Independence

Independence Administrators

Your Group Health Plan

Kessler Topaz Meltzer & Check LLP

HDHP

Effective Date: June 1, 2024

This booklet describes your Kessler Topaz Meltzer & Check LLP Employee Medical Plan (the "Plan"). All benefits becoming due under the Plan are funded directly by Kessler Topaz Meltzer & Check LLP (the "Plan Sponsor"). The Plan Sponsor has the right to amend, modify, or discontinue the Plan at any time and for any reason.

The Plan Sponsor has entered into an agreement with QCC Insurance Company d/b/a Independence Administrators ("Independence Administrators") which provides for Independence Administrators to process benefit claims and provide certain other administrative services under the Plan.

Independence Administrators does not insure or guarantee the benefits described in this booklet.

Your health benefits are entirely funded by the Plan Sponsor. Independence Administrators provides administrative and claims payment services only. Independence Administrators has the authority to interpret claim policy on behalf of the Plan Sponsor. Independence Administrators is not the administrator of the Plan for the purposes of the Employee Retirement and Income Security Act ("ERISA").

Independence Administrators is an independent licensee of the Blue Cross and Blue Shield Association.

Nondiscrimination Notice and Notice of Availability of Auxiliary Aids and Services

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

Independence Administrators:

- Provides free aids and services to people with disabilities to communicate effectively with us and written information in other formats, such as large print
- Provides free language services to people whose primary language is not English and information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Independence Administrators 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.

There are four ways to file a grievance directly with Independence Administrators:

- by mail: Independence Administrators,
  ATTN: Civil Rights Coordinator, 1900 Market Street, Philadelphia, PA 19103;
- by phone: 844-864-4352 (TTY 711),
- by fax: 215-761-0920, or
- by email: **IACivilRightsCoordinator@ibxtpa.com**

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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Language Access Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711).

Spanish: ATENCIÓN: Si usted habla inglés, tiene a su disposición servicios de asistencia de idiomas sin costo. Llame al número que aparece en su tarjeta de identificación de socio (TTY: 711).

Chinese: 请注意：如果您说[中文]，则可以免费使用语言协助服务。请拨打您身份证上的号码（TTY：711）。

Hmong: LUS CEEB TOOM: Yog tias koj hais LUS HMOOB, ces yuav muaj kev pab cuam txhais lus pub dawb rau koj. Hu rau tus nab npawb xov tooj nyob ntawm koj daim npav ID (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói [người việt nam], bạn sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí. Gọi đến số trên thẻ ID của bạn (TTY: 711).

Somali: FIIRO GAAR AH: Haddii aad ku hadashid luuqada Soomaaliga, adeegyada caawinta luuqada, oobilaash ah, ayaa laguu helayaa. Soo wac lambarka ku qoran kaarkaaga Aqoonsiga (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги переводчика. Позвоните по номеру на ID-карте (TTY: 711).

Arabic: انتبه: إذا كنت تتحدث اللغة العربية، تم توفير خدمات المساعدة اللغوية مجانًا. اتصل بالرقم الموجود على بطاقة الهوية الخاصة بك (TTY: ٧١١).

French : ATTENTION : Si vous parlez le français, des services d'assistance linguistique gratuits, vous sont proposés. Appelez le numéro sur votre carte d'identité (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen ein kostenloser Sprachassistent zur Verfügung. Rufen Sie die Nummer auf Ihrem Ausweis an (TTY: 711).

Amharic: ትኩረት፦ [አማርኛ] የሚናገሩ ከሆነ ከክፍያ ነፃ የሆነ የቋንቋ አገልግሎቶች በነጻ ያገኛሉ። ሁሉም ቁጥሮች ID ካርድዎት (TTY: 711) ላይ ይገኛሉ።

Korean: 주의: [한국어]를 사용하는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. ID 카드에 적힌 번호로 전화해주십시오. (TTY:711).

Lao: ສິ່ງທີ່ຄວນຮູ້: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອທາງດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຽຄ່າ. ໃຫ້ໂທເບີໂທລະສັບທີ່ຢູ່ເທິງບັດ ID ຂອງທ່ານ (TTY: 711).

Tagalog: PANSININ: Kung nagsasalita ka ng Tagalog, libre na available sa iyo ang mga serbisyo sa tulong sa wika. Tumawag sa numero sa iyong ID card (TTY: 711).

Navajo: Áhéhee': T'áá ał'nííł nigií bizaad yádaalłti'í nisin, yá'át'ééhá ánída'ál nisin, ákót'éego bee hóló, bizaad yádaalłti'í nisin dah nishłį, yaałtsoh da t'ááji'ígíí ashkii. T'áá baa yáshti' ałkéé'í baa hólǫ́ǫ́dałta'í níshłį (TTY: 711).

Khmer: ប្រុងប្រយ័ត្ន៖ ប្រសិនបើអ្នកនិយាយភាសា [ខ្មែរ] មានផ្តល់សេវាកម្មជំនួយភាសាដែលឥតគិតថ្លៃជូនអ្នក។ ហៅទូរសព្ទទៅលេខនៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក (TTY៖ 711)។

Italian: ATTENZIONE: Per coloro che parlano italiano, sono disponibili i servizi di assistenza linguistica gratuiti. Chiamare al numero indicato sulla carta ID (TTY: 711).

Guajarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો ભાષા સહાય સેવાઓ, તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. તમારા ID કાર્ડ પરના નંબર (TTY: 711) પર કૉલ કરો.

Polish: UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnych usług pomocy językowej. Zadzwoń pod numer znajdujący się na karcie (telefon tekstowy: 711).

Creole: ATANSYON: Si ou pale kreyòl, sèvis asistans lang yo gratis, e yo disponib pou ou. Rele nan 1-888-356-7899 (TTY: 711). Rele nimewo ki sou kat idantite ou an (TTY: 711).

Portuguese: ATENÇÃO: Se você fala português, os serviços de assistência linguística, gratuitos, estão disponíveis para você. Ligue para o número em seu cartão de identificação (TTY: 711).

Japanese: 注記：[日本語] 話者向けの無料の言語支援サービスを利用できます。IDカードの番号に電話してください（TTY: 711）。

Farsi: توجه: اگر زبان شما فارسی است، خدمات کمک زبانی، به صورت رایگان در دسترس شما است. با شماره روی کارت شناسایی‌تان تماس بگیرید (TTY: ۷۱۱).

Urdu: متوجہ ہوں: اگر آپ اُردو بولتے ہیں، تو زبان کی معاونت کی خدمات، آپ کے لیے مُفت دستیاب ہیں۔ اپنے ID کارڈ پر موجود نمبر (TTY: ۷۱۱) پر کال کریں۔

Hindi: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएं उपलब्ध हैं। अपने ID कार्ड पर दिए गए नंबर (TTY: 711) पर कॉल करें।

Telugu: ధ్యాస పెట్టండి: మీరు తెలుగు మాట్లాడగలిగితే, భాషా సహాయక సేవలు మీకు ఉచితంగా లభిస్తాయి. మీ ఐడి కార్డుపై ఉండే నెంబర్‌కు కాల్ చేయండి (TTY: 711).

Swahili: KUMBUKA: Iwapo unazungumza Kiswahili, utapata huduma za usaidizi wa lugha bila malipo. Piga simu kwa nambari iliyo kwenye kitambulisho chako (TTY: 711).

Ojibwe: AMBE: Giishipin wii'wiidookaagooyan ji-noondam Ojibwemowin, ganoozhishinaam Gawain gidaw-diba'anziin. Inganoonaa asigibii'igann bimibizoo-mazina'igaans. (TTY: 711)

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SCHEDULE OF BENEFITS HDHP

This Schedule of Benefits lists benefits, maximums, and allowances that your Plan provides for each enrolled person. The coinsurance rates shown in this table are based on your Plan's allowance for each service. *Read the section on **The Preferred Provider Network** carefully* to see how you can save money by receiving your care from Preferred Providers.

Remember…Your Plan has Clinical Services requirements for all inpatient admissions. It may also require pre-certification for certain outpatient procedures. If you do not comply with these provisions, your Plan may reduce the benefits for those services or may not cover them at all. *Read the sections on **Clinical Services** carefully.*

Service	If the Covered Person uses a Preferred Provider or a BlueCard Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
Plan Year Deductible		
• Individual	$2,000	$5,000
• Family Aggregate	$4,000	$10,000
Out-of-pocket maximum expense you could pay in a Plan Year Includes deductible, coinsurance and copayments; Preferred Provider and Non-Preferred Provider expenses accumulate separately.		
• Individual	$3,000	$10,000
• Family Embedded	$6,000	$20,000
Coinsurance — This table shows the percentage of the Plan's allowance your Plan pays for different covered services. *All payments are based on your Plan's allowance* for the service performed. Your Plan begins to pay for eligible expenses, at the rate shown in the table, *after you meet your Deductible*.		
Coinsurance rates for various services *(based on the Plan's allowance)*		
HOSPITAL BENEFITS		
Inpatient Hospital Facility	100% after deductible	50% after deductible *Benefit maximum of 70 inpatient days combined per benefit period*
Inpatient Hospital Physician	100% after deductible	50% after deductible
Outpatient Surgery Facility	100% after deductible	50% after deductible
Outpatient Surgery Physician	100% after deductible	50% after deductible
Inpatient Maternity *Includes delivery and inpatient services*	100% after deductible	50% after deductible, *Benefit maximum of 70 inpatient days combined per benefit period*
EMERGENCY SERVICES		
Emergency Accident Treatment Facility	100% after deductible	100% after preferred deductible

Service	If the Covered Person uses a Preferred Provider or a BlueCard Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
Non-Emergency Treatment in an Emergency Facility	100% after deductible	100% after preferred deductible
Urgent Care Facility	100% after deductible	50% after deductible
Ambulance Emergency	100% after deductible	100% after preferred deductible
Ambulance Non-Emergency	100% after deductible	50% after deductible
OUTPATIENT SERVICES		
Physician Office Visit	100% after deductible	50% after deductible
Specialist Office Visit	100% after deductible	50% after deductible
Prenatal/Postnatal Office Visit	100% after deductible	50% after deductible
Chiropractic Office Visit *Benefit maximum of 20 visits per benefit period*	100% after deductible	50% after deductible
Diagnostic Test (Blood Work)	100% after deductible	50% after deductible
Diagnostic Test (X-Ray)	100% after deductible	50% after deductible
Diagnostic Imaging *CT, CTA, MRA, MRI, PET, PETT, SPECT and MUGA*	100% after deductible	50% after deductible
THERAPY SERVICES		
Physical & Occupational Therapy *Benefit maximum of 30 visits combined per benefit period*	100% after deductible	50% after deductible
Speech Therapy *Benefit maximum of 20 visits per benefit period*	100% after deductible	50% after deductible
MISCELLANEOUS SERVICES AND SUPPLIES		
Durable Medical Equipment	100% after deductible	50% after deductible
Home Health Care	100% after deductible	50% after deductible
Private Duty Nursing - *Benefit maximum of 360 hours per benefit period*	100% after deductible	50% after deductible
Hospice Care Outpatient	100% after deductible	50% after deductible
Skilled Nursing Facility *Benefit maximum of 120 days per benefit period; Limits for Skilled Care Rehabilitation and Skilled Nursing Facility Visit are combined*	100% after deductible	50% after deductible

Service	If the Covered Person uses a Preferred Provider or a BlueCard Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
INJECTABLE MEDICATIONS		
Infusion Therapy Drugs & Biotech/Specialty Injectables	100% after deductible	50% after deductible
Medical Injectable Drugs & Therapeutic Injections	100% after deductible	50% after deductible
ADULT PREVENTIVE CARE-Age and Frequency limits may apply		
Adult Physical Examination	100%	50%
Routine Gynecological Exam	100%	50%
PAP Test	100%	50%
Mammogram	100%	50%
Other Preventive Care	100%	50%
CHILD PREVENTIVE CARE- Age and Frequency limits may apply		
Well-Child Care Examination	100%	50%
Pediatric Immunizations	100%	50%
MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT		
Inpatient Facility	100% after deductible	50% after deductible, *Benefit maximum of 70 inpatient days combined per benefit period*
Outpatient Facility	100% after deductible	50% after deductible
Outpatient Visit	100% after deductible	50% after deductible

Service	If the Covered Person uses a Preferred Provider or a BlueCard Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
PRESCRIPTION DRUGS Your prescription drug coverage is administered by a third party contracted by Independence Administrators to provide the Prescription Benefit Services.		
Your Plan Deductible must be met before your coinsurance and copayments apply.		
Retail Pharmacy *30-day supply*		
Generic Drugs	$15 copay	50%
Preferred-Brand Drugs	$35 copay	50%
Non-Preferred Drugs	$50 copay	50%
Specialty Drugs	100%	50%
Mail Order *90-day supply*		
Generic Drugs	$30 copay	Not Covered
Preferred-Brand Drugs	$70 copay	Not Covered
Non-Preferred Drugs	$100 copay	Not Covered

ELIGIBILITY

CLASS(ES) ELIGIBLE FOR COVERAGE

The following classes are eligible for coverage under the terms of the Plan:

All Active, Full-time Employees who work 30 or more hours per week.

ELIGIBLE EMPLOYEE

The Employee is eligible to be covered under this Program if the Employee is determined by the Group as eligible to apply for coverage.

Eligibility shall not be affected by the Employee's physical condition and determination of eligibility for the coverage by the employer shall be final and binding.

EMPLOYMENT WAITING PERIOD

Active, Full-time: First (1st) of the month following the Date of Hire

ELIGIBILITY DATE — EMPLOYEE COVERAGE

An Employee will be eligible for coverage upon completion of the Employment Waiting Period.

ELIGIBILITY DATE — DEPENDENT COVERAGE

Each eligible Employee will be eligible for Dependent coverage on the later of:

1. the date the Employee becomes eligible for coverage, if he has Dependents on that date; or
2. the date the Employee acquires a Dependent, if application is made within thirty-one (31) days.
3. Coverage of a newborn child will become effective immediately for routine nursery care, treatment for prematurity, birth abnormalities, congenital defects, or any other Illnesses. The newborn child will be entitled to receive all benefits, in accordance with the terms of the Plan, from birth for thirty-one (31) days. Upon application within the thirty-one (31) day period, the Employee may continue coverage beyond that period for a newborn child who qualifies as an eligible Dependent, subject to payment of any additional contribution if required by the Plan.

No Employee or Dependent may be covered simultaneously as an Employee and Dependent under the Plan. Also, a person may be covered under the Plan as the Dependent of only one Employee.

DEPENDENTS NOT ELIGIBLE FOR COVERAGE

The following Dependents are not eligible for coverage under the Plan in any case:

1. an eligible Employee's spouse if legally separated or divorced from the eligible Employee, unless a court decree directs otherwise, and then only until either the Employee or ex-spouse remarries;
2. an eligible Employee's child 26 or more years of age, with the exception of (a) an unmarried child, 26 or more years of age, who is unable to earn his own living due to physical or Mental Illness or handicap;
3. a foster child;
4. a grandchild; unless legal guardianship is granted.

CONTINUATION OF ELIGIBILITY

Mental or Physical Handicap

An unmarried child who is unable to earn his own living due to physical or Mental Illness or handicap, and is at or reaches a terminating age under the terms of the Plan, will be eligible for coverage if Independence Administrators receives proof, satisfactory to Independence Administrators, that he is unable to earn his own living.

If the dependent wants to be considered for handicap status, they must work with their physician to complete a handicap application/questionnaire. Once the application for handicap status is received, AmeriHealth Medical Management will make a determination whether the child should be approved or denied. Approved dependents can receive a lifetime approval or renewable (non-lifetime). Dependents with non-lifetime approvals (e.g., one year, two year) must complete another questionnaire when the approval term is complete.

Such proof must be received:

a. within thirty (30) days of such Dependent's eligibility date; or
b. within thirty (30) days of the date such Dependent reaches a terminating age under the terms of the Plan.

The Plan reserves the right to require subsequent proof of incapability during the time such Dependent coverage is in effect. Such proof will not be required more than once per year.

COST OF THE COVERAGE

You will be informed of the amount of your contribution when you are invited to enroll.

EFFECTIVE DATE OF COVERAGE

OPEN ENROLLMENT PERIOD

Once in each plan year, the Company will hold an open enrollment period. During this period, an Employee may enroll for coverage, if he or she elected not to enroll when first eligible. Coverage will be effective on the first day of the month following the date the Employee enrolls.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within thirty (30) days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) because you or your dependents were enrolled in Medicaid or your state's State Children's Health Insurance Program and you or your dependent cease to be enrolled in such program as a result of no longer being eligible for the program, you may be able to enroll yourself or your dependents in this Plan in the future, provided that you request enrollment within sixty (60) days after coverage ends. If you or your dependents become eligible for premium assistance for this Plan from Medicaid or your state's State Children's Health Insurance Program and choose to enroll in this Plan, you must request coverage under this Plan within sixty (60) days after the date you or your dependent become eligible for premium assistance.

EFFECTIVE DATE

Employee and/or Dependent coverage shall become effective on the applicable date set forth below.

1. **Non-contributory Funding**

   If contribution from an Employee toward the cost of Employee and Dependent coverage is not required under the Plan, coverage will become effective on the date of eligibility.

2. **Contributory Funding**

   If contribution from an Employee toward the cost of Employee or Dependent coverage is required, and the Employee agrees to make the required contribution, coverage will become effective, upon the payment of such contribution, on the date shown below:

a. the date of eligibility if the application is made and is received by Independence Administrators on or before that date; or

b. the date Independence Administrators receives application, if the application is made within thirty (30) days after the date of eligibility.

