Benefit Plan of the assignment.

The HCA3 sends written notification to the Member/authorized representative of the eligibility of the request based on the preliminary review and of the name and contact information of the assigned IRO. Additionally, the HCA3 notifies the Member/authorized representative they may send the IRO additional information **within 15 business days** of receipt of the HCA3's notification. **Within one business day** of receiving additional information from the Member/authorized representative, the IRO sends a copy of the information to the Health Benefit Plan.

Within five business days of receipt of the name of the assigned IRO from the HCA3, the Health Benefit Plan provides the assigned IRO with all the documents and information considered in making an Adverse Benefit Determination or the final Adverse Benefit Determination. If the Health Benefit Plan fails to provide the assigned IRO with the documents and information within that timeframe, the IRO may proceed with the external review, terminate the external review, and overturn the Health Benefit Plan's decision. The IRO notifies the Member/authorized representative, the HCA3, and the Health Benefit Plan of the action they have taken **within one business day** of making their decision.

Reconsideration by the Health Benefit Plan

Upon receipt of additional information forwarded by the IRO, the Health Benefit Plan may reconsider the Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Health Benefit Plan may not delay or terminate the external review.

An external review may be terminated without an IRO determination if the Health Benefit Plan overturns their decision that is the subject of the external review and provides coverage or payment for the recommended health care service that is the subject of the external review. **Within one business day** of deciding to overturn their decision, the Health Benefit Plan will notify the HCA3, IRO, and the Member/authorized representative in writing of its decision. The assigned IRO will terminate the external review upon receipt of this notice.

Standard External Review IRO Decision

The assigned IRO decides the appeal and sends notification to the Member/authorized representative **within 45 calendar days** of receipt of the external review request. For an external review of experimental/investigative treatment, the assigned IRO makes a decision and sends notification to the Member/authorized representative **within 20 calendar days** of receipt of the external review of the experimental/investigative treatment request. For non-formulary exception requests, the IRO makes a decision and sends notification **within 72 hours** of receipt of the request.

Upon receipt of an IRO overturn decision, the Health Benefit Plan will approve the request that was the subject of the external review **within 24 hours**.

Expedited External Review

The Member or authorized representative may make an oral or written request to the HCA3 for an expedited external review. A retrospective case is not eligible for an expedited external review.

Please refer to the final internal appeal Adverse Benefit Determination letter for specific instructions on how to file the appeal with the HCA3.

A Member/authorized representative may request an expedited external review in the following circumstances:

- The Member has an urgent care condition for which the time for a standard external review decision would seriously jeopardize the life, or health of the Member or jeopardize their ability to regain maximum function.
- The final Adverse Benefit Determination concerns an admission, availability of care, continued stay or health care service for which a Member receives emergency care but has not been discharged from a facility.

A Member/authorized representative may request an expedited external review at the same time as the expedited internal Medical Necessity Appeal process in the following circumstances:

- The Member has an urgent care condition for which the timeframe for completion of an expedited internal review of the Adverse Benefit Determination would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function.
- The final Adverse Benefit Determination involves a determination that the recommended or requested health care service is experimental/investigative, and the Member's treating health care provider certifies in writing that the recommended or requested health care service that is the subject of the Adverse Benefit Determination would be significantly less effective if not promptly initiated.

Preliminary Review of an Expedited External Review Request

Upon receipt of an expedited external review, the HCA3 sends a copy of the request to the Health Benefit Plan **within 24 hours**.

- **Within 24 hours** of receipt of the request from the HCA3, the Health Benefit Plan determines if the request meets the requirements for an external review and notifies the HCA3 and Member/authorized representative of the Health Benefit Plan's eligibility determination.
  - The Member/authorized representative may appeal the Health Benefit Plan's initial determination that the external review request is ineligible for review to the HCA3.
  - Despite the Health Benefit Plan's initial determination, the HCA3 may determine, based upon the terms of the Member's health insurance policy, that a request is eligible for external review. This determination will be binding on the Health Benefit Plan. The Member/authorized representative may appeal to the PID Commissioner. Consideration of this appeal may not delay or terminate the external review.

