Caring for our kids.

CHIP

2022 Member Handbook

Pennsylvania's Children's Health Insurance Program
We Cover All Kids.
Commonwealth of Pennsylvania

BlueCross BlueShield
First Priority Health

chipcoverspakids.com

Nondiscrimination Notice

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

First Priority Health provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters; and
- Written information in other formats (large print, audio, accessible electronic formats).

First Priority Health provides free language services to people whose primary language is not English, such as:

- Qualified interpreters; and
- Information written in other languages.

If you need these services, contact First Priority Health at 1-800-547-9378.

If you believe that First Priority Health 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:

The Bureau of Equal Opportunity,

Room 223, Health and Welfare Building,

P.O. Box 2675,

Harrisburg, PA 17105-2675,

Phone: (717) 787-1127, TTY (800) 654-5484, Fax: (717) 772-4366, or Email: RA-PWBEOAO@pa.gov

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Bureau of Equal Opportunity is available to help you.

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

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ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you.
Call: 1-800-547-9378 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-547-9378 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-547-9378 (телетайп: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。
請致電 1-800-547-9378（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-800-547-9378 (TTY: 711).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.
اتصل برقم 1-800-547-9378 (رقم هاتف الصم والبكم: 711).

ध्यान दिनुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-547-9378 (टिटिवाइ: 711) ।

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-547-9378 (TTY: 711)번으로 전화해 주십시오.

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល
គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-547-9378 (TTY: 711) ។

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-800-547-9378 (ATS : 711).

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊
သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-800-547-9378 (TTY: 711) သို့ ခေါ်ဆိုပါ။

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.
Rele 1-800-547-9378 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Ligue para 1-800-547-9378 (TTY: 711).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারনে, তাহলে নিঃখরচায় ভাষা সহায়তা পরষিবো উপলব্ধ আছে। ফোন করুন ১-800-547-9378 (TTY: 711) ।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.
Telefononi në 1-800-547-9378 (TTY: 711).

સુચના: જો તમેગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષાસહાયસેવાઓતમારામાટેઉપલબ્ધછે.
ફોન કરો 1-800-547-9378 (TTY: 711).

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WELCOME TO CHIP, BROUGHT TO YOU BY FIRST PRIORITY HEALTH

Thank you for choosing CHIP, brought to you by First Priority Health.* Please take a few minutes to review the information in this handbook. It can help you take full advantage of the valuable health care benefits you have selected for your child.

Our CHIP Enrollment and Eligibility Unit administers your child's CHIP coverage. Please call the toll-free Member Service number, **1-800-543-7105, Monday through Friday, from 8:30 a.m. to 4:30 p.m.**, if you have questions about your child's coverage or want information on how to access the program's benefits. Hearing-impaired members may call toll-free TTY **1-877-323-8480.**

PLEASE PAY YOUR PREMIUM ON TIME

The state of Pennsylvania requires that, if you fail to pay your premium for Low-Cost or Full-Cost CHIP as required by applicable insurance laws, your child will lose CHIP coverage.

If you have any questions about this requirement, please call 1-800-543-7105.

** Plans are offered by First Priority Health, a wholly-owned subsidiary of Highmark Inc. d/b/a Highmark Blue Cross Blue Shield. Highmark Blue Cross Blue Shield and First Priority Health are independent licensees of the Blue Cross Blue Shield Association.*

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** Dental coverage is provided by United Concordia Companies, Inc. United Concordia Companies, Inc. is a separate company that administers Highmark dental services.*

*** Vision coverage is provided by Davis Vision, Inc. Davis Vision, Inc. is a separate company that administers Highmark vision benefits.*

UNDERSTANDING HEALTH COVERAGE TERMS

This handy reference section explains commonly used health coverage terms. You might find it useful to refer back to this section as you read your handbook.

Agreement – An agreement describing the health care coverage to which the member is entitled. The Agreement, along with any amendatory riders, applications for coverage and the member's current identification card, represent the entire contract between the plan and the member.

Authorization – Process through which certain services are determined by First Priority Health to be medically necessary and appropriate.

Board Certified – A designation given to those physicians who, after meeting strict standards of knowledge and practices, are certified by the professional board that represents their specialty. The majority of the First Priority Health Network physicians are board certified.

Covered Services or supplies – Medical procedures for which First Priority Health agrees to pay. They are listed in your Agreement.

Credentialing – The detailed review process by which First Priority Health evaluates physicians, hospitals and other health care providers to ensure that the network is made up of qualified providers. Credentialing also involves ongoing, periodic review and evaluation.

Designated Agent – An entity that has contracted with First Priority Health to perform a function and/or service in the administration of this coverage. Such function and/or service may include, but is not limited to, medical management.

Effective Date – The date, as shown in First Priority Health records, on which CHIP coverage begins for your child. The effective date also appears on your child's identification (ID) card.

Exclusions – Specific services or supplies that are not covered, or conditions or circumstances for which CHIP does not provide benefits.

Medically Necessary and Appropriate – a service, item, or medicine that does one of the following: it will, or is reasonably expected to, prevent an illness, condition, or disability; it will, or is reasonably expected to, reduce or improve the physical, mental, or developmental effects of an illness, condition, injury, or disability; it will help a child get or keep the ability to perform daily tasks, taking into consideration both the child's abilities and the abilities of someone of the same age.

Network Provider – A provider of covered services who has entered into a contractual agreement with First Priority Health in order to provide care or supplies to members and who has enrolled and received a PROMISe identification number.

Network Specialist – Specialist providers who have an agreement with First Priority Health, pertaining to payment as network participants for covered services rendered to a member, and has enrolled and received a PROMISe identification number.

Out-of-area Services – Those services provided outside the First Priority Health Network service area.

Participating Dental Provider – A dental care provider that has signed an agreement with United Concordia Companies, Inc.* to accept the amount paid for covered dental services as payment in full, and has enrolled and received a PROMISe identification number.

Participating Vision Provider – A vision care provider that has signed an agreement with Davis Vision, Inc.** to accept the amount paid for covered vision services as payment in full, and has enrolled and received a PROMISe identification number.

Primary Care Provider (PCP) – A provider selected by a member in accordance with provisions established by First Priority Health who has specifically contracted with First Priority Health, to supervise, coordinate or provide specific basic medical services and maintain continuity of patient care.

**Dental coverage is provided by United Concordia Companies, Inc. United Concordia Companies, Inc. is a separate company that administers First Priority Health's dental benefits.*

*** Vision coverage is provided by Davis Vision, Inc. Davis Vision, Inc. is a separate company that administers First Priority Health's vision benefits.*

GET THE MOST OUT OF YOUR CHILD'S CHIP HEALTH CARE COVERAGE

SCHEDULE YOUR CHILD'S WELLNESS EXAMS

CHIP covers your child's preventive care. Be sure to make appointments with your child's Primary Care Provider (PCP) for wellness exams, screenings and required immunizations. Please refer to the enclosed Preventive Schedule for Children to see when your child needs doctor appointments. This handbook includes information about lead screening, explaining why it is important to have your child tested for lead poisoning. (It's very important for children ages 9 months to 2 years.) You also want to be sure to schedule regular dental and eye exams for your child.

USE NETWORK PROVIDERS FOR COVERED SERVICES

To get full coverage for CHIP services, make sure your child uses First Priority Health providers — even if your child is referred by a Primary Care Provider or specialist to another doctor. To search for the providers and/or to find a provider:

- Visit **highmarkchip.com**. Enter your ZIP Code.
- Select **Covered Doctors & Facilities** on the CHIP page.
- Select **Browse Providers** and **Just Browsing/Continue.**
- Enter your ZIP Code and confirm location **– Continue.**
  NOTE: Network should display CHIP – First Priority Health Kids and City/State/ZIP should display your home City and ZIP Code.
- Select **Browse by Category – Medical Care – All Specialties (A – Z)**.
- Search needed specialty provider type.
- Select **View Profile** on the right side across from the doctor's name to see more details.

Except for emergency care and emergency ambulance services, CHIP only covers services performed by network providers, unless First Priority Health pre-authorizes care before your child receives services. The Pennsylvania Department of Human Services (DHS) and the Centers for Medicare and Medicaid Services (CMS) requires all CHIP professional providers to be certified with a PROMISe Identification number. This program requires every CHIP provider to enroll and receive a PROMISe ID to continue providing services to CHIP members. Refer to the Provider Directory or call the number above to verify that your provider participates in the network.

There are instances where you may not have the opportunity to choose your child's provider. In such cases, services will be covered so that you will not be responsible for any greater out-of-pocket amount than if services had been provided by a network provider, and First Priority Health will prohibit the provider from balance billing you.

SEE WHAT SERVICES ARE COVERED

Please review the Agreement in this welcome book to see what CHIP covers. For questions about specific services or medical procedures, please call First Priority Health Member Service at **1-800-547-9378.** Member Service can also help you find a new Primary Care Provider or answer payment questions.

WHERE TO GO WHEN YOU NEED CARE

Go to the emergency room only when necessary. Please remember that the emergency room should be used for medical emergencies and accidents only.

If the situation is not an emergency, there are **four ways to get care** that may save time and money:

1) **Call your PCP.** Start with your primary care doctor. If it's not during office hours, you may be referred to the doctor on call. Many times, this doctor can give you the health advice you need. Refer to your doctor for conditions such as:
   - Colds, flu, earaches, sore throats, migraines, or rashes
   - Sprains, back pain, minor cuts and burns, or minor eye injuries
   - Regular physicals, prescription refills, vaccinations, and screenings
   - Any health problem that requires the advice of a medical professional

If you don't have a doctor, you can find one by using the Covered Doctors and Facilities link at **highmarkchip.com** or by calling Member Service at 1-800-547-9378. Go to **HOW TO OBTAIN INFORMATION REGARDING YOUR PCP** section in this Handbook to learn more about using our online provider directory.

2) **Telemedicine Doctors 24/7**
   You can video chat 24/7 with a U.S. licensed, board-certified doctor who can help diagnose and treat your child's illness from your smartphone, tablet, or computer. They can even prescribe medication when appropriate.

   Eighteen of the top 20 reasons people visit urgent care centers can be treated through a Telemedicine visit — without ever having to leave the comfort of your home. Consider a Telemedicine appointment for:
   - Sinus infections, upper respiratory infections, bronchitis, flu, cough, or sore throat
   - Conjunctivitis (pink eye), allergies, and rashes
   - Headaches and migraines

To access Telemedicine any time of the day or night, seven days a week, visit **Well360VirtualHealth.com** and set up your account. Then when you need the service, all that you need to do is log in.

3) **Blues On Call℠ Nurses.** Call **1-888-258-3428**, anytime, day or night, and speak with a registered nurse who can answer your health questions and help you find the right care for your child.

4) **Visit an Urgent Care Center or Retail Clinic.** These facilities provide care for nonlife-threatening medical conditions or conditions that could become worse if you wait. Urgent care centers and retail clinics provide walk-in appointments and can provide care for conditions such as:
   - Colds, flu, earaches, sore throats, migraines, or rashes
   - Fractures, sprains, back pain, minor cuts and burns, or minor eye injuries

There are a number of urgent care centers and retail clinics near you. Many are open after hours and on weekends, and no appointment is needed. To find an urgent care center or retail clinic near you, call Member Service at 1-800-547-9378 or refer to **highmarkchip.com.**

HOW TO FIND A PROVIDER

Find a provider

To search the providers and/or to find a provider:
- Visit **highmarkchip.com**. Enter your ZIP Code.
- Select **Covered Doctors & Facilities** on the CHIP page.
- Select **Browse Providers** and **Just Browsing/Continue.**
- Enter your ZIP Code and confirm location **– Continue.**
  NOTE: Network should display CHIP – First Priority Health Kids and City/State/ZIP should display your home City and ZIP Code.
- Select **Browse by Category – Medical Care – All Specialties (A – Z)**.
- Search needed specialty provider type.
- Select **View Profile** on the right side across from the doctor's name to see more details.

EXPLORE THE WEBSITE

At **highmarkchip.com** you have 24-hour access to features, tools and information about your child's health care coverage. You can:

- Find a provider in the First Priority Health network
- Locate a participating pharmacy
- Read about child safety and other health and wellness-related topics
- Find information about classes, screenings and other health resources
- See claims and Explanations of Benefits to find out what CHIP paid for your child's care when you login to your Highmark account
- Search for discounts on a wide range of health-related products and services

OTHER RESOURCES

For general questions about your child's CHIP coverage, please call 1-800-543-7105,

Monday through Friday, from 8:30 a.m. to 4:30 p.m. For TTY/TDD hearing-impaired service, please dial 711 and the number on the back of your Identification (ID) card.

Information for Non-English-Speaking Members

Interpreters are provided at no cost to the member. Non-English-speaking members have access to clear benefits information. They can call the toll-free Member Service telephone number on the back of their Identification Card to be connected to a language services interpreter line. Highmark Member Service representatives are trained to make the connection.

Periodic Review of Primary and Preventive Care Services

Highmark periodically reviews the Primary and Preventive Care Covered Services based on recommendations from organizations such as The American Academy of Pediatrics (AAP) Bright Futures, the U.S. Preventive Services Task Force (USPSTF - all services with a rate of A or B current recommendation), The Center for Disease Control (CDC) General Immunization Recommendations, and the Health Resources and Services Administration (HRSA).

Examples of covered "USPSTF A" recommendations are folic acid supplementation, screening for HIV infection, screening for syphilis, and tobacco-use counseling and interventions.

Examples of covered "USPSTF B" recommendations are chlamydia infection screening for non-pregnant women, dental cavities prevention for preschool children, obesity screening and counseling for healthy diet, oral fluoride supplementation, depression screening in adolescents, BRCA risk assessment and genetic counseling and testing, chlamydial infection screening for pregnant members, and sexually transmitted infections counseling. Examples of covered HRSA required benefits include all Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, breast-feeding equipment, and patient education and counseling for all women with reproductive capacity. All services required by HRSA are covered. Accordingly, the Preventive Services are provided at no cost to the Member.

COMMUNITY RESOURCES

If your child has special health care needs or a chronic condition, the Caring Program can help coordinate physician services, give you educational materials and link you to community resources. For questions about the Caring Program, please call 1-866-823-0892, Monday through Friday, from 8:30 a.m. to 4:30 p.m. For more information, go to **highmarkchip.com** and select the **Caring Program** page.

Highmark Community Support

In response to the increased need for access to social service resources during the COVID-19 pandemic, Highmark and First Priority Health will begin providing access to Highmark Community Support, a tool that connects people seeking help with local nonprofits and services in their communities. Highmark Community Support has the largest and most widely

used social care network in the country, offering access to resources such as food, housing, utilities, government benefits, and legal services. COVID-19-specific resources are also available on the site.

How it works

Visit **highmarkchip.com** and select the **Health and Wellness** link at the top of the page, then select **Highmark Community Support**. To further customize the search, you can also add filters, such as hours of availability, language, and distance to agency.

Categories include:

- Food (e.g., emergency food, nutrition education)
- Housing (e.g., help paying for housing, housing advice, temporary shelter)
- Goods (e.g., clothing, baby supplies, home goods)
- Transit (e.g., help paying for transit)
- Health (e.g., dental care, health education, medical care, vision services)
- Money (e.g., financial education, tax preparation, government benefits)
- Care (e.g., adoption and foster care, animal welfare, counseling and support groups)
- Education (e.g., help paying for school, screening and exams)
- Work (e.g., help finding work, skills and training)
- Legal (e.g., legal aid, mediation)

THE IDENTIFICATION CARD

YOUR CHILD'S ACCESS TO CARE

The Blue Cross and Blue Shield symbols on your child's First Priority Health identification (ID) card are recognized around the world. Carry your child's Identification Card with you at all times and show it to the hospital, physician, pharmacy or other health care professional whenever your child needs medical care.

If your child's card is lost or stolen, please contact Highmark Member Service immediately. You can also request additional or replacement cards online by going to **highmarkchip.com** and logging in. It is illegal to lend your child's identification card to any person who is not eligible to use your benefits.

Your child's Identification Card includes the following information:

- Your child's name
- Your child's identification number
- Your child's group number
- Copayment amounts
- The pharmacy network logos
- The toll-free Member Service phone number for questions about your coverage
- *Blues On Call* health information and decision-support phone number
- A number to call when receiving services out of the network
- Address for submitting claims that are either out of the network or out of the 13 counties serviced by First Priority Health

CHOOSING PROVIDERS

CHIP pays for services obtained from providers you select from the networks described below. To receive full coverage for services you receive, your child must use providers from a certified network provider.

FIRST PRIORITY HEALTH HMO FOR COVERED SERVICES*

Your child's hospital, medical-surgical, behavioral health, and hearing benefits are provided through the First Priority Health network of doctors, hospitals and other providers located throughout the 13 counties serviced by First Priority Health.

The network includes Primary Care Providers (PCPs) or personal physicians, specialists, OB-GYNs, hospitals and other professional providers. Network physicians are carefully evaluated before they are accepted into the network, with consideration to their educational background and board certification.

To receive benefits, you should use First Priority Health network providers at all times, unless you receive prior authorization to use a provider who does not participate with First Priority Health network or if your child requires emergency care. If you choose not to use a First Priority Health network provider, you will be responsible for some or all of the provider's charges. For more information about your liability for services your child receives from providers out of the First Priority Health network, please refer to SECTION MC – MANAGED HEALTH CARE in your Agreement.

**Coverage for Medical Care Services is provided by First Priority Health. This managed care plan may not cover all of your health care expenses. Read your contract carefully to determine which health care services are covered. If you have any questions, please call 1-800-547-9378.*

CHOOSING A PRIMARY CARE PROVIDER

When you enroll your child in CHIP, you must select a First Priority Health primary care provider who has a certified PROMISe ID number to guide all of your child's care and serve as your child's family doctor. Primary care providers include family practitioners, general practitioners, internists, Certified registered nurse practitioners and pediatricians.

To search the providers and/or to find a provider:

- Visit **highmarkchip.com**. Enter your ZIP Code.
- Select **Covered Doctors & Facilities** on the CHIP page.
- Select **Browse Providers** and **Just Browsing/Continue.**
- Enter your ZIP Code and confirm location **– Continue.**
  NOTE: Network should display CHIP – First Priority Health Kids and City/State/ZIP should display your home City and ZIP Code.
- Select **Common Searches – Primary Care – Pediatrician, Family Medicine, or General Practice**.
- Select **Accepting New Patients** near the top of the screen and **View Profile** on right side across from doctor name to see more details.

You can also call **1-800-547-9378.** Hearing-impaired may call TTY **1-877-323-8480.**
You may select a new PCP anytime by calling this number or accessing the website.

If you do not choose a primary care provider within 10 days of enrollment, the Highmark CHIP Enrollment and Eligibility Unit will select one for your child.

You have access to your child's primary care provider at all times. After normal business hours, you may call your child's physician anytime of the day or night, any day of the week.

HOW TO OBTAIN INFORMATION REGARDING YOUR PCP

To learn more about a provider or to find a PCP:

Online

- Visit **highmarkchip.com**. Enter your ZIP Code.
- Select **Covered Doctors & Facilities** on the CHIP page.
- Select **Browse Providers** and **Just Browsing/Continue.**
- Enter your ZIP Code and confirm location **– Continue.**
  NOTE: Network should display CHIP – First Priority Health Kids and City/State/ZIP should display your home City and ZIP Code.
- Select **Common Searches – Primary Care – Pediatrician, Family Medicine, or General Practice**.
- Select **Accepting New Patients** near the top of the screen and **View Profile** on right side across from doctor name to see more details.

By phone

Call CHIP Member Services at 1-800-543-7105 to confirm your child's new PCP. The team will update your child's records and send a new ID Card with your new PCP.

Call Member Service at the number on the back of your member ID card to ask for help in locating a PCP with an office near you.

When you search for a provider online, you can view the following information:

- Physician name
- Location/Office hours/Phone numbers
- Whether the provider is accepting new patients
- Professional qualifications
- Clinical specialties
- Medical school attended
- Residency completion
- Board certification status
- Hospital affiliations
- Medical group affiliations
- Patient ratings
- Performance in 13 categories of care
- Parking and public transit nearby
- Handicap accessibility
- Languages spoken
- Gender

You may also obtain more information on network providers by calling Member Service at the number on the back of your member ID card .

NETWORK FOR PRESCRIPTION DRUG COVERAGE

Prescription drugs are covered when you purchase them through any National network pharmacy. For your convenience, the network includes thousands of chains and independent stores located throughout western Pennsylvania and the country. To locate a pharmacy near you, call 1-800-543-7105.

UNITED CONCORDIA COMPANIES, INC. (UCCI) FOR DENTAL CARE*

United Concordia Companies, Inc. (UCCI) provides your child's dental benefits. To locate a UCCI dental provider, please go to the *Dental Provider Directory* at **unitedconcordia.com/pachip,** and click on **Select a PA CHIP dentist**.

DAVIS VISION, INC. FOR VISION CARE**

Davis Vision provides the vision benefits, which are explained in the separate brochure "Vision Care Plan Benefit Description" that Davis Vision mailed to you. To locate a Davis Vision provider, please go to the Davis Vision website at **davisvision.com** or call Davis Vision at 1-800-999-5431.

** Dental coverage is provided by United Concordia Companies, Inc. United Concordia Companies, Inc. is a separate company that administers First Priority Health's dental services.*

*** Vision coverage is provided by Davis Vision, Inc. Davis Vision, Inc. is a separate company that administers First Priority Health's vision benefits.*

SUMMARY OF BENEFITS

CHIP covers a wide range of benefits, including doctor visits, emergency care, outpatient procedures, hospital stays, prescription drugs, rehabilitation therapies, diagnostic services, lab tests and dental and vision services. Except for emergency care and emergency ambulance services, benefits are provided only for services performed by a network provider. If covered services are not available from a network provider, you must obtain a preauthorization from First Priority Health to receive services from a provider outside of the network. Please refer to your child's Identification Card for possible copayments for visits.

This handbook describes some of the most commonly used benefits. For a detailed description of all CHIP benefits and instructions on how your child can receive services through CHIP, please read your Agreement in the back of this handbook.

This program may not cover all of your child's health care expenses. Complete information about covered services, including limits and exclusions, is included in your Agreement. Please read your Agreement carefully to determine which health care services are covered.

Benefits with an asterisk* require preauthorization (authorization of medical necessity and appropriateness) prior to receiving services. If you use a network provider, the provider will request the preauthorization for your child's care.

Benefits	Free	Low-Cost	Full-Cost
Benefit Period	Calendar Year		
Plan Payment Level - Based on the Plan Allowance	100% Plan Allowance		
Lifetime Maximum (per	Unlimited		
Ambulance Service*	100% Plan Allowance - Preauthorization required for non-emergency services Only		
Autism Spectrum Disorders	100% Plan Allowance Benefits for the diagnosis or treatment of Autism Spectrum Disorders are subject to cost sharing amounts as outlined below. Services will be paid according to the benefit category, e.g., speech therapy.		
Applied Behavioral Analysis	100% Plan Allowance No copayment	100% Plan Allowance after $10 copayment	100% Plan Allowance after $25 copayment

*These services require preauthorization.
To access telemedicine any time of the day or night, seven days a week, visit **Well360VirtualHealth.com and set up your account.

Benefits	Free	Low-Cost	Full-Cost
Dental Services Related to Accidental Injury	100% Plan Allowance		
Diabetes Treatment	100% Plan Allowance		
Diagnostic Services -	100% Plan Allowance - Inpatient Services and Outpatient Services		
*Advanced Imaging**	100% Plan Allowance		
Basic Diagnostic Services	100% Plan Allowance		
Durable Medical Equipment, Orthotics and Prosthetics*	100% Plan Allowance		
Emergency Care Services	100% Plan Allowance - **Outpatient emergency care services** *(including Medical/Accident Services and ER Transportation)* **are not subject to preauthorization.**		
Emergency Room Facility Services	100% Plan Allowance No copayment	100% after $25 copayment (waived if admitted)	100% after $50 copayment (waived if admitted)
Enteral(Medical) Foods*	100% Plan Allowance		
Family Planning Services	100% Plan Allowance		
Habilitative Therapy	Limits for Occupational Therapy, Physical Medicine and Speech Therapy do not apply to Habilitative Visits for Mental Illness or Substance Abuse.		
Occupational Therapy	100% Plan Allowance - Limit: thirty (30) visits per benefit period		
Physical Medicine	100% Plan Allowance - Limit: thirty (30) visits per benefit period		
Speech Therapy	100% Plan Allowance - Limit: thirty (30) visits per benefit period		
Hearing Care Services	100% Plan Allowance		
Audiometric Exam	100% Plan Allowance - One per benefit period		
Diagnostic Testing	100% Plan Allowance - One per benefit period		
Hearing Aid	Limit: One hearing aid or device per Ear per two benefit periods. Specialist office visit copayments apply when hearing-aid-related services are rendered by a specialist.		
Home Health Care*	100% Plan Allowance		
Hospice Care *	100% Plan Allowance		
Hospital Services *Inpatient* and Outpatient*	100% Plan Allowance		
Maternity * (Facility & Professional services)	100% Plan Allowance – required to notify Highmark Member Service for possible referral to Medicaid within the first 31 days		

*These services require preauthorization.
To access telemedicine any time of the day or night, seven days a week, visit **Well360VirtualHealth.com and set up your account.