3. Dependent(s)

No Dependents' coverage will become effective for an Employee unless the eligible Employee is, or simultaneously becomes, covered.

Coverage of a newborn child will become effective immediately for routine nursery care, treatment for prematurity, birth abnormalities, congenital defects, or any other Illnesses. The newborn child will be entitled to receive all benefits, in accordance with the terms of the Plan, from birth for thirty-one (31) days. Upon application within the thirty-one (31) day period, the Employee may continue coverage beyond that period for a newborn child who qualifies as an eligible Dependent, subject to payment of any additional contribution if required by the Plan.

THE PREFERRED PROVIDER NETWORK

Your PPO Network Plan is a program, which allows you to maximize your health care benefits by utilizing the PPO Network, which is comprised of Providers that have a contractual arrangement with Independence Administrators and BlueCard PPO providers. These Providers are called "Preferred Providers." You may think of them as "in-network" providers. Preferred Providers are doctors, hospitals and other health care professionals and institutions that are part of the PPO Network, which is designed to provide access to care through a selected managed network of providers. Services by Preferred Providers are delivered through a selected, managed network of providers designed to provide quality care. The PPO Network includes hospitals, primary care physicians and specialists, and a wide range of ancillary providers, including suppliers of Durable Medical Equipment, Hospice and Home Health agencies, Skilled Nursing Facilities, free standing dialysis facilities and Ambulatory Surgical Centers.

When you receive health care through a Provider that is a member of the PPO Network, you incur lower out-of-pocket expenses and there are no claim forms to fill out. Benefits are also provided if you choose to receive health care through a Provider that is not a Preferred Provider. However, the level of benefits will be reduced, and you will be responsible for a greater share of out-of-pocket expenses, and the amount of your expenses could be substantial. You may have to reach a deductible before receiving benefits, and you may be required to file a claim form.

To locate a BlueCard PPO network provider, go to www.IBXTPA.com or call 1-800-810-BLUE (2583). Independence Administrators covers only care that is Medically Necessary. Medically Necessary care is care that is needed for your particular condition and that you receive at the most appropriate level of service. Examples of different levels of service are Hospital Inpatient care, treatment in short procedure units and care in a hospital outpatient department.

Some of the services you receive through this Plan must be pre-certified before you receive them, to determine whether they are Medically Necessary. Failure to pre-certify services to be provided by a Non-Preferred Provider, when required, may result in a reduction of benefits. Pre-certification of services is a vital program feature that reviews the Medical Necessity of certain procedures/admissions. In certain cases, Pre-certification helps determine whether a different treatment may be available that is equally effective. Pre-certification also helps determine the most appropriate setting for certain services. Innovations in health care enable doctors to provide services, once provided exclusively in an inpatient setting, in many different settings – such as an outpatient department of a hospital or a doctor's office.

If the request for Pre-certification is denied, you will be notified in writing that the admission/service will not be paid because it is considered to be medically inappropriate. If you decide to continue treatment or care that has not been approved, you will be asked to do the following:

1. Acknowledge this in writing.
2. Request to have services provided.
3. State your willingness to assume financial liability.

When you seek treatment from a Non-Preferred Provider or a BlueCard Provider, you are responsible for initiating the Pre-certification process. You or your provider should call the Pre-certification number listed on the back of your Identification Card, and give your name, facility's name, diagnosis, and procedure or reason for admission. Failure to pre-certify required services will result in a reduction of benefits payable to you.

For more Information regarding pre-certification please see the ***Clinical Services*** section of this Booklet.

REGARDING USE OF NON-PREFERRED PROVIDERS

While the PPO has an extensive network, it may not contain every Provider that you elect to see. To receive the maximum benefits available under this program, you must obtain Covered Services from Preferred Providers that participate in the PPO Network or is a Blue Card PPO Provider.

In addition, your PPO program allows you to obtain Covered Services from Non-Preferred Providers. If you use a Non-Preferred Provider, you will be reimbursed for Covered Services but will incur significantly higher out-of-pocket expenses including Deductibles and Coinsurance. The Non-Preferred Provider may charge you for the balance of the Provider's bill. This is true whether you use a Non-Preferred Provider by choice, for level of expertise, for convenience, for location, because of the nature of the services or based on the recommendation of a Provider. For payment of Covered Services provided by a Non-Preferred Provider, please refer to the definition of Covered Expense.

For specific terms regarding Non-Preferred Providers, please refer to the following sections: ***Definitions***, including but not limited to the definition of Covered Expense and Non-Preferred Provider, and the Payment of Providers subsection under ***General Provisions***.

BLUECARD PPO PROGRAM

Out-of-Area Services

Overview

Independence Administrators has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside of the geographic area Independence Administrators serves, the claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of Independence Administrators' service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. Independence Administrators explains below how it pays both kinds of providers.

Inter-Plan Arrangements Eligibility - Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by Independence Administrators to provide the specific service or services.

BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, Independence Administrators will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive Covered Services outside Independence Administrator' service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Independence Administrators.

Often this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider.

Sometimes, it is an estimated price that takes into account special arrangements with the Member's healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price. Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price Independence Administrators has used for your claim because they will not be applied after a claim has already been paid.

Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Independence Administrators through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements

If Independence Administrators has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on the Member's behalf, Independence Administrators will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

Nonparticipating Providers Outside Independence Administrators' Service Area

Please refer to the Covered Expense definition in the Defined Terms section of the Benefit Booklet for a description of Independence Administrator's reimbursement for Nonparticipating/Non-Preferred Providers.

Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, the Member should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) (TTY: 711) or call collect at 1.804.673.1177 (TTY: 711), 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

  In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact Independence Administrators to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

PAYMENT OF COVERED MEDICAL CHARGES

1. The Plan Year Deductible is as shown in the ***Schedule of Benefits***. A Covered Person must Incur covered medical charges of at least this amount within a plan year before any benefits are payable during that year, unless otherwise stated in the ***Schedule of Benefits***.

   A Covered Person must satisfy the individual deductible amount only once during a plan year. However, after the Covered Persons in a family unit have satisfied the family deductible amount during a plan year, benefits will be payable for covered medical charges incurred for all Covered Persons in a family unit for the remainder of that plan year. Please refer to the ***Schedule of Benefits*** for individual and family deductible information.

2. When a Covered Person is confined in a Hospital, Rehabilitation Facility, or Skilled Nursing Facility, benefits payable will be determined by the condition primarily being treated. Determination will be made by Independence Administrators based on the Covered Person's medical history and will be conclusive.

3. In counting the number of days of medical care furnished to a Covered Person while confined in a Hospital, Rehabilitation Facility, or Skilled Nursing Facility, either the day of admission or the day of discharge will be counted, but not both.

4. No benefits will be payable under the Plan for charges Incurred after the Hospital's regular discharge hour, provided the Covered Person has been advised by his attending Doctor prior to such discharge that further confinement is not required.

5. Pregnancy benefits will be provided under the same conditions and limitations as any other Illness.

   This Plan does not restrict benefits for any hospital length of stay in connection with childbirth, for the mother or newborn child, to less than the following:

   a. 48 hours following a normal vaginal delivery; or
   b. 96 hours following a caesarean section.

   This Plan does not require that a Provider obtain authorization from the Plan for prescribing a length of stay that does not exceed these periods.

COVERED MEDICAL CHARGES

Subject to "Exceptions and Exclusions" which follows, covered medical charges include the charges described below that are Medically Necessary and Incurred while covered under the Plan. (A charge is deemed Incurred as of the date of the service, treatment, or purchase giving rise to the charge.)

FACILITY SERVICES

1. Room and Board

   a. Semiprivate Room — Includes special diets and general nursing care.

   b. Private Room — In a Facility having primarily private accommodations, the Covered Person is entitled to either the Facility's most common semiprivate room charge, if any, or an allowance agreed upon by Independence Administrators and the Facility. The difference between the Plan's allowance and the Facility's charge is the Covered Person's responsibility.

      Private Room accommodations will be covered in full if Medically Necessary.

   c. Special care accommodations — Special care accommodations include intensive care, cardiac care, and burn treatment or such other special care accommodations approved by Independence Administrators.

2. Ancillary Services — Includes those services and Supplies that are regularly provided and billed by a Facility, such as:

   a. use of operating, delivery, and treatment rooms and equipment;

   b. administration of blood and blood processing including blood and blood plasma to the extent that it is not donated or otherwise replaced;

   c. oxygen and other gases and their administration;

   d. prescribed drugs and medications that are dispensed for use in the Facility;

   e. anesthesia and the administration of anesthetics when performed by an employee of the Facility;

   f. medical and surgical dressings, Supplies, casts, and splints; and

   g. diagnostic services.

   When counting the number of days of care furnished to an Inpatient, either the day of admission or the day of discharge will be counted, but not both.

Charges Incurred after a Facility's regular discharge hour are not covered provided the Covered Person has been advised by his attending Professional Provider prior to such discharge that further confinement is not required.

MEDICAL CARE

Medical care and Facility services rendered to an Inpatient by the Doctor in charge of the case for a condition not related to Surgery or pregnancy, except as specifically provided. Such care includes Inpatient intensive medical care rendered to a Covered Person whose condition requires a Professional Provider's constant attendance and treatment for a prolonged period.

1. Concurrent Care

   Medical care rendered to an Inpatient by a Professional Provider who is not in charge of the case, but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Covered Person, standby services, routine preoperative physical examinations, or medical care routinely performed in the preoperative or postoperative or prenatal or postnatal periods, or medical visits required by a Facility's rules and regulations.

2. Consultation Services

   Consultation services rendered to an Inpatient by a Professional Provider at the request of the attending Professional Provider. Consultation services do not include staff consultations that are required by a Facility's rules and regulations.

   Benefits are provided for one consultation per consultant during each period of confinement.

REHABILITATION HOSPITAL CONFINEMENTS

Facility services and medical care rendered to an Inpatient in a Rehabilitation Hospital.

No benefits are provided for services in a Rehabilitation Facility:

1. once the Covered Person reaches the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment; or

2. when the services are primarily provided to maintain the Covered Person's level of functioning; or to assist the Covered Person with the activities of daily living; or to provide an institutional environment for the convenience of the Covered Person.

SKILLED NURSING FACILITY CONFINEMENTS

Facility services and medical care rendered to an Inpatient in a Skilled Nursing Facility as described in the ***Schedule of Benefits***.

Benefits for medical care in a Skilled Nursing Facility are provided for up to two visits during the first week of confinement and one visit a week for each consecutive week of confinement thereafter.

No benefits are provided for services in a Skilled Nursing Facility:

1. once the Covered Person reaches the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment;

2. when the services are primarily provided to maintain the Covered Person's level of functioning; or to assist the Covered Person with the activities of daily living; or to provide an institutional environment for the convenience of the Covered Person.

SURGICAL SERVICES

Surgery for the treatment of Illness or Accidental Injury.

Covered Surgery includes sterilization procedures regardless of their Medical Necessity.

If more than one surgical procedure is performed by the same Professional Provider during the same operative session, benefits will be provided for the highest paying procedure plus an allowance of 50% of eligible charges for the additional procedure(s), plus any additional payment beyond the 50% that is deemed appropriate due to the nature or circumstances of the procedure. No additional allowance will be provided for those surgical procedures determined by Independence Administrators to be incidental to or an integral part of another surgical procedure performed during the same operative session.

1. Preoperative and Postoperative Medical Care

   The payment allowance for Surgery includes related preoperative and postoperative care rendered by the surgeon within the timeframe based on the surgical procedure.

2. Maternity Delivery

   The payment for maternity delivery includes prenatal and postpartum care normally provided by a Doctor for the care and management of pregnancy.

3. Surgical Assistance

   Services rendered by an assistant surgeon who actively assists the operating surgeons in the performance of Surgery.

   The condition of the Covered Person or the type of Surgery must require the active assistance of an assistant surgeon. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

4. Anesthesia

   Anesthesia and the administration of anesthetics in connection with the performance of covered medical services when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon, or attending Professional Provider.

5. Second Surgical Opinion Consultation

   Consultation services rendered by a surgeon or specialist to determine the Medical Necessity of an Elective Surgery. Such services must be performed and billed by a surgeon or specialist who is not in association with the one who initially recommended the Surgery.

   Benefits are provided for one additional consultation, as a third opinion, in cases where the second opinion disagrees with the first recommendation. In such instances, benefits will be provided for a maximum of two consultations, but limited to one consultation per consultant.

6. Transplant Services

   If a human organ or tissue transplant is provided from a donor to a human transplant recipient:

   a. When both the donor and recipient are covered by the Plan, each is entitled to the benefits of the Plan.

   b. When only the recipient is covered by the Plan, both the donor and recipient are entitled to the benefits of the Plan. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be charged against the recipient's coverage under the Plan.

   c. When only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program available to the recipient. No benefits are provided under the Plan to the non-Covered Person transplant recipient.

   d. If any organ or tissue is sold rather than donated to the Covered Person recipient, no benefits will be payable for the purchase price of such organ or tissue. However, other costs related to evaluation and procurement are covered up to the Covered Person recipient's Plan limit.

PREADMISSION TESTING

Diagnostic tests and studies performed on an Outpatient basis prior to Elective Surgery. Benefits are provided for preadmission testing if:

1. the Covered Person was scheduled for Surgery prior to the testing;
2. the Surgery is not delayed beyond the 14-day period immediately following the testing; and
3. the Surgery to which the testing is related is covered by the Plan.

EMERGENCY ACCIDENT TREATMENT

Ancillary services and medical services by a Professional Provider rendered on an Outpatient basis in connection with the initial treatment of an Emergency Accident, as defined.

Benefits are provided for emergency treatment that commences within 72 hours following the accident.

EMERGENCY MEDICAL TREATMENT

Ancillary services and medical services by a Professional Provider rendered on an Outpatient basis in connection with the initial treatment of a condition with acute symptoms of sufficient severity that the absence of immediate medical attention could:

1. permanently place the Covered Person's health in jeopardy;
2. cause other serious medical consequences;
3. cause serious impairment to bodily functions; or
4. cause serious and permanent dysfunction of any bodily organ or part.

Benefits are provided for emergency treatment that commences within 72 hours following the onset of the medical emergency.

Should any dispute arise as to whether an emergency condition existed, the determination by Independence Administrators will be final.

HOME VISITS, OFFICE VISITS, AND OTHER OUTPATIENT VISITS

Medical visits and consultation services for the examination, diagnosis, and treatment of a condition not related to Surgery, or pregnancy, except as specifically provided.

1. Well-child care and immunizations

Well-child care including routine physical examinations and immunizations. Benefits are provided for these services as prescribed by the American Pediatric Association. Immunizations as recommended by the Department of Health.

Well-child care and immunizations are subject to a maximum described in the ***Schedule of Benefits***.

2. Routine physical examinations

   Examinations including a complete medical history.

   Benefits are provided for these services as prescribed by the American Medical Association. Services provided under a Vision Care program or plan are not covered.

   Routine physical examinations are subject to a maximum described in the ***Schedule of Benefits***.

3. Preventive care services

   100% coverage for certain designated preventive care services. There will be no cost sharing (copayments, coinsurance, deductibles) for the following preventive care services if provided by a Participating Provider:

   a. Evidence-based items/services with a rating of "A" or "B" in the current recommendations of the U.S. Preventative Services Task Force.
   b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
   c. Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents.
   d. With respect to women, additional preventive care and screenings provided for in guidelines supported by HRSA.

   You can find online links to these lists of services at www.Healthcare.gov. Click the *Learn About Prevention* tab.

   Be aware that you may be required to pay some costs of the office visit if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit.

AUTISM SPECTRUM DISORDERS (ASD)

Benefits are provided for the diagnostic assessment and treatment of Autism Spectrum Disorders (ASD) for Covered Persons with a maximum age of twenty-one (21) years, and a benefit amount of, $38,852.00, for non-essential benefits per benefit period.

Diagnostic assessment is defined as Medically Necessary assessments, evaluations or tests performed by a licensed physician, licensed physician assistant, licensed

psychologist or certified registered nurse practitioner, or Autism Service Provider to diagnose whether an individual has an Autism Spectrum Disorder. Results of the diagnostic assessment shall be valid for a period of not less than twelve (12) months, unless a licensed physician or licensed psychologist determines an earlier assessment is necessary.

Treatment of Autism Spectrum Disorders shall be identified in an ASD Treatment Plan and shall include any Medically Necessary Pharmacy Care, Psychiatric Care, Psychological Care, Rehabilitative Care and Therapeutic Care that is: (i) prescribed, ordered or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner, (ii) provided by an Autism Service Provider, including a Behavior Specialist, or (iii) provided by a person, entity or group that works under the direction of an autism service provider. An ASD Treatment Plan shall be developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. Depending on the service that is being requested, members, or a health care provider on their behalf, may be required to submit a treatment plan to Independence Administrators prior to receiving treatment. This plan may need to be reviewed and approved Independence Administrators every six months.