Expedited External Review Process

Upon receipt of the Health Benefit Plan's notification that the request meets the eligibility requirements, the HCA3 assigns an IRO to conduct the expedited external review **within 24 hours**.

The Health Benefit Plan forwards all documents from an Adverse Benefit Determination or final Adverse Benefit Determination to the assigned IRO by the following methods:

- Electronically (typically via the assigned IRO portal).
- By any other available expedited method, if no IRO portal is available.

Expedited External Review IRO Decision

Within 72 hours of receipt of the request, the IRO makes their decision and notifies the Member/authorized representative, the HCA3, and the Health Benefit Plan. For non-formulary exception requests, the IRO makes their decision **within 24 hours** of the request and notifies the Member/authorized representative, the HCA3, and the Health Benefit Plan.

Upon receipt of an IRO overturn decision, the Health Benefit Plan will approve the request that was the subject of the expedited external review **within 24 hours**.

Binding Decision for External Reviews

An IRO decision is binding on the Health Benefit Plan except to the extent the Health Benefit Plan has other remedies available under applicable state law. An IRO decision is binding on the Member/authorized representative, except to the extent the Member/authorized representative has other remedies available under applicable Federal and state laws.

Neither the Member or the authorized representative may file a subsequent request for an external review involving an Adverse Benefit Determination or final Adverse Benefit Determination for which the Member has already received a decision for the same Adverse Benefit Determination or final Adverse Benefit Determination.

If the Member's Health Benefit Plan is subject to the requirements of the Employee Retirement Income Security Act (ERISA), following the Member's appeal, the Member may have the right to bring civil action under Section 502(a) of the Act. For questions about the Member's rights, or for assistance, the Member can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) (TTY: 711) . Additionally, a consumer assistance program may be able to assist the Member at:

Pennsylvania Insurance Department
1325 Strawberry Square
Harrisburg, PA 17111
1-877-881-6388 (TTY: 711)
www.insurance.pa.gov

SECTION 7 - IMPORTANT DEFINITIONS

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

Accredited Educational Institution
A publicly or privately operated academic institution of higher learning which:
- Provides recognized course or courses of instruction and leads to the conference of a diploma, degree, or other recognized certification of completion at the conclusion of the course of study; and
- Is duly recognized and declared as such by the appropriate authority of the state in which such institution is located; provided, however, that in addition to any state recognition, the institution must also be accredited by a nationally recognized accrediting association as recognized by the United States Secretary of Education.

The definition may include, but is not limited to, colleges and universities, and technical or specialized schools.

Adverse Benefit Determination
A determination that includes any denial, reduction, or rescission of health insurance coverage (when, in connection with the rescission, there is an adverse effect on a particular benefit at that time). An Adverse Benefit Determination may be any of the following:
- A determination by the Health Benefit Plan or a utilization review entity on its behalf, that based on the information provided and upon application of utilization review, a request for a benefit under a health insurance policy does not meet the Health Benefit Plan's requirement for Medical Necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental/investigative, such that the requested benefit is therefore denied, reduced or terminated or payment is not provide or made, in whole or in part, for the benefit.
- The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by the Health Benefit Plan of a Member's eligibility for coverage under a health insurance policy or noncompliance with an administrative policy.
- A rescission of coverage determination by the Health Benefit Plan.

Appeal of an Administrative Denial
An appeal of any of the following types of Adverse Benefit Determinations:
- Prior authorization, coverage or payment based on a lack of eligibility, failure to submit complete information or other failure to comply with an administrative policy.
- Certain surprise medical bills received by a Member from an out-of-network provider.
- Rescission of coverage (except for failure to pay premiums or coverage contributions) that has not been resolved by the Health Benefit Plan and has been filed with the Pennsylvania Insurance Department.

This term does not include a Medical Necessity Appeal. It also does not include disputes or objections that were resolved by the Health Benefit Plan and did not result in the filing of an Appeal of an Administrative Denial (written or oral).