Benefits	Free	Low-Cost	Full-Cost
Medical Care	100% Plan Allowance - *Includes Inpatient Visits and Consultations*		
Mental Health Care Services	100% Plan Allowance -*Inpatient* and Outpatient Services* - Members 14 years of age and older can self-refer.		
Office Visits *Primary Care Provider and Retail Clinic Visit*	100% Plan Allowance No copayment	100% Plan Allowance after $5 copayment	100% Plan Allowance after $15 copayment
Specialist Physician & Specialist Virtual Visit	100% Plan Allowance No copayment	100% Plan Allowance after $10 copayment	100% Plan Allowance after $25 copayment
Specialist Virtual Visit Originating Site Fee	100% Plan Allowance		
Urgent Care Visits	100% Plan Allowance No copayment	100% Plan Allowance after $10 copayment	100% Plan Allowance after $25 copayment
*Telemedicine Services***	100% Plan Allowance		
Preventive Services			
Routine Physical Exam	100% Plan Allowance - When provided by the PCP		
Pediatric Immunizations	100% Plan Allowance - When provided by the PCP		
Routine Diagnostic Screening	100% Plan Allowance		
Mammograms	100% Plan Allowance		
Routine Gynecological Exams, including a Pap Test	100% Plan Allowance		
Vision Screening	100% Plan Allowance		
Lead Screening	100% Plan Allowance		
Allergy Testing and Treatment	100% Plan Allowance		
Private Duty Nursing*	100% Plan Allowance		
Skilled Nursing Facility Care*	100% Plan Allowance		
Substance Abuse Services	Members 14 years of age and older can self-refer.		
*Detoxification**	100% Plan Allowance		
*Inpatient Rehabilitation**	100% Plan Allowance		
Outpatient	100% Plan Allowance - Includes Full Session Visits, Equivalent Partial Visits or Equivalent Partial Hospitalization services.		

*These services require preauthorization.
To access telemedicine any time of the day or night, seven days a week, visit **Well360VirtualHealth.com and set up your acccount.

Benefits	Free	Low-Cost	Full-Cost
Surgical Expenses*	100% Plan Allowance - *Includes Assistant at Surgery, Anesthesia, Second Surgical Opinion and Oral Surgery*		
Therapy Services* Inpatient	100% Plan Allowance		
Rehabilitation			
Outpatient Services			
*Cardiac Rehabilitation**	100% Plan Allowance		
*Chemotherapy**	100% Plan Allowance		
*Dialysis Treatment**	100% Plan Allowance		
*Infusion Therapy**	100% Plan Allowance		
Occupational Therapy	100% Plan Allowance Limit: Sixty (60) visits for Rehabilitative Services per benefit period.		
Physical Medicine	100% Plan Allowance Limit: Sixty (60) visits for Rehabilitative Services per benefit period.		
*Radiation Therapy**	100% Plan Allowance		
*Respiratory Therapy**	100% Plan Allowance		
Speech Therapy	100% Plan Allowance Limit: Sixty (60) visits for Rehabilitative Services per benefit period.		
Spinal Manipulations/ Chiropractic Care	100% Plan Allowance Limit: twenty (20) visits per benefit period		
Transplant Services*	100% Plan Allowance		

*These services require preauthorization.
To access telemedicine any time of the day or night, seven days a week, visit **Well360VirtualHealth.com and set up your account.

	Free	Low-Cost	Full-Cost
Generic Drugs	**100% Provider's Allowable Price (PAP) after Copayments below**		
Up to 31 Day Supply	100% Plan Allowance - No copayment	$6 copayment or the PAP, whichever is less	$10 copayment or the PAP, whichever is less
Up to 60 Day Supply	100% Plan Allowance - No copayment	$12 copayment or the PAP, whichever is less	$20 copayment or the PAP, whichever is less
Maintenance Drugs - Up to 90 Day Supply	100% Plan Allowance - No copayment	$18 copayment or the PAP, whichever is less	$30 copayment or the PAP, whichever is less
Brand Drugs *(if medically necessary)*	**100% Provider's Allowable Price (PAP) after Copayments below**		
Up to 31 Day Supply	100% Plan Allowance - No copayment	$9 copayment or the PAP, whichever is less	$18 copayment or the PAP, whichever is less
Up to 60 Day Supply	100% Plan Allowance - No copayment	$18 copayment or the PAP, whichever is less	$36 copayment or the PAP, whichever is less
Maintenance Drugs -Up to 90 Day Supply	100% Plan Allowance - No copayment	$27 copayment or the PAP, whichever is less	$54 copayment or the PAP, whichever is less

Prescription Drug Benefits

Benefits are available through the National Pharmacy Network only.

Prescription drugs are not covered out of network unless it's an emergency.

Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to this program.

Use of the formulary may result in restriction of drug availability.

Provider's Allowable Price (PAP): The amount at which a participating pharmacy has agreed with Highmark Blue Shield to provide prescription drugs to members under this plan.

No cost sharing will apply to self-administered Chemotherapy Medications, including oral Chemotherapy Medications.

Note: Certain covered Preventive Medications purchased at a Network Pharmacy are not subject to Member cost sharing.

Continuous Glucose Monitoring Devices are covered at 100% of Provider's Allowable Price.

PREVENTIVE CARE

It's important to schedule regular preventive care to maintain your child's good health. Refer to the enclosed Preventive Schedule to plan your child's preventive care. CHIP provides excellent preventive care benefits, including routine physical examinations, immunizations, required diagnostic tests, and an annual gynecological exam and Pap test. Routine dental exams and cleanings are covered every six months when your child receives services from a UCCI* dental provider. Routine comprehensive vision exams, eyeglasses and frames are covered as described in this document.**

Pediatric Preventive Care

Pediatric Preventive Care includes the following, with no cost sharing or copays when provided by a network provider:

- Physical examination, routine history, routine diagnostic tests
- Oral health risk assessment, fluoride varnish for children ages 5 months to 5 years old (U.S. Preventive Services Task Force Recommendation)
- Well baby care, and developmental screenings which generally includes a medical history, height and weight measurement, physical examination and counseling
- Blood lead screening and lead testing. This blood test detects elevated lead levels in the blood.
- Diabetes Prevention Program for children who meet certain medical criteria of having a high risk of developing type 2 diabetes.

** Dental coverage is provided by United Concordia Companies, Inc. United Concordia Companies, Inc. is a separate company that administers First Priority Health's dental services.*

*** Vision coverage is provided by Davis Vision, Inc. Davis Vision, Inc. is a separate company that administers First Priority Health's vision benefits*

RETAIL CLINICS

CHIP covers your child for services at retail-based clinics, located in freestanding facilities or drug stores and staffed by primary care providers. Retail clinics provide basic and preventive health care services, such as treating colds, flu or rashes, and have flexible and expanded hours, including weekends. Retail clinics provide a convenient option when your child needs basic care but is unable to see their primary care provider during regular office hours or the provider's office is closed.

TELEMEDICINE

Telemedicine is a medical service that provides 24/7 access to physicians via web-based video consultations free of charge to members. A national network of physicians who are board-certified in internal medicine, family practice, emergency medicine and pediatrics can diagnose, recommend treatment and prescribe medication, when appropriate, for many medical issues, such as cold and flu symptoms, allergies, bronchitis, urinary tract infections, respiratory infections, ear infections, sinus problems and pediatric care.

Telemedicine costs less than an urgent care or emergency room visit. It is a convenient alternative when your child can't leave home or becomes ill in the middle of the night or you cannot reach your child's primary care provider. This service does not replace a PCP. To access Telemedicine any time of the day or night, seven days a week, visit Well360VirtualHealth.com and set up your account.

SPECIALIST CARE

Your child has direct access to First Priority Health network specialists who have a PROMISeID number. Specialists are professional providers who limit their practice to a particular branch of medicine or surgery. Some examples are ear, nose and throat specialists; audiologists; allergists; and cardiologists. You do not need a referral from your child's PCP to see a specialist — you may take your child directly to any participating First Priority Health specialist who has a certified PROMISe ID number. Please refer to your child's Identification Card for possible copayments for specialist visits.

To locate a specialist:

- Visit **highmarkchip.com**. Enter your ZIP Code.
- Select **Covered Doctors & Facilities** on the CHIP page.
- Select **Browse Providers** and **Just Browsing/Continue.**
- Enter your ZIP Code and confirm location **– Continue.**
  NOTE: Network should display CHIP – First Priority Health Kids and City/State/ZIP should display your home City and ZIP Code.
- Select **Browse by Category – Medical Care – All Specialties (A – Z)**.
- Search needed specialty provider type.
- Select **View Profile** on the right side across from the doctor's name to see more details.

Or call **1-800-547-9378.** If needed, your child may see a specialist who is not in the First Priority Health Network by obtaining proper authorization from First Priority Health. Please call Member Service toll-free at **1-800-547-9378** to request an authorization.

VIRTUAL VISITS

Your child's coverage will include virtual visits with a family practitioner, general practitioner, pediatrician, and specialists. Virtual visits via audio/video conferencing technology can be used after your child has seen a doctor for an initial visit for any follow-up care your child may need. Specialist virtual visits can take place in real time at your child's primary care physician's office, a clinic or other location close to you. Specialist copays may apply.

Specialist virtual visits are convenient if you live in an area where the specialists your child needs aren't close by, if your child needs a certain kind of specialist for a rare or complex condition, if your child needs ongoing specialist visits to reduce the risk of complications, or if your child's health makes it difficult to travel. You can search for providers who offer this service at **highmarkchip.com** or by checking with your child's primary care provider or specialist.

HEARING CARE SERVICES

Hearing aids and devices and the fitting and adjustment of such devices are covered when determined to be medically necessary.

Benefit Limits: One routine hearing examination and one audiometric examination per 12 months. One hearing aid or device per ear every 24 months. Batteries for hearing aids and devices are not covered. **No monetary limits apply.**

URGENT CARE

CHIP covers your child for care received at urgent care centers. An urgent care center is a freestanding, full-service, walk-in health care clinic, with no appointment needed. Centers are normally open 8 a.m. until 8 p.m. weekdays, and eight hours daily on weekends (hours may vary). Urgent care centers are generally staffed by physicians who provide the same services as a family or primary medical care physician, such as treatment of minor illnesses and injuries, physicals and immunizations, and common testing services, including X-rays and blood tests.

If your child has a non-life-threatening emergency, such as the flu, a cold, a rash, sore throat, earache, a minor cut, vomiting, diarrhea or a sprain, you might consider going to an urgent care center instead of the emergency room.

HOSPITAL CARE

Covered hospital care includes all types of medically necessary and appropriate inpatient and outpatient medical services, from pre-admission to therapy. Planned inpatient stays require Prior Authorization.

If your child requires an emergency admission to a facility that is not in the First Priority Health network, you must contact Member Service toll-free at **1-800-547-9378** within 48 hours, or as soon as possible after the condition is stabilized, to let them know your child was admitted.

In some cases, your child may need to have a procedure performed at a hospital or other licensed facility that does not require an overnight stay. Certain outpatient procedures, services or equipment and ambulatory care procedures must also be authorized before your child receives these services. Your child’s First Priority Health participating providers are aware of procedures that need an authorization and will work with First Priority Health as required.

WOMEN’S CARE

First Priority Health recognizes the importance of a patient's relationship with their gynecologist. That’s why your child has two options for gynecological care. Your child can see the PCP or go directly to any network gynecologist or nurse-midwife without a referral. To make it easier for your child to get needed care, a network gynecologist can directly refer for diagnostic tests related to gynecological problems. If your child needs additional care that is not related to a gynecological problem, contact the PCP.

CHIP does not provide coverage for elective abortions, except those abortions necessary to avert the death of the member, or to terminate the pregnancies caused by rape or incest. However, services rendered to treat illness or injury resulting from an elective abortion are covered.

There is no cost sharing for preventive services under the services of Family Planning, Women's health, and Contraceptives.

Well Woman Preventive Care includes services and supplies as described under the Women's Preventive Services provision of the Patient Protection and Affordable Care Act. Covered Services and Supplies include, but are not limited to, the following:

Routine Gynecological Exam, Pap Smear: Members are covered for one (1) routine gynecological exam each Benefit Period. This includes a pelvic exam and clinical breast exam and routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists. Members have "direct access" to care by an Obstetrician or Gynecologist. This means there is no Primary Care Physician Referral needed.

Mammograms: Coverage will be provided for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service Provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992. Copayments, if any, do not apply to this benefit.

Breast-feeding: Comprehensive support and counseling from trained Providers; access to breast-feeding supplies, including coverage for rental of hospital-grade breast-feeding pumps under DME with medical necessity review; and coverage for lactation support and counseling provided during postpartum hospitalization, Mother's Option visits, and obstetrician or pediatrician visits for pregnant and nursing members at no cost share to the Member.

Contraception: Food and Drug Administration-approved contraceptive methods, including contraceptive devices, injectable contraceptives, IUDs and implants; voluntary sterilization procedures; and patient education and counseling, not including abortifacient drugs, at no cost share to the Member.

Mastectomy and Breast Reconstruction: Benefits are provided for a mastectomy performed on an inpatient or outpatient basis, and for the following:

- Surgery to reestablish symmetry or alleviate functional impairment, including but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy, surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Coverage for initial and subsequent prosthetic devices to replace the removed breast or portions thereof, due to a Mastectomy; and
- Physical complications of all stages of Mastectomy, including lymphedemas.
- Coverage is also provided for one Home Health Care visit, as determined by the Member's physician, received within forty-eight (48) hours after discharge.

Reconstructive Surgery will only be covered when required to restore function following accidental injury, result of a birth defect, infection, or malignant disease in order to achieve reasonable physical or bodily function; in connection with congenital disease or anomaly through

the age of 18; or in connection with the treatment of malignant tumors or other destructive pathology that causes functional impairment; or breast reconstruction following a Mastectomy.

MATERNITY CARE

A CHIP member who becomes pregnant during the 12-month term of CHIP eligibility will remain in CHIP for the duration of the 12-month term. If the member is still covered by CHIP when the baby is born, the CHIP member must contact the First Priority Health CHIP Enrollment and Eligibility Unit toll-free at **1-800-543-7105** immediately so we can screen the newborn for CHIP or Medical Assistance eligibility. We will determine which program the newborn is eligible for using the appropriate information on income and family size contained on the member's original application.

A member may select a participating provider for maternity and gynecological services without a referral or prior authorization. Hospital and physician care services relating to antepartum, intrapartum and postpartum care, including complications resulting from the member's pregnancy or delivery, are covered.

- Under federal law, health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse-midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

- Coverage is also provided for at least one (1) home health care visit following an inpatient release for maternity care when the CHIP member is released prior to forty-eight (48) hours for a normal delivery and ninety-six (96) hours for a caesarean delivery in consultation with the mother and provider, or in the case of a newborn, in consultation with the mother or the newborn's authorized representative. Home health care visits include, but are not limited to, parent education, assistance and training in breast- and bottle-feeding, infant screening and clinical tests, and the performance of any necessary maternal and neonatal physical assessments. A licensed health care Provider whose scope of practice includes postpartum care must make such home health care visits. At the mother's sole discretion, the home health care visit may occur at the facility of the Provider. Home health care visits following an Inpatient stay for maternity services are not subject to Copayments, Deductibles, or Coinsurance, if otherwise applicable to this coverage.

NEWBORN CARE

CHIP covers care of a member's newborn child for 31 days following birth. CHIP continues to provide care, if the newborn is enrolled in CHIP within 31 days of birth and appropriate premium payments are received (if the child is eligible for Low-Cost or Full-Cost CHIP). Care includes routine nursery care, prematurity services, preventive health care services, as well as coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

CHIP members who give birth should contact the Highmark CHIP Enrollment and Eligibility Unit for information about applying for Medical Assistance. If the newborn is not eligible for Medical Assistance, the CHIP Enrollment and Eligibility Unit will evaluate the child's eligibility for CHIP.

Immunizations

- Coverage will be provided for pediatric Immunizations (except those required for employment or travel), including the immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and U.S. Department of Health and Human Services. Pediatric and adult Immunization ACIP schedules may be found by accessing the following link: http://www.cdc.gov/vaccines/recs/schedules/default.htm.

- **Influenza Vaccines** can be administered by a participating pharmacy for members starting at the age of 9 years old, with parental consent, according to PA Act 8 of 2015.

EMERGENCY CARE

Emergency care is covered in full for all CHIP members. Members with Low-Cost or Full-Cost CHIP are required to pay a copayment, which is waived if the child is admitted to the hospital as a result of the emergency.

Your child is covered for all reasonably necessary costs associated with emergency care and services provided during the period of emergency. In an emergency situation where you believe you need immediate treatment, go directly to your nearest emergency room or call 911 or your local emergency number. Once the crisis has passed, it's wise to contact your PCP to arrange for appropriate follow-up care.

You should use emergency services only when appropriate — for emergencies, accidents or urgent care. For everyday sick visits and non-urgent care, you should see your child's PCP. The PCP can treat many conditions in the office, helping you avoid delays waiting in an emergency room and paying any applicable emergency room copayments.

MENTAL HEALTH/SUBSTANCE ABUSE SERVICES

If your child requires mental health and/or substance abuse services, you may take your child directly to any network behavioral health specialist, and the Network Specialist is responsible for obtaining all necessary authorizations. You do not need to obtain an authorization, and you do not need to get a referral from your child's PCP. Your child's participating First Priority Health behavioral health provider should obtain all necessary authorizations for treatment. Members as young as the age of 14 can self-refer.

The First Priority Health Provider Directory lists behavioral health specialists in the counties that First Priority Health serves.

To check if your child's current provider participates in the First Priority Health network as a behavioral health provider, access the **highmarkchip.com** website, or call 1-800-628-0816. Your child's PCP may also be able to recommend a behavioral health provider.

HOW TO FIND A PROVIDER

To search the providers and/or to find a provider:

- Visit **highmarkchip.com**. Enter your ZIP Code.
- Select **Covered Doctors & Facilities** on the CHIP page.
- Select **Browse Providers** and **Just Browsing/Continue.**
- Enter your ZIP Code and confirm location **– Continue.**
  NOTE: Network should display CHIP – First Priority Health Kids and City/State/ZIP should display your home City and ZIP Code.
- Select **Browse by Category – Medical Care – All Specialties (A – Z)**.
- Search needed specialty provider type.
- Select **Accepting New Patients** and **View Profile** next to the doctor's name to see more details.

In an emergency, go straight to the nearest provider and notify First Priority Health within 48 hours or as soon as possible after the condition is stabilized.

OSTEOPOROSIS SCREENING (Bone Mineral Density Testing, or BMDT)

Coverage is provided for Bone Mineral Density Testing using a U.S. Food and Drug Administration approved method. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength, which is the aggregate of bone density and bone quality. Bone quality refers to architecture, turnover and mineralization of bone. The BMDT must be prescribed by a Professional Provider legally authorized to prescribe such items under law.

HABILITATIVE SERVICES

Habilitative services are health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities that are provided in a variety of outpatient settings.

Covered services are limited to 30 visits per calendar year for physical medicine, 30 visits per calendar year for occupational therapy and 30 visits per calendar year for speech therapy, for a combined visit limit of 90 days per calendar year.

HOME HEALTH CARE SERVICES

Home Health Care provided to a CHIP member who is homebound by a home health care provider in the CHIP member's home, if within the service area. This benefit is offered with no copayments and no limitations. See the Description of Benefits section in the back of this handbook for additional details.

PRESCRIPTION DRUG BENEFITS

Your child is covered for prescription drugs using a drug formulary. The formulary includes medications listed on the Highmark Comprehensive formulary and many other drugs that aren't listed on the formulary. Your child's drug benefit includes FDA-approved prescription drugs and select medications in every therapeutic category.

When clinically appropriate drugs are requested by the Member, but are not covered by the health plan, the Member shall call Customer Service at the telephone number on the back of the member's identification card to obtain information for the process required to obtain the prescription drugs.

See your Agreement in the back of this handbook for more details and exclusions regarding your prescription drug benefits.

When a Prescription Drug is available as a Generic, the HMO will only provide benefits for that Prescription Drug at the Generic Drug level. If the prescribing Physician indicates that the Brand-Name Drug is medically necessary and should be dispensed, the brand-name drug is covered at the generic cost sharing amount by the contractor.

To fill prescriptions ordered by a PCP or specialist, you should use the National Pharmacy network. You may call 1-800-543-7105 to confirm that your Pharmacy is in the National Pharmacy network for CHIP members. You will need to show your child's First Priority Health member identification card at the pharmacy. Depending on the CHIP group in which your child is enrolled, you may owe copayments* for prescription drugs.

You can purchase a 90-day supply of your child's prescription drugs. Your child must use generic drugs anytime they are available. Otherwise, you will be responsible for paying any difference between an available generic drug and the brand-name drug you requested. A brand-name drug can be acquired at the generic cost if the brand is medically necessary.

If you are required to pay for a covered prescription drug up front and need to request reimbursement, please call First Priority Health at **1-800-547-9378** to request a drug claim form. When submitting a claim form, be sure to enclose a copy of the receipt (and remember to keep one for your records) listing the prescription drug name and the amount you paid. You should receive your reimbursement within three to five weeks.

Please visit our website at highmarkchip.com to view the Highmark Comprehensive Formulary to check coverage for the drug(s) your child may currently be taking.

To find a drug in the Formulary:

1. Visit **highmarkchip.com** (if this is your first visit to the site, you will be prompted to enter member zip code location).
2. Select **Doctors, Hospitals & Rx** link, and:
3. Select **CHIP Formulary** under the section titled **Is your drug covered?**
4. Type in the name of the drug or select by clicking the **Therapeutic Class**.

Select Over-the-Counter (OTC) products may be covered if mandated by the Patient Protection and Affordable Care Act (PPACA). If your child has a prescription for the over-the-counter medication, the medication is listed in the formulary, and your child has been diagnosed with certain medical conditions, the medication may be covered. If you have questions about whether an over-the-counter medication is covered, call Member Services at the number on the back of your Member Identification Card.

Covered Preventive Medications
Select medications, such as contraceptives, iron supplements, sodium fluoride, folic acid supplements, vitamins, aspirin, smoking deterrents, tamoxifen and raloxifene, are considered preventive medications and covered at no cost to you when filled at a participating pharmacy with a valid prescription. If you have questions about whether a preventive medication is covered, call Member Services at the number on the back of your member ID card.

Early Refill
No coverage is provided for any refill of a covered medication that is dispensed before your child's predicted use of at least 90% of the days' supply of the previously dispensed covered medication, unless your child's physician obtains preauthorization from First Priority Health for an earlier refill.

DIABETICS: FREE BLOOD GLUCOSE MONITORS

If your child has diabetes, it's important to monitor you child's blood sugar carefully. To make that as easy as possible, your child's prescription drug benefit allows you to select any blood glucose monitoring system and test strips. Here is information about the monitoring systems offered by LifeScan, Inc. and Abbott Diabetes Care, plus instructions on how to order. You are encouraged to take this information with you the next time you visit your child's doctor, so you can discuss blood glucose monitoring systems together. Your doctor will give you a prescription to order your blood glucose monitoring supplies.

If you select one of the monitors offered by LifeScan or Abbott, you will receive a glucose monitoring system (meter, lancet device with lancets, and a sample quantity of test strips) at no charge. You may choose LifeScan's OneTouch® system or Abbott's FreeStyleTM or PrecisionTM brand system. If you have any questions about these systems, please call LifeScan toll-free at **1-800-227-8862** or Abbott at **1-800-522-5226**. To order a LifeScan monitor, please call **1-877-764-5393.** To order an Abbott monitor, call **1-866-224-8892.** For more information about your prescription drug benefit, please call First Priority Health Member Service at the phone number listed on the back of your child's identification card.

LifeScan OneTouch is a registered trademark of LifeScan, a Johnson & Johnson Company. LifeScan is an independent company.

FreeStyle and Precision are service marks of Abbott Industries.

Abbott Industries is an independent company that administers diabetic supplies and testers.

Continuous glucose monitoring (CGM) system products are available for you to access at your participating network pharmacies or under your child's medical benefit plan, should you chose to obtain through participating durable medical equipment (DME) providers.

Blood Glucose Meters (BGM) measure glucose levels at a single moment in time, while Continuous Glucose Monitoring (CGM) systems continually check glucose levels throughout the day and night.