Treatment of Autism Spectrum Disorders will include any of the following Medically Necessary services that are listed in an ASD Treatment Plan developed by a licensed physician or licensed psychologist:

1. Applied Behavioral Analysis – The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.
2. Pharmacy Care – Medications prescribed by a licensed physician, licensed physician assistant or certified registered nurse practitioner and any assessment, evaluation or test prescribed or ordered by a licensed physician, licensed physician assistant or certified registered nurse practitioner to determine the need or effectiveness of such medications. The ASD medications may be purchased at a pharmacy, subject to the cost-sharing arrangement applicable to the prescription drug coverage. Benefits for ASD medications are subject to the ASD annual benefit maximum.
3. Psychiatric Care – Direct or consultative services provided by a physician who specializes in psychiatry.
4. Psychological Care – Direct or consultative services provided by a psychologist.
5. Rehabilitative Care – Professional services and treatment programs, including applied behavioral analysis, provided by an Autism Service Provider to produce socially significant improvements in human behavior or to prevent loss of

attained skill or function.

6. Therapeutic Care – Services provided by speech language pathologists, occupational therapists or physical therapists.

UPON FULL OR PARTIAL DENIAL OF COVERAGE FOR ANY AUTISM SPECTRUM DISORDERS BENEFITS, A COVERED PERSON SHALL BE ENTITLED TO FILE AN APPEAL. THE APPEAL PROCESS WILL: 1) PROVIDE INTERNAL REVIEW FOLLOWED BY INDEPENDENT EXTERNAL REVIEW; AND, 2) HAVE LEVELS, EXPEDITED AND STANDARD APPEAL TIME FRAMES, AND OTHER TERMS ESTABLISHED BY THE CARRIER CONSISTENT WITH APPLICABLE PENNSYLVANIA AND FEDERAL LAW. APPEAL FILING PROCEDURES WILL BE DESCRIBED IN NOTICES DENYING ANY AUTISM SPECTRUM DISORDERS BENEFITS.

DIAGNOSTIC SERVICES

The following procedures when ordered by a Professional Provider to determine a definite condition because of specific symptoms:

1. diagnostic X-ray consisting of radiology, ultrasound, and other diagnostic X-ray procedures.

2. diagnostic laboratory and pathology tests;

3. diagnostic medical procedures consisting of EKG, EEG, and other diagnostic medical procedures; and

4. allergy testing consisting of percutaneous, intracutaneous, and patch tests.

THERAPY SERVICES

The following Therapy Services:

1. Radiation Therapy, including the cost of radioactive materials;

2. Chemotherapy by intravenous, intra-arterial, or intracavity injection infusion or perfusion, subcutaneous and intramuscular routes. Oral chemotherapy, including its administration, is also covered. The cost if listed as approved or indicated for the diagnosis under treatment by one or more of the following: FDA, NCCN, NIH, NCI. Notwithstanding experimental and investigational use of chemotherapy agents is not covered. All chemotherapy is subject to medical necessity review as antineoplastic agents is covered, provided they are administered as described in this paragraph;

3. Dialysis Treatment;

4. Physical Therapy;

5. Cardiac Rehabilitation;

6. Any other therapy services Independence Administrators determines necessary to treat Accidental Injury or Illness.

HOME HEALTH CARE SERVICES

The following services, as described in the ***Schedule of Benefits***, when provided to an essentially homebound Covered Person by a Home Health Care Agency:

1. Skilled Nursing Care; and
2. Therapy Services;
3. Medical Social Work;
4. Nutritional Services
5. Health services furnished by a home health aide;
6. Medical appliances;
7. Medical equipment;
8. Special meals;
9. Diagnostic or therapeutic services, including surgical services furnished;
    a. In an outpatient department of a Hospital;
    b. In a Physician's office; or
    c. At any other licensed health care facility.

Benefits are also provided for certain other medical services when furnished along with a primary service. Such other services include prescription drugs, diagnostic services, Supplies, and other Medically Necessary services.

No benefits are provided for services in connection with:

1. Custodial Care, food, housing, homemaker services, home delivered meals, and supplementary dietary assistance;
2. services provided by a member of the Covered Person's Immediate Family;
3. patient transportation, including Ambulance services;
4. visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional occupational therapy or social services;
5. services provided to Covered Persons who are not essentially home bound for medical reasons; or

6. visits solely for the purpose of assessing the Covered Person's condition and determining whether or not the Covered Person requires and qualifies for home health care services.

HOSPICE SERVICES

Hospice benefits, as described in the ***Schedule of Benefits***, are provided when the Covered Person's attending Doctor certifies that the Covered Person has a terminal Illness with a medical prognosis of six months or less to live.

Hospice benefits are provided for the following services when rendered by a Hospice or under arrangements made by a Hospice in accordance with a Hospice care program and approved by Independence Administrators.

1. Medical care by a Doctor affiliated with the Hospice care program;
2. Nursing care by an R.N., or L.P.N., or home health aide;
3. Medical social services;
4. Therapy services except for dialysis treatments;
5. Dietary services;
6. Laboratory services;
7. Prescribed drugs and medicines;
8. Family counseling services;
9. Pastoral services;
10. Bereavement counseling;
11. Ambulance services when Medically Necessary to transport the Covered Person to and from the nearest Inpatient Hospice Facility;
12. The following medical services, Supplies, and equipment:
    a. oxygen, including the rental of oxygen equipment;
    b. artificial limbs or other prosthetic devices, but not including replacement;
    c. rental of Durable Medical Equipment;
13. Inpatient Hospice care when needed to control pain and other symptoms associated with the terminal Illness, but only if the Covered Person's attending Doctor certifies that it is Medically Necessary for the care to be provided on an Inpatient basis rather than in a home setting or on an Outpatient basis;

14. Inpatient respite care in a Hospice, which may be subject to a benefit maximum.

Special Exclusions and Limitations

1. The Hospice care program must deliver Hospice care in accordance with a treatment plan approved by and periodically reviewed by Independence Administrators.
2. No Hospice care benefits will be provided for:
   a. Medical care rendered by the Covered Person's private Doctor;
   b. Volunteers who do not regularly charge for services;
   c. Homemaker services;
   d. Food or home delivered meals;
   e. Legal or financial services or counseling;
   f. Curative treatment or services.

PRIVATE DUTY NURSING SERVICES

The following services, as described in the ***Schedule of Benefits***, when provided by an actively practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) and ordered by a Doctor. **Prior authorization of services is required.**

1. Home Services

   Nursing services that Independence Administrators determines require the skills of an R.N. or L.P.N. No benefits are provided for the services of a nurse who ordinarily resides in the Covered Person's home or is a member of the Covered Person's Immediate Family.

AMBULANCE SERVICES

Ambulance service by an authorized agency or a Facility providing local transportation of a sick or injured Covered Person:

1. from the site of injury or medical emergency to the nearest Facility; or
2. from the first Facility to the nearest Facility that can provide services Medically Necessary for the treatment of the Covered Person's condition, but only if the services necessary to treat the condition are not available at the first Facility.

Benefits are provided for air Ambulance transportation only if Independence Administrators determines that the Covered Person's condition, and the type of service required for the treatment of the Covered Person's condition, and the type of Facility

required to treat the Covered Person's condition justify the use of air Ambulance instead of another means of transport.

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC APPLIANCES

1. Durable Medical Equipment

   The rental or purchase of Durable Medical Equipment when prescribed by a Doctor and required for therapeutic use.

   a. Rental — Benefits are provided for rental fees up to an amount that equals, but does not exceed, the purchase price of the equipment.

   b. Purchase — Benefits may be provided for the purchase of Durable Medical Equipment at the option of the Plan.

   If a Claim is filed for equipment containing features of an aesthetic nature or features of a medical nature that are not required by the Covered Person's condition or if there exists a reasonable or feasible and medically appropriate alternative piece of equipment that is less costly than the equipment furnished, the benefit provided is based on the charge for the equipment that meets the Covered Person's medical needs. **Payment for the purchase or rental of Durable Medical Equipment may require preauthorization. Preauthorization may be obtained by calling Independence Administrators' Clinical Services Department at the number listed on your identification (ID) card.**

2. Prosthetic Appliances

   The first purchase and fitting of artificial limbs, eyes, and other prosthetic appliances that replace all or part of an absent or inoperative or malfunctioning body organ but only if required for the replacement of natural parts of the body lost or becoming inoperative while covered by the Plan (excluding dental appliances).

3. Replacement and Modification

   Benefits are provided for the replacement or modification of Durable Medical Equipment, orthotics, and prosthetic appliances when Medically Necessary due to a change in the Covered Person's physical condition. Benefits for the replacement of such items are provided to the extent that the cost of the purchase is less expensive than the modification. In no event will the Plan pay for contact lenses other than the initial pair of contact lenses following cataract surgery.

4. Diabetic Education

5. Orthotics

   Benefits are provided if orthotics are an integral part of a leg brace and the cost is included in the orthotist's charges, including the initial purchase, fitting and repair of

orthotic appliance that are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an injury or illness.

DENTAL SERVICES

1. Dental treatment performed within six months following Accidental Injury to sound natural teeth, but only if such injury occurs while covered by the Plan. Accidental Injury does not include injuries that result from biting or chewing.

2. Oral Surgery performed for the removal of impacted teeth partially or totally covered by bone.

ROUTINE NEWBORN CARE

Professional visits to examine the newborn while an Inpatient in a Hospital or Birthing Center. Facility charges for ordinary nursery care of the newborn as well as routine newborn circumcisions are also covered.

MENTAL ILLNESS BENEFITS

Treatment of Mental Illness is eligible anywhere when performed by a Professional Provider as follows:

1. Psychiatric Visits

2. Electro-Convulsive Therapy

3. Individual Psychotherapy

4. Group Psychotherapy

5. Psychological Testing

6. Family Counseling

   Counseling with family members to assist in the Covered Person's diagnosis and treatment.

Facility Services for Mental Illness

1. Inpatient Facility Services

   Facility services provided for Inpatient treatment of Mental Illness by a Facility.

2. Partial Hospitalization

   Treatment of Mental Illness in a planned therapeutic program when such services are rendered during the day only or during the night only.

3. Outpatient Mental Illness Services

Facility services and supplies provided to an Outpatient by a Facility.

SUBSTANCE ABUSE BENEFITS

1. Inpatient Detoxification Services

   Benefits are payable for a detoxification program provided either in a Hospital or in a licensed Substance Abuse Treatment Facility.

   a. Room and board

   b. Doctors, psychologist, nurse, certified addictions counselor, and trained staff services

   c. Diagnostic X-ray

   d. Psychiatric, psychological, and medical laboratory testing

   e. Drugs, medicine, equipment, and Supplies

2. Inpatient Rehabilitation Services

   Benefits are payable for Inpatient services provided in a licensed Substance Abuse Treatment Facility provided the Covered Person: (a) has been certified by a Doctor or psychologist as a person who suffers from Substance Abuse or dependency; and (b) is referred for treatment by such Doctor or psychologist.

   a. Room and board

   b. Doctors, psychologist, nurse, certified addictions counselor, and trained staff services

   c. Rehabilitation therapy and counseling

   d. Family counseling and intervention

   e. Psychiatric, psychological, and medical laboratory testing

   f. Drugs, medicine, equipment, and Supplies

3. Outpatient Rehabilitation Services

   Benefits are payable for Outpatient services provided in a licensed Substance Abuse Treatment Facility provided the Covered Person: (a) has been certified by a Doctor or psychologist as a person who suffers from Substance Abuse or dependency; and (b) is referred for treatment by such Doctor or psychologist.

   a. Doctors, psychologist, nurse, certified addictions counselor, and trained staff services;

   b. rehabilitation therapy and counseling;

   c. family counseling and intervention;

d. psychiatric, psychological, and medical laboratory testing; and

e. drugs, medicine, equipment, and Supplies.

ROUTINE PATIENT COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS

Benefits are provided for Routine Patient Costs Associated With Participation in a Qualifying Clinical Trial (see ***Definitions*** section). To ensure coverage and appropriate claims processing, the Plan must be notified in advance of the Covered Person's participation in a Qualifying Clinical Trial. Benefits are payable if the Qualifying Clinical Trial is conducted by a Preferred Professional Provider and conducted in a Preferred Facility Provider. If there is no comparable Qualifying Clinical Trial being performed by a Preferred Professional Provider, and in a Preferred Facility Provider, then the Plan will consider the services by a Non-Preferred Provider, participating in the clinical trial, as covered if the clinical trial is deemed a Qualifying Clinical Trial (see ***Definitions*** section) by the Plan.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

In accordance with this law, the required mastectomy coverage includes:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical complications of all stages of a mastectomy, including lymphedemas.

The benefits for these services must be provided in a manner determined in consultation with the attending doctor and the patient. These services may be subject to the deductibles and coinsurance amounts applicable to your group health plan.

CHILD IMMUNIZATION COVERAGE

Coverage will be provided for those child immunizations, including the immunizing agents, which, as determined by the Department of Health, conform with standards of the Advisory Committee on Immunization Practices of the Center of Disease Control, U.S. Department of Health and Human Services. Benefits will be exempt from deductibles or dollar limits.

ANNUAL GYNECOLOGICAL EXAMINATION AND ROUTINE PAP SMEARS

- Annual gynecological examination, including a pelvic examination and clinical breast examination; and
- Routine pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

These gynecological examination/pap smear benefits are exempt from any deductible or dollar limit provisions in the contract. However, they may be subject to any copayment or coinsurance amounts applicable to your group health plan.

COLORECTAL CANCER SCREENING COVERAGE

Coverage for colorectal cancer screening may be subject to annual deductibles, coinsurance, and copayment requirements applicable to your group health plan.

Benefits for preventive care colorectal cancer screening are subject to the requirements as established by the U.S. Preventive Services Task Force Recommendations and may be different from the benefits detailed below. For more information on preventive care colorectal cancer screening, please visit www.healthcare.gov.

Symptomatic individuals;

Colonoscopy
Sigmoidoscopy
Colorectal Screening Tests (any combination thereof as determined by the treating Physician)

Non-symptomatic individuals covered over age 45;

Annual Fecal Occult Blood Test
Sigmoidoscopy – a screening barium enema test once every five years
Colonoscopy once every 10 years
Colon Cancer test at least once every 5 years

Non-symptomatic coverage for individuals at high or increased risk of colorectal cancer under age 45;

Colonoscopy
Any combination of colorectal cancer screening tests.

PRESCRIPTION DRUG COVERAGE

Your prescription drug coverage is administered by a third party contracted by Independence Administrators to provide the IA Prescription Benefit Services. Your plan sponsor has chosen the Premium Drug Formulary, which provides you with access to a carefully managed set of prescriptions drug options. One (1) ID card is used for access to both Medical and Prescription drug benefits.

You are responsible for a copayment for each prescription drug or refill. You may also be responsible for a prescription drug or plan deductible that must first be met before any benefits are payable. This amount is shown in the Schedule of Benefits.

If you purchase your prescription at a pharmacy that participates, simply present your ID card and pay the copayment and/or deductible.

If you purchase your prescription at a Doctor's office or pharmacy that does not participate, pay the full cost of the prescription and have the Doctor or pharmacist complete their portion of a "Direct Reimbursement" form. Submit this form to the Prescription Benefit services provider and they will reimburse you for the cost of the prescription minus your copayment and/or deductible.

PRIOR AUTHORIZATION

Your prescription drug coverage requires prior authorization of certain covered drugs to ensure that the drug prescribed is medically necessary and appropriate and is being prescribed according to the Food and Drug Administration (FDA) guidelines. The approval criteria were developed and endorsed by the Prescription Drug benefit services provider Therapeutics Committee, which is an established group of medical directors and practicing physicians and pharmacists.

Using these approved criteria, clinical pharmacists evaluate requests for these drugs based on: clinical data; information submitted by the plan member's prescribing physician; and the plan member's available prescription drug therapy history. Their review includes a determination that: there are no drug interactions or contra indications; that dosing and length of therapy are appropriate; and that other drug therapies, if necessary, were used.

Without prior authorization, the plan member's prescription will not be covered at your health benefits program's retail or mail order pharmacy.

The prior authorization process may take up to two working days once the Prescription Drug benefit services provider receives complete information from the prescribing physician. Incomplete information will result in a delayed decision. Prior authorization

approvals for some drugs may be limited to 6 to 12 months. If the prior authorization for a drug is limited to a certain time frame, the approval will include an expiration date. If the physician wants a plan member to continue the drug therapy after the expiration date, he or she will need to get approval for a new prior authorization request in order for coverage to continue.

DRUGS THAT REQUIRE PRIOR AUTHORIZATION

You can see what drugs require prior authorization online. Visit the website listed on your identification (ID) card and click Prescription Drug Program > More information.
If you prefer to talk with a representative, please call 1-888-678-7013.

APPEALING A DECISION

If a request for prior authorization/preapproval or override results in a denial, the plan member or physician, on the plan member's behalf, may file an appeal. Both the plan member and the physician will receive written notification of a denial, which will include the telephone number and address to which they can direct an appeal. In all cases, the physician must be involved in the appeals process to provide the required medical information for the basis of the appeal.

REQUEST PRIOR AUTHORIZATION/PREAPPROVAL OR OVERRIDE

The physician prescribing the medication completes a prior authorization form or writes a letter of medical necessity and faxes it to 215-241-3073 or 1-888-671-5285. Or the physician may request the form by calling 1-888-678-7013. Plan members may request the form through Customer Service on the physician's behalf, but the physician must complete and submit it.

The Prescription Drug benefit services provider will review the prior authorization request or letter of medical necessity. If a clinical pharmacist cannot approve the request based on established criteria, a medical director will review it.

CLINICAL SERVICES

You MUST CALL the number for Clinical Services listed on your identification (ID) card to fulfill the requirements of Clinical Services.