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 Health Benefit Plan. A charge shall be considered Incurred on the date the service or supply was provided to a Member.

Billed Charge
An amount billed by a Supplier or Professional Provider for treatment, services or supplies rendered to a Member.

Coinsurance
A specific percentage of the Provider's Reasonable Charge for Covered Services set forth in the section entitled ***Schedule of Benefits*** of this Benefit Booklet, for which the Member is responsible.

- Program Coinsurance - a specified percentage of the Provider's Reasonable Charge applied to all Covered Services for which the Member is responsible.
- Benefit Coinsurance - a specified percentage of the Provider's Reasonable Charge applied to a specific Covered Service for which the Member is responsible.

Complaint
Any expression of dissatisfaction, verbal or written, by a Member.

Contract
The Group Policy of Vision Care Benefits, including the Group Application, riders and/or endorsements, if any, between the Health Benefit Plan and the Contractholder, also referred to as the Group Contract.

Contractholder
Any individual, corporation or other entity who, as the representative of an enrolled group of Employees (Members) and as Agent for the Members is acceptable to the Health Benefit Plan. The Contractholder has agreed to pay the charges payable under the Contract to the Health Benefit Plan and to receive any information from the Health Benefit Plan on behalf of the Applicants.

Copayment
A specified amount of expenses applied to a specific Covered Service for which the Member is responsible per Covered Service.

Covered Service
A service or supply specified in this Benefit Booklet for which benefits will be provided when rendered by a Professional Provider or Supplier. For purposes of this Program, the term "Covered Services and Supplies" means Covered Services, with the exception of Eye Examination Services.

Dependent
A Member other than the Employee as specified in the section entitled ***Who Is Covered***.

Domestic Partner (Domestic Partnership)
A member of a domestic partnership is one of two partners, each of whom:

- Is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time;
- Is not related to the other partner by adoption or blood;
- Is the sole Domestic Partner of the other partner, with whom the person has a close committed and personal relationship, and has been a member of this domestic partnership for the last six months;
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner;

- Meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for domestic partnerships; and
- Demonstrates financial interdependence by submission of proof of three or more of the following documents:
  - A Domestic Partner agreement;
  - A joint mortgage or lease;
  - A designation of one of the partners as beneficiary in the other partner's will;
  - A durable property and health care powers of attorney;
  - A joint title to an automobile, or joint bank account or credit account; or
  - Such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

  The Health Benefit Plan reserves the right to request documentation of any of the foregoing prior to commencing coverage for the Domestic Partner.

Effective Date
A date on which coverage for a Member begins under the Group Contract.

Employee
An individual in the Contract Holder who meets the eligibility requirements for enrollment and who is so specified for enrollment.

Eye Examination Services
A comprehensive examination and evaluation of the eyes performed by a physician, Ophthalmologist or Optometrist, which shall include, but not be limited to, the services listed in the "Eye Examination Services" subsection of the section entitled ***Vision Care Benefits***.

Family Coverage
Coverage for the Employee and one or more of the Employee's Dependents.

Incurred
A charge shall be considered Incurred on the date a Member receives the service or supply for which the charge is made.

Lens
A transparent refracting medium, usually made of plastic.
- Aphakic - a lens prescribed for those who have had the crystalline lens of the eye removed during cataract surgery or who were born without a crystalline lens.
- Bifocal - a lens containing two different powers, one for distance vision, and one for near vision.
- Disposable Contact - a soft plastic contact lens that is applied to the eye for correcting refractive errors for a period of approximately one to two weeks and is then discarded.
- Hard Contact - a curved glass or plastic lens that is applied to the eye for correction of refractive errors.
- Lenticular - a type of aphakic lens prescribed to replicate the crystalline lens of the eye.
- Single Vision - a lens with one correction, for either distance or near vision.
- Soft Contact - a lens for correcting refractive errors. They are of soft plastic material.
- Trifocal - a lens that has three distinct areas for visual focus.

Limitations
The Maximum frequency as set forth in the section entitled ***Schedule of Benefits***, for which a Covered Service is allowed.