In order for Highmark to cover the continuous glucose monitoring (CGM) system, you must obtain a prescription from your child's doctor and fill the prescription at a participating pharmacy. Depending on your continuous glucose monitoring (CGM) system product supporting components may also be obtained from your participating pharmacy such as the transmitter, receiver, and sensor. Listed below are the preferred continuous glucose monitoring (CGM) systems under Highmark's prescription drug benefit:

- Dexcom Continuous Glucose Monitoring System
- FreeStyle Libre Glucose Monitoring System

CARING PROGRAM: CARE COORDINATION FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Your coverage includes the Caring Program, a comprehensive, community-based, care coordination program for children with special health care needs or chronic conditions. Nurses and other health care staff work directly with you to help you clearly understand your child's medical condition and treatment. They coordinate services among physicians and help you find and receive the services you need to meet your child's needs. They also give you educational materials and link you to community resources that can help your family.

For questions about the Caring Program, please call **1-866-823-0892** and leave a message. A staff member will return your call within two business days. The Caring Program is available Monday through Friday, from 8:30 a.m. to 4:30 p.m. For more information about the Caring Program, go to **highmarkchip.com.**

CLINICAL TRIALS

Routine Costs associated with Qualifying Clinical Trials
Benefits are provided for routine patient costs associated with participation in a qualifying Clinical Trial. To ensure coverage and appropriate claims processing, First Priority Health must be notified in advance of the Member's participation in a Qualifying Clinical Trial.

Benefits are payable if the Qualifying Clinical Trial is conducted by a Participating Professional Provider, and conducted in a Participating Facility Provider facility. If there is no comparable Qualifying Clinical Trial being performed by a Participating Professional Provider, and in a Participating Facility Provider facility, then First Priority Health will consider the services by a Non-Participating Provider participating in the clinical trial as covered if the clinical trial is deemed a Qualifying Clinical Trial by First Priority Health.

Qualifying Clinical Trials
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.

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), if for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be (A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

B. The study or 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.

The citation for reference is 42 U.S.C. § 300gg-8. The statute requires the issuer to provide coverage for routine patient care costs for qualified individuals participating in approved clinical trials and issuer "may not deny the individual participation in the clinical trial."

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

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.

LEAD AWARENESS AND YOUR CHILD

There are approximately half a million U.S. children ages 1-5 with blood lead levels above 5 micrograms per deciliter (µg/dL), the reference level at which CDC recommends public health actions be initiated. You may have lead around your building without knowing it because you can't see, taste, or smell lead. You may have lead in the dust, paint, or soil in and around your home, or in your drinking water or food. Because it does not break down naturally, lead can remain a problem until it is removed.

Before we knew how harmful it could be, lead was used in paint, gasoline, water pipes, and many other products. Now that we know the dangers of lead, today house paint is almost lead-free, leaded gasoline has been phased out, and household plumbing is no longer made with lead materials in the United States.

HOW LEAD AFFECTS YOUR CHILD'S HEALTH

The long-term effects of lead in a child can be severe. They include learning disabilities, decreased growth, hyperactivity, impaired hearing, and even brain damage. If caught early, these effects can be limited by reducing exposure to lead and/or by medical treatment. If you are pregnant, avoid exposing yourself to lead. Lead can pass through your body to your baby. The good news is that there are simple things you can do to help protect your family.

Go to **highmarkchip.com** and the section **Schedule a Lead Screening for Your Child** near the bottom of the page to read more about lead and how you can protect your family.

EPA's Safe Drinking Water Hotline
1-800-426-4791

National Lead Information Center
1-800-424-LEAD

Website: **www.epa.gov/lead**

Adapted from United States Environmental Protection Agency, Office of Pollution Prevention and Toxics (7404), EPA 747-K-00-003, October 2000.

UNDERSTANDING CHIP GUIDELINES

APPLYING FOR NEW COVERAGE

Either parent/legal guardian may apply for CHIP coverage; however, only one parent/legal guardian may apply. The address of the parent/legal guardian who applies is the address that is used for identification cards and other correspondence. The applying parent/legal guardian must select the child's primary care provider and is the only parent/legal guardian who may change it.

ELIGIBILITY REQUIREMENTS

Children applying for CHIP must meet all of the following eligibility requirements:

- Must be age birth through 18
- Must be a Pennsylvania resident and continue to reside in Pennsylvania
- Must lawfully reside within the United States as a U.S. citizen, a U.S. national or a qualified alien
- Must not be covered by a health insurance plan, a self-insurance plan or a self-funded plan
- Must be ineligible for Medical Assistance (also known as Medicaid, MA or ACCESS) and/or Medicare

Families with incomes that qualify for Full-Cost CHIP can purchase CHIP coverage **at full cost** for their children if they meet the following criteria:

- Private coverage costs more than 10% of the family's annual income; or
- Private coverage costs more than 150% of the CHIP monthly premium; or
- The child or family has been denied full or partial private coverage due to a preexisting condition.

PREEXISTING CONDITIONS

The health condition of any person in the family will NOT be used to determine eligibility for the CHIP program (including any preexisting conditions). Medical underwriting is not performed to determine eligibility for CHIP. Every child who meets the eligibility requirements is enrolled regardless of your child's health condition.

RENEW YOUR CHILD'S COVERAGE NEXT YEAR BY USING THE PHONE, MAIL OR INTERNET

Renewing your child's coverage each year is easy! We mail you a form every year. You can fill out the form and mail it back or call us and renew over the phone. You can also renew online — the website address is printed on your renewal form. Please make sure you call and tell us if you move so we have your current address.

We will automatically send you an eligibility renewal form in the mail each year, 90 days before your child's eligibility anniversary date. Please complete the form before the anniversary date. The anniversary date for your family (which includes all children enrolled in CHIP) is determined by the original effective date of the first child you enrolled in CHIP.

You are required to complete the annual renewal regardless of subsidy level. Failure to do so will result in cancellation of coverage. We must receive a complete renewal form no later than 15 days before your child's anniversary date to continue coverage without interruption. You may renew coverage in one of three ways: you can mail the form back, you can call the Highmark CHIP Enrollment and Eligibility Unit to renew over the phone or you can renew coverage online. The renewal form includes details about all three ways to renew.

CHANGES IN ELIGIBILITY

Please notify the Highmark CHIP Enrollment and Eligibility Unit if your household experiences a change in any of the following:

- The enrolled child's name, address or phone number
- Marital status (marriage or divorce) of the member or parent/guardian
- Addition of a dependent (birth, placement for adoption or adoption) to the household
- A change in household size if someone moves out (or in) or is no longer a member of the household for any reason
- If your child becomes eligible for Medical Assistance or Medicare
- If your child becomes enrolled in other health insurance
- If an enrolled child becomes pregnant
- If there is a change in household income

Changes must be reported within 31 days of their occurrence.

TRANSFERS

To transfer your child's CHIP coverage to a different CHIP insurance company, contact the Highmark CHIP Eligibility Unit toll-free weekdays between 8:30 a.m. and 4:30 p.m. at 1-800-543-7105 (or hearing impaired callers may reach us at 1-877-323-8480) and request the transfer. Before you request the transfer, be sure to verify that the insurance company you would like to switch to participates in CHIP in your area and that your doctor participates with that insurance company. The change will take place shortly after you have contacted the Highmark CHIP Unit and there will be no lapse in CHIP coverage. You will be told the effective date of change by your customer service representative and you will receive a letter

confirming this information. Until that date, your child must continue to use their CHIP benefits through Highmark.

CHANGES IN YOUR ADDRESS

All program notices, including renewal forms, invoices, benefit changes, Explanation of Benefits (EOBs), etc., will be mailed to the last known address on file. It is the responsibility of the member and/or the member's parent/legal guardian to inform the CHIP Enrollment and Eligibility Unit of any changes to your mailing address or phone number.

IMPARTIAL REVIEWS OF ELIGIBILITY DETERMINATIONS

If your child has been determined ineligible for CHIP, has been terminated from CHIP because your child was no longer eligible, or has transferred from Free CHIP coverage to Low-Cost or Full-Cost CHIP coverage, you have the option to request an impartial review of the eligibility determination if you do not agree with the decision.

Before requesting this review, you should make an attempt to resolve eligibility questions with the CHIP Enrollment and Eligibility Unit. You may request a copy of the procedures on which the eligibility decision was based by calling the CHIP Enrollment and Eligibility Unit at **1-800-543-7105,** Monday through Friday, from 8:30 a.m. to 4:30 p.m., to discuss your concerns.

If you want to request a review, the CHIP Eligibility Review Unit will conduct an interview with the parent/guardian and a representative of the Highmark CHIP Enrollment and Eligibility Unit to consider the information that was used to determine that the child was not eligible for CHIP. You may choose to have someone act as your representative at this interview.

To request an impartial review, you may submit a written request to us within 30 days from the date of receiving the eligibility determination notice. Please include the following:

- A written, dated request stating why you disagree with our decision
- A copy of your eligibility determination notice
- Any additional documentation to support your case
- A phone number where you can be reached during the day

Mail this information to:

First Priority Health
CHIP Eligibility Review Unit
120 Fifth Avenue Suite 2335
Pittsburgh, PA 15222

We may contact you for more information. If we cannot solve your issue, we will forward your written request and any additional information to the Department of Human Services. You may also receive more detailed information from the Department of Human Services, including the time and date that a phone interview will be held, if needed.

ENDING CHIP COVERAGE

An enrollee is no longer eligible for CHIP, administered by First Priority Health, when he/she moves out of the First Priority Health service area, turns 19, obtains private health insurance, becomes eligible for Medical Assistance or Medicare, dies, voluntarily requests disenrollment or provides misinformation on the application that would have resulted in a determination of ineligibility had the correct information been provided. A member's coverage will be terminated if he/she tries to obtain benefits through misrepresentation or fraud. In addition, a Low-Cost or Full-Cost CHIP member's coverage may terminate if the premium payment is not paid in full by the due date.

Every terminated CHIP member will receive a 30-day termination notice prior to the coverage cancellation date unless the member or the parent/guardian requested an expedited cancellation of coverage (in which case, the notice may be provided less than 30 days before cancellation).

PAYING FOR CHIP COVERAGE

CHIP is a program for which state and federal funds are available. For many families, including American Indians and Alaskan Natives, CHIP is free. Families with higher incomes that do not qualify them for Free CHIP are responsible for monthly premiums.

PAYMENT DUE DATES

Premiums must be paid on or before the 15th of each month for members enrolled in Low-Cost or Full-Cost CHIP. Premiums must be received on or before the 15th of the month in which they are due. If the 15th of a month falls on a weekend or holiday, the premium must be received on the next business day after the 15th. **We strongly recommend that you mail your child's premium payment on or before the 10th of each month.**

PAYMENT OPTIONS

After your child is enrolled, you may elect to pay your premium monthly, quarterly, semi-annually or annually. Payments may be made by personal check or money order. Payments should be made payable to **"Highmark."** You must remit your child's payment with the invoice slip provided, and you should note your child's account number on the "note" line of your check or money order. Send your payment to:

Highmark
P.O. Box 643306
Pittsburgh, PA 15264-3306

CHIP now offers an option to pay online. To pay online:

1. Visit **highmarkbcbs.com** and click on **Pay Premium**.
2. Click on **Guest Pay** button on eBill login page.
3. On Guest Pay screen, click on the check box for **Click here to pay CHIP invoice**.
4. Enter your Account Number and Billing ID. Click **Next**.
5. When **Make Invoice Payment** appears, select complete payment details – Account Type, Institution Name, Routing Number and Bank Account Number. Click Next.
6. When the Confirm Payment Screen appears, confirm the Payment Amount and Payment Method. Click **Confirm & Pay**.
7. When your Payment ID reference is displayed, you can enter your email address if you'd like to receive a payment processing notification via email.
8. Click **Exit** to close the Guest Pay screen.

LATE PAYMENTS

If your child has Low-Cost or Full-Cost CHIP and you fail to make timely payments of your premium, your child's coverage may terminate at the end of the last month for which payment was made. After 31 days of delinquency, the member's account will be cancelled retroactively to the end of the last month for which the premium was due. Once the account is delinquent, we require two months' payment of premium to reinstate the account and another month's payment for the upcoming month, for a total of three months' payment.

Any and all claims for service incurred after the cancellation date will become the member's responsibility.

PREMIUM INCREASES

The monthly amount may be adjusted in the event of a rate change. Members will be notified of any change to the monthly premium due at least 30 days in advance of the change.

RECEIVING A BILL FOR SERVICES

If your child uses participating providers in the networks servicing CHIP members and receives care for covered services under CHIP, you should not receive a bill for any portion of the charges.

If you receive a bill for a service, check it over carefully. Sometimes bills do not include correct insurance information and/or some might have been filed incorrectly. Make sure your child's member identification number is correct (found on your child's identification card). Correct the spelling of the patient's name that appears on the bill, if necessary. If you feel you have received a bill in error, please contact the appropriate company to see if they received a claim for the service in question. A Member Service representative will investigate the claim for you, answer any questions you may have about it and keep you informed of its status. The Member Service numbers are:

First Priority Health 1-800-547-9378
Davis Vision 1-800-999-5431
United Concordia 1-800-332-0366

TO OBTAIN A CLAIM FORM

Claim forms are available at **highmarkchip.com**. Log into your Highmark account or by calling the Member Service telephone number on the back of your child's ID card. When completing a claim form, make sure all of the information is accurate, then sign and date the form, attach any itemized bills and mail to the address listed on the form.

IF YOUR CHILD HAS OTHER HEALTH INSURANCE

CHIP is provided for uninsured children who do not have other insurance available. Children found to have other health insurance in addition to CHIP (under another government program or through individual or group policies) will be contacted and

evaluated for cancellation of CHIP coverage. Coverage will be cancelled back to the effective date of the other coverage, or, if the other coverage was in force prior to the date CHIP coverage began, back to the original effective date for CHIP. Claims will be denied under CHIP if other health insurance exists. CHIP providers who receive payments for services that should have been paid under the other health insurance will refund those payments to First Priority Health Premiums for Low-Cost or Full-Cost CHIP coverage will be refunded, as appropriate.

When a First Priority Health member is also covered by a state program for Workers' Compensation or motor vehicle insurance, it must be determined which coverage has primary liability — that is, which coverage will pay first for eligible medical services and which coverage has secondary liability, or pays second payor.

CHIP coverage is always secondary for claims that result from work-related injuries or illness. Workers' Compensation and Occupational Disease laws place the primary liability on a member's employer for medical expenses resulting from injury or disease related to their employment. A motor vehicle insurance carrier is always primary for any medical expenses up to the policy's limit.

IF YOU SUSPECT FRAUD OR PROVIDER ABUSE

First Priority Health providers should not send you bills for covered services that are covered 100 percent under CHIP coverage. If you receive a balance bill from a provider showing unpaid charges, please contact First Priority Health Member Service toll-free at **1-800-547-9378** to find out why you received a bill.

If you suspect that a provider is committing fraud by submitting claims for services that were never provided to your child or by adding on extra charges for services that were not provided or giving your child treatment for services your child does not need, please call the toll-free First Priority Health **Fraud Hotline at 1-800-438-2478**.

YOUR RIGHTS AND RESPONSIBILITIES FOR YOUR CHILD'S CARE

The First Priority Health Agreement, together with the member handbook, explains in detail the benefits provided through CHIP coverage. Please read this document carefully and keep it in a safe place where you can refer to it when you have a question about specific covered health care services.

As a First Priority Health member, your child has certain rights and responsibilities that you should be aware of to maximize your child's benefits in a managed care environment.

The key to getting the most out of your child's coverage and maintaining your child's health is to develop a cooperative, trusting relationship with your child's PCP. Both you and your child's PCP have the right to request an end to this relationship if one feels the other is not fulfilling their responsibilities. To change your child's PCP, please call First Priority Health toll-free at **1-800-547-9378**.

YOUR RIGHTS

1. You have the right to get information about the following:
    - Our company, products, and services
    - Our doctors, facilities, and other professional providers
    - Your rights and responsibilities
2. You have the right to be treated with respect. You have the right to have your dignity and right to privacy recognized.
3. You have the right to make decisions about your health care with your providers. This includes identifying your problem, illness, or disease and treatment plan in words you can understand. You have the right to help make decisions about your care.
4. You have the right to openly discuss treatment decisions that are right and necessary for you. You have the right to do this without concern for cost or coverage. We do not restrict information shared between you and your providers. We have policies telling providers to openly discuss all treatment options with you.
5. You have the right to voice a complaint or appeal about your coverage or care. You have the right to get a reply in a reasonable amount of time.
6. You have the right to be free from any form of restraint or seclusions used as a means of coercion, discipline, convenience or retaliation.

7. You have the right to be free to exercise your rights and exercising these rights will not adversely affect the way Highmark treats you.

8. You have the right to recommend rights and responsibilities to us.

YOUR RESPONSIBILITIES

1. You have the responsibility to give us as much information as you can. We need this information to make care available to you. It's also what providers need to take care of you.
2. You have the responsibility to follow the plans and instructions for care that you agree to with your providers.
3. You have the responsibility to talk openly with the provider you choose. Ask questions. Make sure you understand explanations and instructions you get. Help develop treatment goals you agree to with your providers. Develop a trusting and cooperative relationship with your providers.

If you have any questions, please call Member Service at the number on the back of your identification card.

Informal dissatisfaction resolution
If you are dissatisfied with any aspect of CHIP, or you have any objection regarding the First Priority Health participating providers, coverage, operations or management policies, please contact Member Service:

- In writing at:

First Priority Health Member Services
Penn Avenue Place
501 Penn Avenue
Pittsburgh, PA 15222

- Or by phone by calling the toll-free Member Service number on the back of your ID card.

The appropriate designated unit representative will review, research and respond to your inquiry as quickly as possible.

Complaint and grievance processes
If the informal dissatisfaction process is not successful and does not meet your needs, you have the right to have your objection reviewed through First Priority Health complaint and grievance processes. Please refer to SECTION GP—GENERAL PROVISIONS of your Agreement and any applicable riders to the Agreement for complete details about how these processes work. Or call a Member Service representative at the toll-free number on the back of your Identification Card for information and assistance with the processes, or to request a copy of the Agreement.

HOW TO SUBMIT A COMPLAINT

You can submit a complaint if you are not satisfied with:

- Any part of your health care benefits
- A participating health care provider
- Coverage
- Operations
- Management policies

Please contact Member Service at the number on the back of your member Identification Card or by mail at the address listed below. Please include your identification and group numbers as displayed on your Identification Card.

Highmark
Member Appeals Department
P.O. Box 2717
Pittsburgh, PA 15230-2717

If this process does not meet your needs, your objection can be reviewed through an appeal process. Please refer to your Agreement in the back of this booklet for more details regarding your appeal rights. You may also call Member Service at the number on your member Identification Card.

ENSURING YOUR CHILD RECEIVES QUALITY CARE

For benefits to be paid under First Priority Health HMO, services and supplies must be considered medically necessary and appropriate. First Priority Health is responsible for ensuring that quality care is delivered to members within the proper setting, at the appropriate cost and with the right outcomes. First Priority Health will review your child's care to ensure that it is medically necessary and appropriate. This means that services or supplies that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms are:

- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

No benefits will be provided unless it is determined that the service or supply is medically necessary and appropriate. If we denied coverage of a service or claim, you have the right to appeal the denial decision. For a description of your child's right to file a complaint or grievance appeal concerning an adverse determination involving a service or claim, see the Complaint and Grievance Processes subsection in the RESOLVING PROBLEMS section of this benefit booklet.

THE CARE/UTILIZATION PROCESS

To ensure that your child gets appropriate care, First Priority Health conducts a care utilization review process. The process consists of prospective, concurrent and retrospective reviews. In addition, First Priority Health conducts discharge planning. A care manager working closely with a physician adviser who is in direct contact with your child's physician conducts these activities via phone or on-site.

Following is a brief description of the care utilization review procedures:

Prospective review
Prospective review, also known as pre-certification or preadmission review, begins when a request for medical services is received. Requests can be for services such as outpatient hospital care, specific therapies and home health services. After receiving the request for medical services, the care manager:

- Gathers information needed to make a decision, including patient demographics, diagnosis and plan of treatment
- Confirms care is "medically necessary and appropriate"
- Authorizes care or refers to a physician adviser for a determination
- Assigns an appropriate length of hospital stay, when required

Concurrent review
Concurrent review occurs during the course of inpatient hospitalization and is used to ensure appropriateness of admission, length of stay and level of care at an inpatient facility. The care manager:

- Contacts the facility's utilization reviewer
- Checks the member's progress and ongoing treatment plan
- Decides, when necessary, to either extend the member's care, offer an alternative level of care or refer to the physician adviser for further determination of care

Discharge planning
Discharge planning is a review of the case to identify the member's discharge needs. The process begins prior to admission and extends throughout the member's stay in a facility. Discharge planning ensures continuous, quality care and is coordinated with input from the member's physician. To plan effectively, the care manager assesses the member's:

- Level of function pre- and post-admission
- Ability to perform self-care
- Primary caregiver and support system
- Living arrangements pre- and post-admission
- Special equipment, medication and dietary needs
- Obstacles to care
- Need for a referral to case management or disease management
- Availability of benefits or need for benefit adjustments

Retrospective review
Retrospective review occurs when a service or procedure has been rendered before Highmark is notified. While services or procedures are expected to be prospectively reviewed, providers are permitted a 24-hour grace period of notification to Highmark.

CASE MANAGEMENT SERVICES

If a First Priority Health member has a serious injury or chronic illness, case management services can provide critical care support. Case management can help:

- Coordinate a treatment plan to enable the member to reach optimum recovery in a timely manner
- Identify available resources and information and assist in coordinating services, as well as education related to wellness and preventive care
- Work with the member to obtain the maximum level of health care coverage

RESOLVING PROBLEMS

Complaint and Grievance Processes
In the event you are dissatisfied with any aspect of CHIP or you have any objection regarding a participating provider or First Priority Health coverage, operations or management policies, you should contact First Priority Health Member Service at 1-800-547-9378. If you are not satisfied with the response you receive by calling First Priority Health Member Service, First Priority Health also maintains a formal complaint and grievance process, which is outlined in the HMO Agreement in SECTION GP — GENERAL PROVISIONS.

Other Types of Coverage
When a First Priority Health member is also covered by a state program for Workers' Compensation or motor vehicle insurance, it must be determined which coverage has primary liability — that is, which coverage will pay first for eligible medical services and which coverage has secondary liability, or pays second.

CHIP coverage is always secondary for claims that result from work-related injuries or illness. Workers' Compensation and Occupational Disease laws place the primary liability on a member's employer for medical expenses resulting from injury or disease related to their employment. A motor vehicle insurance carrier is always primary for any medical expenses up to the policy's limit.

Coverage available under other government programs, individual or group policies is not permitted while enrolled in CHIP.

The program is provided for uninsured children who do not have other insurance available. If it is determined that a child covered under this program has other insurance coverage, Highmark CHIP Enrollment and Eligibility Unit will contact the parent/guardian to discuss cancellation, if appropriate. Prepaid premiums for CHIP will be refunded, as appropriate.

IF YOU NEED ADDITIONAL INFORMATION

You may, upon written request, receive information on any of the following:

- A list of the names, business addresses and official positions of the membership of the First Priority Health Board of Directors and Officers.
- The procedures adopted to protect the confidentiality of medical records and other member information.
- A description of the credentialing process for health care providers.
- A list of the participating health care providers affiliated with a specific hospital. Please note the hospital for which you want this information.
- A description of how First Priority Health determines if a medical technology is experimental.
- A summary of the methods used to reimburse plan providers.
- A description of First Priority Health quality assurance program. Please describe your request in detail, include your child's name, address and phone number, and mail the request to:

Member Information
P.O. Box 226
120 Fifth Avenue
Pittsburgh, PA 15230

HOW WE DECIDE IF A TECHNOLOGY OR DRUG IS EXPERIMENTAL

Medical researchers constantly experiment with new medical equipment, drugs, and other technologies. They also look for new applications for existing technologies. These could be for medical and behavioral health procedures, drugs, and devices.

A panel of medical professionals must evaluate these new technologies and new applications for existing technologies for:

- Safety
- Effectiveness
- Product efficiency

We may recommend that the technology be considered a medical practice and a covered benefit. Or the technology may be considered "experimental or investigative." This technology is not generally covered. We may also re-evaluate it in the future.

EVALUATING NEW DRUGS

A Pharmacy and Therapeutics (P&T) Committee composed of network-employed pharmacists and physicians evaluates new drugs based on items such as:

- National and international data
- Current research
- Opinions from leading clinicians

The review process addresses factors such as:

- Safety
- Drug effectiveness
- Unique value
- Patient compliance
- Local physician and specialist input
- Financial impact of the drug

The P&T Committee then makes a recommendation.

You may decide to pursue an experimental or investigative treatment. If a service you are going to receive may be experimental or investigational, find out if it's covered. You, the hospital, or a professional provider can call Member Service about coverage.