The pre-certification process reviews the Medical Appropriateness/Medical Necessity of the requested services only. Pre-certification is not a guarantee of eligibility for the coverage or payment of a Claim. Coverage and payment are dependent upon, among other things, the Covered Person being eligible, i.e., actively enrolled in the health benefits plan when the services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request.

A. UTILIZATION REVIEW PROCESS

A basic condition of the Plan's benefit plan coverage is that in order for a health care service to be covered or payable, the service must be Medically Appropriate/Medically Necessary. Medically Appropriate/Medically Necessary care is care that is needed for your particular condition and that you receive at the most appropriate level of service. Examples of different levels of service are Hospital Inpatient care, treatment in Short Procedure Units and care in a Hospital Outpatient Department. To assist Independence Administrators' delegate in making coverage determinations for requested health care services, Independence Administrators uses established medical policies and medical guidelines based on clinically credible evidence to determine the Medical Appropriateness/Medical Necessity of the requested services. The appropriateness of the requested setting in which the services are to be performed is part of this assessment. The process of determining the Medical Appropriateness/Medical Necessity of requested health care services for coverage determinations based on the benefits available under a Covered Person's benefit plan is called utilization review.

It is not practical to verify Medical Appropriateness/Medical Necessity on all procedures on all occasions; therefore, certain procedures may be determined by Independence Administrators to be Medically Appropriate/Medically Necessary and automatically approved based on the accepted Medical Appropriateness/Medical Necessity of the procedure itself, the diagnosis reported, or an agreement with the performing Provider. An example of such automatically approved services is an established list of services received in an emergency room which has been approved by Independence Administrators' delegate based on the procedure meeting emergency criteria and the severity of diagnosis reported (e.g. rule out myocardial infarction, or major trauma). Other requested services, such as certain elective Inpatient or Outpatient procedures may be reviewed on a procedure specific or setting basis.

Utilization review generally includes several components which are based on when the review is performed. When the review is required before a service is performed, it is called a pre-certification review. Reviews occurring during a Hospital stay are called a concurrent review, and those reviews occurring after services have been performed are called either retrospective or post-service reviews. Independence Administrators' delegate follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.

Generally, where a requested service is not automatically approved and must undergo Medical Appropriateness/Medical Necessity review, nurses perform the initial case review using medical policies, established guidelines and evidence-based clinical criteria and protocols; however, only a medical director employed by Independence Administrators or its delegate may deny coverage for a procedure based on Medical Appropriateness/Medical Necessity. The evidence-based clinical protocols evaluate the Medical Appropriateness/Medical Necessity of specific procedures and the majority are computer-based. Information provided in support of the request is entered into the computer-based system and evaluated against the clinical protocols. Nurses apply applicable guidelines and evidence-based clinical criteria and protocols, taking into consideration the Covered Person's condition and applying sound professional judgment. When the clinical criteria are not met, the given service request is referred to a medical director for further review for approval or denial. Independent medical consultants may also be engaged to provide clinical review of specific cases or for specific conditions. Should a procedure be denied for coverage based on lack of Medical Appropriateness/Medical Necessity, a letter is sent to the requesting Provider and the Covered Person in accordance with applicable law.

Independence Administrators' utilization review program encourages peer dialogue regarding coverage decisions based on Medical Appropriateness/Medical Necessity by providing physicians with direct access to Independence Administrators' or its delegate's medical directors to discuss coverage of a case. Medical directors and nurses receive salaries. Contracted external physicians and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. Neither Independence Administrators nor its delegates specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization.

B. CLINICAL CRITERIA, GUIDELINES AND RESOURCES

The following guidelines, clinical criteria and other resources are used to help make Medically Appropriate/Medically Necessary coverage decisions.

Clinical Decision Support Criteria — Clinical Decision Support Criteria is an externally validated and computer-based system used to assist Independence Administrators or its delegate in determining Medical Appropriateness/Medical Necessity. This evidence-based, Clinical Decision Support Criteria is nationally recognized and validated. Using a model based on evaluating intensity of service and severity of Illness, these criteria assist clinical staff in evaluating the Medical Appropriateness/Medical Necessity of services based on a Covered Person's specific clinical needs. Clinical Decision Support Criteria helps promote consistency in plan determinations for similar medical issues and requests: and, reduces practice variation among Independence Administrators' or its delegate's clinical staff to minimize subjective decision-making.

Clinical Decision Support Criteria may be applied for Covered Services including but not limited to the following: some elective Surgeries - settings for Inpatient and Outpatient procedures (e.g., hysterectomy and sinus surgery), Inpatient hospitalizations, Inpatient and Outpatient rehabilitation, diagnostic procedures, Home Health Care, Durable Medical Equipment, and Skilled Nursing Facility.

Medical Policies — Independence Administrators and its delegates maintain an internally developed set of policies, which document the coverage and conditions for certain medical/surgical procedures and ancillary services.

Covered Services for which Medical Polices are applied include, but are not limited to: Ambulance, Infusion, Speech Therapy, Occupational Therapy, Durable Medical Equipment, and review of potential cosmetic procedures.

Internally Developed Guidelines — A set of guidelines developed with input by clinical experts based on accepted practice guidelines within the specific fields and reflecting medical policies for coverage.

C. DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA

Independence Administrators has agreements with state licensed utilization review entities, where required, and a NCQA (National Committee for Quality Assurance) accredited utilization management program. Independence Administrators has delegated certain utilization review activities, including pre-certification review, concurrent review, and case management, to entities with an expertise in medical management of certain conditions and services (such as, mental illness/substance abuse), or certain membership populations (such as, neonates/premature infants), or after-hours pre-certification services. In such instances, a formal delegation and oversight process is established in accordance with applicable law and nationally-recognized accreditation standards. In such cases, the delegate's utilization review criteria are generally used, with Independence Administrators' approval.

D. PRE-CERTIFICATION REVIEW

When required, Pre-certification review evaluates the Medical Necessity, including the appropriateness of the setting, of proposed services for coverage under the Covered Persons benefit plan. Examples of these services include planned or elective Inpatient admissions and selected Outpatient procedures. For Covered Persons located in the PPO Network service area, Pre-certification review may be initiated by the Provider or the Covered Person depending on whether the Provider is a PPO Network Provider. For Covered Person's located outside Independence Administrators PPO Network who are accessing BlueCard PPO Providers, the Covered Person is responsible for initiating or requesting the Provider to initiate the Pre-certification review. Where Pre-certification review is required, Independence Administrators' coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties may be applied where Pre-certification review is required for a procedure but is not obtained.

1. INPATIENT PRE-ADMISSION REVIEW

Inpatient Admissions

In accordance with the criteria and procedures described above, Inpatient admissions, other than an emergency admission, must be pre-certified in accordance with the standards of Independence Administrators as to the Medical Appropriateness/Medical Necessity of the admission. The pre-certification requirements for emergency admissions are set forth in the "Emergency Admission Review" subsection immediately following below. The Covered Person is responsible to have the admission (other than for an Emergency or maternity admission) certified in advance as an approved admission.

a. To obtain Pre-certification, the Covered Person is responsible to contact or have the admitting Physician or other Facility Provider contact Independence Administrators prior to admission to the Hospital, Skilled Nursing Facility, or other Facility Provider. Independence Administrators will notify the Covered Person, admitting Physician and the Facility Provider of the determination. The Covered Person is eligible for Inpatient benefits at the Preferred or Non-Preferred level shown in the ***Schedule of Benefits*** if, and only if, prior approval of such benefits has been certified in accordance with the provisions of this booklet.

b. If such prior approval for a Medically Appropriate/Medically Necessary Inpatient Admission has not been certified as required, there will be a penalty for non-compliance and benefits for Covered Services will be reduced, 20%, per hospitalization to the Covered Person. Such penalty, and any difference

in what is covered by the Plan and the Covered Person's obligation to the Provider, will be the sole responsibility of, and payable by, the Covered Person.

c. If a Covered Person elects to be admitted to the Facility Provider after review and notification that the reason for admission is not approved for an Inpatient level of care, Inpatient benefits will not be provided, and the Covered Person will be financially liable for non-covered Inpatient charges.

d. If Pre-certification is denied, the Covered Person, the Physician or the Facility Provider may appeal the determination and submit information in support of the claim for Inpatient benefits. A final determination concerning eligibility for Inpatient benefits will be made and the Covered Person, Physician, or Facility Provider will be so notified.

2. EMERGENCY ADMISSION REVIEW

Emergency Admissions

a. Covered Persons are responsible for notifying Independence Administrators of an emergency admission within two (2) business days of the admission, or as soon as reasonably possible, as determined by Independence Administrators.

b. Failure to initiate Emergency admission review will result in a penalty for non-compliance and benefits for Covered Services will be reduced, 20%, per hospitalization to the Covered Person. Such penalty will be the sole responsibility of, and payable by, the Covered Person.

c. If the Covered Person elects to remain hospitalized after Independence Administrators and the attending Doctor have determined that an Inpatient level of care is not Medically Appropriate/Medically Necessary, the Covered Person will be financially liable for non-covered Inpatient charges from the date of notification.

3. CONCURRENT AND RETROSPECTIVE/POST-SERVICE REVIEW, PRE-NOTIFICATION AND DISCHARGE PLANNING

Concurrent review may be performed while services are being performed. If concurrent review is performed during an Inpatient stay, the expected and current length of stay is evaluated to determine if continued hospitalization is Medically Appropriate/Medically Necessary. When performed, the review assesses the level of care provided to the Covered Person and coordinates discharge planning. Concurrent review continues until the patient is discharged. Not all Inpatient stays are reviewed concurrently. Concurrent review may not be performed where an Inpatient Facility is paid based on a per case or diagnosis-related basis, or where an agreement with a Facility does not require such review.

Retrospective/post-service review occurs after services have been provided. This may be for a variety of reasons, including when Independence Administrators has not been notified of a Covered Person's admission until after discharge, or where medical charts are unavailable at the time of a concurrent review. Certain services are only reviewed on a retrospective/post-service basis.

In addition to these standard utilization reviews, Independence Administrators may determine coverage of certain procedures and other benefits available to Covered Persons through pre-notification as required by the Covered Person's benefit plan and discharge planning.

Pre-notification is advance notification to Independence Administrators of an Inpatient admission or Outpatient service where no Medical Appropriateness/Medical Necessity review is required, such as maternity admissions/deliveries. Pre-notification is primarily used to identify Covered Persons for concurrent review needs, to ascertain discharge planning needs proactively, and to identify Covered Persons who may benefit from case management programs.

Discharge planning is performed during an Inpatient admission and is used to identify and coordinate a Covered Person's needs and benefit coverage following the Inpatient stay, such as covered home care, ambulance transport, acute rehabilitation, or Skilled Nursing Facility placement. Discharge planning involves Independence Administrators' authorization of covered post-Hospital services along with identifying and referring Covered Persons for disease management or case management services.

E. TRANSPLANT SERVICES

Independence Administrators requests notification of transplant services as soon as the need for an organ or tissue transplant is known. For a complete list of services requiring Pre-certification please call the number for Clinical Services or visit the website listed on your identification (ID) card. This list may be subject to change.

F. MATERNITY SERVICES

Independence Administrators requests maternity care notification as soon as the pregnancy is confirmed by a Doctor.

Pre-certification requirements apply when:

1. a Covered Person is admitted for any condition or procedure other than delivery of the baby;
2. the type of delivery anticipated or place of service changes before admission for delivery;

3. the Covered Person's medical condition requires a stay longer than 48 hours after a vaginal delivery or 96 hours after an approved cesarean section. Independence Administrators must pre-certify additional Inpatient days;

4. the baby is required to stay after the mother is discharged. Independence Administrators must pre-certify additional Inpatient days.

A Covered Person is encouraged to call Independence Administrators if medical problems develop during the pregnancy.

G. OTHER PRE-CERTIFICATION REQUIREMENTS

Pre-certification is required by Independence Administrators in advance for Home Health Care, Hospice Care, certain surgical and diagnostic procedures, Inpatient and Partial Hospitalization services for Substance Abuse, Mental Illness and Serious Mental Illness. For a complete list of Pre-certification requirements please call the number for Clinical Services listed on your identification (ID) card or visit the website listed on your identification (ID) card. This list may be subject to change. When a Covered Person plans to receive any of these listed procedures, Independence Administrators will review the Medical Appropriateness/Medical Necessity for the procedure or treatment in accordance with the criteria and procedures described above and grant prior approval of benefits accordingly.

Surgical, diagnostic and other procedures that are performed during an emergency, as determined by Independence Administrators, do not require pre-certification. However, Independence Administrators should be notified within two (2) business days of emergency services for such procedures, or as soon as reasonably possible, as determined by Independence Administrators. A complete list of Pre-certification requirements is available by calling the number for Clinical Services listed on your identification (ID) card or by visiting the website listed on your identification (ID)card. This list may be subject to change.

The Covered Person is responsible to have the Provider performing the service contact Independence Administrators to initiate pre-certification. Independence Administrators will notify the Covered Person, the Doctor and the Facility, if applicable, of the determination.

If such prior approval is not obtained and the Covered Person undergoes the Surgical Procedure, diagnostic or other procedure, or treatment then benefits will be provided for Medically Appropriate/Medically Necessary treatment, but there will be a penalty for non-compliance. Benefits for Covered Services will be reduced, 20%, per service to the Covered Person. Such penalty, and any difference in what is covered by Independence Administrators and the Covered Person's obligation to the Provider, may be the sole responsibility of, and payable by, the Covered Person. For a complete list of services requiring Pre-certification please call the number for

Clinical Services listed on your identification (ID) card or visit the website listed on your identification (ID) card. This list may be subject to change.

H. SERVICES REQUIRING PRE-CERTIFICATION

For a complete list of services requiring Pre-certification please call the number for Clinical Services listed on your identification (ID) card or visit the website listed on your identification (ID) card. This list may be subject to change.

I. CASE MANAGEMENT

Case management serves individuals who have been diagnosed with a complex, catastrophic, or chronic Illness or injury. The objectives of case management are to facilitate access by the patient to ensure the efficient use of appropriate health care resources, link Covered Persons with appropriate health care or support services, assist Providers in coordinating prescribed services, monitor the quality of services delivered, and improve outcomes of Covered Persons. Case management supports Covered Persons and Providers by locating, coordinating, and/or evaluating services for a Covered Person who has been diagnosed with a complex, catastrophic or chronic Illness and/or injury across various levels and sites of care.

Independence Administrators will provide case management services for those identified Covered Persons that would benefit from:

- Support during the continuum of care;
- Improved self-management skills;
- Improved transition and coordination among multiple Providers and/or levels of care;
- Assistance to maximize the effective use of health plan benefits;
- Reduction of acute exacerbation of a chronic Illness; and,
- Reduction of preventable complications.

Covered Persons may be identified for case management through the pre-certification process or through claims review. External referrals are also accepted from Covered Persons' Providers or family members. Covered Persons referred to case management are screened and accessed prior to acceptance into the program. Only those Covered Persons likely to benefit from case management are accepted into case management.

A case manager will consult with the patient, the patient's authorized representative, the caregiver and the attending Doctor in order to develop a plan of care for approval by the patient's attending Doctor and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the care giver to offer assistance and support;
- monitoring Inpatient care;
- identifying available resources for appropriate care;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

The case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The attending Doctor, the patient and the patient's caregiver must all agree to the alternate treatment plan. Once agreement has been reached, Independence Administrators may reimburse necessary expenses in the treatment plan, even if some expenses normally would not be paid by the benefit plan.