Maximum
The greatest amount payable by the Health Benefit Plan set forth in the ***Schedule of Benefits***, for Covered Services. This could be expressed in dollars or a specified number of services for a specified period of time.

- Program Maximum - the greatest amount payable by the Health Benefit Plan for Covered Services.
- Benefit Maximum - the greatest amount payable by the Health Benefit Plan for a specific Covered Service.

Medical Necessity Appeal
An appeal of an Adverse Benefit Determination that the request for a benefit under a health insurance policy does not meet the Health Benefit Plan's requirement for Medical Necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental/investigative. This includes an Adverse Benefit Determination that does any of the following:

- Disapproves full or partial payment for a requested health care service;
- Approves the provision of a requested health care service for a lesser scope or duration than requested; or
- Disapproves payment of the provision of a requested health care service but approves payment for the provision of an alternative health care service.

The term does not include an Appeal of an Administrative Denial. It also does not include disputes or objections regarding Medical Necessity that were resolved by the Health Care Plan and did not result in the filing of a Medical Necessity Appeal (written or oral).

Member
An enrolled Employee and their Eligible Dependents who have satisfied the specifications under the section entitled ***Who Is Covered*** of this Benefit Booklet.

Non-Participating Provider
A Professional Provider that does not participate in the Health Benefit Plan's programs and is not required to accept the Health Benefit Plan's payment as payment-in-full.

Ophthalmologist
Is a Physician who specializes in the diagnosis, treatment and prescription of medications and lenses related to conditions of the eye, and who may perform Eye Examination and Refractive Services.

Optician
Is a person who makes, fits, supplies and adjusts eyeglasses in accordance with a prescription written by a Professional Provider to correct a Member's optical defects. Opticians are not Professional Providers.

Optometrist
Is a person licensed to practice optometry in accordance with the provisions of the Optometric Practice and Licensure Act, and whom may perform Eye Examination and Refractive Services.

Participating Provider
A Professional Provider that has an agreement with the Health Benefit Plan pertaining to payment for Covered Services rendered to a Member.

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.

Professional Provider
A person or practitioner licensed where required and performing within the scope of such licensure. The Professional Providers include:
- Doctor of Medicine
- Doctor of Ophthalmology
- Doctor of Optometry
- Doctor of Osteopathy
- Physician

Provider's Reasonable Charge
The dollar amount on which a Member's Coinsurance, Benefit Maximums and benefits will be calculated. "Provider's Reasonable Charge" shall mean the following:
- For services rendered by a Participating Provider, "Provider's Reasonable Charge" means the rate of reimbursement for Covered Services determined by contract, or the Billed Charge, whichever is less; or
- For services rendered by a Non-Participating Provider, "Provider's Reasonable Charge" means the Reasonable and Customary Charges, or Benefit Maximums amount, or Billed Charge, whichever is less.

Reasonable And Customary
Means the amount that is the usual or customary charge for the service or supply as determined by the Health Benefit Plan. The chosen standard is an amount which is most often charged by other providers for similar services or supplies within the same geographic area where the service or supply is provided and who have training, experience and professional standing comparable to those of the actual provider of the service or supply. If no comparison exists, the Health Benefit Plan determines what is reasonable by the severity and/or complexity of the Member's condition for which the service or supply is provided.

Supplier
A provider engaged in dispensing ophthalmic material (For example, contact lenses, spectacle lenses) in accordance with a prescription written by a Professional Provider. Supplies include, but are not limited to, Opticians and retail optical dispensing firms.

Total Disability
Except as otherwise specified in this Benefit Booklet, a Member who, due to illness or injury, cannot perform any duty of their occupation or any occupation for which they are, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if they cannot engage in the normal activities of a person in good health and of like age and sex. The Member or Dependent person must be under the regular care of a Physician.

INDEPENDENCE BLUE CROSS NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION[1]

PLEASE REVIEW IT CAREFULLY.