HOW WE PROTECT YOUR RIGHT TO CONFIDENTIALITY

At First Priority Health, we have established policies and procedures to protect the privacy of our members' protected health information from unauthorized or improper use.

As permitted by law, First Priority Health may use or disclose protected health information for treatment, payment and health care operations, such as: claims management, routine audits, coordination of care, quality assessment and measurement, case management, utilization review, performance measurement, customer service, credentialing, medical review and underwriting.

With the use of measurement data, we are able to manage members' health care needs, even targeting certain individuals for quality improvement programs, such as health, wellness and disease management programs.

If we ever use your protected health information for non-routine uses, we will ask you to give us your permission by signing a special authorization form, except with regard to court orders and subpoenas.

You have the right to access the information your doctor has been keeping in your medical records and any such request should be directed first to your network physician.

You benefit from many safeguards we have in place to protect the use of data and personal health information (PHI), including oral PHI, that we maintain from unauthorized or improper use. This includes requiring First Priority Health employees to sign statements in which they agree to protect your confidentiality, not discussing PHI outside of our offices (e.g., in hallways or elevators), verifying your identity before we discuss PHI with you over the phone, using computer passwords to limit access to your PHI, and including confidential language in our contracts with doctors, hospitals, vendors and other health care providers.

Our Privacy Department reviews and approves policies regarding the handling of confidential information.

Recognizing that you have a right to privacy in all settings, we even inspect the privacy of examination rooms when we conduct on-site visits to physicians' offices. It's all part of safeguarding the confidentiality of your protected health information.

YOUR CHILD'S CHIP DENTAL BENEFITS

This section describes your child's CHIP dental benefits.

DEFINITIONS

1. **Coordination of Benefits ("COB")** — A method of integrating benefits for Covered Services under more than one plan to prevent duplication.
2. **Cosmetic** — Those procedures which are not Dentally Necessary and which are undertaken primarily, in the opinion of the Group, to improve or otherwise modify the member's appearance, when the cause is not related to accidental injury.
3. **Covered Service(s)** — A service or supply specified in this Member Handbook for which benefits will be covered when rendered by a dentist, or if specifically approved by the Group.
4. **Dentally Necessary** — A dental service or procedure as determined by a dentist to either establish or maintain a patient's dental health. Such determinations are based on the professional diagnostic judgment of the dentist and the standards of care that prevail in the professional community. The determination as to when a dental service is necessary shall be made by the dentist in accordance with guidelines established by the Group. In the event of any conflict of opinion between the dentist and the Group as to when a dental service or procedure is necessary, the opinion of the Group shall be final.
5. **Effective Date** — The date on which coverage for the member begins.
6. **Experimental or Investigative** — The use of any treatment, procedure, facility, equipment, drug, or drug us device or supply which the Group, relying on the advice of the general dental community which includes, but is not limited to, dental consultants, dental journals and/or governmental regulations, determines are not acceptable standard dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval which approval has not been granted at the time the services were rendered.
7. **Group** —CHIP dental program administered by United Concordia Companies Inc.
8. **Limitation(s)** — The maximum frequency or set forth in the Schedule of Exclusions and Limitations incorporated by reference into this book.
9. **Maximum(s)** — The greatest amount the Group is obligated to pay for Covered Services during a specified period.
10. **Maximum Allowable Charge** —The maximum amount the Plan will allow for a Covered Service.
11. **Non-Participating Dentist** — A dentist who has not signed a contract with the United Concordia PA CHIP Network.
12. **Participating Dentist** — A dentist who has executed a Participating Dentist Contract with the United Concordia PA CHIP Network.
13. **Plan** — Dental benefits pursuant to this book.
14. **Member** — An individual who meets the eligibility requirements for CHIP.
15. **Pretreatment Estimate** — The review by the Plan of a Treatment Plan to determine the

coverage for services in accordance with this book, the Schedule of Exclusions and Limitations, and the Plan allowance for such services.

16. **Termination Date** — The date on which the dental benefits are no longer in effect.
17. **Treatment Plan(s)** — The written report of a series of procedures recommended for the treatment of a specific dental disease, defect or injury, prepared for a member by a dentist as a result of an examination.

AMENDMENT

Except as otherwise herein provided, this Member Handbook may be amended, changed or modified only in writing and attached hereto as part of this book.

COVERED SERVICES

Services provided under the Plan will be according to this book and/or the Schedule of Exclusions and Limitations. Certain services may be subject to Coinsurances, Deductibles, Maximums, Limitations and Waiting Periods as listed in this book and/or Schedule of Exclusions and Limitations. Coinsurances, Deductibles, Maximums, Limitations and Waiting Periods as listed will be reviewed periodically and may be adjusted.

Participating Dentists have agreed to accept a Maximum Allowable Charge as payment in full for Covered Services and to complete and submit claim forms (proofs of loss) for those members receiving Covered Services. Upon receipt of a claim from a Participating Dentist, the Plan will reimburse the Participating Dentist directly. Participating Dentists will make no additional charge to members for Covered Services except in the case of certain Coinsurances or amounts exceeding the Maximums referred to in this book. When Plan payment of the Maximum has been met, payment to the Participating Dentist will be the responsibility of the member.

When a Non-Participating Dentist performs Covered Services, the member will be responsible for completing and submitting claim forms. Members may owe any balance due after the Plan pays. A Pretreatment Estimate is required for specific procedures as outlined in the covered benefits and is used by the Group to determine the extent of Covered Services of members. Substantiating material, such as radiographs and study models, must be submitted to estimate benefits when requested by the Group. If substantiating material requested by the Group to make a Pretreatment Estimate is not submitted, the Group reserves the right to determine benefits payable, taking into account alternative procedures, services or courses of treatment, based upon accepted standards of dental practice. Any amount estimated by the Group shall be subject to such adjustments by the Group at the time of final payment in order to correct any mathematical errors and to comply with the member's Plan in effect at the time the Covered Service is completed.

The Group shall not be liable under this coverage for any Covered Services, including those Covered Services determined by a Pretreatment Estimate, which are performed at a time the members' Plan is no longer in effect.

NOTICE OF CLAIM

Written notice of claim must be given to the Group within twenty (20) days after the occurrence or commencement of any loss covered by the Plan, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the member to the Group, or to any authorized agent of the Group, with information sufficient to identify the member, shall be deemed notice to the Group.

CLAIM FORMS

The Group, upon receipt of a notice of claim, will furnish to the member for delivery to such person such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after the Group received notice of any claim under the Plan, the person making such claim shall be deemed to have complied with the requirements of the Plan as to proof of loss upon submitting within the time fixed in the Plan for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

The Group will provide claim forms to, and accept claims for, filing proof of loss submitted by a custodial parent of an eligible child who is the subject of a court or administrative order relating to provision of health care coverage. If services are provided by a Non-Participating Dentist, the Group will make payments directly to such custodial parent or to the Pennsylvania Department of Human Services if benefits are payable under Medical Assistance.

PROOF OF LOSS

Written proof of loss must be furnished to the Group at its said office in case of claim for loss for which this Plan provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the Group is liable and in case of a claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

The acknowledgment by the Group of the receipt of notice given or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the Group in defense of any claim arising under such Plan.

TIMELY PAYMENT OF CLAIMS

All benefits payable under this Plan for any loss other than loss for which this Plan provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Plan provides periodic payment will be paid quarterly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS

All benefits under this Plan shall be payable to the Participating Dentist or the Insured Person, or to his designated beneficiary or beneficiaries, or to his estate, except that if the member is a minor or otherwise not competent to give a valid release, such benefits may be made payable to his custodial parent, guardian or other person actually supporting him. All or a portion of any indemnities provided by this Plan on account of dental services may, at the option of the Group and unless the member requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the dental office rendering such services.

DENTAL COMPLAINT AND GRIEVANCE PROCESS

Procedures to appeal dental benefit decisions follow Act 68 legislation, which offers three levels of review, including a final review process at the Department of Health. Information on how to file an appeal will be included on your child's dental Explanation of Benefits anytime a service or benefit is denied. Please refer to the Table of Contents in this book for Complaint and Grievance Process information. You can call UCCI Dental Customer Service at 1-800-332-0366 for additional information on filing an appeal.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the Plan prior to the expiration of 60 days after written proof of loss has been filed in accordance with the requirements of the Plan. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

EXTENSION OF BENEFITS

The Group will extend coverage for completion of a dental procedure, requiring two or more visits on separate days, for a period of 90 days after termination.

WORKERS' COMPENSATION

When a member is eligible for Workers' Compensation benefits through the member's employer, the Group may exclude expenses for injuries, which are covered through the member's Workers' Compensation benefits. Therefore, if the Group provides services that are covered by a Workers' Compensation Plan, the Group has the right to obtain reimbursement. The member must provide the assistance necessary, including providing information and signing necessary documents, for the Group to receive reimbursement. The member must not do anything that may limit the Group's reimbursement.

COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies to this Plan when a member has dental care coverage under more than one Plan. 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.

ASSIGNMENT AND DELEGATION

The Group may assign this coverage and its rights hereunder and delegate its duties hereunder to any entity into which it is merged or which substantially acquires all its assets.

DENTAL BENEFITS

CHIP covers dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions. There are no copayments for dental services, and no referrals are needed from your PCP to make an appointment, so making sure your child gets high-quality dental care couldn't be easier. Your CHIP dental benefits are administered by United Concordia Companies, Inc. ("United Concordia"), which is an independent company that does not provide First Priority Health products or services. United Concordia is solely responsible for the products it provides.

Tooth decay is the most common chronic childhood disease. Help prevent your child from suffering the effects of tooth decay by encouraging them to practice good oral hygiene daily and taking them to see the dentist for regularly scheduled checkups even if their teeth appear to be healthy.

Benefit Category[1]	**CONCORDIA FLEX PLAN** **In-Network[2] and Out-of-Network**	
Exams	100%	
Bitewing X-rays		
All Other X-rays		
Cleanings & fluoride Treatments		
Sealants		
Palliative Treatment		
Class II – Basic Services		
Basic Restorative (Fillings)	100%	
Simple Extractions		
Space Maintainers		
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures		
Endodontics		
Nonsurgical Periodontics		
Surgical Periodontics		
Complex Oral Surgery[3]		
General Anesthesia		
Class III – Major Services		
Inlays, Onlays, Crowns	100%	
Bridges		
Dentures		
Implants		
Orthodontics for any age (when medically necessary)		
Diagnostic, Active, Retention Treatment	100%	Out-of-Network Not Covered

Maximums and Deductibles	
Annual Program Deductible (per person/per family)	None
Annual Program Maximum (per person)	$0
Lifetime Orthodontic Maximum (per person)	$0

Representative listing of covered services – You should contact United Concordia Member Services at 1-800-332-0366 for detailed information regarding covered benefits, exclusions and limitations that may apply.

1. *Eligible CHIP members only to age 19.*
2. *Reimbursement is based on our schedule of maximum allowable charges (MACs). Network dentists agree to accept our allowances as payment in full for covered services. Non-network dentists may bill the member for any difference between our allowance and their fee (also known as balance billing. United Concordia Dental's exclusions and limitations apply.*
3. *May be covered under Medical Benefits.*

WHO CAN MY CHILD SEE FOR DENTAL CARE?

You may make an appointment with any participating United Concordia dentist in the PA CHIP network who has enrolled and received a PROMISe identification number. You may find a list of United Concordia providers on the United Concordia website at **ucci.com/pachip** by clicking on **Select a PA CHIP dentist** or by calling United Concordia Customer Service at 1-800-332-0366.

If you need help finding a dental provider or getting an appointment, please call United Concordia Member Services at 1-800-332-0366 and someone will assist you.

CAN MY CHILD RECEIVE SERVICES FROM A NON-PARTICIPATING DENTAL PROVIDER?

Yes, except for orthodontics treatment. Orthodontic treatment must be provided by a participating United Concordia Orthodontist. If you take your child to a non-participating dentist for other than orthodontic treatment, you will be responsible for paying the difference between the non-participating dentist's charge and the allowance for covered services.

HOW MUCH DOES DENTAL CARE COST?

Except in the case of an emergency, in order for the dental benefit to be completely covered by CHIP, dental care must be provided by a dentist who is a participating United Concordia provider. Covered dental benefits must be provided by a participating provider and approved as required by United Concordia.

Some non-participating dental providers will expect payment in full for services at the time of the visit. In this case, it will be your responsibility to pay the bill, and then submit the bill to United Concordia and request reimbursement. You will be sent a check for the allowed

amount of the covered services your child received. This check may be less than the amount you paid the non-participating dentist.

In a case involving a covered service in which the member's parent selects a more expensive course of treatment than is customarily provided for the dental condition, payment under this benefit will be based on the charge allowance for the lesser procedure. In this case, the dentist may choose to balance bill you for the difference between the charge of the actual service rendered and the amount received from United Concordia.

WHAT DENTAL SERVICES ARE NOT COVERED BY CHIP?

Dental services performed for cosmetic purposes rather than medical necessities are not covered. Additional treatment that is needed due to non-compliance with prescribed dental care is not covered.

WHAT DENTAL SERVICES ARE COVERED BY CHIP?

As long as services are provided within the dental benefit limits, your child is eligible to have a routine examination and cleaning once per six months, with the exception of a member under the care of a medical professional for pregnancy, who shall be eligible for one additional prophylaxis during pregnancy, completely free of cost when provided by a participating dentist.

Your child is eligible for a number of other dental benefits as well. Some dental benefits are restricted to certain age groups, may be limited by how often your child may receive them, may be restricted to a particular facility setting or may require prior authorization to determine whether the service is medically necessary for your child. You should contact United Concordia Member Services at 1-800-332-0366 for detailed information regarding specific benefit limitations that may apply to non-routine services.

Dental-related services your child may be eligible to receive are listed below. Certain services require prior authorization and may only be available if they are determined to be medically necessary and appropriate for your child.

Diagnostic Services

- Routine examinations — once per a six-month period
- Panoramic X-rays, including full mouth X-rays — once per 3 years
- Bitewing X-rays once per a six-month period

Preventive Services

- Routine prophylaxis (including cleaning, scaling and polishing of teeth) — once in a six-month period with the exception of a member under care for a pregnancy — one additional cleaning is available in the benefit period
- Topical application of fluoride — three per calendar year
- Plaque control programs and oral hygiene education

- Sealants — limited to permanent molars free from cavities and/or restorations. One treatment per tooth per three years, except when visible evidence of clinical failure is evident.
- Fixed space maintainers

Restorative Care
- Amalgam (silver) and Resin-based (white) composite restorations
- Occlusal Guards by report — 1 in 12 months for members 13 years and older

Endodontic Services (prior authorization mandatory)
- Pulpotomies — deciduous teeth only
- Pulpal Therapy — incisors up to age six 6 and cuspids and molars up to age 11 — once per tooth per two years
- Root canals — permanent teeth only
- Apicoectomy

Periodontic Services
- Periodontal scaling and root planing — four or more teeth per quadrant once per 24 months per area of the mouth
- Periodontal maintenance — four services in 12 months
- Gingival Flap Procedure — one service per quadrant per 36 months
- Osseous Surgery — one service per quadrant every 36 months
- Gingivectomy or gingivoplasty — one service per quadrant every three years
- Full mouth debridement — once per lifetime after three years from last cleaning

Prosthodontic (prior authorization mandatory)
- Full and Partial Removable Dentures — limited — once every five years
- Fixed Partials Limited — replacement to once every five years
- Repairs/relines/adjustments
- Crowns — Only if the tooth cannot be restored with another material (e.g., amalgam); limited to 1 every 60 months; Pre-op X-ray required
- Implants — one per tooth per five years

Oral Surgery
- Simple Extractions

Oral and Maxillofacial Surgery (prior authorization mandatory)
- Surgical extractions not covered by the member's medical oral surgery benefit, including those involving wisdom teeth
- Soft tissue wisdom teeth
- Brush biopsies
- Alveoloplasties
- Removal of tooth-related/non-tooth-related cysts
- Incision and drainage of abscesses
- Oroantral fistula closure

- Surgical exposure and placement of device for eruption facilitation
- Tooth reimplantation and/or stabilization of an accidentally evulsed tooth
- Frenulectomy/Frenotomy
- Removal of exostosis; mandibular or palatal tori; reduction of osseous tuberosities

Orthodontic Services (prior authorization mandatory and must be provided by a participating orthodontist)

- Evaluation for braces — limited to once per benefit period
- Comprehensive orthodontic treatment — limited to once per lifetime
- Orthodontic retention
- Only covered if your child is diagnosed with a significant handicapping malocclusion or other severe condition (such as cleft palate) and orthodontic treatment is determined to be the only method capable of restoring your child's oral structure to health and function

Adjunctive General Services

- General anesthesia in conjunction with a covered service
- Intravenous conscious sedation
- Non-intravenous conscious sedation-under age 13 when medically necessary
- Inhalation of Nitrous Oxide/anxiolysis, analgesia

Emergency Services

- Temporary crown for treatment of a fractured tooth
- Apicoectomy/periradicular surgery
- Palliative treatment of dental pain

Dental Specific Exclusions:

- Claims involving covered services in which the dentist and the member select a more expensive course of treatment than is customarily provided by the dental profession and consistent with sound professional standards of dental practice for the dental condition concerned
- Dentures and other prosthodontics unless medically necessary as a result of surgery for trauma or a disease process that renders the dental condition untreatable by a less intensive restorative procedure
- Implantology and related services
- Duplicate and temporary devices, appliances and services
- Gold foil restorations
- Labial veneers
- Laminates done for cosmetic purposes
- Oral surgery that is covered under the medical portion of the benefits
- Plaque control programs, oral hygiene education and dietary instruction
- Retainer replacement
- Orthodontics (braces) that do not meet the criteria required
- Procedures to alter vertical dimension and/or restore or maintain the occlusion, attrition and restoration for malalignment of teeth

- Any treatment that is necessitated by lack of cooperation by the member or the eligible member's family with the dentist or noncompliance with prescribed dental care
- A contract between the member or member's family and dentist prior to the effective date of coverage

LIMITATIONS

If an eligible child transfers from the care of one dentist to that of another dentist during the course of treatment, or if more than one dentist performs covered services for one dental procedure, the Plan shall be liable for not more than the amount that it would have been liable for had but one dentist performed the covered service.

In all cases involving covered services in which the dentist and an eligible child or the eligible child's family select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, payment under this benefit will be based on the charge allowance for the lesser procedure.

A contract between the eligible child or the eligible child's family and dentist prior to the effective date of coverage under the contract is not invalidated by a subsequent contract made between the Plan and/or the eligible child or the eligible child's family and/or dentist. The eligible child or the eligible child's family will be liable for any difference due to the dentist under such a contract after the Plan liability has been satisfied. Any additional treatment that is necessitated by lack of cooperation by the eligible child or the eligible child's family with the dentist or noncompliance with prescribed dental care that results in additional liability will be the responsibility of the eligible child or the eligible child's family.

IMPORTANT DENTAL PHONE NUMBERS AND ADDRESSES

The CHIP dental benefits plan is administered by United Concordia and all communications regarding your child's dental coverage should be directed to them.

When writing to United Concordia, be sure to reference your child's name (last and first), your child's Social Security number and the name of the group (CHIP) that your child is enrolled under.

OTHER QUESTIONS

Call United Concordia: 1-800-332-0366 Weekdays 8 a.m.–6 p.m. EST
Hearing-Impaired callers please call:
1-800-345-3837

United Concordia Dental Claims Submissions:
Dental Claims
P.O. Box 69421
Harrisburg, PA 17106-9421

YOUR CHILD'S CHIP VISION BENEFITS

CHIP covers vision services for children. These benefits are administered by Davis Vision, an independent company that does not provide First Priority Health products or services. Davis Vision is solely responsible for the products it provides. Visits for routine eye exams and glasses or medically necessary contacts are covered at the highest level when received from a Davis Vision participating provider who has enrolled and received a PROMISe identification number. Your child does not need a referral from a PCP to see a vision provider. There are no copayments for routine eye examinations when received from a Davis Vision participating provider. If any vision service is provided under the medical benefit for a diagnosis of cataracts, keratoconus, or aphakia, a copayment may apply.

The benefit grid below displays the cost sharing for your child's vision services.

Highmark CHIP Program

In-Network Benefits	Plan Design
Frequency – Once Every:	**Fashion**
Eye Examination inclusive of Dilation (when professionally indicated)	6 Months
Spectacle Lenses	6 Months
Frame	12 Months
Contact Lens Evaluation, Fitting & Follow-Up Care (in lieu of eyeglasses)	6 Months
Contact Lenses (in lieu of eyeglasses)	6 Months
Copayments	
Eye Examination	$0
Spectacle Lenses	$0
Contact Lens Evaluation, Fitting & Follow-Up Care (in lieu of eyeglasses)	$0
Eyeglass Benefit – Frame	
Non-Collection Frame Allowance (Retail):	Up to $130 Plus a 20% discount on any overage **
Davis Vision Frame Collection * (in lieu of Allowance):**	
Fashion level	Included
Designer level	$15
Premier level	$35
Eyeglass Benefit - Spectacle Lenses	**Member Charges**
Clear plastic or glass single-vision, bifocal, trifocal or lenticular lenses (any Rx)	Included
Tinting of Plastic Lenses	Included
Scratch-Resistant Coating	Included
Oversized Lenses	Included
Polycarbonate Lenses (Children / Adults)	Included
Ultraviolet Coating	Included
Glass Grey #3 Prescription Lenses	Included
Blended Segmented Lenses	$20
Intermediate Lenses	$30

Anti-Reflective (AR) Coating (Standard/Premium/Ultra)	$35/$48/$60
Ultimate Anti-Reflective (AR) Coating	$85
Progressive Lenses (Standard/Premium/Ultra)	$50/$90/$140
Ultimate Progressive Lenses	$175
High-Index Lenses– 1.67	$55
High-Index Lenses – 1.74	$120
Polarized Lenses	$75
Plastic / Glass Photochromic Lenses	$65 / $20
Scratch Protection Plan: Single Vision | Multifocal Lenses	$20|$40
Contact Lens Benefit (in lieu of eyeglasses)	
Non-Collection Contact Lenses: Materials Allowance	Up to $130 Plus a 15% discount on any overage **
- Evaluation, Fitting & Follow-Up Care – Standard Lens Types (in lieu of eyeglasses)	15% Discount **
- Evaluation, Fitting & Follow-Up Care – Specialty Lens Types (in lieu of eyeglasses)	15% Discount **
Collection Contact Lenses *** (in lieu of Allowance): Materials - Disposable - Planned Replacement	 4 boxes/multi-packs 2 boxes/multi-packs
- Evaluation, Fitting & Follow-up Care	Included
Visually Required Contact Lenses (with prior approval) - Materials, Evaluation, Fitting & Follow-Up Care	Included

Out-of-Network Reimbursement Schedule: up to			
Eye Examination: $40	Single Vision Lenses: $39	Trifocal Lenses: $72	Elective Contact Lenses: $50
Frame: $55	Bifocal/Progressive Lenses: $56	Lenticular Lenses: Single Vision / Bifocal: $39 / $56	Visually Required CL: $225

** Additional discounts not applicable at Walmart, Sam's Club or Costco locations.

*** Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select torics and multifocals.

Note: Additional discounts **may be** available from participating providers.

Replacement of lost, stolen or broken frames and lenses (one original and one replacement per calendar year, when deemed medically necessary).

Note: In some instances, participating providers charge separately for the evaluation, fitting or follow-up care relating to contact lenses. Should this occur and the value of the Contact Lenses received is less than the allowance, you may submit a claim for the remaining balance (the combined reimbursement will not exceed the total allowance).

Expenses in excess of $600 for medically necessary contact lenses, with pre-approval. These conditions include: Aphakia, pseudophakia or keratoconus, if the patient has had cataract surgery or implant, or corneal transplant surgery, or if visual activity is not correctable to 20/40 in the worse eye by use of spectacle lenses in a frame but can be improved to 20/40 in the worse eye by use of contact lenses.

Low Vision:

One comprehensive low vision evaluation every 5 years, with a maximum charge of $300; maximum low vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care — four visits in any five-year period, with a maximum charge of $100 per visit. Providers will obtain the necessary pre-authorization for these services.

HOW DOES MY CHILD RECEIVE SERVICES FOR VISION CARE?

You may make an appointment with any participating Davis Vision provider. To obtain the list of network providers, visit the Davis Vision website at **davisvision.com** or call Davis Vision at **1-800-999-5431.**

CAN MY CHILD RECEIVE SERVICES FROM A NON-PARTICIPATING VISION PROVIDER?

Your child may receive services from a non-participating provider, although your child will receive the greatest value and maximize their benefit dollars if you select a participating provider. If you take your child to a non-participating provider, you must pay the provider directly for all charges and then submit a claim for reimbursement. **Out of Network coverage only applies if child is unexpectedly out of the area, e.g. on vacation, and they need replacement contacts or eyeglasses, their expenses can be sent to the plan for reimbursement.**

The member is responsible to pay the provider for any amount over the plan maximum. All services should be submitted at the same time, as you can only submit one claim for reimbursement per benefit cycle. Additional benefits may also be available. Please contact Davis Vision to learn more.