Case management is a voluntary service. Covered Persons must provide their consent for enrollment into case management. There is no reduction in benefits if the patient and the patient's family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

EXCEPTIONS AND EXCLUSIONS

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

1. Which are not Medically Necessary as determined by the Plan for the diagnosis or treatment of illness or injury;
2. Which are Experimental/Investigative in nature, except, a) as approved by the Plan, or b) Routine Patient Costs Associated With Qualifying Clinical Trials that meets the definition of a Qualifying Clinical Trial under the Plan;
3. Which were Incurred prior to the Covered Person's effective date of coverage;
4. Which are in excess of the Covered Expense, as defined herein;
5. Which were or are Incurred after the date of termination of the Covered Person's coverage;
6. For any loss sustained or expenses Incurred during military service while on active duty as a member of the armed forces of any nation; or as a result of enemy action or act of war, whether declared or undeclared;
7. For which a Covered Person would have no legal obligation to pay, or another party has primary responsibility;
8. Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
9. Paid or payable by Medicare when Medicare is primary. For purposes of this plan, a service, supply or charge is "payable under Medicare" when the Covered Person is eligible to enroll for Medicare benefits, regardless of whether the Covered Person actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits;
10. For any occupational 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 Covered Person claims the benefits or compensation;
11. To the extent a Covered Person is legally entitled to receive when provided by the Veteran's Administration or by the Department of Defense in a government facility reasonably accessible by the Covered Person;
12. For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the state's Motor Vehicle Financial Responsibility Law or similar law;
13. Which are not billed and performed by a Provider as defined under this coverage as a "Professional Provider", "Facility Provider" or "Ancillary Provider" except as otherwise indicated under the subsections entitled: (a) Therapy Services" (that identifies covered therapy services as provided by licensed therapists) and (b) "Ambulance Services" in the ***Covered Medical Charges*** section;
14. Rendered by a member of the Covered Person's Immediate Family;

15. Performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program and are provided through a Hospital or university;
16. For ambulance services except as specifically provided under this Plan;
17. For services and operations for cosmetic purposes which are done to improve the appearance of any portion of the body, and from which no improvement in physiologic function can be expected. However, benefits are payable to correct a condition resulting from an accident. Benefits are also payable to correct functional impairment which results from a covered disease, injury or congenital birth defect. This exclusion does not apply to mastectomy related charges as provided for in this booklet;
18. For telephone consultations unless otherwise indicated, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
19. For alternative therapies/complementary medicine, including but not limited to, acupuncture, music therapy, dance therapy, equestrian/hippotherapy, homeopathy, primal therapy, rolfing, psychodrama, vitamin or other dietary supplements and therapy, aromatherapy, massage therapy, therapeutic touch, recreational, wilderness, educational and sleep therapies;
20. For marriage counseling;
21. For Custodial Care, domiciliary care or rest cures;
22. For equipment costs related to services performed on high-cost technological equipment as defined by the Plan, such as, but not limited to, computer tomography (CT) scanners, magnetic resonance imagers (MRI) and linear accelerators, unless the acquisition of such equipment by a Professional Provider was approved through the pre-certification process and/or by the Plan;
23. For dental services related to the care, filling, removal or replacement of teeth (including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia or dentinogenesis imperfecta), and the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as otherwise specifically stated in this booklet/certificate. Services not covered include, but are not limited to, apicoectomy (dental root resection), prophylaxis of any kind, root canal treatments, soft tissue impactions, alveolectomy, bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and treatment of periodontal disease unless otherwise indicated;
24. For dental implants for any reason;
25. For dentures, unless for the initial treatment of an Accidental Injury/trauma;
26. For orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate;
27. For injury as a result of chewing or biting (neither is considered an Accidental Injury);
28. For palliative or cosmetic foot care including treatment of bunions (except for capsular or bone surgery), toenails (except surgery for ingrown nails), the treatment of subluxations of the foot, care of corns, calluses, fallen arches, pes planus (flat feet), weak feet, chronic foot strain, and other routine podiatry care, unless

associated with the Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes;

29. For supportive devices for the foot (orthotics), such as, but not limited to, foot inserts, arch supports, heel pads and heel cups, and orthopedic/corrective shoes. This exclusion does not apply to orthotics and podiatric appliances required for the prevention of complications associated with diabetes;
30. For treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury;
31. For treatment of obesity, except for surgical treatment of obesity when the Plan (a) determines the surgery is Medically Necessary; and (b) the surgery is limited to one surgical procedure per lifetime regardless of whether such procedure was covered by the Plan or another Plan. Any new or different obesity surgery, revisions, repeat, or reversal of any previous surgery are not covered. The exclusion of coverage for a repeat, reversal or revision of a previous obesity surgery does not apply when the procedure results in technical failure or when the procedure is required to treat complications, which if left untreated, would result in endangering the health of the Covered Person;
32. For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;
33. For diagnostic screening examinations, except for mammograms and preventive care as provided in the ***Covered Medical Charges*** section;
34. For routine physical examinations for non-preventive purposes, such as pre-marital examinations, physicals for college, camp or travel, and examinations for insurance, licensing and employment;
35. For travel, whether or not it has been recommended by a Professional Provider or if it is required to receive treatment at an out of area Provider;
36. For immunizations required for employment purposes, or for travel except for those immunizations recommended by the Centers for Disease Control and Prevention's Advisory Committee for Immunization Practices;
37. For care in a nursing home, home for the aged, convalescent home, school, camp, institution for intellectually disabled children, Custodial Care in a Skilled Nursing Facility;
38. For counseling or consultation with a Covered Person's relatives, or Hospital charges for a Covered Person's relatives or guests, except as may be specifically provided;
39. For home blood pressure machines, except for Covered Persons: (a) with pregnancy-induced hypertension, (b) with hypertension complicated by pregnancy, or (c) with end-stage renal disease receiving home dialysis;
40. As described in the "Durable Medical Equipment" section in the ***Covered Medical Charges*** section for personal hygiene, comfort and convenience items; equipment and devices of a primarily nonmedical nature; equipment inappropriate for home use; equipment containing features of a medical nature that are not required by the Covered Person's condition; non-reusable supplies; equipment which cannot reasonably be expected to serve a therapeutic purpose; duplicate equipment,

whether or not rented or purchased as a convenience; devices and equipment used for environmental control; and customized wheelchairs;

41. For medical supplies such as but not limited to thermometers, ovulation kits, early pregnancy or home pregnancy testing kits;
42. For prescription drugs, except as may be provided in the ***Prescription Drug Coverage*** section of this booklet. This exclusion does not apply to insulin, insulin analogs and pharmacological agents for controlling blood sugar levels as provided for the treatment of diabetes;
43. For over-the-counter drugs and any other medications that may be dispensed without a doctor's prescription, except for medications administered during an Inpatient admission;
44. For amino acid supplements, non-elementals formulas, appetite suppressants or nutritional supplements. This exclusion includes basic milk, soy, or casein hydrolyzed formulas (e.g., Nutramigen, Alimentun, Pregestimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy or protein allergy;
45. For Inpatient Private Duty Nursing services;
46. For any care that extends beyond traditional medical management for pervasive development disorders, attention deficit disorder, learning disabilities, behavioral problems, intellectual disability or autism spectrum disorders; or treatment or care to effect environmental or social change;
47. For maintenance of chronic conditions;
48. For charges Incurred for expenses in excess of Benefit limits as specified in the ***Schedule of Benefits***;
49. For any therapy service provided for: the ongoing Outpatient treatment of chronic medical conditions that are not subject to significant functional improvement; additional therapy beyond this Plan's limits, if any, shown on the ***Schedule of Benefits***; work hardening; evaluations not associated with therapy; or therapy for back pain in pregnancy without specific medical conditions;
50. For cognitive rehabilitative therapy, except when provided integral to other supportive therapies, such as, but not limited to physical, occupational and speech therapies in a multidisciplinary, goal-oriented and integrated treatment program designed to improve management and independence following neurological damage to the central nervous system caused by illness or trauma (e.g. stroke, acute brain insult, encephalopathy);
51. For self-injectable Prescription Drugs, regardless of whether the drugs are provided or administered by a Provider. Drugs are considered self-injectable Prescription Drugs even when initial medical supervision and/or instruction is required prior to patient self-administration. This exclusion does not apply to self-injectable Prescription Drugs that are: (a) mandated to be covered by law, such as insulin or any drugs required for the treatment of diabetes, unless these drugs are covered by Prescription Drug coverage under the Plan or free-standing Prescription Drug Contract issued to the Group by the Plan; or (b) required for treatment of an emergency condition that requires a self-injectable drug;

52. For treatment of temporomandibular joint syndrome (TMJ), also known as craniomandibular disorders (CMD), with intraoral devices or with any non-surgical method to alter vertical dimension;
53. For hearing aids, including cochlear electromagnetic hearing devices, and hearing examinations or tests for the prescription or fitting of hearing aids. Services and supplies related to these items are not covered;
54. For assisted fertilization techniques such as, but not limited to, in-vitro fertilization, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT);
55. For cranial prostheses, including wigs intended to replace hair;
56. For any Surgery performed for the reversal of a sterilization procedure;
57. For diagnosis and treatment of autism spectrum disorders that is provided through a school as part of an individualized education program;
58. For diagnosis and treatment of autism spectrum disorders that is not included in the autism spectrum disorders treatment plan for autism spectrum disorders;
59. For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses unless otherwise indicated;

For any other service or treatment except as provided under this Plan.

COORDINATION OF BENEFITS

APPLICABILITY

1. This Coordination of Benefits ("COB") provision applies to This Plan when an Employee or the Employee's covered Dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

2. If this COB provision applies, the Order Of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

   a. shall not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another Plan; but

   b. may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in "Effect on the Benefits of This Plan."

DEFINITIONS

1. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

   a. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage. It does not include school accident-type coverage, group or group-type hospital indemnity benefits of $100 per day or less.

   b. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid. It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

   Each contract or other arrangement for coverage under (a) or (b) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. **"This Plan"** is the part of the group contract that provides benefits for health care expenses.

3. **"Primary Plan/Secondary Plan."** The Order Of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

   When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. **"Allowable Expense"** means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

   The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

   When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

5. **"Claim Determination Period"** means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

ORDER OF BENEFIT DETERMINATION RULES

1. **General.** When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

   a. the other Plan has rules coordinating its benefits with those of This Plan; and

   b. both those rules and This Plan's rules, in subparagraph 2 below, require that This Plan's benefits be determined before those of the other Plan.

2. **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:

   a. **Non-dependent/Dependent.** The benefits of the Plan which covers the person as other than a dependent are determined before those of the Plan which covers the person as a dependent.

   b. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in subparagraph 2 (c) below, when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

(1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but

(2) if both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period.

However, if the other Plan does not have the rule described in (1) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. **Dependent Child/Parents Separated or Divorced**. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) first, the Plan of the parent with custody of the child;

(2) then, the Plan of the spouse of the parent with custody of the child; and

(3) finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. **Active/Inactive Employee.** The benefits of a Plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

e. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee longer are determined before those of the Plan that covered that person for the shorter time.

EFFECT ON THE BENEFITS OF THIS PLAN

1. **When this Section Applies.** This section applies when, in accordance with "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other

Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in 2 immediately below.

2. **Reduction in This Plan's Benefits.** The benefits of This Plan will be reduced when the sum of:

   a. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

   b. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

      When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

3. Independence Administrators, however, shall not be required to determine the existence of any other Plan or the amount of benefits payable under any such Plan, and the payment of benefits under this Program shall be affected by the benefits that would be payable under any and all other Plans only to the extent that Independence Administrators is furnished with information relative to such other Plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Independence Administrators has the right to release or obtain benefit information in order to implement this provision.

FACILITY OF PAYMENT

If payments should have been made under this Plan but were made under any other Plan(s), Independence Administrators may make payments to such other Plan(s) to satisfy the intent of the provision. Benefits under this Plan will then be deemed paid. The Plan will no longer be liable for such payments.

RIGHT OF RECOVERY

Independence Administrators has the right to recover any excess payments made to satisfy the intent of this provision.

TERMINATION OF COVERAGE

EMPLOYEE

Coverage for an Employee will end on the earliest of:

1. the date the Plan terminates;
2. the end of the month in which coverage terminates under the Plan for the class of Employees to which the Employee belongs;
3. the end of the month in which the Employee transfers to an ineligible class of Employees;
4. the end of the period covered by the last contribution made by the Employee for coverage under the Plan;
5. the date in which the Employee's employment is terminated;
6. the date the Employee begins full-time active duty as a member of any military organization;
7. the date the Employee becomes involved in a labor dispute, strike, or work stoppage. Coverage will be reinstated only upon the return of such Employee to the Plan.

DEPENDENTS

Coverage for a Dependent will end on the earliest of:

1. the date an Employee's coverage terminates under the Plan;
2. the end of the month in which the Dependent no longer satisfies the eligibility requirements for coverage as a Dependent under the Plan;
3. the end of the period covered by the last contribution made by the Employee for Dependent coverage.

CONTINUATION OF COVERAGE DURING CERTAIN LEAVES OF ABSENCE

In certain instances, the Company may allow you to continue your coverage while you are on an approved leave of absence. Please refer to the Company's leave of absence policies outlined in a separate document.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

COBRA affects employers who have employed 20 or more Employees on more than 50% of the typical business days during the previous calendar year. The employer is responsible for notifying each qualified beneficiary of their rights under COBRA.

Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain cases, the covered employee. In order to be a qualified beneficiary an individual must generally be covered under a group health plan on the day before the event that causes a loss of coverage (such as a termination of employment, or a divorce from or death of the covered employee). A child who is born to the covered employee, or who is placed for adoption with the covered employee, during a period of COBRA continuation coverage is also a qualified beneficiary.

Each qualified beneficiary, as defined under the Consolidated Omnibus Budget Reconciliation Act of 1985, whose coverage would end under the Contract as a result of a qualifying event (listed below) will have an opportunity to elect continuation coverage under the Contract as required by law.

The employer retains full responsibility for notifying Employees of the rights of continuation coverage and for administering the exercise of continuation rights, as required by COBRA.

Each Employee has a right to continue coverage if:

1. employment with the employer ends for a reason other than gross misconduct;
2. work hours are reduced.

Each Dependent has a right to continue coverage if:

1. the Employee's employment with the employer ends for a reason other than gross misconduct;
2. the Employee's work hours are reduced;
3. the Employee dies;
4. in the case of the Employee's spouse, such spouse ceases to be an eligible Dependent as a result of divorce or legal separation;
5. the Employee is entitled to Medicare benefits, or
6. in the case of a Dependent child, such child ceases to be an eligible Dependent according to the terms of the Contract.

If any of the qualifying events occur, each qualified beneficiary, as reported to Independence Administrators by the employer, will receive a form from the employer to decide whether or not to elect COBRA continuation. Each qualified beneficiary will then have 45 days to pay the premium due. Premiums are payable from the date of the qualifying event.

In the case of the Employee's termination of employment or reduction in work hours, the coverage may be continued for up to 18 months, or 29 months if the individual is disabled either at the time of his qualifying event or during the first 60 days of COBRA coverage and has received notification of disability eligibility from the Social Security Administration and notifies the employer within 60 days after receiving such notification.

If the individual entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, those non-disabled family members are also entitled to the 29-month disabilities extension. With respect to all other events, coverage may be continued for up to 36 months.

However, coverage will cease earlier if one of the following events occurs:

1. the employer ceases to provide group health coverage to any Employee; or
2. the qualified beneficiary fails to make timely payments of any premium required; or
3. the qualified beneficiary is covered under another group health plan; or
4. the qualified beneficiary is entitled to benefits under Title XVIII of the Social Security Act (Medicare); or
5. the spouse remarries and becomes covered under another group health insurance plan.

Independence Administrators will have no obligation to ensure that any termination instructions received by it from the employer comply with the requirement of COBRA.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

THIRD PARTY RECOVERY PROVISION

To the extent payment for the Illness or injury is made, or may be made in the future, by or for the party or parties legally responsible (as a settlement, judgment or in any other way), charges arising from that Illness or injury are not considered to be eligible charges under the terms of the Plan. If, however, payment by or for the party or parties legally responsible has not yet been made and the Covered Person(s) involved (or if incapable, that person's legal representative) agrees in writing to pay back promptly the benefits paid as a result of the Illness or injury to the extent of any future payments made by or for the party or parties legally responsible for the Illness or injury, the Plan will consider charges arising from that Illness or injury as eligible charges and benefits will be paid under the terms of the Plan. The agreement is to apply whether or not: (a) liability for the payments is admitted by the party or parties legally responsible; and (b) such payments are itemized.

When a Covered Person incurs medical expenses which are payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or if medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, the Covered Person shall reimburse the Plan for the cost of any and all medical expenses out of any funds or monies that he recovers from any third party, whether by coverage under another program, statute, insurance policy, lawsuit, settlement, judgment or otherwise.

Because the Plan is entitled to reimbursement for any payment which a Covered Person may receive from a third party if the Plan has paid medical benefits for expenses that arose from the same circumstances that were the basis for the payment received from the third party, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that a Covered Person may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount and/or recovery from a third party. This right to reimbursement comes first regardless of the manner in which the recovery is structured or worded, and/or even if the Covered Person has not been paid fully or reimbursed for all of his/her damages or expenses. Therefore, the Plan's share of the recovery shall not be reduced because the Covered Person has not received the full damages or expenses claimed unless the Plan agrees in writing to such reduction.

Each Covered Person hereby consents and agrees that a constructive trust, lien and/or an equitable lien by agreement in favor of the Plan exists with regard to any payment, amount and/or recovery from a third party; and in accordance with that constructive trust, lien and/or equitable lien by agreement, each Covered Person agrees to cooperate with the Plan in reimbursing it for the Plan's costs and expenses.

To that end, once a Covered Person has any reason to believe that he may be entitled to recovery from any third party, he must notify the Plan. And, at that time, the Covered Person (and his attorney, if applicable) must sign a subrogation/reimbursement agreement that acknowledges the Plan's subrogation rights and its right to be reimbursed for expenses arising from circumstances that entitle the Covered Person to any payment, amount and/or recovery from a third party.

If a Covered Person fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to the Covered Person and/or any of his dependents until the agreement is signed. Alternatively, if a Covered Person fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of the Covered Person, the Covered Person's acceptance of such benefits shall constitute his or her agreement to the Plan's right to subrogation or reimbursement from any recovery by the Covered Person from any third party that is based on the circumstances from which the expenses or benefits paid by the Plan arose, and the Covered Person's agreement to a constructive trust, lien and/or an equitable lien by agreement in favor of the Plan on any payment, amount or recovery that the Covered Person recovers from any third party.

The Plan also may enforce its subrogation or reimbursement rights by requiring the Covered Person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorneys' fees or costs associated with the Covered Person's claim or lawsuit without express written authorization from the Plan Sponsor.

Each Covered Person consents and agrees that he/she shall not assign his/her rights to any payment, amount or recovery against a third party to any other party, including his/her attorneys without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

The Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorneys fund" doctrine, regulatory diligence or any other equitable defense that may affect the Plan's right to subrogation or reimbursement.

If the Plan shall become aware that a Covered Person has received a third-party payment amount and/or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further payments related to the Covered Person and/or his or her dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to the Covered Person.