Independence Blue Cross[2] values you as a customer, and protection of your privacy is very important to us. In conducting our business, we will create and maintain records that contain protected health information about you and the health care provided to you as a member of our health plans.

Note: "Protected health information" or "PHI" is information about you, including information that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We protect your privacy by:

- limiting who may see your PHI;
- limiting how we may use or disclose your PHI;
- informing you of our legal duties with respect to your PHI;
- explaining our privacy policies; and
- adhering to the policies currently in effect.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members' protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We also are required by the federal Health Insurance Portability and Accountability Act (or "HIPAA") Privacy Rule to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information.

[1] If you are enrolled in a self-insured group benefit program, this Notice is not applicable. If you are enrolled in such a program, you should contact your Group Benefit Manager for information about your group's privacy practices. If you are enrolled in the Federal Employee Service Benefit Plan, you will receive a separate Notice.

[2] For purposes of this Notice, "Independence Blue Cross" refers to the following companies: Independence Blue Cross, Keystone Health Plan East, QCC Insurance

Company, and Vista Health Plan, Inc. – independent licensees of the Blue Cross and Blue Shield Association.

This revised Notice took effect on July 18, 2017, and will remain in effect until we replace or modify it.

Copies of this Notice
You may request a copy of our Notice at any time. If you want more information about our privacy practices, or have questions or concerns, please contact Member Services by calling the telephone number on the back of your Member Identification Card, or contact us using the contact information at the end of this Notice.

Changes to this Notice
The terms of this Notice apply to all records that are created or retained by us which contain your PHI. We reserve the right to revise or amend the terms of this Notice. A revised or amended Notice will be effective for all of the PHI that we already have about you, as well as for any PHI we may create or receive in the future. We are required by law to comply with whatever Privacy Notice is currently in effect. You will be notified of any material change to our Privacy Notice before the change becomes effective. When necessary, a revised Notice will be mailed to the address that we have on record for the contract holder of your member contract, and will also be posted on our web site at www.ibx.com.

Potential Impact of State Law
The HIPAA Privacy Rule generally does not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

How We May Use and Disclose Your Protected Health Information (PHI)
In order to administer our health benefit programs effectively, we will collect, use and disclose PHI for certain of our activities, including payment of covered services and health care operations.

The following categories describe the different ways in which we may use and disclose your PHI. Please note that every permitted use or disclosure of your PHI is not listed below.
However, the different ways we will, or might, use or disclose your PHI do fall within one of the permitted categories described below.

Treatment: We may disclose information to doctors, pharmacies, hospitals and other health care providers who take care of you to assist in your

treatment or the coordination of your care.

Payment: We may use and disclose your PHI for all payment activities including, but not limited to, collecting premiums or to determine or fulfill our responsibility to provide health care coverage under our health plans. This may include coordinating benefits with other health care programs or insurance carriers, such as Medicare or Medicaid. For example, we may use and disclose your PHI to pay claims for services provided to you by doctors or hospitals which are covered by your health plan(s), or to determine if requested services are covered under your health plan. We may also use and disclose your PHI to conduct business with other Independence Blue Cross affiliate companies.

Health Care Operations: We may use and disclose your PHI to conduct and support our business and management activities as a health insurance issuer. For example, we may use and disclose your PHI to determine our premiums for your health plan, to conduct quality assessment and improvement activities, to conduct business planning activities, to conduct fraud detection programs, to conduct or arrange for medical review, or to engage in care coordination of health care services.

We may also use and disclose your PHI to offer you one of our value added programs like smoking cessation or discounted health related services, or to provide you with information about one of our disease management programs or other available Independence Blue Cross health products or health services.

We may also use and disclose your PHI to provide you with reminders to obtain preventive health services, and to inform you of treatment alternatives and/or health related benefits and services that may be of interest to you.

Marketing: Your PHI will not be sold, used or disclosed for marketing purposes without your authorization except where permitted by law. Such exceptions may include: a marketing communication to you that is in the form of (a) a face-to-face communication, or (b) a promotional gift of nominal value.