IMPORTANT PHONE NUMBERS AND ADDRESSES

The CHIP vision benefit plan is administered by Davis Vision, and all communication regarding your child's vision coverage should be directed to them.

Call Davis Vision: 1-800-999-5431
Member Service Representatives are available:
Monday through Friday, 8 a.m to 11 p.m., Eastern Time, Saturday, 9 a.m. to 4 p.m., Eastern Time
Sunday, noon to 4 p.m, Eastern Time
If you need to use TTY services, you may do so by calling 1-800-523-2847.

Davis Vision Claims Submissions:
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

TAKE CHARGE OF YOUR CHILD'S HEALTH

Take an active role in your child's health. Be well-informed about current health topics. Get answers to your health care questions. CHIP gives your child so much more than health care coverage ... it offers a full array of member services and resources to help you make the decisions you need to help your child live a healthy lifestyle.

MEMBER NEWSLETTER KEEPS YOU INFORMED

First Priority Health makes it easy for you to stay up to date on the latest care and coverage developments. Your quarterly member newsletter contains news about your coverage, a wide variety of health and preventive care articles and "stay healthy" tips. Watch for your copy in the mail.

OUR WEBSITE OFFERS TOOLS, CLASSES AND RESOURCES

The Highmark CHIP website offers a wealth of online tools and resources to help you manage your child's coverage and improve or maintain your child's health.

To manage your child's coverage, you can:

- Review your benefits
- Search for a provider
- Get information about the costs of medical services
- Compare costs for procedures
- Track claims and health care costs
- Rate your child's physicians with the Patient Experience Review
- Maintain a Personal Health Record to store and track your child's vital health information
- Order a replacement identification card

To improve or maintain your child's health, you can:

- Research health conditions and treatment options
- Work with digital health assistants to provide guidance and support to help your child lose weight, reduce stress, quit smoking, get in better shape or manage a health condition
- Use trackers to record your child's progress in managing health measures, like blood pressure, cholesterol and weight
- Learn about medical symptoms, what to do about them and when to contact a doctor

- Access articles, videos and information links on modifiable health risks like alcohol use, blood pressure and blood sugar

To take advantage of these tools and resources, go to **highmarkchip.com** and log into your Highmark account**.**

WEBSITE VERIFICATION

On your first visit to the website, you will be asked to register, choose a login ID and password and select a security question and answer. Once you are registered, you can request that you receive your PIN immediately by email, text message or phone. The PIN is a security enhancement designed to protect your private account information.

When you receive your PIN, log in with your ID and password and enter your PIN on the PIN verification page. When your PIN is confirmed, you will be able to view all features of the website, including your confidential and protected health information. You will only need to use the PIN the first time you log into the website. Once you are verified, all you need is your ID and password to fully access a variety tools and resources about your coverage, your spending, your health, choosing providers and other health topics.

MY CARE NAVIGATOR

If you need help finding a doctor, scheduling appointments with a hard-to-reach specialist, or transferring medical records from one physician to another for your child, My Care Navigator can help.

With My Care Navigator, a health navigation and advocacy service, you can talk to a dedicated health advocate who addresses and resolves these and other health care and coverage-related issues for you. This patient advocate service is available as part of your child's CHIP health care coverage.

My Care Navigator can help you to:

- Find the right primary care physician
- Find the right specialist
- Get scheduled for a prompt appointment
- Have your child's medical records transferred
- Understand your child's prescription drug coverage
- Receive help in getting a second opinion
- Get maximum value from your child's health coverage

To contact a health advocate, any time of the day, any day of the week, call **1-888-BLUE-428** and wait for the prompt to My Care Navigator.

CALL BLUES ON CALL FOR 24-HOUR HEALTH INFORMATION AND SUPPORT

Your coverage includes *Blues On Call*, a comprehensive health information and support program focused on your total health care needs. Calling *Blues On Call* connects you to a specially trained registered nurse Health Coach, who will provide you with health care assistance on any health matter that concerns you, such as a recent diagnosis, surgery or scheduled medical test.

For answers to health care questions and for help in making your health care decisions, call *Blues On Call* anytime of the day or night, seven days a week, at **1-888-BLUE-3428 (1-888-258-3428).** Or contact a *Blues On Call* Health Coach at **highmarkchip.com**.

HELP YOUR CHILD TO QUIT TOBACCO

Highmark offers the How to Be Tobacco Free program that may help your child quit smoking, vaping, or chewing tobacco. The program offers a personal wellness coach who will guide you in developing a personalized quit plan and help you learn new skills through proven quit methods. There is no additional cost for this program.

Know the facts and tell your children:

- Every cigarette your child smokes shortens their life by 11 minutes.
- Ninety percent of all adult smokers started when they were kids.
- Chewing tobacco is a major contributor to cavities and gum disease, heart problems, mouth sores and oral cancer.
- Cigarette smoke delivers to your body at least 75 known cancer-causing chemicals, tiny amounts of poisons such as arsenic and cyanide, and more than 4,000 other substances.
- One-fifth of all deaths in the United States are smoking-related.
- According to the FDA, e-cigarettes are not a safer alternative to smoking in that they still emit nicotine and have other known toxic substances including cancer-causing agents like acrolein.

Source: www.cdc.gov/tobacco

Nicotine is the addictive substance in chewing tobacco, cigarettes, and e-cigarettes. Many kids who use tobacco products, including e-cigarettes, don't understand the long-term effects. Nicotine exposure during adolescence affects a person's brain development, mood, memory, concentration, as well as the heart, lungs, digestive and nervous systems. Over time, serious chronic conditions may develop, such as cancer, heart disease and emphysema. E-cigarette's are not effective in helping to quit. In fact, youth who use e-cigarettes are more likely to go onto using regular cigarettes.

Through the program, you will learn important skills and strategies to:

- Discuss tobacco use and triggers
- Learn from proven quit methods
- Prepare to cope with cravings
- Cope with stress
- Create a quit plan that includes health lifestyle tips

For more information or to enroll, you or your child can call 1-800-650-8442 to get connected with a wellness coach.

ENJOY MEMBER DISCOUNTS

Our wellness discounts offer special savings exclusively for members. Discounts are available from leading national companies in a wide range of categories, just by showing your identification card, or downloading and printing a coupon or code. To find a practitioner, go to **highmarkchip.com** and select Health and Wellness. You are responsible for paying the practitioner directly at the time the service is received.

BABY BLUEPRINTS®

If your child does not qualify for medical assistance, you may want to have them enrolled in Baby Blueprints.

If you are expecting a baby, this is an exciting time for you. It's also a time when you have many questions and concerns about you and your developing baby's health.

To help you understand and manage every stage of pregnancy and childbirth, Highmark offers the Baby Blueprints Maternity Education and Support Program.

By enrolling in this free program you will have access to online information on all aspects of pregnancy and childbirth. Baby Blueprints will also provide you with personal support from a nurse Health Coach available to you throughout your pregnancy.

Easy Enrollment
Just call toll-free at 1-866-918-5267. You can enroll at any time during your pregnancy.

SIGN YOUR CHILD UP FOR A WELLNESS CLASS

Wellness and preventive health classes, such as personal nutrition coaching and stress management, are available at area locations. Call **1-800-879-2217** for locations near you and class offerings.

CHIP Notice of Privacy Practices

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

The Children's Health Insurance Program (CHIP) Program is run by the Commonwealth of Pennsylvania's Department of Human Services. The department hires private health insurance companies to provide your insurance coverage under the CHIP program. You have also received a privacy notice from the company you chose to provide your health benefits. That company determines your eligibility for CHIP, pays claims for your care, and performs other activities necessary to administer your health plan.

Please note that the CHIP program has very limited access to your personal health information (also known as "PHI"). *We do not receive or keep a file containing your medical records. In most cases, your health insurance company or health care providers may possess the PHI that you are seeking.* However, the CHIP program will *also* have access to a limited amount of your PHI. This notice explains how the CHIP program keeps this information confidential and private.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We are required to follow the terms of this notice. We reserve the right to change this notice. If we make an important change in our privacy policies or procedures, we will post a revised copy of the notice on our website and/or provide you with a new privacy notice by mail. You may request a paper copy of this notice at any time.

What is PHI?

PHI is any health or personal information that identifies you or your child as a CHIP enrollee. This includes:

- Your Name (or names of your children)
- Member ID Number
- Telephone Number
- Address
- Date of Birth
- Social Security Number

Why is my PHI used and disclosed by CHIP?

Under HIPAA (the federal law governing privacy of health information), we may use or disclose your PHI without your consent or authorization for treatment, payment and health care operations. There are different reasons why CHIP Program staff may need to use or disclose your PHI.

- **For eligibility purposes:** We may have access to your PHI when coordinating your eligibility for the program with the health insurance company you chose to provide your benefits. For example, we may use or see your PHI when we perform eligibility reviews.
- **For operating our programs:** We may use or disclose information in the course of our ordinary business as we manage the CHIP Program. For example, we may use your PHI to contact you about additional opportunities or programs that may be available to you as a CHIP member.
- **For public health activities:** We may report PHI to other government agencies who track things such as contagious diseases, immunization information, and other diseases, such as cancer.

- **For law enforcement purposes and as required by legal proceedings:** We will disclose information to the police or other law enforcement authorities as required by court order.
- **For government programs:** We may disclose information to a government agency or other program, such as Medicaid, that needs to know if you are enrolled in CHIP.
- **For national security:** We may disclose information requested by the federal government when they are investigating something important to protect our country.
- **For public health and safety:** We may disclose information to prevent serious threats to health or safety of a person or the public.
- **For research:** We may disclose information for permitted research purposes and to develop reports. These reports do not identify specific people.
- **For reasons otherwise required by law:** We may use or disclose your PHI to the extent that the use or disclosure is otherwise required by law. The use or disclosure is made in compliance with the law and is limited to the requirements of the law.

Do other uses of my PHI require my authorization under HIPAA?

Yes. Any use of PHI not listed above requires you to sign a written authorization. For example, HIPAA requires that you provide a written authorization before a covered entity uses or discloses psychotherapy notes, uses PHI for marketing purposes, or sells your PHI. If you do sign a written authorization, you may revoke it any anytime (except to the extent that CHIP has already relied upon the authorization to release PHI).

What are my rights regarding my PHI?

As stated above, the CHIP program has very limited access to your PHI. However, you have the following rights regarding your PHI that CHIP uses and discloses. If we deny your request, we will provide you a written explanation for the denial and your rights regarding the denial decision.

- **Right to see and copy your PHI:** You have the right to see most of your PHI in our possession and to receive a copy for a small fee.
- **Right to correct and add information:** If you think some of the PHI we have is wrong, you may ask us in writing to correct or add new information and to send it to others who have received your PHI from us.
- **Right to receive a list of disclosures:** You have the right to receive a list of where your PHI has been sent by us, unless it was sent for purposes relating to treatment, payment, operating our programs, or if the law says we are not required to add the disclosure to the list.
- **Right to request restrictions on use and disclosure:** You have the right to ask us to restrict the use and disclosure of your PHI in our possession.
- **Right to request confidential communication:** You may ask us to communicate with you in a certain way or at a certain location. For example, you may ask us to contact you only by mail.
- **Right to be notified in case of a breach:** You will receive notification from us if there is a breach of your unsecured PHI.

May I ask CHIP to use or disclose my PHI?

Sometimes, you may need or want to have your PHI sent outside of the CHIP program. If so, you may be asked to sign an authorization form allowing us to send your PHI to your requested location. The authorization form tells us what, where and to whom the information will be sent. You may cancel or limit the amount of information sent at any time by letting us know in writing.

Do other laws also protect certain health information about me?

CHIP also follows other federal and state laws that provide additional privacy protections for the use and disclosure of information about you.

Whom do I contact about my rights, to ask questions about this notice or to file a complaint?

If you: wish to receive a paper copy of this notice; have a question about this notice; or want to file a complaint about how CHIP used or disclosed your PHI, you may write to the CHIP Program's Privacy Officer at:

PA Department of Human Services
CHIP
HIPAA Privacy Officer
1142 Strawberry Square
Harrisburg, PA 17120
(717) 346-1363

You may also file a complaint with the United States Secretary of Health & Human Services:

Region III
U.S. Department of Health & Human Services
Office for Civil Rights
150 S. Independence Mall West - Suite 372
Philadelphia, PA 19106-9111

There is no penalty for filing a complaint. Your benefits will not be affected or changed if you file a complaint. We cannot and will not retaliate against you for filing a complaint.

Last modified on June 21, 2016

HIGHMARK NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE ALSO DESCRIBES HOW WE COLLECT, USE AND DISCLOSE NONPUBLIC PERSONAL FINANCIAL INFORMATION.

Our Legal Duties

At Highmark Blue Cross Blue Shield, we are committed to protecting the privacy of your protected health information. “Protected health information” (PHI) is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, you or your child's employer or a health care clearinghouse that relates to:

(i) your past, present or future physical or mental health or condition;
(ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle and protect our members’ protected health information. We are required by applicable federal and state laws to maintain the privacy of your protected health information.

We also are required by the HIPAA Privacy Rule (45 C.F.R. parts 160 and 164, as amended) to give you this Notice about our privacy practices, our legal duties and your rights concerning your protected health information. We are also required to notify affected individuals following a breach of unsecured health information.

We will inform you of these practices the first time you become a Highmark customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice became effective September 23, 2013, and will remain in effect unless we replace it.

On an ongoing basis, we will review and monitor our privacy practices to ensure the privacy of our members’ protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this Notice. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will become effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. Before we make a material change in our privacy practices, we will change this Notice and notify all affected members in writing in advance of the change. Any changes to this notice will be posted on our website and we will further notify you of any changes in our annual mailing.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. Uses and Disclosures of Protected Health Information

In order to administer our health benefit programs effectively, we will collect, use and disclose protected health information for certain of our activities, including payment and health care operations.

A. Uses and Disclosures of Protected Health Information for Payment and Health Care Operations

The following is a description of how we may use and/or disclose protected health information about you for payment and health care operations:

Payment

We may use and disclose your protected health information for all activities that are included within the definition of "payment" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "payment," so please refer to 45 C.F.R. § 164.501 for a complete list.

For example:
We may use and disclose your protected health information to pay claims from doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and/or to issue explanations of benefits to the person who subscribes to the health plan in which you participate.

Health Care Operations

We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "health care operations," so please refer to 45 C.F.R. § 164.501 for a complete list.

For example:
We may use and disclose your protected health information to rate our risk and determine the premium for your health plan, to conduct quality assessment and improvement activities, to credential health care providers, to engage in care coordination or case management, and/or to manage our business.

B. Uses and Disclosures of Protected Health Information to Other Entities

We also may use and disclose protected health information to other covered entities, business associates or other individuals (as permitted by the HIPAA Privacy Rule) who assist us in administering our programs and delivering health services to our members.

(i) Business Associates

In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services (such as Member Service support, utilization management, subrogation or pharmacy benefit management). To perform these functions or to provide the services, business associates will receive, create, maintain, use or disclose

protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

(ii) Other Covered Entities
In addition, we may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain of their health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

II. Other Possible Uses and Disclosures of Protected Health Information
In addition to uses and disclosures for payment, and health care operations, we may use and/or disclose your protected health information for the following purposes:

A. To Plan Sponsors
We may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us regarding a member's question, concern, issue regarding a claim, benefits, service, coverage, etc. We may also disclose summary health information (this type of information is defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

B. Required by Law
We may use or disclose your protected health information to the extent that federal or state law requires the use or disclosure. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.

C. Public Health Activities
We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury or disability.

D. Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

E. Abuse or Neglect
We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence.

F. Legal Proceedings

We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information.

G. Law Enforcement

Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; or (2) it is necessary to locate or identify a suspect, fugitive, material witness or missing person.

H. Coroners, Medical Examiners, Funeral Directors and Organ Donation

We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

I. Research

We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

J. To Prevent a Serious Threat to Health or Safety

Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

K. Military Activity and National Security, Protective Services

Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

L. Inmates

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

M. Workers' Compensation

We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

N. Others Involved in Your Health Care

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

O. Underwriting

We may disclose your child's protected health information for underwriting purposes; however, we are prohibited from using or disclosing your child's genetic information for these purposes.

P. Health Information Exchange

We all participate in a Health Information Exchange (HIE). An HIE is primarily a secure electronic data sharing network. In accordance with federal and state privacy regulations, regional health care providers participate in the HIE to exchange patient information in order to facilitate health care, avoid duplication of services, such as tests, and to reduce the likelihood that medical errors will occur.

The HIE allows your health information to be shared among authorized participating healthcare providers, such as health systems, hospitals and physicians, for the purposes of Treatment, Payment or Healthcare Operations purposes. Examples of this health information may include:

- General laboratory, pathology, transcribed radiology reports and EKG Images
- Results of outpatient diagnostic testing (GI testing, cardiac testing, neurological testing, etc.)
- Health Maintenance documentation/Medication
- Allergy documentation/Immunization profiles
- Progress notes, Urgent Care visit progress notes
- Consultation notes
- Inpatient operative reports
- Discharge summary/Emergency room visit discharge summary notes

All participating providers who provide services to your child will have the ability to access your child's information. Providers that do not provide services to your child will not have access to your information. Information may be provided to others as necessary for referral, consultation, treatment or the provision of other healthcare services, such as pharmacy or laboratory services. All participating providers have agreed to a set of standards relating to their use and disclosure of the information available through the HIE. Your child's health information shall be available to all participating providers through the HIE.

You cannot choose to have only certain providers access your child's information. Patients who do not want their health information to be accessible through the HIE may choose not to participate or may "opt-out."

In order to opt-out, you must call the customer service number located on the back of your child's membership card. You should be aware, if you choose to opt-out, your child's health care providers will

not be able to access your child's health information through the HIE. Even if you chose to opt-out, your child's information will be sent to the HIE, but provider will not be able to access this information. Additionally, your opt-out does not affect the ability of participating providers to access health information entered into the HIE prior to your opt-out submission.

III. Required Disclosures of Your Protected Health Information
The following is a description of disclosures that we are required by law to make:

A. Disclosures to the Secretary of the U.S. Department of Health and Human Services
We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

B. Disclosures to You
We are required to disclose to you most of your protected health information that is in a "designated record set" (defined below) when you request access to this information. We also are required to provide, upon your request, an accounting of many disclosures of your protected health information that are for reasons other than payment and health care operations.

IV. Other Uses and Disclosures of Your Protected Health Information
Sometimes we are required to obtain your written authorization for use or disclosure of your child's health
information. The uses and disclosures that require an authorization under 45 C.F.R. § 164.508(a) are:

1. For marketing purposes
2. If we intend to sell your PHI
3. For use of Psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. An Authorization for use of psychotherapy notes is required unless:

    a. Used by the person who created the psychotherapy note for treatment purposes, or
    b. Used or disclosed for the following purposes:
        (i) the provider's own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;
        (ii) for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;
        (iii) if required for enforcement purposes;
        (iv) if mandated by law;
        (v) if permitted for oversight of the provider that created the note;
        (vi) to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or
        (vii) if needed to avert a serious and imminent threat to health or safety.

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

V. Your Individual Rights

The following is a description of your rights with respect to your protected health information:

A. Right to Access

You have the right to look at or get copies of your protected health information in a designated record set. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so; if you request the information in an electronic format that is not readily producible, we will provide the information in a readable electronic format as mutually agreed upon. You must make a request in writing to obtain access to your protected health information.

To inspect and/or copy your protected health information, you may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. The first request within a 12-month period will be free. If you request access to your designated record set more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. If you request an alternative format, we will charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure. We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request.

Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

B. Right to an Accounting

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment or health care operations. You should know that most disclosures of protected health information will be for purposes of payment or health

care operations. An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or submitting your request in writing to the Highmark Privacy Department, 1800 Center Street, Camp Hill, PA 17089. Your request may be for disclosures made up to six years before the date of your request, but in no event, for disclosures made before April 14, 2003.

The first list you request within a 12-month period will be free. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

C. Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing. We have the right to terminate this restriction; however, if we do so, we must inform you of this restriction. You may request a restriction by contacting us at the Customer Service phone number on the back of your identification card, or writing to the Highmark Blue Cross Blue Shield Privacy Department, 1800 Center Street, Camp Hill, PA 17089. In your request, tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

D. Right to Request Confidential Communications

If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. For example, you may ask that we contact you only at your work address or via your work email.

You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence by the alternative means or to the alternative location you want. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the subscriber of the health plan in which you participate.

In the event that a Confidential Communication is placed against you, you will no longer have the ability to access any of your child's health and/or policy information online.

E. Right to Request Amendment

If you believe that your protected health information is incorrect or incomplete, you have the right to request that we amend your protected health information. Your request must be

in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

F. Right to a Paper Copy of this Notice

If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this Notice in written form. Please contact us using the information listed at the end of this Notice to obtain this Notice in written form.

VI. Questions and Complaints

If you want more information about our privacy policies or practices or have questions or concerns, please contact us using the information listed below.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made to amend or restrict the use or disclosure of your protected health information or to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed below.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

For questions about this Privacy Notice, please contact:
Contact Office:Highmark Privacy Department
Telephone: 1-866-228-9424 (toll free) Fax:1-412-544-4320
Address: 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222

PART II – NOTICE OF PRIVACY PRACTICES (GRAMM-LEACH–BLILEY)

Highmark Blue Cross Blue Shield is committed to protecting its members' privacy. This notice describes our policies and practices for collecting, handling and protecting personal information about our members. We will inform each group of these policies the first time the group becomes a Highmark Blue Cross Blue Shield customer and will annually reaffirm our privacy policy for as long as the group remains a Highmark Blue Cross Blue Shield customer. We will continually review our privacy policy and monitor our business practices to help ensure the security of our members' personal information. Due to changing circumstances, it may become necessary to revise our privacy policy in the future. Should such a change be required, we will notify all affected customers in writing in advance of the change.

In order to administer our health benefit programs effectively, we must collect, use and disclose non-public personal financial information. Non-public personal financial information is information that identifies an individual member of a Highmark Blue Cross Blue Shield health plan. It may include the member's name, address, telephone number and Social Security number or it may relate to the member's participation in the plan, the provision of health care services or the payment for health care services. Non-public personal financial information does not include publicly available information or statistical information that does not identify individual persons.

Information we collect and maintain:

We collect non-public personal financial information about our members from the following sources:

- We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.

- We collect and create information about our members' transactions with Highmark Blue Cross Blue Shield, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits/payments (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances. Information we may disclose and the purpose: We do not sell any personal information about our members or former members for marketing purposes. We use and disclose the personal information we collect (as described above) only as necessary to deliver health care products and services to our members or to comply with legal requirements.

- Some examples are:

- We use personal information internally to manage enrollment, process claims, monitor the quality of the health services provided to our members, prevent fraud, audit our own performance or to respond to members' requests for information, products or services.

- We share personal information with our affiliated companies, health care providers, agents, other insurers, peer review organizations, auditors, attorneys or consultants who assist us in administering our programs and delivering health services to our members. Our contracts with all such service providers require them to protect the confidentiality of our members' personal information.

- We may share personal information with other insurers that cooperate with us to jointly market or administer health insurance products or services. All contracts with other insurers for this purpose require them to protect the confidentiality of our members' personal information.

- We may disclose information under order of a court of law in connection with a legal proceeding.

- We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.

- We may disclose information under a subpoena or summons to government agencies that investigate fraud or other violations of law. How we protect information: We restrict access to our members' non-public personal information to those employees, agents, consultants and health care providers who need to know that information to provide health products or services. We maintain physical, electronic and procedural safeguards that comply with state and federal regulations to guard non- public personal financial information from unauthorized access, use and disclosure.

For questions about this Privacy Notice, please contact:

Contact Office:Highmark Privacy Department

Telephone: 1-866-228-9424 (toll free) Fax:1-412-544-4320

Address: 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222

CONTACT INFORMATION

You may, upon written request, receive information on any of the following:

- A list of the names, business addresses and official positions of the membership of the First Priority Health Board of Directors and Officers.
- The procedures adopted to protect the confidentiality of medical records and other member information.
- A description of the credentialing process for health care providers.
- A list of the participating health care providers affiliated with a specific hospital. Please note the hospital for which you want this information.
- A description of how First Priority Health determines if a medical technology is experimental.
- A summary of the methods used to reimburse plan providers.
- A description of First Priority Health's quality assurance program.