GENERAL PROVISIONS

REGARDING TREATMENT WHICH IS NOT MEDICALLY NECESSARY

Independence Administrators only covers treatment which it determines Medically Necessary. A Preferred Provider accepts Independence Administrators decision and contractually is not permitted to bill the Covered Person for treatment which Independence Administrators determines is not Medically Necessary unless the Preferred Provider specifically advises the Covered Person in writing, and the Covered Person agrees in writing that such services are not covered by Independence Administrators, and that the Covered Person will be financially responsible for such services. A Non-Preferred Provider, however, is not obligated to accept Independence Administrators determination and the Covered Person may not be reimbursed for treatment which Independence Administrators determines is not Medically Necessary. The Covered Person is responsible for these charges when treatment is received by a Non-Preferred Provider. You can avoid these charges simply by choosing a Preferred Provider for your care. The term "Medically Necessary" is defined in the ***Definitions*** section.

LIMITATION OF LIABILITY

Independence Administrators will not be liable for any injury(ies) or damage(s) resulting from acts or omissions of any person, institution or other Provider furnishing services or supplies to the Covered Person.

No legal action may be taken to recover benefits provided by the Plan until 30 days after Independence Administrators has received a properly completed claim. In no event may such action be taken later than one year after services or Supplies were performed or provided.

NOTICE OF CLAIMS

Payments of benefits will not be made under the Plan unless proper notice is furnished to Independence Administrators that covered expenses have been provided to a Covered Person. **Written notice must be given within 60 days after expenses are Incurred for covered expenses.**

Failure to give notice to Independence Administrators within the specified time will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but **in no event will Independence Administrators be required to accept notice more than one year after covered expenses are Incurred.**

PAYMENT OF BENEFITS

Independence Administrators is authorized by the Plan to make payment directly to Facilities and Preferred Providers furnishing Covered Services for which benefits are provided under the Plan.

However, Independence Administrators reserves the right to make the payments directly to the Covered Person. The right of the Covered Person to receive payment is not otherwise assignable unless required by State law.

If any benefit remains unpaid at the death of the Employee, payment will be made to the Employee's estate. If no estate is probated or expected to be probated, Independence Administrators will have the right to make payment to a third party who has paid covered expenses for the Employee, upon receipt of proper documentation of such payment. Independence Administrators will incur no liability due to such payment made pursuant to this provision.

A request for payment of benefits will be deemed to authorize Independence Administrators to institute an investigation and to have access to all pertinent data, including all records of a Hospital and/or Doctor pertaining to the Covered Person.

COVERED PERSON/PROVIDER RELATIONSHIP

1. The choice of a Provider or choice of treatment by a Provider is solely that of the Covered Person.

2. The Plan does not furnish Covered Services but only makes payment for Covered Services received by a Covered Person. The Plan is not liable for any act or omission of any Provider. The Plan has no responsibility for a Provider's rendering of, failure or refusal to render Covered Services to a Covered Person.

PAYMENT OF PROVIDERS

1. PREFERRED PROVIDER REIMBURSEMENT

Reimbursement of health care providers who participate in the Preferred Provider Network is intended to encourage the provision of quality, cost-effective care. Set forth below is a general description of the reimbursement programs, by type of Network health care provider.

Please note that these reimbursement programs may change from time to time, and the arrangements with particular Providers may be modified as new contracts are negotiated. If you have any questions about how your health care provider is compensated, please speak with your healthcare provider directly or contact Customer Service.

PHYSICIANS

Network physicians, including primary care physicians (PCPs) and specialists, are paid on a fee-for-service basis, meaning that payment is made according to the Network fee schedule for the specific medical services that the Physician performs.

INSTITUTIONAL PROVIDERS

Hospitals

For most Inpatient medical and surgical services, Hospitals are paid per diem rates, which are specific amounts paid for each day a Covered Person is in the Hospital. These rates usually vary according to the intensity of the Covered Services provided. Some Hospitals are also paid case rates, which are set dollar amounts paid for a complete Hospital stay related to a specific procedure or diagnosis, e.g., transplants. For most Outpatient and Emergency Services and procedures, most Hospitals are paid specific rates based on the type of Covered Service performed. For a few Covered Services, Hospitals are paid based on a percentage of billed charges. Most Hospitals are paid through a combination of the above payment mechanisms for various services.

Independence Administrators is implementing a quality incentive program with a few of the Hospitals in the Network. This program will provide increased reimbursement to these Hospitals based on them meeting specific quality criteria, including "Patient Safety Measures". Such patient safety measures are consistent with recommendations by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and are designed to help reduce medical and medication errors. Other criteria are directed at improved patient outcomes, higher nursing staff ratios, and electronic submissions. This is a new incentive program that is expected to evolve over time.

Skilled Nursing Facilities, Rehabilitation Hospitals, and other care facilities

Most Skilled Nursing Facilities and other special care facilities are paid per diem rates, which are specific amounts paid for each day a Covered Person is in the Facility. These amounts may vary according to the intensity of the Covered Services provided.

Ambulatory Surgical Centers ("ASCs")

Most ASCs are paid specific rates based on the type of Covered Service performed. For a few services, some ASCs are paid based on a percentage of billed charges.

Physician Group Practices, Physician Associations and Integrated Delivery Systems

Certain physician group practices, independent physician associations ("IPAs") and integrated hospital/physician organizations called Integrated Delivery Systems ("IDS") employ or contract with individual physicians to provide medical services. These groups are paid as described in the Physicians reimbursement subsection outlined above. These groups may pay their affiliated physicians a salary and/or provide incentives based on production, quality, service, or other performance standards.

Ancillary Service Providers, certain Facility Providers and Mental Health/Substance Abuse Providers

Ancillary service providers, such as Durable Medical Equipment providers, laboratory providers, Home Health Care agencies, and Mental Health and Substance Abuse providers are paid on the basis of fee-for-service payments according to the Network fee schedule for the specific Covered Services performed. In some cases, such as for mental health and substance abuse benefits, one vendor arranges for all such services through a contracted set of Providers. Independence Administrators reimburses the contracted Providers of these vendors on a fee-for-service basis. An affiliate of Independence Administrators has less than a three percent ownership interest in this mental health/substance abuse vendor.

Hospitalists

Independence Administrators currently does not have a hospitalist program in place but is considering implementing such a program in the future. However, Independence Administrators continues to maintain interest in encouraging Hospitals to contract with Physicians who specialize in providing emergency room consultation and inpatient management services.

2. PAYMENT METHODS

The Covered Person or the Provider may submit bills directly to Independence Administrators and, to the extent that benefits are payable within the terms and conditions of this booklet, reimbursement will be furnished as detailed below. The Covered Person's benefits for Covered Services are based on the rate of reimbursement as set forth under "Covered Expense" in the ***Definitions*** section of this Booklet.

FACILITY PROVIDERS

Preferred Facility Providers

Preferred Facility Providers are members of the PPO Network and have a contractual arrangement with Independence Administrators for the provision of services to Covered Persons. Benefits will be provided as specified in the ***Schedule of Benefits*** for Covered Services which have been performed by a Preferred Facility Provider. Independence Administrators will compensate the Preferred Facility Providers in accordance with the contracts entered into between such Providers and Independence Administrators. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. No payment will be made directly to the Covered Person for Covered Services rendered by any Preferred Facility Provider.

Non-Preferred Facility Providers

Non-Preferred Facility Providers include facilities that are not part of the PPO Network.

When a Covered Person seeks care from a Non-Preferred Facility Provider, benefits will be provided to the Covered Person at the Non-Preferred cost sharing level specified in the ***Schedule of Benefits***. The reimbursement rate is specified under "Covered Expense" in the ***Definitions*** section of this Booklet.

If Independence Administrators determines that Covered Services were for Emergency Care you are protected from surprise billing or balance billing. If you have an emergency medical condition and get emergency services from a Non-Preferred provider or facility, the most the provider or facility may bill you under law is your plan's Preferred cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition unless, you give written consent and give up your protections not to be balanced billed for these post-stabilization services. Emergency admissions must be certified within two (2) business days of admission, or as soon as reasonably possible, as determined by Independence Administrators. Payment for emergency services provided by Non-Preferred Provider will be the lesser of the billed charge or the plan's median contracted rate, referred to as the qualifying payment amount (QPA).

If you are balance billed by the Non-Preferred Facility Provider, you will need to contact Independence Administrators at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, Independence Administrators will do everything within our control to resolve the balance-billing.

Once Covered Services are rendered by a Facility Provider, the Plan will not honor a Covered Person's request not to pay for claims submitted by the Facility Provider. The Covered Person will have no liability to any person because of its rejection of the request.

PROFESSIONAL PROVIDERS

Preferred Professional Providers

Independence Administrators is authorized by the Covered Person to make payment directly to the Preferred Professional Providers furnishing Covered Services for which benefits are provided under this coverage. Preferred Professional Providers have agreed to accept the rate of reimbursement determined by a contract as payment in full for Covered Services. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. Preferred Professional Providers will make no additional charge to Covered Persons for Covered Services except in the case of certain Copayments, Coinsurance or other cost sharing features as specified under this program. The Covered Person is responsible, within 60 days of

the date in which Independence Administrators finalizes such services, to pay, or make arrangements to pay, such amounts to the Preferred Professional Provider.

Benefit amounts, as specified in the ***Schedule of Benefits*** of this coverage, refer to Covered Services rendered by a Professional Provider which are regularly included in such Provider's charges and are billed by and payable to such Provider. Any dispute between the Preferred Professional Provider and a Covered Person with respect to balance billing shall be submitted to Independence Administrators for determination. The decision of Independence Administrators shall be final.

Once Covered Services are rendered by a Professional Provider, Independence Administrators will not honor a Covered Person's request not to pay for claims submitted by the Professional Provider. Independence Administrators will have no liability to any person because of its rejection of the request.

Emergency Care by Non-Preferred Providers

Payment for emergency services provided by Non-Preferred Providers will be the lesser of the billed charge or the plan's median contracted rate, referred to as the qualifying payment amount (QPA). For payment of Covered Services provided by a Non-Preferred Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet. Inpatient admissions for Emergency Care must be certified within two business days of admission, or as soon as reasonably possible, as determined by Independence Administrators.

When you receive Emergency Care you are protected from surprise billing or balance billing. If you have an emergency medical condition and get emergency services from a Non-Preferred provider or facility, the most the provider or facility may bill you under law is your plan's Preferred cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition unless, you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

If you are balance billed by the Emergency Care Non-Preferred Provider, you will need to contact Independence Administrators at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, Independence Administrators will do everything within our control to resolve the balance-billing.

Non-Preferred Hospital-Based Provider

When you receive covered services from a Preferred Hospital or ambulatory surgical center, certain providers there may be Non-Preferred. In these cases, the most those providers may bill you under law is your plan's Preferred cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers

can't balance bill you and may not ask you to give up your protections not to be balance billed.

For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet.

If you get other services at these in-network facilities, Non-Preferred Providers can't balance bill you, unless you give written consent and give up your protections.

If you get balance billed by the Hospital Based Non-Preferred Provider, you will need to contact Independence Administrators at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, Independence Administrators will do everything within our control to resolve the balance-billing.

Note that when you elect to see a Non-Preferred Hospital-Based Provider for follow-up care or any other service where you have the ability to select a Preferred Provider, the Covered Services will be covered at the Non-Preferred benefit level. Except for Emergency Treatment, if a Non-Preferred Provider admits you to a Hospital or other Facility Provider, Covered Services provided by a Non-Preferred Hospital-Based Provider will be reimbursed at the Non-Preferred benefit level. For such Covered Services, payment will be made to the Provider. The Covered Person will be responsible to reimburse the Provider for the difference between Independence Administrators payment and the Provider's charge.

For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet.

Inpatient Hospital Consultations by a Non-Preferred Professional Provider

When you receive Covered Services for an Inpatient hospital consultation from a Non-Preferred Professional Provider while you are Inpatient at a Preferred Facility Provider, and the Covered Services are referred by a Preferred Professional Provider, the Non-Preferred Professional Provider can't balance bill you, unless you give written consent and give up your protections.

In these cases, the most the Non-Preferred Professional Provider may bill you under law is your plan's Preferred cost-sharing amount. The Non-Preferred Professional Provider can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get balance billed by the Non-Preferred Professional Provider, you will need to contact Independence Administrators at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, Independence Administrators will do everything within our control to resolve the balance-billing.

For such Covered Services, payment will be made to the Provider. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet.

Note that when you elect to see a Non-Preferred Professional Provider for follow-up care or any other service when you have the ability to select a Preferred Provider, the Covered Services will be covered at a Non-Preferred benefit level. Except for Emergency Care, if a Non-Preferred Professional Provider admits you to a Hospital or other Facility Provider, services provided by Non-Preferred Professional Provider will be reimbursed at the Non-Preferred benefit level. For such Covered Services, payment will be made to the Provider. The Covered Person will be responsible to reimburse the Provider for the difference between Independence Administrators' payment and the Provider's charge.

For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet.

Non-Preferred Professional Provider

Except as set forth above, when a Covered Person seeks care from a Non-Preferred Professional Provider, benefits will be provided to the Covered Person at the Non-Preferred cost sharing level specified in the ***Schedule of Benefits***. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this booklet. When a Covered Person seeks care and receives Covered Services from a Non-Preferred Professional Provider, the Covered Person will be responsible to reimburse the Non-Preferred Professional Provider for the difference between Independence Administrators payment and the Non-Preferred Professional Provider's charge.

ANCILLARY PROVIDERS

Preferred Ancillary Providers

Preferred Ancillary Providers include members of the PPO Network that have a contractual relationship with Independence Administrators for the provision of services or supplies to Covered Persons. Benefits will be provided as specified in the ***Schedule of Benefits*** for the provision of services or supplies provided to Covered Persons by Preferred Ancillary Providers. Independence Administrators will compensate Preferred Ancillary Providers in the PPO Network in accordance with the contracts entered into between such Providers and Independence Administrators.

Non-Preferred Ancillary Providers

Non-Preferred Ancillary Providers are not members of the PPO Network. Benefits will be provided to the Covered Person at the Non-Preferred cost sharing level. The Covered Person will be penalized by the application of higher cost sharing. For payment of Covered Services provided by a Non-Preferred Ancillary Provider, please refer to the definition of Covered Expense in the Definitions section of this Booklet. When a Covered Person seeks care and receives Covered Services from a Non-Preferred Ancillary Provider, the Covered Person will be responsible to reimburse the Non-Preferred Ancillary Provider for the difference between Independence Administrators payment and the Non-Preferred Ancillary Provider's charge.

ASSIGNMENT OF BENEFITS TO PROVIDERS

The right of a Covered Person to receive benefit payments under this coverage is personal to the Covered Person and is not assignable in whole or in part to any person, Hospital, or other entity nor may benefits of this coverage be transferred, either before or after Covered Services are rendered. However, a Covered Person can assign benefit payments to the custodial parent of a Dependent covered under the coverage, as required by law.

RIGHT TO RECOVER EXCESS PAYMENTS

Independence Administrators reserves the right to recover claim payments made in excess of the benefits payable for Covered Services under the Plan. Independence Administrators may request that the payee, either a Covered Person or Provider, return the excess payment to Independence Administrators.

TRANSFER OF COVERAGE

An Employee may enroll in the Plan's coverage during the annual Open Enrollment Period established by the Company.

If written application is made during the annual Open Enrollment Period, coverage under the Plan will be effective on the first of the month following the month of the established Open Enrollment Period.

Notwithstanding anything in this provision to the contrary, the Employee and/or Dependent must satisfy all other eligibility requirements under the Plan prior to or simultaneously with the date that such Employee's coverage under the Plan is effective.

WHEN YOU HAVE A CLAIM

FROM A DOCTOR OR FACILITY

If you are treated for a covered Accidental Injury or Illness at a Facility or a participating doctor's office, present your Independence Administrators identification card. Independence Administrators will pay the provider directly for covered expenses.

If you are required to pay the Facility or the Doctor, be sure to get a receipted, itemized bill. Besides the itemized charges it should show:

- your name and address
- patient's name and age
- doctor's or hospital's name and address
- Provider or Facility identification number
- date of admission or treatment

ADVERSE DETERMINATIONS

An adverse determination is a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part*) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on: a determination that a benefit is not a covered benefit; the source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or a determination that a benefit is experimental, investigational, or not medically necessary or appropriate. This can include both pre-service claims as well as post-service claims. The scope of adverse benefit determination eligible for internal claims and appeals includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).

*Including a denial of part of the claim due to the terms of a plan or health insurance coverage regarding copayments, deductibles, or other cost-sharing requirements.

COMPLAINT PROCESS

Independence Administrators has a process for a Covered Person to express complaints. To register a complaint, the Covered Person should call the Customer Service Department at the telephone number on their identification card or write to Independence Administrators at the address listed below.

Independence Administrators
c/o Processing Center
P.O. Box 21974
Eagan, MN 55121

Most Covered Persons' concerns are resolved informally at this level. However, if Independence Administrators is unable to immediately resolve the complaint, it will be investigated, and the Covered Person will receive a response within thirty (30) days.

APPEAL PROCESS

Filing an Appeal

Independence Administrators maintains procedures for the resolution of appeals. Appeals may be filed within 180 days of the receipt of a decision from Independence Administrators stating an adverse benefit determination. An appeal occurs when the Covered Person or another authorized representative requests a change of a previous decision made by Independence Administrators by following the procedures described here. In order to authorize someone else to be your representative for the appeal, you must complete a valid authorization form.

Contact Independence Administrators at the address listed above or access your online services at the address on your identification card to obtain a form to authorize an appeal by a provider or other representative or for questions regarding the requirements for an authorized representative.