Release of Information to Plan Sponsors: Plan sponsors are employers or other organizations that sponsor a group health plan. We may disclose PHI to the plan sponsor of your group health plan as follows:

- We may disclose “summary health information” to your plan sponsor to use to obtain premium bids for providing health insurance coverage or to modify, amend or terminate its group health plan. “Summary health information” is information that summarizes claims history, claims expenses, or types of claims experience for the individuals who participate in the plan sponsor’s group health plan;

- We may disclose PHI to your plan sponsor to verify enrollment/disenrollment in your group health plan;
- We may disclose your PHI to the plan sponsor of your group health plan so that the plan sponsor can administer the group health plan; and
- If you are enrolled in a group health plan, your plan sponsor may have met certain requirements of the HIPAA Privacy Rule that will permit us to disclose PHI to the plan sponsor. Sometimes the plan sponsor of a group health plan is the employer. In those circumstances, we may disclose PHI to your employer. You should talk to your employer to find out how this information will be used.

Research: We may use or disclose your PHI for research purposes if certain conditions are met. Before we disclose your PHI for research purposes without your written permission, an Institutional Review Board (a board responsible under federal law for reviewing and approving research involving human subjects) or Privacy Board reviews the research proposal to ensure that the privacy of your PHI is protected, and to approve the research.

Required by Law: We may disclose your PHI when required to do so by applicable law. For example, the law requires us to disclose your PHI:

- When required by the Secretary of the U.S. Department of Health and Human Services to investigate our compliance efforts; and
- To health oversight agencies, to allow them to conduct certain Health Oversight Activities described below.

Public Health Activities: We may disclose your PHI to public health agencies for public health activities that are permitted or required by law, such as to:

- prevent or control disease, injury or disability;
- maintain vital records, such as births and deaths;
- report child abuse and neglect;
- notify a person about potential exposure to a communicable disease;
- notify a person about a potential risk for spreading or contracting a disease or condition;
- report reactions to drugs or problems with products or devices;
- notify individuals if a product or device they may be using has been recalled; and
- notify appropriate government agency(ies) and authority(ies) about the potential abuse or neglect of an adult patient, including domestic violence.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits;

investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Health oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Lawsuits and Other Legal Disputes: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process once we have met all administrative requirements of the HIPAA Privacy Rule.

Law Enforcement: We may disclose your PHI to law enforcement officials under certain conditions. For example, we may disclose PHI:

- to permit identification and location of witnesses, victims, and fugitives;
- in response to a search warrant or court order;
- as necessary to report a crime on our premises;
- to report a death that we believe may be the result of criminal conduct; or
- in an emergency, to report a crime.

Coroners, Medical Examiners, or Funeral Directors: We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties.

Organ and Tissue Donation: We may use or disclose your PHI to organizations that handle organ and tissue donation and distribution, banking, or transplantation.

To Prevent a Serious Threat to Health or Safety: As permitted by law, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Military and National Security: We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counter-intelligence, and other national security activities.

Inmates: If you are a prison inmate, we may disclose your PHI to the prison or to a law enforcement official for: (1) the prison to provide health care to you; (2) your health and safety, and the health and safety of others; or (3) the safety and security of the prison.

Underwriting: We will not use genetic information about you for underwriting purposes.

Workers' Compensation: As part of your workers' compensation claim, we may have to disclose your PHI to a worker's compensation carrier.

To You: When you ask us to, we will disclose to you your PHI that is in a "designated record set." Generally, a designated record set contains medical, enrollment, claims and billing records we may have about you, as well as other records that we use to make decisions about your health care benefits. You can request the PHI from your designated record set as described in the section below called "Your Privacy Rights Concerning Your Protected Health Information."

To Your Personal Representative: If you tell us to, we will disclose your PHI to someone who is qualified to act as your personal representative according to any relevant state laws. In order for us to disclose your PHI to your personal representative, you must send us a completed Independence Blue Cross Personal Representative Designation Form and documentation that supports the person's qualification according to state law (such as a power of attorney or guardianship). To request the Independence Blue Cross Personal Representative Designation Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at www.ibx.com, or write us at the address at the end of this Notice. However, the HIPAA Privacy Rule permits us to choose not to treat that person as your personal representative when we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse or neglect by the person; (ii) treating the person as your personal representative could endanger you; or (iii) in our professional judgment, it is not in your best interest to treat the person as your personal representative.