Please describe your request in detail, include your child's name, address and phone number, and mail the request to:

Member Information
Highmark Blue Cross and Blue Shield
P.O. Box 226
120 Fifth Avenue
Pittsburgh, PA 15230

For questions about premium payments, billing, enrollment or eligibility:

First Priority Health
CHIP Eligibility Review Unit
120 Fifth Avenue Suite 2335
Pittsburgh, PA 15222
1-800-543-7105
1-877-323-8480 TTY
1-866-308-1253 Fax

For CHIP premium payments:

Highmark
P.O. Box 643306
Pittsburgh, PA 15264-3306
1-800-543-7105
1-877-323-8480 TTY

For questions about medical claims, covered benefits or the provider network:

First Priority Health
Penn Avenue Place 501 Penn Avenue
Pittsburgh, PA 15222
1-800-547-9378
1-800-452-8086 TTY

For dental claims:

United Concordia Companies, Inc. (UCCI)
P.O. Box 69421
Harrisburg, PA 17106-9421
1-800-332-0366
1-800-345-3837 TTY

For vision claims:

Davis Vision
Customer Relationship and Information Technology Center
Capital Region Health Park, Suite 301 711 Troy-Schenectady Road
Latham, NY 12110
1-800-999-5431
1-800-523-2847 TTY

IMPORTANT NOTE:
THE DOCUMENT THAT FOLLOWS IS SEPARATE
FROM YOUR MEMBER HANDBOOK AND CONSTITUTES YOUR

PREVENTIVE SCHEDULE

WHICH IS CONSIDERED TO BE PART OF YOUR SUBSCRIBER AGREEMENT.

The Highmark Preventive Schedule is maintained and updated using Bright Futures in addition to mandates from CDC, Women's Preventive Health Initiatives, the US Preventive Services Task Force recommendations, and State Law.

2022 Preventive Schedule

Plan your child's care: Know what your child needs and when to get it

Preventive or routine care helps your child stay well or finds problems early, when they are easier to treat. Most of these services may not have cost sharing if you use the plan's in-network providers. Make sure you know what is covered by your health plan and any requirements before you schedule any services for your child.

Services include Bright Futures recommendations. CHIP members may have additional preventive services and coverage. Please check the CHIP member booklet for further details of CHIP coverage of preventive services.

It's important to talk with your child's doctor. The frequency of services, and schedule of screenings and immunizations, depends on what the doctor thinks is right for your child.

Questions?

- Call Member Service
- Ask your doctor
- Log in to your account

Children: Birth to 30 Months[1]

GENERAL HEALTH CARE	BIRTH	1M	2M	4M	6M	9M	12M	15M	18M	24M	30M
Routine Checkup* (This exam is not the preschool- or day care-related physical.)	●	●	●	●	●	●	●	●	●	●	●
Hearing Screening	●										
SCREENINGS											
Autism Screening									●	●	
Critical Congenital Heart Disease (CCHD) Screening With Pulse Oximetry	●										
Developmental Screening						●			●		●
Hematocrit or Hemoglobin Anemia Screening							●				
Lead Screening**							●			●	
Newborn Blood Screening and Bilirubin	●										
IMMUNIZATIONS											
Chicken Pox							Dose 1				
Diphtheria, Tetanus, Pertussis (DTaP)			Dose 1	Dose 2	Dose 3			Dose 4			
Flu (Influenza)***					Ages 6 months to 30 months: 1 or 2 doses annually						
Haemophilus Influenzae Type B (Hib)			Dose 1	Dose 2	Dose 3		Dose 4				
Hepatitis A							Dose 1		Dose 2		
Hepatitis B	Dose 1	Dose 2			Dose 3						
Measles, Mumps, Rubella (MMR)							Dose 1				
Pneumonia			Dose 1	Dose 2	Dose 3		Dose 4				
Polio (IPV)			Dose 1	Dose 2	Ages 6 months to 18 months: Dose 3						
Rotavirus			Dose 1	Dose 2	Dose 3						

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance. Additional: Instrument vision screening to assess risk for ages 1 and 2 years.

** Per Bright Futures, and refer to state-specific recommendations as needed.

*** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.

Children: 3 Years to 18 Years[1]

GENERAL HEALTH CARE	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	15Y	18Y
Routine Checkup* (This exam is not the preschool- or day care-related physical)	●	●	●	●	●	●	●	●	Once a year from ages 11 to 18			
Ambulatory Blood Pressure Monitoring**												●
Depression Screening										Once a year from ages 12 to 18		
Illicit Drug Use Screening												●
Hearing Screening***		●	●	●		●		●		●	●	●
Visual Screening***	●	●	●	●		●		●		●	●	
SCREENINGS												
Hematocrit or Hemoglobin Anemia Screening			Annually for females during adolescence and when indicated									
Lead Screening	When indicated (Please also refer to your state-specific recommendations)											
Cholesterol (Lipid) Screening							Once between ages 9-11 and ages 17-21					
IMMUNIZATIONS												
Chicken Pox		Dose 2								If not previously vaccinated: Dose 1 and 2 (4 weeks apart)		
Diphtheria, Tetanus, Pertussis (DTaP)		Dose 5							One dose Tdap			
Flu (Influenza)******	Ages 3 to 18: 1 or 2 doses annually											
Human Papillomavirus (HPV)							Provides long-term protection against cervical and other cancers. 2 doses when started ages 9-14. 3 doses, all other ages.					
Measles, Mumps, Rubella (MMR)		Dose 2										
Meningitis*******									Dose 1		Age 16: One-time booster	
Pneumonia	Per doctor's advice											
Polio (IPV)		Dose 4										
CARE FOR PATIENTS WITH RISK FACTORS												
BRCA Mutation Screening (Requires prior authorization)					Per doctor's advice							
Cholesterol Screening	Screening will be done based on the child's family history and risk factors											
Fluoride Varnish (Must use primary care doctor)	Ages 5 and younger											
Hepatitis B Screening									Per doctor's advice			
Hepatitis C Screening												●
Latent Tuberculosis Screening												High-risk
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)									For all sexually active individuals HIV routine check once between ages 15-18			
Tuberculin Test	Per doctor's advice											

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance; alcohol and drug abuse, and tobacco use assessment. ** To confirm new diagnosis of high blood pressure before starting treatment. *** Hearing screening once between ages 11-14, 15-17, and 18-21. Vision screening covered when performed in doctor's office by having the child read letters of various sizes on a Snellen chart. Includes instrument vision screening for ages 3, 4, and 5 years. A comprehensive vision exam is performed by an ophthalmologist or optometrist and requires a vision benefit. **** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network. ***** Meningococcal B vaccine per doctor's advice.

Children: 6 Months to 18 Years[1]

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Oral Fluoride	For ages 6 months to 16 years whose primary water source is deficient in fluoride

PREVENTION OF OBESITY, HEART DISEASE, DIABETES, AND STROKE	
Children with a BMI in the 85th to 94th percentile (overweight) and the 95th to 98th percentile (obese) are eligible for:	• Additional annual preventive office visits specifically for obesity • Additional nutritional counseling visits specifically for obesity • Recommended lab tests: – Alanine aminotransferase (ALT) – Aspartate aminotransferase (AST) – Hemoglobin A1c or fasting glucose (FBS) – Cholesterol screening
Age 18 with a diagnosis of Hypertension, High Blood Pressure, Dyslipidemia, or Metabolic Syndrome	Nutritional counseling

ADULT DIABETES PREVENTION PROGRAM (DPP) AGE 18	
Applies to Adults • Without a diagnosis of diabetes (does not include a history of gestational diabetes) • Overweight or obese (determined by BMI) • Fasting Blood Glucose of 100–125 mg/dl or HGBA1c of 5.7% to 6.4% or Impaired Glucose Tolerance Test of 140–199mg/dl	Enrollment in certain select CDC-recognized lifestyle change DPP programs for weight loss

Women's Health Preventive Schedule

SERVICES	
Well-Woman Visits (Includes: preconception and first prenatal visit, urinary incontinence screening)	Up to 4 visits each year for developmentally and age-appropriate preventive services
Contraception (Birth Control) Methods and Discussion*	All women planning or capable of pregnancy

SCREENINGS/PROCEDURES	
Diabetes Screening	• High-risk: At the first prenatal visit • All women between 24 and 28 weeks pregnant • Postpartum women without diabetes but with a history of gestational diabetes
HIV Screening and Discussion	All sexually active women: Once a year
Human Papillomavirus (HPV) Screening Testing	Beginning at age 30: Every 3 years
Domestic and Intimate Partner Violence Screening and Counseling	Once a year
Breast-feeding (Lactation) Support and Counseling, and Costs for Equipment	During pregnancy and/or after delivery (postpartum)
Sexually Transmitted Infections (STI) Discussion	All sexually active women: Once a year
Screening for Anxiety	The Women's Preventive Services Initiative recommends screening for anxiety in adolescent girls and adult women, including those who are pregnant or postpartum.

* FDA-approved contraceptive methods may include sterilization and procedures as prescribed. One form of contraception in each of the 18 FDA-approved methods is covered without cost sharing. If the doctor recommends a clinical service or FDA-approved item based on medical necessity, there will be no cost sharing.

Information About the Affordable Care Act (ACA)

This schedule is a reference tool for planning your family's preventive care, and lists items and services required under the Affordable Care Act (ACA), as amended. It is reviewed and updated periodically based on the advice of the U.S. Preventive Services Task Force, laws and regulations, and updates to clinical guidelines established by national medical organizations. Accordingly, the content of this schedule is subject to change. Your specific needs for preventive services may vary according to your personal risk factors. Your doctor is always your best resource for determining if you're at increased risk for a condition. Some services may require prior authorization. If you have questions about this schedule, prior authorizations, or your benefit coverage, please call the Member Service number on the back of your member ID card.

[1]Information About Children's Health Insurance Program (CHIP)

Because the Children's Health Insurance Program (CHIP) is a government-sponsored program and not subject to ACA, certain preventive benefits may not apply to CHIP members and/or may be subject to copayments.

The ACA authorizes coverage for certain additional preventive care services. These services do not apply to "grandfathered" plans. These plans were established before March 23, 2010, and have not changed their benefit structure. If your health coverage is a grandfathered plan, you would have received notice of this in your benefit materials.

Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

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

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

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

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

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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HIGHMARK

highmarkbcbs.com

IMPORTANT NOTE:
THE DOCUMENT THAT FOLLOWS IS YOUR

CHIP AGREEMENT

FIRST PRIORITY HEALTH

Children's Health Insurance Program ("CHIP")

Utilizing the First Priority Health Network

administered by Highmark Inc.
on behalf of the Commonwealth of Pennsylvania

HMO SUBSCRIBER AGREEMENT

DESCRIPTION OF COVERAGE: This Subscription Agreement (Agreement") sets forth a comprehensive program of inpatient and outpatient health care benefits for children under nineteen (19) years of age who meet certain eligibility requirements outlined herein. Although referrals are not required in order to receive benefits for covered services, the child covered under this Subscriber Agreement, or the child's parent or guardian, must still select a primary care physician upon enrollment. Except for emergency care services, benefits are provided only for services performed by a Network provider. If covered services are not available from a Network provider, a preauthorization from First Priority Health must be obtained to receive services from a provider outside the Network. Several specific services are covered only when rendered by a primary care physician. Additionally, some covered services require preauthorization from First Priority Health. Certain benefits are subject to Copayments and/or visit limits.

A HIGHMARK Company

Independent Licensee of the Blue Cross and Blue Shield Association

Children's Health Insurance Program
("CHIP")

Upon payment of the applicable rate, First Priority Health, (hereinafter referred to as "FPH"), agrees to make payment for those services as set forth in this Subscriber Agreement ("Agreement"). Subject to the right of FPH to terminate coverage in accordance with Subsections V. and W. of **SECTION GP - GENERAL PROVISIONS**, this Agreement is renewable subject to the consent of FPH, and may be renewed by payment of any applicable renewal premiums when due. Subject to **SECTION SE - SCHEDULE OF ELIGIBILITY**, coverage shall renew for a period of twelve (12) consecutive months and thereafter from year to year, as long as the required renewal form is submitted to and approved by FPH. The benefits set forth in this Agreement will serve as evidence of coverage to each Member covered hereunder.

A CORPORATION OPERATING UNDER THE SUPERVISION OF
THE INSURANCE DEPARTMENT AND THE DEPARTMENT OF HEALTH
OF THE COMMONWEALTH OF PENNSYLVANIA

First Priority Health
Fifth Avenue Place
120 Fifth Avenue
Pittsburgh, PA 15222-3099

CHIP Enrollment and Eligibility Unit
1-800-543-7105
TTY: 1877-323-8480

Thomas Doran

Thomas A. Doran
Executive Vice-President
COO Health Plan and President HMIG

First Priority Health and Highmark Inc.
are Independent Licensees of the Blue Cross and Blue Shield Association

Nondiscrimination Notice

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

First Priority Health provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters; and
- Written information in other formats (large print, audio, accessible electronic formats).

First Priority Health provides free language services to people whose primary language is not English, such as:

- Qualified interpreters; and
- Information written in other languages.

If you need these services, contact First Priority Health at 1-800-547-9378.

If you believe that First Priority Health 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:

The Bureau of Equal Opportunity,

Room 223, Health and Welfare Building,

P.O. Box 2675,

Harrisburg, PA 17105-2675,

Phone: (717) 787-1127, TTY (800) 654-5484, Fax: (717) 772-4366, or Email: RA-PWBEOAO@pa.gov

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Bureau of Equal Opportunity is available to help you.

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

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ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you.
Call: 1-800-547-9378 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-547-9378 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-547-9378 (телетайп: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。
請致電 1-800-547-9378（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-800-547-9378 (TTY: 711).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.
اتصل برقم 1-800-547-9378 (رقم هاتف الصم والبكم: 711).

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-547-9378 (टिटिवाइ: 711) ।

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-547-9378 (TTY: 711)번으로 전화해 주십시오.

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល
គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-547-9378 (TTY: 711) ។

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-800-547-9378 (ATS : 711).

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊
သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-800-547-9378 (TTY: 711) သို့ ခေါ်ဆိုပါ။

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.
Rele 1-800-547-9378 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Ligue para 1-800-547-9378 (TTY: 711).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-547-9378 (TTY: 711)।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.
Telefononi në 1-800-547-9378 (TTY: 711).

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષાસહાયસેવાઓતમારામાટેઉપલબ્ધછે.
ફોન કરો 1-800-547-9378 (TTY: 711).

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SECTION DE - DEFINITIONS

This Section provides an explanation of the terms that are used throughout this Agreement. Refer to SECTION DB - DESCRIPTION OF BENEFITS, SECTION EX - EXCLUSIONS and SECTION SC - SCHEDULE OF MAXIMUMS AND LIMITATIONS for details regarding the Benefits provided under this Agreement.

1. **AMBULANCE SERVICE** - a Facility Provider licensed by the state which, for compensation from its patients, provides transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

2. **AMBULATORY SURGICAL FACILITY** - a Facility Provider, with an organized staff of Physicians, which is licensed as required by the state, and which, for compensation from its patients:

   a. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;

   b. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;

   c. does not provide Inpatient accommodations; and

   d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

3. **AMENDATORY RIDER** - a legal document which modifies the terms of this Agreement, either by expanding, decreasing, or defining Benefits, or adding or excluding certain conditions from coverage.

4. **AMERICAN INDIAN/ALASKA NATIVE** - an individual who meets one (1) or more of the following criteria:

   a. a member of a Federally recognized Indian tribe, band, or group;

   b. an Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. §1601 et seq.; or

   c. a person who is considered by the Secretary of the Interior to be an Indian for any purpose.

An American Indian and Alaska Native child is also an individual who is entitled to Special Eligibility Rights as set forth in **SECTION SE - SCHEDULE OF ELIGIBILITY** of this Agreement, as determined by the Commonwealth of Pennsylvania.

5. **ANESTHESIA** - the administration of regional or rectal 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.

6. **APPLICATION** - the properly completed request for membership or enrollment as deemed acceptable by Highmark Inc.

7. **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.

8. **AUDIOLOGIST** - a licensed audiologist or where there is no licensure law, the audiologist must be certified to be clinically competent by the American Speech and Hearing Association or one who can provide evidence of having successfully completed equivalent academic training and clinical experience.

9. **AUDIOMETRIC EXAMINATION** - an examination to measure the extent of hearing loss.

10. **BARIATRIC SURGERY** - operations on the stomach and/or intestines intended to help promote weight loss**,** including but not limited to vertical banded gastroplasty, gastric stapling, laparoscopic adjustable gastric banding, mini-gastric bypass, gastric bypass with Roux-en-Y, biliopancreatic diversion, biliopancreatic diversion with duodenal switch, long-limb gastric bypass, intestinal gastric bypass, or any other surgical procedures designed to restrict a Member's ability to assimilate food. **Bariatric Surgery is not covered as stated in SECTION EX - EXCLUSIONS.**

11. **BENEFITS** - see definition of Covered Service in this Section.

12 **BIRTHING FACILITY** - a Facility Provider licensed by the state which, for compensation from its patients, is primarily organized and staffed to provide Maternity care and which is under the supervision of a Nurse-Midwife.

13. **BLUE CROSS BLUE SHIELD GLOBAL CORE** - a program sponsored by the Blue Cross and Blue Shield Association that provides Members access to Covered Services from a network of health care Providers outside the United States.

14. **BLUES ON CALL (HEALTH EDUCATION AND SUPPORT PROGRAM)** - a program administered by FPH's Designated Agent through which the Member receives health

education and support services, including assistance in the self-management of certain health conditions.

15. **BRAND DRUG** - a recognized trade name drug product, usually either the innovator product for new drugs still under patent protection or a more expensive product marketed under a brand name drug for multi-source drugs, and noted as such in the pharmacy database used by FPH.

16. **CERTIFIED REGISTERED NURSE** - a certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any registered professional nurses employed by a health care facility, as defined in the Health Care Facilities Act, or by an anesthesiology group.

17. **CERTIFIED UTILIZATION REVIEW ENTITY (CRE)** - an entity certified by the Pennsylvania Department of Health to perform utilization review.

18. **CLAIM** - a request made by or on behalf of a Member for Preauthorization or prior approval of a Covered Service, as required under this Agreement, or for the payment or reimbursement of the charges or costs associated with a Covered Service that has been received by a Member. Claims for Benefits provided under this Agreement include:

a. Pre-service Claim

A request for Preauthorization or prior approval of a Covered Service which, as a condition to the payment of Benefits under this Agreement, must be approved by FPH before the Covered Service is received by the Member.

b. Urgent Care Claim

A Pre-service Claim which if decided within the time periods established by FPH for making non-urgent care Pre-service Claim decisions could seriously jeopardize the life or health of the Member, the ability of the Member to regain maximum function or in the opinion of a Physician with knowledge of the Member's medical condition would subject the Member to severe pain that cannot be adequately managed without the Service requested.

c. Post-service Claim

A request for payment or reimbursement of the charges or costs associated with a Covered Service that has been received by a Member.

For purposes of the claim determination and complaint or grievance appeal procedure provisions of this Agreement, whether a Claim or a complaint or grievance appeal of a denied Claim involves a Pre-service Claim, an Urgent Care Claim or a Post-service Claim

will be determined at the time that the Claim or complaint or grievance appeal is filed with FPH in accordance with its procedures for filing Claims and complaint or grievance appeals.

19. **CLINICAL LABORATORY** - a medical laboratory licensed where required and performing within the scope of such licensure that is not affiliated or associated with a Hospital or Physician.

20. **COMFORT/CONVENIENCE ITEMS** - items or equipment which serve a comfort or convenience function or are primarily for the convenience of a person caring for the Member or is used for environmental control or to enhance the environmental setting in which the Member is placed. Such items include but are not limited to: connections from medical devices to computers for monitoring purposes, air conditioners, humidifiers, dehumidifiers, diapers, electric air cleaners, physical fitness equipment, "barrier free" modifications, ramps, stair glides, elevators/lifts, posture chairs, pools and hot tubs. Comfort/Convenience Items include those items which are not Primarily Medical in Nature. **Comfort/Convenience Items are not covered as stated in SECTION EX - EXCLUSIONS.**

21. **COPAYMENT** - a specified amount of expense required to be paid by a Member's for a specific Covered Service set forth in this Agreement. Copayments, if any, are set forth in **SECTION SC - SCHEDULE OF MAXIMUMS AND LIMITATIONS.**

22. **COVERED MEDICATIONS** - Prescription Drugs and Over-the-Counter Drugs ordered by a Professional Provider by means of a valid Prescription Order, which FPH is contractually obligated to pay or provide as a benefit to a Plan Member.

23. **COVERED SERVICE** - a Service or supply specified in **SECTION DB - DESCRIPTION OF BENEFITS** for which coverage will be provided when rendered under the terms of this Agreement.

24. **CUSTODIAL CARE** - care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting the activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Multiple non-Skilled Nursing Services/non-Skilled Rehabilitation Services in the aggregate do not constitute Skilled Nursing Services/Skilled Rehabilitation Services. Custodial Care includes but is not limited to help in walking, bathing, dressing, feeding, toileting, preparation of special diets and supervision over administration of medications not requiring Skilled Nursing Services/Skilled Rehabilitation Services provided by trained and licensed medical personnel. **Custodial Care is not covered as stated in SECTION EX - EXCLUSIONS.**

25. **DAY/NIGHT PSYCHIATRIC FACILITY** - a Facility Provider licensed by the state which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the treatment of Mental Illness only during the day or during the night.

26. **DESIGNATED AGENT** - an entity that has contracted with FPH to perform a function and/or service in the administration of this Agreement. Such function and/or service may include, but is not limited to, medical management.

27. **DETOXIFICATION** - the process whereby an alcohol-intoxicated or drug-intoxicated or alcohol-dependent or drug-dependent person is assisted, in a facility licensed by the Pennsylvania Department of Health or on an Outpatient basis, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other drugs, alcohol and other drug dependency factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

28. **DIABETES EDUCATION PROGRAM** - an Outpatient program of self-management, training and education, including medical nutrition therapy, for the treatment of diabetes. Such Outpatient Program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education Services will be covered subject to the criteria of FPH. These criteria are based on the certification programs for Outpatient diabetes education developed by the American Diabetes Association (ADA) and the Pennsylvania Department of Health.

29. **DIABETES PREVENTION PROGRAM** - a twelve (12) month program utilizing a curriculum approved by the Centers for Disease Control to deliver a prevention lifestyle intervention for individuals at high risk of developing type 2 diabetes. The Diabetes Prevention Program includes behavioral and motivational content focusing on moderate changes in both diet and physical activity.

30. **DIABETES PREVENTION PROVIDER -** an entity that offers a Diabetes Prevention Program.

31. **DIAGNOSTIC SERVICES** - procedures ordered by a Provider, because of specific symptoms, to determine a definite condition or disease or, for purposes of routine screening. Diagnostic Services are set forth in **SECTION DB -DESCRIPTION OF BENEFITS**.

32. **DIALYSIS TREATMENTS** - the treatment of acute renal failure or chronic irreversible renal insufficiency by removal of waste materials from the body through hemodialysis or peritoneal dialysis.

33. **DURABLE MEDICAL EQUIPMENT** - items which can withstand repeated use, are primarily and customarily used to serve a medical purpose, are generally not useful to a person in the absence of illness, injury or disease, are appropriate for use in the home, do not serve as Comfort/Convenience Items, and do not include Orthotic Devices and Prosthetic Appliances.

34. **EFFECTIVE DATE** - according to **SECTION SE - SCHEDULE OF ELIGIBILITY**, the date on which coverage for a Member begins under this Agreement.

35. **ELECTIVE ABORTION** - abortions which are not necessary to avert the death of the woman, or which are not performed in order to terminate a pregnancy caused by rape or incest. **Elective Abortions are not covered as stated in SECTION EX - EXCLUSIONS.**

36. **EMERGENCY CARE SERVICES** - the initial treatment:

a. for bodily injuries resulting from an accident; or

b. following the sudden onset of a medical condition; or

c. following, in the case of a chronic condition, a sudden and unexpected medical event; that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one or more of the following:

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

   ii) serious impairment to bodily functions; or

   iii) serious dysfunction of any bodily organ or part.

A psychiatric emergency includes a potentially life-threatening condition where the Member is at risk of injury to himself/herself or others.
Treatment for an occupational injury for which benefits are provided under any Workers' Compensation Law or any similar Occupational Disease Law is not covered.

Transportation and related emergency services provided by an Ambulance Service shall constitute an Emergency Care Service if the injury or the condition satisfies the criteria above.

Use of an ambulance as transportation to an emergency Facility Provider for an injury or condition that is not an emergency, will not be covered as an Emergency Care Service.

37. **ENTERAL FOODS** - a liquid source of nutrition equivalent to a Prescription Drug that is administered orally or enterally and which may contain some or all nutrients necessary to meet minimum daily nutritional requirements. Enteral Foods are intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are identified through medical evaluation.

38. **EXCLUSIVE PHARMACY PROVIDER** - a Pharmacy Provider performing within the scope of its license that has an agreement with FPH pertaining to the payment and exclusive dispensing of selected Prescription Drugs as set forth in this Agreement, provided to a Member.