The Covered Person or other authorized person on behalf of the Covered Person, may request an appeal by calling or writing to Independence Administrators, as stated in the letter notifying the Covered Person of the decision.

Types of Appeals

The following are the two types of appeals and the issues they address.

- **Medical Necessity Appeal** — An appeal by or on behalf of a Covered Person that focuses on issues of Medical Appropriateness/Medical Necessity and requests Independence Administrators to change its decision to deny or limit the provision of a Covered Service. Medical Necessity appeals include appeals of adverse benefit determinations based on failure to meet established medical guidelines and peer review of medical appropriateness. It may also include the exclusions for Experimental/Investigational services or cosmetic services. Internal and External Appeals apply.*
- **Administrative Appeal** — An appeal by or on behalf of a Covered Person that focuses on unresolved disputes or objections regarding Independence Administrators' decision that concerns coverage terms such as exclusions and non-covered benefits, exhausted benefits, certain surprise medical bills with balance billing, and claims payment issues. Although an administrative appeal may present issues related to Medical Appropriateness/Medical Necessity, these are not the primary issues that affect the outcome of the appeal. Internal and External Appeals may apply.*

* **First Step — Internal Appeal** — An appeal filed with your health plan/plan administrator for evaluation and determination.

* **Second Step — External Appeal** — An appeal filed with your health plan/plan administrator for evaluation and determination by an independent review organization (IRO).

Timeframe Classifications

The timeframes described below for completing a review of each appeal depend on whether the appeal is classified as standard appeal or an expedited appeal for urgent care.

- Standard appeal timeframes apply to both pre-service appeals and post-service appeals that concern claims for non-urgent care.

  Standard pre-service appeal — An appeal for benefits that, under the terms of the Plan, must be pre-certified or pre-approved (either in whole or in part) *before* medical care is obtained in order for coverage to be available.

  Standard post-service appeal — An appeal for benefits that is not a pre-service appeal. (Post-service appeals concerning claims for services that the Covered Person has already obtained do not qualify for review as expedited/urgent appeals.)

  Urgent-care/Expedited appeal timeframes may apply to pre-service or on-going requests for urgent care.

- **Expedited appeal for urgent care** — An appeal that provides faster review, according to the procedures described below, on a pre-service issue. Independence Administrators will conduct an urgent-care/expedited appeal on a pre-service issue when it determines, based on applicable guidelines, that delay in decision-making would seriously jeopardize the Covered Person's life, health or ability to regain maximum function or would subject the Covered Person to severe pain that cannot be adequately managed while awaiting a standard appeal decision.

Information for the Appeal Review including Matched Specialist's Report

The Covered Person or other authorized person on behalf of the Covered Person, may submit to Independence Administrators additional information pertaining to your case. You may specify the remedy or action being sought. Upon request at any time during the appeal process, Independence Administrators will provide you or your authorized representative, free of charge, access to, and copies of, all relevant documents and records, including any additional information received and reviewed by the decision maker(s) on the appeal.

Input from a matched specialist is obtained for certain Medical Necessity Appeals. A matched specialist is a licensed physician or psychologist in the same or similar specialty as typically manages the care under review. The matched specialist cannot be the person who made the initial adverse benefit determination nor can they be a subordinate of the person who made that determination.

Appeal Decision makers

Independence Administrators has representatives that have been designated to act as decision maker(s) on the appeal. The decision maker(s) did not make the initial adverse benefit determination at issue in the appeal. Each decision maker will review all relevant information for the appeal, whether from the Covered Person or his authorized representative, or obtained from other sources during the investigation of the appeal issues. If the additional information meets plan guidelines the appeal may be overturned by the decision maker(s). To avoid conflict of interest and for compliance with regulatory and accreditation requirements, Independence Administrators also utilizes peer medical reviewers including contracted external review organizations for matched-specialty (peer) reviews, and for review of administrative and medical necessity external appeal review requests. Matched specialty /peer reviewers were not involved in the initial review process and are not subordinates of the person who made the initial determination.

Full and Fair Review

If the reviewer upholds the original decision, Independence Administrator's will provide the Covered Person with the rational and new or additional evidence considered or relied upon in connection with the appeal. This is to give the Covered Person a reasonable opportunity to respond prior to the final determination.

Right to Pursue Civil Action

If you are enrolled in a group health plan that is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you have the right to bring a civil action under Section 502(a) of the Act after completing the appeal processes described here.

Changes in Appeal Processes

Please note that the Appeal processes described here may change due to changes that Independence Administrators makes to comply with applicable state and federal laws and regulations and/or accreditation standards or to improve the appeal processes.

External Review of Adverse Determination/Appeals

You are entitled to the external review process described below for all appeals of adverse determination (denials) concerning:

- Rescission of coverage;
- Certain surprise medical bills with balance billing;
- Medical judgment (including, based on the plans requirements, medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer.

Standard External Review Procedures

External appeals may be filed up to four (4) months after receipt of the notice from Independence Administrators of an adverse determination (denial) or final adverse determination (denial) for appeals involving the above stated issues.

You or your authorized representative can file an external appeal by calling the number listed on your ID card.

The Covered Person may be responsible for a nominal fee for the administrative duties performed in order to process the appeal for the external review.

Preliminary Review

Within five (5) business days following the date of receipt of the external review request, we will complete a preliminary review of the request to determine eligibility for the external review. Within one (1) business day after completion of this preliminary review, we will issue a written notification informing you if it is eligible for external review and if not, the reason why not and additional contact information. If your request is incomplete, we will inform you of the additional information needed to make the request for external review complete. If your request is eligible for external review you may submit, within ten (10) business days following the date of receipt of the notice, additional information that the Independent Review Organization (IRO) will consider when conducting the external review.

Referral to Independent Review Organization (IRO)

Eligible external review requests will be referred to a contracted, accredited independent review organization.

Final external review decisions are made by the external review organization within 45 days and will be forwarded in writing to the claimant and the Plan (Plan Administrator). The external decision is binding on Independence Administrators.

If you have any questions or concerns during the external review process or if you want to initiate an urgent care claim review, you (or your authorized representative) can call the toll-free number on your identification (ID) card.

Expedited External Review Process

If you (the claimant) have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your (claimant's) life or health or would jeopardize the ability to regain maximum function or if the matter concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility then you or your authorized representative (including your healthcare provider with knowledge of your condition) may request an expedited external review.

You may make a written or oral request for the expedited (urgent) external review.

- Urgent care reviews may be initiated by calling the toll-free number on your identification (ID) card.

Preliminary Review

Immediately upon receipt, we (or the Plan) will determine whether the request meets the eligible review requirements for an expedited (urgent) external review and will notify you of the eligibility for expedited (urgent) review or standard external review.

Referral to Independent Review Organization (IRO)

Upon the determination that a request is eligible for expedited (urgent) external review following the preliminary review we (or the Plan) will assign an independent review organization and provide them all necessary documents and information considered in making the adverse determination or final adverse benefit determination.

If during the external review process, we (or the Plan) reconsiders and decides to provide coverage, we (or the Plan) will provide oral notice followed by written notice within 48 hours.

Notice of the Final External Review Decision

- The IRO/external examiner provides notice of the final external review decision.
- The decision is completed as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for the expedited external review.
- If the notice is not in writing, the assigned IRO must provide written confirmation of the decision to you (the claimant) and the Plan. within 48 hours after the date of providing that notice,

The external decision is binding on Independence Administrators.

If the Adverse Determination (denial) is Reversed

Upon our receipt of the notice of the external review decision, we immediately will authorize to provide the coverage or payment for the claim as required by federal rule set under the Patient Protection and Affordable Care Act.

NOTICE: Please see the subsection entitled "NOTICE OF CLAIMS" found under the *General Provisions* section of this booklet.

DEFINITIONS

ACCIDENTAL INJURY — A sudden, unforeseen, and identifiable event causing injury to a Covered Person, which is the direct result of the event and which occurs while coverage under the Plan for the Covered Person is in force.

ADMINISTRATIVE SERVICES AGREEMENT — The agreement between the Plan Sponsor and Independence Administrators, under which Independence Administrators provides administrative services to the Plan Sponsor in connection with the Plan.

AMBULANCE — A specially designed and medically equipped vehicle used solely for the transportation of the sick and/or injured.

AMBULATORY SURGICAL CENTER — A Facility that: (1) has permanent facilities and equipment for the primary purpose of performing Surgery on an Outpatient basis; and (2) provides such treatment by or under the supervision of an organized staff of Doctors; and (3) provides nursing services whenever the patient is in the Facility; and (4) does not provide Inpatient accommodations; and (5) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by Medicare, or by Independence Administrators; and (6) is not, other than incidentally, a Facility used as an office or clinic for the private practice of a Professional Provider.

AMENDMENT — A supplement made a part of the Plan, which alters the benefits or terms of the Plan.

ANCILLARY PROVIDER — An individual or entity that provides services, supplies or equipment (such as, but not limited to, home infusion therapy services, Durable Medical Equipment and ambulance services), for which benefits are provided under the Plan.

ANESTHESIA — The administration of regional or local anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation, or loss of consciousness.

BIRTHING CENTER — A Facility that: (1) is primarily organized and staffed to provide maternity care by a Nurse Midwife; and (2) is licensed as a Birthing Center under the laws of the state where it is located; or (3) is approved by Independence Administrators.

BLUECARD PPO PROGRAM — A program that allows a Covered Person travelling or living outside of their plan's area to receive coverage for services at an in-network benefit level if the Covered Person receives services from Blue Cross Blue Shield providers that participate in the BlueCard PPO Program.

BLUECARD PPO PROVIDER — A Provider that participates in the BlueCard PPO Program as a Preferred Provider.

CERTIFIED REGISTERED NURSE — A Professional Provider who: (1) is a certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist; and (2) is certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing.

CLAIM — A request for payment of benefits for services rendered or Supplies received, which is presented to Independence Administrators for payment. Such request must be submitted to Independence Administrators with all statements, questionnaires, certifications, instruments, documents, and affidavits requested by Independence Administrators that are necessary to properly process the request for benefits. Claim forms will be provided by Independence Administrators.

COINSURANCE — The specified percentage of Covered Expense the Covered Person is required to pay.

COMPANY — Kessler Topaz Meltzer & Check LLP

CONDITIONS FOR DEPARTMENTS (for Qualifying Clinical Trials) — The conditions described in this paragraph, for a study or investigation conducted by the Department of Veteran Affairs, Defense or Energy, are that the study or investigation has been reviewed and approved through a system of peer review that the Government determines:

A. To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and

B. Assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review.

COVERED EXPENSE — Refers to the basis on which a Covered Person's Deductibles, Coinsurance, benefit Maximums and benefits are calculated.

A. For Covered Services provided by a Facility Provider, "Covered Expense" means the following:

   i. For Covered Services provided by a Preferred Facility or BlueCard PPO Provider, "Covered Expense" for Outpatient services means the amount payable to the Provider under the contractual arrangement in effect with Independence Administrators or the BlueCard PPO Provider.

   ii. For Covered Services provided by a Preferred Facility or BlueCard PPO Provider, "Covered Expense" for Inpatient services means the amount payable to the Provider under the contractual arrangement in effect with Independence Administrators or the BlueCard PPO Provider.

   iii. For Covered Services provided by a Non-Preferred Facility Provider, "Covered Expense" for Outpatient services means the lesser of 1.5 times the Medicare Allowable Payment for Facilities or the Facility Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare

traditional program, the amount is determined by reimbursing fifty percent (50%) of the Facility Provider's charges for Covered Services.

For Covered Services provided by a Non-Preferred Facility Provider "Covered Expense" for emergency services means the lesser of the billed charge or the plan's median contracted rate, referred to as the qualifying payment amount (QPA).

iv. For Covered Services provided by a Non-Preferred Facility Provider, "Covered Expense" for Inpatient services means the lesser of 1.5 times the Medicare Allowable Payment for Facilities or the Facility Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing fifty percent (50%) of the Facility Provider's charges for Covered Services.

For Covered Services provided by a Non-Preferred Facility Provider "Covered Expense" for **emergency services** means the lesser of the billed charge or the plan's median contracted rate, referred to as the qualifying payment amount (QPA).

B. For Covered Services provided by a Professional Provider, "Covered Expense" means the following:

i. For Covered Services by a Preferred Professional Provider or BlueCard PPO Provider, "Covered Expense" means the rate of reimbursement for Covered Services that the Professional Provider has agreed to accept as set forth by contract with Independence Administrators, or the BlueCard PPO Provider.

ii. For a Non-Preferred Professional Provider, "Covered Expense" means the lesser of the Medicare Professional Allowable Payment or the Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing fifty percent (50%) of the Professional Provider's charges for Covered Services.

For Covered Services provided by a Non-Preferred Professional Provider "Covered Expense" for **emergency services** means the lesser of the billed charge or the plan's median contracted rate, referred to as the qualifying payment amount (QPA).

C. For Covered Services provided by an Ancillary Provider now defined as a "**Hospital-Based Provider**".

i. For Covered Services provided by a Preferred Ancillary Provider (Hospital-Based Provider) or BlueCard PPO Provider, "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with Independence Administrators or BlueCard PPO Provider.

ii. For Covered Services provided by a Non-Preferred Ancillary Provider (Hospital-Based Provider), "Covered Expense" means the lesser of the billed charge or the

plan's median contracted rate, referred to as the qualifying payment amount (QPA).

D. Nothing in this section shall be construed to mean that Independence Administrators would provide coverage for services other than Covered Services.

COVERED PERSON — The Employee and/or his Dependent, if any, covered under the Plan.

COVERED SERVICE — A service, Supply, equipment, device, or drug specified in the Plan for which benefits will be provided when billed for by a Professional Provider, Facility, or Supplier.

CUSTODIAL CARE — Care that is provided primarily to assist the patient in meeting his activities of daily living. Such care is not provided primarily for its restorative or therapeutic value in the treatment of an Illness, injury, disease, or condition.

DEPENDENT — The Employee's: (1) spouse under a legally valid existing marriage; or (2) natural born or legally adopted child (including a child for whom adoption proceedings have been initiated), including a stepchild; or (3) unmarried child age 26 or older who is unable to earn his own living due to a physical or Mental Illness or handicap (subject to Eligibility — Continuation of Eligibility).

Dependent spouses may not be on active military service.

DOCTOR — A practitioner, other than a Covered Person, who is acting within the scope of his license as a Doctor of medicine; osteopathy; podiatry; dentistry; optometry; chiropractic; licensed speech pathologist; licensed audiologist; licensed teacher of the hearing impaired; or any other practitioner that the Plan must by law recognize as a Doctor legally entitled to render treatment.

DURABLE MEDICAL EQUIPMENT — Charges for: (1) non-disposable equipment that is primarily medical in nature, such as wheelchairs and hospital beds; and (2) orthotics or medical devices that are applied to or around the body for care or treatment of an injury or Illness; and (3) assorted medical items necessary for the treatment of respiratory diseases, such as oxygen tanks, oxygen contents, and oxygen masks.

EMERGENCY ACCIDENT TREATMENT — Provider expenses charged for the initial treatment of an Accidental Injury. Such treatment must begin within 72 hours of the injury that is being treated and excludes Ambulance services.

EMERGENCY MEDICAL TREATMENT — Provider expenses charged for the initial treatment of a condition with acute symptoms that is life threatening or that could cause serious damage to a bodily function. Such treatment must begin within 72 hours of the onset of the condition that is being treated and excludes Ambulance services.

EMPLOYEE — A person employed by the Company.

EMPLOYMENT WAITING PERIOD — The period, beginning with the date of employment, that an Employee must serve continuously before he is eligible to receive benefits under the Plan.

EXPERIMENTAL/INVESTIGATIVE — A drug, biological product, device, medical treatment or procedure which meets any of the following criteria:

A. Is the subject of ongoing clinical trials;

B. Is the research, experimental, study or investigational arm of an on-going clinical trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;

C. Is not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition;

D. Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the diagnosis or treatment of the Covered Person's particular condition; or

E. Is generally recognized, based on Reliable Evidence, by the medical community as a diagnostic or treatment intervention for which additional study regarding its safety and efficacy for the diagnosis or treatment of the Covered Person's particular condition, is recommended.

A drug will not be considered Experimental/Investigative if it has received final approval by the U.S. Food and Drug Administration (FDA) to market with a specific indication for the particular diagnosis or condition present. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational New Drug Exemption (as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the established referenced Compendia identified in the Company's policies recognize the usage as appropriate medical treatment.

Any biological product, device, medical treatment or procedure is not considered Experimental/Investigative if it meets all of the criteria listed below:

A. Reliable Evidence demonstrates that the biological product, device, medical treatment or procedure has a definite positive effect on health outcomes.

B. Reliable Evidence demonstrates that the biological product, device, medical treatment or procedure leads to measurable improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.

C. Reliable Evidence clearly demonstrates that the biological product, device, medical treatment or procedure is at least as effective in improving health outcomes as established technology or is usable in appropriate clinical contexts in which established technology is not employable.

D. Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above in paragraph C, is possible in standard conditions of medical practice, outside clinical investigatory settings.

E. Reliable Evidence shows that the prevailing opinion among experts regarding the biological product, device, medical treatment or procedure is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.

FACILITY — An institution or entity licensed, where required, to provide care. Such Facilities include:

- Alcoholism Treatment Facility
- Ambulatory Surgical Center
- Birthing Center
- Freestanding Dialysis Facility
- Freestanding Outpatient Facility
- Home Health Care Agency
- Hospital
- Psychiatric Hospital
- Rehabilitation Facility
- Skilled Nursing Facility
- Substance Abuse Treatment Facility

FAMILY UNIT — An Employee and his covered Dependents.