To Family and Friends: Unless you object, we may disclose your PHI to a friend or family member who has been identified as being involved in your health care. We also may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your PHI, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

Parents as Personal Representatives of Minors: In most cases, we may disclose your minor child's PHI to you. However, we may be required to deny a parent's access to a minor's PHI according to applicable state law.

Health Information Exchanges

We share your health information electronically through certain Health Information Exchanges ("HIEs"). A HIE is a secure electronic data sharing network. In accordance with applicable federal and state privacy and security requirements, regional health care providers participate in HIEs to exchange patient information in real-time to help facilitate delivery of health care, avoid duplication of services, and more efficiently coordinate care. As a participant in HIEs, Independence shares your health information we may have received when a claim has been submitted for services you have received among authorized participating providers, such as physicians, hospitals, and health systems for the purpose of treatment, payment and

health care operations as permitted by law.
During an emergency, patients and their families may forget critical portions of their medical history which may be very important to the treating physician who is trying to make a quick, accurate diagnosis in order to treat the sick patient. Independence, through its participation in an HIE, makes pertinent medical history, including diagnoses, studies, lab results, medications and the treating physicians we may receive on a claim available to participating emergency room physicians while the patient is receiving care. This is invaluable to the physician, expediting the diagnosis and proper treatment of the patient.

Your treating providers who participate with an HIE, and also submit health information with the HIE, will have the ability to access your health information through the HIE and send records to your treating physicians. Through direct requests to the HIE, we will receive various types of protected health information such as pharmacy or laboratory services, or information when you have been discharged from a hospital which may be used to coordinate your care, provide case management services, or otherwise reduce duplicative services and improve the overall quality of care to our members. All providers that participate in HIEs agree to comply with certain privacy and security standards relating to their use and disclosure of the health information available through the HIE.

As an Independence member, you have the right to opt-out which means your health information will not be accessible through the HIE. Through the regional HIE (www.hsxsepa.org/patient-options-opt-out-back) website or the State HIE (https://www.dhs.pa.gov/providers/Providers/Documents/opt%20out.pdf) website consumers or providers can access an online, fax, or mail form permitting patients to remove themselves (opt-out) or reinstate themselves (opt back in) to the HIE. It will take approximately one business day to process an opt-out request. If you choose to opt-out of the HIE, your health care providers will not be able to access your information through the HIE. Even if you opt-out, this will not prevent your health information from being made available and released through other means (i.e. fax, secure email) to authorized individuals, such as network providers for paying claims, coordinating care, or administering your health benefits in accordance with the law and in the normal course of conducting our business as permitted under applicable law. For more information on HIEs, please go to www.hsxsepa.org/consumers-0 or to https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Information%20Technology/Health-Information-Exchange-Citizens.aspx.

Right to Provide an Authorization for Other Uses and Disclosures

- Other uses and disclosures of your PHI that are not described above will be made only with your written authorization.
- You may give us written authorization permitting us to use your PHI or disclose it to anyone for any purpose.

- We will obtain your written authorization for uses and disclosures of your PHI that are not identified by this Notice, or are not otherwise permitted by applicable law.

Any authorization that you provide to us regarding the use and disclosure of your PHI may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Of course, we are unable to take back any disclosures that we have already made with your authorization. We may also be required to disclose PHI as necessary for purposes of payment for services received by you prior to the date when you revoked your authorization.

Your authorization must be in writing and contain certain elements to be considered a valid authorization. For your convenience, you may use our approved Independence Blue Cross Authorization Form. To request the Independence Blue Cross Authorization Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at www.ibx.com, or write us at the address at the end of this Notice.