39. **EXPERIMENTAL/INVESTIGATIVE** - the use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by FPH to be medically effective for the condition being treated. FPH will consider an intervention to be Experimental/Investigative if:

a. the intervention does not have Federal Food and Drug Administration (FDA) approval to market for the specific relevant indication(s); or

b. available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or

c. the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or

d. the intervention does not improve health outcomes; or

e. the intervention is not proven to be applicable outside the research setting.

If an intervention as defined above is determined to be Experimental/Investigative at the time of service, it will not receive retroactive coverage even if it is found to be in accordance with the above criteria at a later date. **Experimental/Investigative Services are not covered as stated in SECTION EX - EXCLUSIONS.**

40. **FACILITY PROVIDER** - an entity which is licensed, where required, to render Covered Services. Facility Providers include:

Ambulance Service
Ambulatory Surgical Facility
Birthing Facility
Day/Night Psychiatric Facility
Freestanding Dialysis Facility
Facility Freestanding Nuclear Magnetic Resonance Facility/Magnetic Resonance Imaging Facility
Home Health Care Agency
Home Infusion Therapy Provider
Hospice
Hospital
Independent Diagnostic Testing Facility (IDTF)
Infusion Therapy Suite Provider
Outpatient Physical Rehabilitation Facility
Outpatient Psychiatric Facility
Outpatient Substance Abuse Treatment
Pharmacy Provider
Psychiatric Hospital
Rehabilitation Hospital
Skilled Nursing Facility
State-Owned Psychiatric Hospital
Substance Abuse Treatment Facility

41. **FIRST PRIORITY HEALTH (FPH)** - a licensed Health Maintenance Organization (HMO) operating under the supervision of the Pennsylvania Insurance Department and the Department of Health of the Commonwealth of Pennsylvania. Any reference to FPH may also include its Designated Agent as defined herein and with whom FPH has contracted to perform a function or service in the administration of this Agreement

42. **FORMULARY** – a listing of Prescription Drugs and Over-the-Counter Drugs selected by FPH based on an analysis of clinical efficacy, unique value, safety, and pharmacoeconomic impact. This listing is subject to periodic review and modification by FPH or a designated committee of Physicians and pharmacists.

43. **FREE CHIP COVERAGE** - the medical coverage provided to an eligible child whose family income falls below the income guidelines established by the Department of Human Services of the Commonwealth of Pennsylvania ("Department") for Low-Cost CHIP coverage and exceeds the Medicaid (Medical Assistance) guidelines. Eligibility guidelines are reviewed and updated periodically by the Department and are subject to change.

44. **FREESTANDING DIALYSIS FACILITY** - a Facility Provider licensed and approved by the appropriate governmental agency and which, for compensation from its patients, is primarily engaged in providing Dialysis Treatment, maintenance or training to patients on an Outpatient or home care basis.

45. **FREESTANDING NUCLEAR MAGNETIC RESONANCE FACILITY/ MAGNETIC RESONANCE IMAGING FACILITY** - a Facility Provider which, for compensation from its patients, is primarily engaged in providing, through an organized professional staff, nuclear magnetic resonance/magnetic resonance imaging scanning. These facilities do not include Inpatient beds, medical or health-related services.

46. **FULL-COST CHIP COVERAGE** - the medical coverage provided to an eligible child whose family income exceeds the income guidelines established by the Department of Human Services of the Commonwealth of Pennsylvania ("Department") for Low-Cost CHIP Coverage. The family must pay the full cost of the premium, which has been approved by the Department. Eligibility guidelines are reviewed and updated periodically by the Department and are subject to change.

47. **FULL SESSION VISIT** - a period of forty-five to fifty (45-50) minutes devoted to individual or family medical psychotherapy for the treatment of problems related to Substance Abuse, with continuing medical diagnostic evaluation, and drug management when indicated. Medical psychotherapy may include individual psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy.

48. **GENERIC DRUG** - a drug that is available from more than one (1) manufacturing source, accepted by the Federal Food and Drug Administration ("FDA") as a substitute for those products having the same active ingredients as a Brand Drug, and listed in the FDA "Approved Drug Products with Therapeutic Equivalence Evaluations," otherwise known as the Orangebook, and noted as such in the pharmacy database used by FPH.

49. **GROUP** - the party entering into a Contract on behalf of the Members. For purposes of this Agreement, the Group is the Department of Human Services of the Commonwealth of Pennsylvania.

50. **HEALTH MAINTENANCE ORGANIZATION (HMO)** - an organized system that combines the delivery and financing of health care and which provides basic health services to voluntarily enrolled Members.

51. **HEARING AID** - a prescribed device including ear mold to improve hearing acuity but excluding batteries and limited to the following types of hearing aids:

a. in the ear;

b. behind the ear, including air and bone conduction types;

c. on the body; and

d. eyeglass type hearing aids, which are covered in the same manner as behind the ear hearing aids.

52. **HEARING AID DEALER/FITTER** - a person engaged in the practice of fitting and selling Hearing Aids.

53. **HEARING AID EVALUATION TEST** - a test to determine the appropriate make and model of Hearing Aid for use by a patient with hearing loss based on the recent Audiometric Examination.

54. **HIGHMARK INC. (HIGHMARK)** - an independent licensee of the Blue Cross Blue Shield Association. FPH is a wholly owned subsidiary of Highmark.

55. **HOME HEALTH CARE AGENCY** - a Facility Provider program for home health care, licensed by the state and certified by Medicare which, for compensation from its patients:

a. provides skilled nursing and other services on a visiting basis in the Member's home; and

b. is responsible for supervising the delivery of such services under a plan prescribed by the attending Physician.

57. **HOME INFUSION THERAPY PROVIDER** - an Ancillary Provider licensed by the state, accredited by The Joint Commission, if appropriate, and organized to provide Infusion Therapy to patients at their place of residence

58. **HOSPICE** - a Facility Provider, licensed by the state which, for compensation from its patients, is primarily engaged in providing palliative care to terminally ill individuals.

59. **HOSPICE CARE** - a program which provides an integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients and their families. Hospice services are centrally coordinated through an interdisciplinary team directed by a Physician.

60. **HOSPITAL** - a duly licensed Provider that is a general or special hospital which has been approved by Medicare, the Joint Commission on the Accreditation of Health Care Organizations or by the American Osteopathic Hospital Association, which:

a. for compensation from its patients is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians; and

b. provides twenty-four (24)-hour nursing service by or under the supervision of Registered Nurses.

61. **HOUSEHOLD** - is limited to the Member and the Member's biological or adoptive parents, legal guardian(s), sibling and/or Member's spouse. Household may also include the Member's stepparent, another individual exercising care and control of the child(ren), the putative father of the child(ren), non-Member siblings or stepsiblings.

62. **IDENTIFICATION CARD** - the currently effective card issued to the Member by FPH.

63. **IMMEDIATE FAMILY** - the Member's spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law, grandchild, grandparent, stepparent, stepbrother or stepsister.

64. **INCURRED** - a charge is considered Incurred on the date a Member receives the Service or supply for which the charge is made.

65. **INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF)** - a fixed location or a mobile entity, which is licensed where required and enrolled with and approved and/or certified by Medicare, which performs diagnostic testing services, other than clinical laboratory or pathology testing, using diagnostic testing and imaging equipment, including, but not limited to, mobile x-ray providers and cardiac event monitoring providers and other diagnostic imaging providers. Such technical services do not include the interpretation of test results by a Professional Provider.

66. **INFERTILITY** - the medically documented inability to conceive with unprotected sexual intercourse between a male and female partner for a period of at least twelve (12) months. The condition may be present in either the male or female partner. **Infertility Services are not covered as stated in SECTION EX - EXCLUSIONS.**

67. **INFUSION THERAPY** - the administration of Medically Necessary and Appropriate fluid or medication via a central or peripheral vein to patients.

68. **INFUSION THERAPY SUITE PROVIDER** - a Facility Provider, which has been licensed by the Pennsylvania Department of Health, accredited by the Joint Commission on the Accreditation of Health Care Organizations and Medicare, if appropriate, and is organized to provide Infusion Therapy to patients.

69. **INPATIENT** - a Member who is a registered bed patient in a Facility Provider and for whom a room and board charge is made.

70. **INPATIENT HOSPITAL SERVICES** - the Covered Services as described in this Agreement when rendered to a Member who is admitted as a registered overnight bed patient in a Facility Provider.

71. **LOW-COST CHIP COVERAGE** - the medical coverage provided to an eligible child whose family income falls within a specified percentage of the Federal Poverty Level. This specified percentage is established by the Department of Human Services of the Commonwealth of Pennsylvania ("Department") for CHIP low-cost coverage. The family must pay a subsidized premium, which has been approved by the Department. Eligibility guidelines are reviewed and updated periodically by the Department and are subject to change.

72. **MAINTENANCE PRESCRIPTION DRUGS** - Prescription Drugs ordered by a Professional Provider by means of a valid Prescription Order for the control of a chronic disease or illness or to alleviate the pain and discomfort associated with a chronic disease or illness.

73. **MASTER LEVEL THERAPIST** - a person licensed in an accepted human service specialty including, but not limited to a master level Psychologist, professional counselor or marriage and family therapist and performing services within the scope of such licensure. Where there is no licensure law, the Master Level Therapist must be certified by the appropriate professional body.

74. **MATERNITY** - obstetrical care, including prenatal and postnatal care, complications of pregnancy and childbirth.

75. **MAXIMUM** - the greatest amount payable by FPH for Covered Services. This could be expressed in dollars, number of days, or number of Services for a specified period of time.

76. **MEDICAID (Medical Assistance)** - a jointly funded cooperative venture between the Federal and State governments to assist States in the provision of adequate medical care to eligible needy persons. The program, established by Title XIX of the Social Security Act, provides medical assistance for certain individuals and families with low incomes and resources.

77. **MEDICALLY NECESSARY AND APPROPRIATE (MEDICAL NECESSITY AND APPROPRIATENESS)** a Service, item or medicine that does one of the following:

a. it will, or is reasonably expected to, prevent an illness, condition, or disability;

b. it will, or is reasonably expected to, reduce or improve the physical, mental or developmental effects of an illness, condition, injury or disability; or

c. it will help the Member get or keep the ability to perform daily tasks, taking into consideration both the Member's abilities and abilities of someone of the same age.

No benefits hereunder will be provided unless FPH determines that the Service or supply is Medically Necessary and Appropriate

78. **MEDICAL SUPPLY/SUPPLIES** - non-reusable items or items with limited reusability which are:

a. Primarily Medical in Nature;

b. used in the treatment of illness or injury;

c. used for a therapeutic purpose; and

d. not a Comfort/Convenience Item.

79. **MEDICARE** - the programs of health care for the aged (65 years and older) and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

80. **MEMBER (SUBSCRIBER)** - an individual who meets the eligibility requirements as set forth in **SECTION SE - SCHEDULE OF ELIGIBILITY** of this Agreement.

81. **MENTAL ILLNESS** - an emotional or mental disorder characterized by a neurosis, psychoneurosis, psychopathy, or psychosis without demonstrable organic origin.

82. **NETWORK** - all FPH Providers, approved as a Network by the Pennsylvania Department of Health, that have entered into a contractual agreement either directly or indirectly with FPH to provide health care services to Members under this Agreement.

83. **NETWORK DIABETES PREVENTION PROVIDER -** a Diabetes Prevention Provider that contracts with:

a. FPH to offer a Diabetes Prevention Program based on a digital model; or

b. FPH or the local licensee of the Blue Cross Blue Shield Association to offer a Diabetes Prevention Program based on an in-person/onsite model.

84. **NETWORK PROVIDER** - Providers that have an agreement with FPH pertaining to payment as Network participants for Covered Services rendered to a Member and who have enrolled and received a PROMISe identification number.

85. **NETWORK SPECIALIST** - a Specialist Provider who has an agreement with FPH pertaining to payment as a Network participant for Covered Services rendered to a Member.

86. **NON-HOSPITAL RESIDENTIAL TREATMENT** - the provision of medical, nursing, counseling or therapeutic services to patients suffering from substance abuse or dependency in a residential environment, according to individualized Treatment Plans.

87. **NURSE-MIDWIFE** - a person who is legally licensed, and performing services within the scope of such licensure, to practice the profession of midwifery. Where there is no licensure law, the Nurse-Midwife must be certified by the appropriate professional body.

88. **ORTHOTIC DEVICES** - a rigid or semi-rigid supportive device which restricts, modifies or eliminates motion of a weak or diseased body part. Such a device must be Primarily Medical in Nature and not be a Comfort/Convenience Item.

89. **OUT OF AREA SERVICES** - those services provided outside the Network Service Area.

90. **OUTPATIENT** - a Member who receives services or supplies and is not admitted as a registered bed patient in a Facility Provider.

91. **OUTPATIENT PHYSICAL REHABILITATION FACILITY** - a Facility Provider which, for compensation from its patients, is primarily engaged in providing Physical Medicine services for rehabilitation purposes on an Outpatient basis.

92. **OUTPATIENT PSYCHIATRIC FACILITY** - a Facility Provider which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the treatment of Mental Illness on an Outpatient basis.

93. **OUTPATIENT SERVICES** - the Covered Services described in **SECTION DB - DESCRIPTION OF BENEFITS** when rendered to a Member who is not admitted as a registered bed patient in a Facility Provider.

94. **OUTPATIENT SUBSTANCE ABUSE TREATMENT FACILITY** - a Facility Provider which, for compensation from its patients, is primarily engaged in providing rehabilitative counseling services, diagnostic and therapeutic services for the treatment of Substance Abuse. This Facility must also meet the minimum standards set by the Pennsylvania Department of Health, the Pennsylvania Office of Drug and Alcohol Programs, or other appropriate governmental agency.

95. **OVER-THE-COUNTER DRUG** - a select non-prescription Brand or Generic Drug which is therapeutically similar to an available federal legend product or such non-prescription drug that FPH deems clinically appropriate.

96. **PARTIAL HOSPITALIZATION** - the provision of medical, nursing, counseling or therapeutic Mental Health Services on a planned and regularly scheduled basis in a Facility Provider, designed for a patient or client who would benefit from more intensive services than are generally offered through Outpatient treatment but who does not require Inpatient care.

97. **PARTICIPATING PHARMACY PROVIDER** - a Pharmacy Provider licensed where required and performing within the scope of its license that has an agreement with FPH pertaining to the payment of Prescription Drugs provided to a Member.

98. **PHARMACY PROVIDER** - an entity licensed by the state which is engaged in dispensing Prescription Drugs through a licensed pharmacist.

99. **PHYSICAL THERAPIST** - a person who is legally licensed, and performing services within the scope of such licensure, the profession of physical therapy. Where there is no licensure law, the Physical Therapist must be certified by the appropriate professional body.

100. **PHYSICIAN** - a person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed and legally entitled to practice medicine in all its branches, perform Surgery and dispense drugs where permitted to do so.

101. **PREAUTHORIZATION** - the process whereby the PCP, or the Network Specialist, must contact FPH to determine the eligibility of coverage for and/or the Medical Necessity or Appropriateness of certain Covered Services, as specified in this Agreement. Such Preauthorization must be obtained prior to providing Covered Services for Members except as provided herein. If the PCP or the Network Specialist is required to obtain Preauthorization, but provides or authorizes Covered Services without obtaining such Preauthorization, the Member will not be responsible for payment.

102. **PRESCRIPTION DRUGS** - any drugs or medications ordered by a Professional Provider by means of a valid Prescription Order, bearing the federal legend: "Caution: Federal law prohibits dispensing without a prescription," or legend drugs under applicable state law and dispensed by a licensed pharmacist. Also included are prescribed insulin and other pharmacological agents used to control blood sugar, diabetic supplies and insulin syringes.

103. **PRESCRIPTION ORDER** - the request for medication issued by a Professional Provider.

104. **PRIMARILY MEDICAL IN NATURE** - an item which is used in connection with the treatment of an illness or injury or other medical purpose, and which is not generally useful in the absence of illness or injury.

105. **PRIMARY CARE PROVIDER (PCP)** - a Professional Provider who has contracted with FPH to: a) be designated as a PCP; b) supervise, coordinate and provide specific basic medical services to Members; and c) maintain continuity of patient care. Each Member covered under this Agreement must select a PCP in accordance with provisions established by FPH.

106. **PROFESSIONAL PROVIDER** - a person, practitioner or entity licensed where required and performing services within the scope of such licensure. Professional Providers include:

Audiologist	Physical Therapist
Certified Registered Nurse	Physician
Chiropractor	Podiatrist
Clinical Laboratory	Psychologist
Dentist	Respiratory Therapist
Master Level Therapist	Social Worker
Nurse-Midwife	Speech-Language Pathologist
Occupational Therapist	Optometrist

107. **PROSTHETIC APPLIANCES** - devices and related Medical Supplies which replace all or part of:

a. An absent body limb or body organ (including adjoining tissue); and/or

b. The basic function of a permanently inoperative or malfunctioning body organ. Such

appliance must be Primarily Medical in Nature and not a Comfort/Convenience Item.

108. **PROVIDER** - a Facility Provider or Professional Provider licensed where required, and performing within the scope of such licensure.

109. **PROVIDER'S ALLOWABLE PRICE (PAP)** - the amount at which a Participating Pharmacy has agreed with FPH to provide Prescription Drugs to Members under this Agreement.

110. **PSYCHIATRIC HOSPITAL** - a Facility Provider approved by the Joint Commission on the Accreditation of Health Care Organizations or by the American Osteopathic Hospital Association which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the treatment of Mental Illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

111. **PSYCHOLOGIST** - a person who is legally licensed, and performs services within the scope of such licensure, to practice the profession of psychology. When there is no licensure law, the Psychologist must be certified by the appropriate professional body.

112. **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:

i) The National Institutes of Health (NIH);

ii) The Centers for Disease Control and Prevention (CDC);

iii) The Agency for Healthcare Research and Quality (AHRQ);

iv) The Centers for Medicare and Medicaid Services (CMS);

v) 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);

vi) 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), if for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be (A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

b. The study or 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.

d. Such other clinical trial must be approved by FPH as a Qualifying Clinical Trial.

113. REHABILITATION HOSPITAL - a Facility Provider approved by the Joint Commission on the Accreditation of Health Care Organizations or by the Commission on Accreditation of Rehabilitation Facilities or certified by Medicare which for compensation from its patients is primarily engaged in providing Skilled Rehabilitation Services on an Inpatient basis.

114. RESPITE CARE - short-term care for a terminally ill patient provided by a Facility Provider when necessary to relieve a person (caregiver) who is caring for the patient at home free of charge.

115. RETAIL CLINIC - a Professional Provider licensed or certified, where required, and performing within the scope of such license or certification which, for compensation from its patients, is primarily organized and staffed to provide preventive care and medical care for minor illnesses and injuries on an Outpatient basis.

116. SERVICE - each treatment rendered by a Provider to a Member for a Covered Service.

117. SERVICE AREA - the geographic area designated by FPH which may be modified from time to time, served by the Network and approved by the Pennsylvania Department of Health.

118. SKILLED NURSING FACILITY - a Facility Provider licensed by the state and certified by Medicare as a Skilled Nursing Facility which, for compensation from its patients, is primarily engaged in providing Skilled Nursing Services on an Inpatient basis to patients requiring twenty-four (24)-hour Skilled Nursing Services but not requiring confinement in an acute care general Hospital. Such care is rendered by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

a. minimal care, Custodial Care, ambulatory care, or part-time care services; or

b. care or treatment of Mental Illness, Substance Abuse, or pulmonary tuberculosis.

119. SKILLED NURSING SERVICES/SKILLED REHABILITATION SERVICES - Services which have been ordered by and under the direction of a Physician, and are provided either directly by or under the supervision of a medical professional: e.g., Registered Nurse, Physical Therapist, Licensed Practical Nurse, Occupational Therapist, Speech-Language Pathologist or Audiologist with the treatment described and documented in the patient's medical record. Unless otherwise determined, in the sole discretion of FPH Skilled Nursing Services/Skilled Rehabilitation Services shall be subject to the following:

a. the Skilled Nursing Services/Skilled Rehabilitation Services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified licensed medical professional and must be such that the care could not be performed by a non-medical individual instructed to deliver such Services.

b. Skilled Rehabilitation Services consist of the combined use of medical, social, educational and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Skilled Rehabilitation Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse. The Skilled Rehabilitation Services must be provided with the expectation that the patient has restorative potential and the condition will improve materially in a reasonable and generally predictable period of time. Once a maintenance level has been established or no further progress is attained, the services are no longer classified as Skilled Rehabilitation, and will be considered to be Custodial Care.

The mere fact that a Physician has ordered or prescribed a therapeutic regimen does not, in itself, determine whether a service is a Skilled Nursing Service or a Skilled Rehabilitation Service.

120. SOCIAL WORKER - a person holding a master's degree or doctoral degree in social work, licensed where required and performing services within the scope of such licensure.

121. SPECIALIST - a Physician, other than a Primary Care provider, who limits his or her practice to a particular branch of medicine or Surgery.

122. SPECIALIST VIRTUAL VISIT - a real-time office Visit with a Specialist at a remote location, conducted via interactive audio and streaming video telecommunications.

123. SPECIALTY PRESCRIPTION DRUGS - selected Prescription Drugs which are typically used to treat rare or complex conditions and which may require special handling, monitoring and/or special or limited distribution systems, including dispensing through an Exclusive Pharmacy Provider.

124. SPEECH-LANGUAGE PATHOLOGIST - any person who is qualified by training and experience to engage in the practice of the evaluation, counseling, habilitation and rehabilitation of individuals whose communicative disorders involve the function of speech, voice or language. A person is deemed to be a Speech-Language Pathologist if he offers such services under any title incorporating the words speech-language pathologist, speech

consultant, speech therapist, speech correctionist, speech clinician, speech specialist, language pathologist, logopedist, communication therapist, voice therapist, aphasia therapist, aphasiologist, communicologist, or any similar title or description of service.

125. **STATE-OWNED PSYCHIATRIC HOSPITAL** - a Facility Provider, that is owned and operated by the Commonwealth of Pennsylvania, which has been approved by Medicare, the Joint Commission on Accreditation of Healthcare Organizations, or the American Osteopathic Hospital Association and which, for compensation from its patients, is primarily engaged in providing treatment and/or care for the Inpatient treatment of Mental Illness for individuals (aged 18 or older) whose hospitalization is ordered by a court of competent jurisdiction through a civil commitment proceeding.

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

127. **SUBSTANCE ABUSE TREATMENT FACILITY** - a Facility Provider licensed by the state, approved by the Joint Commission on Accreditation of Health Care Organizations which, for compensation from its patients, is primarily engaged in providing Detoxification and/or rehabilitation treatment for alcohol abuse and/or drug abuse (including Non-Hospital Residential Treatment). This facility must also meet the minimum standards set by the Pennsylvania Department of Health, the Pennsylvania Office of Drug and Alcohol Programs, or other appropriate governmental agency.

128. **SUITE INFUSION THERAPY PROVIDER** - an Ancillary Provider licensed by the state, accredited by The Joint Commission, if appropriate, and organized to provide Infusion Therapy to patients at an infusion suite.

129. **SUPPLIER** - an individual or entity that is in the business of leasing and selling Durable Medical Equipment and supplies. Suppliers include, but are not limited to, the following: orthotic and prosthetic Suppliers, pharmacy/Durable Medical Equipment Suppliers.

130. **SURGERY** - the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures and the correction of fractures and dislocations. Payment for Surgery includes an allowance for usual and related Inpatient pre-operative and post-operative care.

131. **TELEMEDICINE PROVIDER** - a Physician, licensed where required and performing within the scope of such licensure, who provides Telemedicine Services.

132. **TELEMEDICINE SERVICE** - a real time interaction between a Member and a Telemedicine Provider who is a Network Provider conducted by means of telephonic or audio and video telecommunications, for the purpose of providing specific Outpatient Covered Services.

133. **THERAPY AND REHABILITATION SERVICES** - the following services or supplies ordered by a Professional Provider to promote the recovery of the Member. Therapy and Rehabilitation Services are covered to the extent specified in **SECTION DB - DESCRIPTION OF BENEFITS** and **SECTION SC- SCHEDULE OF MAXIMUMS AND LIMITATIONS**.

a. Cardiac Rehabilitation Therapy

The physiological and psychological rehabilitation of patients with cardiac conditions through regulated exercise programs.

b. Chemotherapy

The treatment of malignant disease by chemical or biological antineoplastic agents.

c. Infusion Therapy

The administration of Medically Necessary and Appropriate fluid or medication via a central or peripheral vein to patients when performed, furnished and billed by a Facility Provider in accordance with accepted medical practice. Benefits include pharmaceuticals, pharmacy Services, intravenous solutions, medical/surgical supplies and nursing Services associated with Infusion Therapy. Specific adjunct non-intravenous therapies are included only when administered in conjunction with Infusion Therapy.

d. Occupational Therapy

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

e. Physical Medicine

The treatment by physical means or modalities, such as, but not limited to mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities, and rehabilitative procedures, performed to relieve pain and restore level of function following disease, illness or injury.

f. Pulmonary Rehabilitation

Treatment for pulmonary disease that includes services such as therapeutic exercises, education management, breathing training and bronchial hygiene training.

g. Radiation Therapy

The treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

h. Respiratory Therapy

Introduction of dry or moist gases into the lungs for treatment purposes.

i. Speech Therapy

Treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

134. TREATMENT PLAN

A plan of care which is prescribed in writing by a Professional Provider for the treatment of an injury or illness. The Treatment Plan should be limited in scope and extent to that care which is Medically Necessary and Appropriate.