FULL-TIME EMPLOYEE — An Employee of the Company who works at least 30 hours per week for the Company for compensation in the form of salary, wages, or commission. In the case of a proprietorship or partnership, the individual proprietor or each of the partners whose principal occupation is the conduct of the Company's business, and whose duties for the Company normally require at least 30 hours per week, shall be deemed a Full-time Employee.

No member of the Board of Directors shall be deemed a Full-time Employee unless such person is otherwise eligible as a bona fide Employee of the Company.

HOME HEALTH AGENCY — An agency, association, or part of a Hospital that: (1) provides Skilled Nursing Care in the patient's home for the treatment of a physical Illness or injury that requires medical supervision and treatment; and (2) provides such care by or under the supervision of a Registered Nurse acting under the direction of a Doctor; and (3) is approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare.

HOSPICE — A Facility that: (1) is primarily engaged in providing palliative care to terminally ill individuals; and (2) is licensed and operated according to the laws of the state in which it is located and approved by Independence Administrators.

HOSPITAL — A short-term, acute care Facility that: (1) is a duly licensed institution; and (2) is primarily engaged in providing Inpatient diagnostic and medical services for the

care or treatment of sick and injured persons; and (3) provides such care by or under the supervision of an organized staff of Doctors; and (4) has organized departments of medicine; and (5) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (6) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by Independence Administrators. A Hospital is not, other than incidentally, a:

- Nursing Home
- Place for Rest
- Place for the Aged
- Place for the Provision of Hospice care
- Place for the Provision of Rehabilitation Care
- Place for the Treatment of Alcoholism or other Drug Abuse
- Place for the Treatment of Mental Illness
- Skilled Nursing Facility
- Spa or Sanitarium

HOSPITAL-BASED PROVIDER - A physician who provides Medically Necessary services in a Hospital or Preferred Facility Provider supplemental to the primary care being provided in the Hospital or Preferred Facility Provider, for which the Covered Person has limited or no control of the selection of such physician. Hospital-based providers include physicians in the specialties of radiology, anesthesiology and pathology and/or other specialties as determined by Independence Administrators. When these physicians provide services other than in the Hospital or Preferred Facility, they are not considered Hospital-Based Providers.

ILLNESS — A condition marked by pronounced deviation from the normal, healthy state.

IMMEDIATE FAMILY — The Covered Person's spouse, parent, child, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, or son-in-law.

INCURRED — A charge is deemed Incurred as of the date of the service or purchase giving rise to the charge.

INPATIENT — A person who is treated as a registered overnight bed patient in a Facility.

LICENSED PRACTICAL OR VOCATIONAL NURSE (L.P.N. OR L.V.N.) — A nurse who has graduated from a formal practical or vocational nursing education program and is licensed by the appropriate state authority.

LIFE-THREATENING DISEASE OR CONDITION (for Qualifying Clinical Trials) — Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

MAINTENANCE CARE — Care provided to maintain the patient's current level of functioning or to prevent deterioration. Such care is not primarily provided for its

therapeutic value in the treatment of an Illness, disease, injury, or condition and does not require participation or administration by professional medical personnel.

MEDICALLY APPROPRIATE/MEDICALLY NECESSARY (or MEDICAL APPROPRIATENESS/MEDICAL NECESSITY) — An intervention will be covered if it is (a) a Covered Service, (b) not specifically excluded, and (c) Medically Appropriate/Medically Necessary. An intervention is Medically Appropriate/Medically Necessary if, as ordered by the treating Professional Provider and determined by Independence Administrator's medical director or physician designee, it meets all of the following criteria:

A. It is a "Health Intervention". A Health Intervention is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat or palliate) a "medical condition" or to maintain or restore functional ability. A medical condition is one of the following: disease; Illness; injury; genetic or congenital defect; pregnancy; biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

B. It is the most appropriate Supply or level of service, considering the potential benefit and harm to the Subscriber.

C. It is known to be "effective" in improving "health outcomes". Effective means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. Health outcomes are outcomes that affect health status. The effectiveness of an intervention is based upon being a "new" or "existing" intervention.

i. New interventions: Effectiveness is determined by Scientific Evidence. An intervention is considered new if it is not yet in widespread use for (a) the medical condition, and (b) the patient indications being considered.

"Scientific Evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used.

Partially controlled observational studies and uncontrolled clinical series may be suggestive. These do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by (a) the natural history of the medical condition, or (b) potential experimental biases.

New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

ii. **Existing interventions**: Effectiveness is determined first by Scientific Evidence, then by professional standards, then by expert opinion. For existing interventions, Scientific Evidence should be considered first and, to the greatest extent possible, be the basis for a determination of Medical Necessity. If no Scientific Evidence is available, professional standards of care should be considered. If professional standards of care do not exist, are outdated, or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to Scientific Evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive Scientific Evidence. Existing interventions can meet the contractual definition of Medical Necessity in the absence of Scientific Evidence if: (a) there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, (b) in the absence of such standards, convincing expert opinion.

D. **It is cost-effective for this condition compared to alternative interventions, including no intervention.** "Cost effective" does not necessarily mean lowest price. An intervention is considered cost effective if the benefit and harm relative to costs represent an economically, efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

An intervention may be medically indicated yet not be a Covered Service or meet this Medically Appropriate/Medically Necessary definition.

MEDICARE ALLOWABLE PAYMENT FOR FACILITIES — The payment amount, as determined by the Medicare program, for the Covered Service for a Facility Provider.

MEDICARE ANCILLARY ALLOWABLE PAYMENT — The payment amount, as determined by the Medicare program, for the Covered Service for an Ancillary Provider.

MEDICARE PARTS A AND B — "Hospital Insurance Benefits for the Aged and Disabled" under Title XVIII, Part A and/or Part B respectively, of the Social Security Act, as amended from time to time.

MEDICARE PROFESSIONAL ALLOWABLE PAYMENT — The payment amount, as determined by the Medicare program, for the Covered Service based on the Medicare Par Physician Fee Schedule.

MENTAL ILLNESS — An emotional or mental disorder characterized by an abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional, or behavioral disturbances are the dominating feature.

Mental or nervous disorders that have a demonstrable organic origin will not be considered Mental Illness.

NON-PREFERRED ANCILLARY PROVIDER — An Ancillary Provider that is not a member of the PPO Network or is not a BlueCard PPO Provider.

NON-PREFERRED FACILITY PROVIDER — A Facility Provider that is not a member of the PPO Network or is not a BlueCard PPO Provider.

NON-PREFERRED PROFESSIONAL PROVIDER — A Professional Provider who is not a member of the PPO Network or is not a BlueCard PPO Provider.

NON-PREFERRED PROVIDER — A Facility Provider, Professional Provider or Ancillary Provider that is not a member of the PPO Network or is not a BlueCard PPO Provider.

NURSE MIDWIFE — A Professional Provider who: (a) is certified to practice as a Nurse Midwife; and (b) is licensed by the appropriate state authority as a Registered Nurse; and (c) has completed a program for the preparation of Nurse Midwife that is approved by the state in which the person is practicing.

OPEN ENROLLMENT PERIOD — The 31-day period immediately prior to the anniversary date of the Plan.

ORGANIC DISEASE — Includes any health condition in which there is an observable and measurable disease process (biomarker), e.g. inflammation or tissue damage: Non organic diseases or functional disorders, demonstrate no disease process which is visible or which can be established through standard diagnostic testing.

OUTPATIENT — A person who receives services or Supplies while not an Inpatient.

PLAN — Kessler Topaz Meltzer & Check LLP Employee Benefit Plan.

PLAN SPONSOR — Kessler Topaz Meltzer & Check LLP

PLAN YEAR DEDUCTIBLE — The amount of eligible expenses the Covered Person is required to pay each plan year before the Plan begins to pay benefits.

PREFERRED ANCILLARY PROVIDER — An Ancillary Provider that is a member of the PPO Network or is a BlueCard PPO Provider and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services and/or supplies to Covered Persons.

PREFERRED FACILITY PROVIDER — A Facility Provider that is a member of the PPO Network or is a BlueCard PPO Provider and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services to Covered Persons.

PREFERRED PROFESSIONAL PROVIDER — A Professional Provider who is a member of the PPO Network or is a BlueCard PPO Provider and has agreed to a rate of reimbursement determined by contract for "in-network" Covered Services rendered to a Covered Person.

PREFERRED PROVIDER — A Facility Provider, Professional Provider or Ancillary Provider that is a member of the PPO Network or is a BlueCard PPO Provider, authorized to perform specific "in-network" Covered Services at the Preferred level of benefits.

PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK — The network of Providers with whom Independence Administrators has contractual arrangements and BlueCard PPO Providers.

PRIOR AUTHORIZATION — Written approval by Independence Administrators for medical or surgical treatment given prior to such treatment that outlines the Plan's liability for such treatment. Such approval will be given only after Independence Administrators: (1) reviews the case; and (2) receives the Covered Person's medical history and an explanation of the condition and treatment to be given (including any Surgical Procedures to be performed) written by his Doctor, and any supporting documentation.

PRIVATE ROOM — Accommodations in a room designed as such by the Hospital, Rehabilitation Facility, or Skilled Nursing Facility and containing not more than one bed.

PROFESSIONAL PROVIDER — A licensed person or practitioner performing services within the scope of such licensure. The Professional Providers include:

- Certified Registered Nurse
- Chiropractor
- Dentist
- Doctor
- Independent Clinical Laboratory
- Licensed Practical Nurse (LPN)
- Licensed Vocational Nurse (LVN)
- Nurse Midwife
- Optometrist
- Physical Therapist
- Podiatrist
- Psychologist

PROVIDER — A Facility, Professional or Ancillary Provider, licensed where required.

PSYCHIATRIC HOSPITAL — A Facility that: (1) is primarily engaged in providing Inpatient diagnostic, medical, and psychiatric services for the care or treatment of Mental Illness; and (2) provides such services by or under the supervision of an organized staff of Doctors; and (3) provides continuous 24-hour nursing services by or under the supervision of Registered Nurses; and (4) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by Independence Administrators.

QUALIFIED INDIVIDUAL (for Clinical Trials) — A Covered Person who meets the following conditions:

A. The Covered Person is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening Disease or Condition; and

B. Either:

1. The referring health care professional is a health care provider participating in the clinical trial and has concluded that the Covered Person's participation in such trial would be appropriate based upon the individual meeting the conditions described above; or

2. The Covered Person provides medical and scientific information establishing that their participation in such trial would be appropriate based upon the Covered Person meeting the conditions described above.

QUALIFYING CLINICAL TRIAL — A phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease Or Condition and is described in any of the following:

A. Federally funded trials: the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
   1. The National Institutes of Health (NIH);
   2. The Centers for Disease Control and Prevention (CDC);
   3. The Agency for Healthcare Research and Quality (AHRQ);
   4. The Centers for Medicare and Medicaid Services (CMS);
   5. Cooperative group or center of any of the entities described in 1-4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
   6. Any of the following, if the Conditions For Departments are met:
      a. The Department of Veterans Affairs (VA);
      b. The Department of Defense (DOD); or
      c. The Department of Energy (DOE).

B. The study of investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or

C. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

In the absence of meeting the criteria listed above, the clinical trial must be approved by the Plan as a Qualifying Clinical Trial.

REGIONAL NETWORK DISCOUNT — The percentage reduction from Facility charges for Covered Services that Independence Administrators passes on to its customers as a share of the savings Independence Administrators is expected to realize from its negotiated Hospital contracts. The balance of any savings not passed on to its customers is for the sole benefit of Independence Administrators. The amount of the discount may be changed prospectively from time to time.

REGISTERED NURSE (R.N.) — A nurse who has graduated from a formal program of nursing education (diploma school, associate degree program, or baccalaureate program) and is licensed by the appropriate state authority.

REHABILITATION FACILITY — An institution or part of an institution that: (1) specializes in providing restorative and therapeutic services on an Inpatient and Outpatient basis for the treatment of a physical Illness or injury, Mental Illness, drug addiction and alcoholism;

and (2) provides such services by or under the supervision of a staff of Doctors; and (3) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (4) is approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare.

RELIABLE EVIDENCE — Only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, biological product, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, biological product, device, medical treatment or procedure.

ROUTINE PATIENT COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS — Routine patient costs include all items and services consistent with the coverage provided under this Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial.

Routine patient costs do not include:

A. The investigational item, device, or service itself;

B. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

C. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

SCHEDULE OF BENEFITS — The Schedule of Benefits, which describes benefits, maximums, and allowances of the coverage provided under the Plan for each Covered Person.

SECOND SURGICAL OPINION/CONSULTATION — A written evaluation by another surgeon/specialist, who is not associated in practice with the first surgeon, as to the Medical Necessity of the surgery recommended by the first surgeon.

SEMIPRIVATE ROOM — Accommodations in a room designated as such by the Hospital, Rehabilitation Facility, or Skilled Nursing Facility and containing no less than two nor more than four beds.

SKILLED NURSING CARE — All covered medical expenses charged for services that are primarily restorative and therapeutic in treatment of a physical Illness or injury that requires medical supervision of a Registered Nurse acting under the direction of a Doctor.

SKILLED NURSING FACILITY — An institution or part of an institution that: (1) specializes in providing Skilled Nursing Care on an Inpatient basis for the treatment of a physical Illness or injury that requires extended medical supervision and treatment; and (2) provides such care by or under the supervision of a staff of Doctors; and (3) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (4) is

approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare.

SUBSTANCE ABUSE — Any use of alcohol or other drug that produces a pattern of pathological use causing impairment in social or occupational functions or that produces physiological dependency evidenced by physical tolerance or withdrawal.

SUBSTANCE ABUSE TREATMENT FACILITY — A Facility that: (1) is primarily engaged in providing detoxification and/or rehabilitation services for alcoholism and/or other drug abuse and (2) is approved by the Joint Commission on Accreditation of Healthcare Organizations, appropriate government agency, or by Independence Administrators.

SUPPLIES — Charges made by a Hospital or Doctor for nonprescription, nondurable, disposable medical and surgical items that are necessary for the care or treatment of an Illness or Accidental Injury.

SURGERY/SURGICAL PROCEDURE — Treatment of an Illness, injury, or deformity by manual and operative methods.

A. **Cosmetic Surgery** — A Surgical Procedure for the correction of superficial areas of the body to enhance appearance or to change contour. Such surgeries are performed without the expectation of restoring function to the body area.

B. **Elective Surgery** — A Surgical Procedure that is of a non-emergency nature and not required to be immediately carried out.

C. **Reconstructive Surgery** — A Surgical Procedure for the correction, restoration, or improvement of bodily functions, or the relief of pain.

THERAPY SERVICES — The following services and Supplies when prescribed by a Doctor for the treatment of an Illness or injury to promote the recovery of the Covered Person:

A. **Radiation Therapy** — Treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

B. **Chemotherapy** — Treatment of malignant disease by chemical or biological antineoplastic agents.

C. **Dialysis Treatment** — Treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body. This includes hemodialysis or peritoneal dialysis.

D. **Physical Therapy** — Treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neurophysiological principles, and devices to relieve pain and restore maximum function following disease, injury, or loss of body part.

E. **Respiratory Therapy** — Introduction of dry or moist gases into the lungs for treatment purposes.

F. **Occupational Therapy** — Treatment of a disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

G. **Speech Therapy** — Treatment to restore speech lost or impaired through Illness or injury, or to correct an impairment due to a congenital defect for which corrective Surgery has been performed.

TOTAL DISABILITY — The inability of the Employee to work at any job for which he is reasonably suited based on education, training, and experience due to Illness or Accidental Injury; the complete inability of a Dependent to engage in the normal activities of a person of the same age and sex in good health; or a disability that will presumably last for a Covered Person's lifetime and that prevents a Covered Person from engaging in any occupation for which he is reasonably suited.

ADMINISTRATIVE INFORMATION

This booklet has been prepared to meet the Summary Plan Description Requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

PLAN NAME	Kessler Topaz Meltzer & Check LLP Employee Benefit Plan
EMPLOYER AND PLAN SPONSOR	Kessler Topaz Meltzer & Check LLP 280 King of Prussia Road Radnor, PA 19087
EMPLOYER IDENTIFICATION NUMBER	23-2977382
TYPE OF PLAN	Health and Welfare
ERISA PLAN YEAR ENDS	5/31
PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS	Kessler Topaz Meltzer & Check LLP 280 King of Prussia Road Radnor, PA 19087
PLAN ADMINISTRATIVE SERVICES PROVIDED BY	Independence Administrators c/o Processing Center P.O. Box 21974 Eagan, MN 55121
PLAN'S INDEPENDENCE ADMINISTRATORS GROUP NUMBER(S)	050377
PLAN COSTS	See ***Eligibility***

Upon request, Covered Persons will be given a copy of this booklet which provides a description of each benefit. If misplaced, an additional copy can be obtained from the Plan Administrator, upon request.

ERISA STATEMENT OF RIGHTS

As a participant in this Plan, a Covered Individual is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision

without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.



Administered by Independence Administrators

To find a network doctor, get forms, or view your health benefits information, visit the website on your identification card.

c/o Processing Center • P.O. Box 21974 • Eagan, MN 55121

Independence Administrators is an independent licensee of the Blue Cross and Blue Shield Association.