Your Privacy Rights Concerning Your Protected Health Information (PHI)
You have the following rights regarding the PHI that we maintain about you. Requests to exercise your rights as listed below must be in writing. For your convenience, you may use our approved Independence Blue Cross form(s). To request a form, please contact Member Services at the telephone number listed on the back of your Member Identification card or write to us at the address listed at the end of this Notice.

Right to Access Your PHI: You have the right to inspect or get copies of your PHI contained in a designated record set. Generally, a “designated record set” contains medical, enrollment, claims and billing records we may have about you, as well as other records that we may use to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies of your PHI in a format other than photocopies such as by electronic means in certain situations. We will use the format you request unless we cannot practicably do so. We may charge a reasonable fee for copies of PHI (based on our costs), for postage, and for a custom summary or explanation of PHI. You will receive notification of any fee(s) to be charged before we release your PHI, and you will have the opportunity to modify your request in order to avoid and/or reduce the fee. In certain situations, we may deny your request for access to your PHI. If we do, we will tell you our reasons in writing, and explain your right to have the denial reviewed.

Right to Amend Your PHI: You have the right to request that we amend

your PHI if you believe there is a mistake in your PHI, or that important information is missing. Approved amendments made to your PHI will also be sent to those who need to know, including (where appropriate) Independence Blue Cross's vendors (known as "Business Associates"). We may also deny your request if, for instance, we did not create the information you want amended. If we deny your request to amend your PHI, we will tell you our reasons in writing, and explain your right to file a written statement of disagreement.

Right to an Accounting of Certain Disclosures: You may request, in writing, that we tell you when we or our Business Associates have disclosed your PHI (an "Accounting"). Any accounting of disclosures will **not** include those we made:

- for payment, or health care operations;
- to you or individuals involved in your care;
- with your authorization;
- for national security purposes;
- to correctional institution personnel; or
- before April 14, 2003.

The first accounting in any 12-month period is without charge. We may charge you a reasonable fee (based on our cost) for each subsequent accounting request within a 12- month period. If a subsequent request is received, we will notify you of any fee to be charged, and we will give you an opportunity to withdraw or modify your request in order to avoid or reduce the fee.

Right to Request Restrictions: You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to your request. However, if we do agree, we will be bound by our agreement except when required by law, in emergencies, or when information is necessary to treat you. An approved restriction continues until you revoke it in writing, or until we tell you that we are terminating our agreement to a restriction.

Right to Request Confidential Communications: You have the right to request that we use alternate means or an alternative location to communicate with you in confidence about your PHI. For instance, you may ask that we contact you by mail, rather than by telephone, or at work, rather than at home. Your written request must clearly state that the disclosure of all or part of your PHI at your current address or method of contact we have on record could be an endangerment to you. We will require that you provide a reasonable alternate address or other method of contact for the confidential communications. In assessing reasonableness, we will consider our ability to continue to receive payment and conduct health care operations effectively, and the subscriber's right to payment information. We may exclude certain communications that are commonly provided to all members from confidential communications. Examples of such communications include benefit booklets and newsletters.

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of our Notice of Privacy Practices. You can request a copy at any time, even if you have agreed to receive this Notice electronically. To request a paper copy of this Notice, please contact Member Services at the telephone number on the back of your Member Identification Card.

Right to Notification of a Breach of Your PHI: You have the right to and will be notified following a breach of your unsecured PHI or if a security breach occurs involving your PHI.

Your Right to File a Privacy Complaint

If you believe your privacy rights have been violated, or if you are dissatisfied with Independence Blue Cross's privacy practices or procedures, you may file a complaint with the Independence Blue Cross Privacy Office and with the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

To file a privacy complaint with us, you may contact Member Services at the telephone number on the back of your member ID card, or you may contact the Privacy Office as follows:

Independence Blue Cross Privacy Office
P.O. Box 41762
Philadelphia, PA 19101 – 1762

Fax: 215-241-4023 or 1-888-678-7006 (toll-free)
E-mail: Privacy@ibx.com
Phone: 215-241-4735 or 1-888-678-7005 (toll-free)

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