135. URGENT CARE CENTER

A formally structured hospital-based or freestanding full-service, walk-in health care clinic, outside of a hospital-based emergency room, that is open twelve (12) hours a day, Monday through Friday and eight (8) hours a day on Saturdays and Sundays, that primarily treats patients who have an injury or illness that requires immediate care, but is not serious enough to warrant a visit to an emergency room. An Urgent Care Center can also provide the same services as a family Physician or Primary Care Provider, such as treatment of minor illnesses and injuries, physicals, x-rays and immunizations.

136. VISIT

a. the physical presence of a Member at a location designated by the Provider for the purpose of providing Covered Services; or

b. an interaction between a Member and a Provider for the purpose of providing Outpatient Covered Services conducted by means of:

i) audio and video telecommunications system for the treatment of Mental Illness; or

ii) the internet or similar electronic communications for the treatment of skin conditions or diseases.

SECTION SE - SCHEDULE OF ELIGIBILITY

A. EFFECTIVE DATE OF COVERAGE

Subject to the Highmark CHIP Unit's receipt of an Application from or on behalf of each prospective Member, and the provisions of this Agreement, coverage under this Agreement shall become effective as follows:

1. When a person applies for membership on or prior to the date he/she satisfies the eligibility requirements set forth in Subsection B. **ELIGIBILITY** of this Section, coverage shall be effective as of the first day of the month following the date the eligibility requirements are satisfied. If the completed Application is received and eligibility is determined between the first (1st) and fifteenth (15th) day of the month, the coverage will become effective the first (1st) day of the following month. If the completed Application is received and eligibility is determined between the sixteenth (16th) and the last day of the month, the change will become effective the first (1st) day of the second month after it is received.

2. For a newborn child of a Member, coverage shall become effective from the moment of birth to a Maximum of thirty-one (31) days.

3. Coverage for Members who are required to be covered under a Court Order will be effective no later than thirty (30) days from Highmark's receipt of the Court Order, provided such Member has submitted a completed Application and that he/she meets the eligibility requirements set forth in Subsection B. **ELIGIBILITY**.

4. The Effective Date of coverage under this Agreement is shown on the Member's initial Identification Card. A Member may also obtain confirmation of the Effective Date of his or her coverage by contacting the Member Service Department at the toll-free telephone number listed on the Member's Identification Card.

5. If on the date on which coverage under this Agreement becomes effective, the Member is an Inpatient in a Hospital, Benefits described in this Agreement will be provided to the extent that they are not provided under prior coverage.

6. In the case of children eligible for CHIP coverage requiring a premium payment, coverage shall become effective upon receipt of two (2) months' worth of premium.

B. **ELIGIBILITY**

To be eligible as a Member, an individual must meet all of the following criteria. A Member must:

1. be under nineteen (19) years of age;

2. be either a United States citizen, an alien in lawful immigration status or refugee as determined by the U.S. Immigration and Naturalization Services;

3. be a resident of the Commonwealth of Pennsylvania;

4. reside in the Network Service Area;

5. meet the guidelines established by the Department of Human Services of the Commonwealth of Pennsylvania regarding Household size, income and prior private health insurance coverage; and

6. not be enrolled in any other health care coverage, or be eligible for Medicare or Medicaid.

C. **NEWBORN CHILDREN**

A newborn child of a Member is covered under this Agreement for the first thirty-one (31) days immediately following birth. A newborn child of a Member is not eligible for coverage as a dependent of the Member. In order to assure that the newborn child remains covered beyond the first thirty-one (31) days following its birth, the Member should apply for a type of coverage for which the newborn child is eligible, which may include the Children's Health Insurance Program ("CHIP") or Medicaid.

D. **NOTICE OF INELIGIBILITY**

It shall be the Member's responsibility to notify the Highmark CHIP Unit of any changes which will affect eligibility for coverage under this Agreement. If a Member becomes covered in full or in part by any other health care coverage, whether private or government-sponsored, that Member is no longer eligible for coverage under this Agreement. The Member must immediately notify the Highmark CHIP Unit upon obtaining such coverage.

Subject to Subsection B. **BENEFITS AFTER TERMINATION OF COVERAGE** of **SECTION GP - GENERAL PROVISIONS**, a Member's coverage automatically terminates and all Benefits hereunder cease, whether or not notice to terminate is received by the Highmark CHIP Unit, at the end of the month following the date in which such Member ceases to be eligible as set forth in this Subsection. Highmark will refund any premium payment for coverage extending beyond the termination date.

E. OTHER CHANGES IN STATUS

Requests for changes in Household size, such as additions or deletions of eligible children, shall be sent to the Highmark CHIP Unit in writing, and shall become effective and a part of this Agreement upon acceptance by the Highmark CHIP Unit.

F. RULES OF ELIGIBILITY

No person will be refused enrollment or re-enrollment by the Highmark CHIP Unit because of health status, age (except as provided in Subsection B. **ELIGIBILITY**), requirements for health services or the existence, on the Effective Date of coverage under this Agreement, of a preexisting physical or mental condition, including pregnancy. In addition, no Member's coverage shall be terminated by the Highmark CHIP Unit due to health status or health care needs.

G. OTHER HEALTH INSURANCE

If it is found that any Member covered under this Agreement is also covered under other health insurance, this Agreement will be terminated as of the effective date of the other health insurance. In the event that the other health insurance was in effect prior to the Effective Date of this Agreement, this Agreement will be rendered void. In all instances, no Claims will be paid, and FPH will seek repayment for any payments made to Providers in connection with the Benefits of this Agreement. Any premiums paid for CHIP Coverage will be refunded as appropriate.

H. SPECIAL ELIGIBILITY RIGHTS

American Indian and Alaska Native children are entitled to special eligibility rights as determined by the Commonwealth of Pennsylvania, in accordance with Federal Regulations 42 C.F.R. §457.535. Those rights guarantee that, for an American Indian or Alaska Native child, coverage under this Agreement is exempt from any premium, deductible, coinsurance, Copayment or any other cost-sharing requirement that may be applicable to CHIP coverage. Verification of the child's status as an American Indian or Alaska Native must be provided upon application for coverage. In the event that an American Indian or Alaska Native child is found to be eligible for either the Full-Cost CHIP Coverage or the Low-Cost CHIP Coverage, the child will be automatically enrolled in the Free CHIP Coverage to ensure that his/her coverage is exempt from all cost-sharing requirements.

SECTION MC - MANAGED HEALTH CARE

The receipt of Covered Services described herein is subject to all terms, definitions and exclusions specified in this Agreement, and to the following provisions:

A. AUTHORIZED REPRESENTATIVE

Nothing shall preclude a duly authorized representative of the Member from filing or otherwise pursuing a Preauthorization request or other Pre-service Claim on behalf of a Member. FPH reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member. Such procedures as adopted by FPH shall, in the case of an Urgent Care Claim, permit a Professional Provider with knowledge of the Member's medical condition to act as the Member's authorized representative.

B. BLUES ON CALL (HEALTH EDUCATION AND SUPPORT PROGRAM)

The Blues On Call Program ("Blues On Call") addresses the total health care needs of Members rather than focusing on one (1) specific disease, condition or illness through interaction with both the patient and the Physician. Blues On Call promotes the philosophy of shared decision-making by helping Members work with their Physicians in the task of choosing treatment options that take into account the Member's values and preferences. Blues On Call provides Members with health care support services, including assistance in the self-management of certain health conditions. Members have twenty-four (24) hour access, seven (7) days a week, to health information and personalized support for health decisions.

Support services may include:

1. assessment of the Member's functional and health status, including co-morbidities, risk factors, motivation and confidence in managing their health, and receptivity for change;

2. assessment of the Member's knowledge of their particular condition and their understanding and adherence to the recommendations and instructions of his/her health care Provider;

3. Member education and training on health-related topics that can be helpful in improving the Member's overall health status, such as appropriate diet and nutrition, smoking cessation and exercise; and

4. ongoing monitoring (coaching) to optimize the Member's health status, ensuring adherence to the Physician's Treatment Plan, identifying and addressing barriers that prevent or hinder adherence to the Physician's Treatment Plan, and assessing the need for case management services.

Members may contact Blues On Call at the toll-free telephone number appearing in the Member's handbook or on the back of their Identification Card.

C. COVERED SERVICE MAXIMUMS AND LIMITATIONS

Certain Covered Services are also subject to Benefit Maximums and Limitations. Refer to **SECTION SC - SCHEDULE OF MAXIMUMS AND LIMITATIONS** in this Agreement to determine if a Benefit described in **SECTION DB - DESCRIPTION OF BENEFITS** includes a Maximum or any other limitation.

D. DESIGNATION OF A NETWORK SPECIALIST AS A PCP

A Member with a life-threatening, degenerative or disabling disease or condition can continue to receive care from any Network Specialist with clinical expertise in treating the disease or condition, or shall, upon request, receive an evaluation by FPH and, if the established requirements of FPH are met, be permitted to designate a Network Specialist to assume responsibility to provide and coordinate the Member's primary and specialty care. The Network Specialist once designated, will be able to provide those Covered Services which are indicated as being covered only when rendered by the PCP as set forth in **SECTION DB - DESCRIPTION OF BENEFITS**. The designation of a Network Specialist shall be in accordance with a Treatment Plan approved by FPH in consultation with the PCP and/or the Network Specialist and the Member.

E. EMERGENCY CARE SERVICES (Within or Outside the Service Area)

In the event that the Member requires Emergency Care Services, the Member should immediately proceed to the nearest emergency services Provider. No prior authorization is required for Emergency Care Services, whether received within or outside of the Service Area.

F. MEDICAL NECESSITY AND APPROPRIATENESS

The services or supplies described in **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement are covered only when they are Medically Necessary and Appropriate. The determination of Medical Necessity and Appropriateness is made by the Member's PCP, the Network Specialist and/or FPH. Any Covered Services requested by a Member which are not Medically Necessary and Appropriate will not be covered. The Member's receipt of a Preauthorization from FPH to receive services from a Provider outside the Network shall constitute proof of Medical Necessity and Appropriateness for purposes of determining a Member's potential liability for Covered Services.

G. MEMBER LIABILITY

Except when certain Maximums or other limitations or exclusions are specified in this Agreement, the Member is not liable for any charges for Covered Services when such Services are received from a Network Provider or Preauthorized, when appropriate, by FPH.

In the event a Member receives Covered Services from a Provider outside the Network without the required Preauthorization, except for Emergency Care Services, or as otherwise provided herein, the Member will be responsible for all charges associated with those Services regardless of whether the Services received were Medically Necessary and Appropriate.

If a Member receives emergency Ambulance Services, benefits will be provided under this Agreement. However, if such services are received from other than a Network Provider, the Member may be responsible for any amounts billed by that Provider that are in excess of the Plan Allowance.

If a Member receives services not covered under this Agreement, the Member is responsible for all charges associated with those services.

If FPH terminates the contract of a Network Provider for cause, FPH will not be responsible for health care services or supplies provided to the Member by that terminated Provider following the date of termination.

H. NOTIFICATION OF PREAUTHORIZATION AND OTHER PRE-SERVICE CLAIM DETERMINATIONS

Preauthorization of Covered Services, when required under this Agreement, and all other Pre-service Claims including requests to extend a previously approved course of treatment will be processed and notice of FPH's determination, whether adverse or not, will be given to the Member within the following time frames unless otherwise extended by FPH for reasons beyond its control:

1. In the case of an Urgent Care Claim, as soon as possible, taking into account the medical circumstances involved, but not later than seventy-two (72) hours following FPH's receipt of the Urgent Care Claim. This time frame may be shortened when the Urgent Care Claim seeks to extend a previously approved course of treatment and the request is made at least twenty-four (24) hours prior to the expiration of such previously approved course of treatment. In that situation, notice of FPH's determination will be given to the Member as soon as possible, taking into account the medical circumstances involved, but no later than twenty-four (24) hours following receipt of the request.

2. In the case of a non-urgent care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days following FPH's receipt of the non-urgent care Pre-service Claim.

   Notice of FPH's approval of a Pre-service Claim will include information sufficient to apprise the Member that the request has been approved. In the event that FPH renders an adverse determination on a Pre-service Claim, the notification shall include, among other items, the specific reason or reasons for the adverse determination and a statement describing the right of the Member to file a complaint or grievance appeal.

I. OUT OF NETWORK SERVICES

In the event that a Member requires non-emergency Covered Services that are not available within the Network, the Member may receive Services from a Provider outside the Network only when the Preauthorization from FPH has been obtained. Preauthorization by FPH is not required for Covered Services received at a Facility Provider outside of the Network which is a State-Owned Psychiatric Hospital.

J. PREAUTHORIZATION

Certain Covered Services require Preauthorization by FPH. The PCP or any other Network Specialist is responsible for obtaining the Preauthorization.

K. PRESCRIPTION DRUG CARE MANAGEMENT

Coverage under this Agreement is subject to the following in order to determine the Medical Necessity and Appropriateness of Prescription Drugs and supplies described in this Agreement.

1. Prior Authorization

Certain Prescription Drugs, as designated by FPH, may require prior authorization to ensure the Medical Necessity and Appropriateness of the Prescription Order. The Member's PCP or Network Specialist must obtain authorization from FPH prior to the dispensing of the drug at a Participating Pharmacy. If it is determined by FPH that the Prescription Drug is Medically Necessary and Appropriate, the Prescription Drug will then be dispensed by the Participating Pharmacy.

2. Managed Prescription Drug Coverage

A Prescription Order or refill which exceeds the manufacturer's recommended dosage over a specified period of time will be denied by FPH when presented to the Participating Pharmacy. FPH will contact the prescribing Physician to discuss the Member's drug therapy. If it is determined by FPH that the Prescription Drug is Medically Necessary

and Appropriate, the Prescription Drug will then be dispensed by the Participating Pharmacy.

3. Early Refill

No coverage is provided for any refill of a Covered Medication that is dispensed before the date of the Member's predicted use of at least ninety percent (90%) of the days' supply of the previously dispensed Covered Medication, unless the Member's Physician obtains Preauthorization from FPH for an earlier refill.

L. SELECTION OF PROVIDERS

Members covered under this Agreement must receive Covered Services from Network Providers, except in the following circumstances: 1) for Emergency Care Services; 2) when a Member receives Preauthorization to receive Services from a Provider outside the Network; 3) as provided in Subsection M. **TRANSITION/CONTINUITY OF CARE** of this Section; 4) when Covered Services are received at a Facility Provider outside the Network which is a State-Owned Psychiatric Hospital or 5) as otherwise provided herein.

1. Selection of a Primary Care Physician

Upon initial enrollment, each Member must select a PCP. If a Member fails to select a valid PCP within ten (10) days of membership in this program, FPH and/or the Highmark CHIP Unit reserves the right to select a PCP for the Member. However, if no PCP is selected, the Member may be responsible for payment for certain Covered Services. Members should always contact the PCP to verify whether that Provider is accepting new patients.

2. Changing a Primary Care Physician

a. If a Member wishes to transfer from one PCP to another PCP, the Member may contact FPH at the toll-free telephone numbers or through the website listed on his/her Identification Card. Upon receiving the appropriate information, FPH will process the change of the PCP. A Member may also initiate a change of PCP in writing by requesting a "PCP Change Form" which may be completed and mailed to FPH. In all cases:

i) if the change is received between the first (1^{st}) and fifteenth (15^{th}) day of the month, the PCP change will become effective the first (1^{st}) day of the following month; or

ii) if the change is received between the sixteenth (16^{th}) and the last day of the month, the change will become effective the first (1^{st}) day of the second month after it is received.

b. Transfer of a Member to another PCP may be required if FPH determines the Member-PCP relationship is unsatisfactory.

c. If the PCP terminates his/her relationship with FPH, the Member must select another PCP within thirty (30) days of notification of such termination. FPH will assist the Member in the selection of another PCP. Upon transfer to a new PCP, the Member will receive a new Identification Card with the new PCP's name and telephone number.

M. SPECIAL SERVICES

FPH reserves the right to authorize coverage for services which are not expressly listed in this Agreement, or which are received from a Provider who is not a Network Provider. In certain instances services that FPH determines may be a more effective means of treatment may be authorized or extended.

N. TRANSITION/CONTINUITY OF CARE

Benefits are also provided for Services and supplies received by a Member for the following:

1. Transition of Care

If a Member is receiving medical care from a non-Network Provider at the time of his/her Effective Date of coverage, which is not otherwise covered by his/her prior coverage, the Member may, at his/her option, continue an ongoing course of treatment with that Provider for a period of up to sixty (60) days from the Member's Effective Date of coverage. FPH must be notified by the Member of his/her request to continue an ongoing course of treatment for the transition of care period.

2. Continuity of Care

If at the time a Member is receiving medical care from a Network Provider, notice is received from FPH that it intends to terminate or has terminated the contract of that Network Provider for reasons other than cause, the Member may, at his/her option, continue an ongoing course of treatment with that Provider for a period of up to sixty (60) days from the date of the notification of the termination or pending termination. If, however, the Network Provider is terminated for cause and the Member continues to seek treatment from that Provider, FPH will not be liable for payment for health care services provided to the Member following the date of termination. Members may also receive continuation of care through the postpartum period for members in their second or third trimester of pregnancy.

This transition/continuity of care period may be extended if determined to be Medically Necessary and Appropriate by FPH following consultation with the Member and the Provider. In the case of a Member who is in the second or third trimester of pregnancy on the Effective Date of coverage or at the time notice of the termination or pending termination is received, care may continue with the Provider through postpartum care related to delivery. Any Services authorized under this Subsection will be covered in accordance with the same terms and conditions as applicable to Network Providers. Nothing in this Subsection shall require FPH to pay benefits for health care services that are not otherwise provided under the terms and conditions of this Agreement.

SECTION DB - DESCRIPTION OF BENEFITS

REFER TO SECTION SC - SCHEDULE OF MAXIMUMS AND LIMITATIONS TO DETERMINE IF ANY BENEFIT MAXIMUM OR LIMITATION APPLIES TO ANY OF THE BENEFITS DESCRIBED IN THIS SECTION. ALSO, SEE SECTION EX - EXCLUSIONS FOR CONDITIONS WHICH MAY AFFECT COVERAGE.

The following are Covered Services:

A. OUTPATIENT BENEFITS

1. AMBULANCE SERVICES

Benefits are provided for transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured: from a home, scene of an accident, or a medical emergency to a Hospital; between Hospitals; between a Hospital and a Skilled Nursing Facility; from a Hospital or Skilled Nursing Facility to a home; or from a home to a Professional Provider's office. In an emergency, Preauthorization is not required.

2. ANESTHESIA

Benefits are provided for Anesthesia Services when performed in connection with Covered Services, except as provided in connection with the **ORAL SURGERY** Benefits set forth in this Section.

3. AUTISM SPECTRUM DISORDERS

Benefits are provided for all Members for the following:

a. Diagnostic Assessment of Autism Spectrum Disorders

Medically necessary and appropriate assessments, evaluations or tests performed by a physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner to diagnose whether an individual has an autism spectrum disorder.

b. Treatment of Autism Spectrum Disorders

Services must be specified in a treatment plan developed by a licensed physician or licensed psychologist following a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. FPH may review a

treatment plan for autism spectrum disorders once every six months, or as agreed upon between FPH and the physician or psychologist developing the treatment plan.

Treatment may include the following medically necessary and appropriate services:

i) Pharmacy care

Prescription drugs approved by the Food and Drug Administration (FDA) and designated by FPH for the treatment of autism spectrum disorders and which are prescribed by a physician, licensed physician assistant or certified registered nurse practitioner. Also included is 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 prescription drugs.

ii) Psychiatric and psychological care

Direct or consultative services provided by a physician or by a psychologist who specializes in psychiatry.

iii) 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.

iv) Therapeutic care

Services that are provided by a speech language pathologist, occupational therapist or physical therapist.

4. **DENTAL AND OTHODONTIA**

Benefits are provided under this Contract for dental Services, including orthodontia services, received from a Dentist.

See Member Handbook for description of those dental Services which are covered, with or without limitations and those services which are excluded under this Contract.

5. **DIABETES TREATMENT**

Coverage is provided for the following when required in connection with the treatment of diabetes, and when prescribed by a Physician legally authorized to prescribe such items under the law:

a. Equipment and Supplies. Coverage is provided for blood glucose monitors, monitor supplies, syringes, injection aids and insulin infusion devices.

b. Diabetes Education. When the Member's Physician certifies that a Member requires diabetes education as an Outpatient, coverage is provided for the following when rendered through a Diabetes Education Program:

i) Visits Medically Necessary and Appropriate upon the diagnosis of diabetes; and

ii) subsequent Visits under circumstances whereby a Physician: a) identifies or diagnoses a significant change in the Member's symptoms or conditions that necessitates changes in a patient's self-management; or b) identifies as Medically Necessary and Appropriate, a new medication or therapeutic process relating to the Member's treatment and/or management of diabetes.

c. Prescription Drugs**.** Coverage is provided for insulin and pharmacological agents for controlling blood sugar.

6. **DIAGNOSTIC SERVICES**

Benefits are provided for the following Diagnostic Services:

a. Advanced Imaging Services

Include, but are not limited to, computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET scan), positron emission tomography/computed tomography (PET/CT scan).

b. Basic Diagnostic Services

i) Standard Imaging Services - procedures such as skeletal x-rays, ultrasound and fluoroscopy;

ii) Laboratory and Pathology Services - procedures such as non-routine Papanicolaou (PAP) smears, blood tests, urinalysis, biopsies and cultures;

iii) Diagnostic Medical Services - procedures such as electrocardiograms (ECG), electroencephalograms (EEG), echocardiograms, pulmonary studies, stress tests, audiology testing; and

iv) Allergy Testing Services - allergy testing procedures such as percutaneous, intracutaneous, and patch tests.

Diagnostic Services provided for preventive purposes in accordance with a predefined schedule based on age and sex described in Paragraph U. **PREVENTIVE SERVICES** paragraph of this Subsection are exempt from Copayments.

7. DIALYSIS

Benefits are provided for Dialysis Treatments when Preauthorized by FPH and when provided in the Outpatient facilities of a Hospital, a free-standing renal dialysis facility which has been approved by FPH or in the home with the Preauthorization of FPH. In the case of home dialysis, Covered Services will include equipment, training, and Medical Supplies. The decision to provide Benefits for the purchase or rental of necessary equipment for home dialysis will be made by FPH. When the Member becomes eligible for Medicare coverage for dialysis, dialysis Benefits provided in this Agreement will be coordinated with such Medicare coverage.

8. DURABLE MEDICAL EQUIPMENT

Benefits will be provided for the rental (but not to exceed the total cost of purchase) or, at the option of FPH the purchase, adjustment, repairs and replacement, if necessitated because of normal wear and not neglect, of Durable Medical Equipment determined to be the standard to restore basic function, when prescribed by a Professional Provider within the scope of their license and required for therapeutic use. If more than one (1) type of Durable Medical Equipment exists, FPH will Preauthorize coverage for only the Durable Medical Equipment Medically Necessary and Appropriate to restore basic function. Medical Supplies which are necessary for the essential function of the Durable Medical Equipment and are Primarily Medical in Nature, not a Comfort/Convenience Item, and used for therapeutic purposes are also eligible under this Benefit. Durable Medical Equipment does not include Prosthetic Appliances and Orthotic Devices.

9. ENTERAL FOODS

Coverage is provided for Enteral Foods when administered on an Outpatient basis for the following:

a. amino acid-based elemental medical formulae ordered by a Physician for infants and children for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short bowel syndrome; and

b. nutritional supplements administered under the direction of a Physician for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.

Coverage does not include normal food products used in the dietary management of the disorders set forth in this Subsection.

10. GYNECOLOGICAL SERVICES

Members may receive treatment for any gynecological medical condition at any time from a Network PCP, gynecologist or a Network Nurse-Midwife. The Network gynecologist or Network Nurse-Midwife may coordinate any Preauthorization required for Covered Services with FPH.

11. HABILITATIVE SERVICES

Benefits are provided for health care services that help a Member keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of outpatient settings. Covered Services also include also include inpatient therapy for the treatment of CVA (Cerebral Vascular Accidents), head injury, spinal cord injury or as required as a result of post-operative brain surgery and chiropractic care.

See **SECTION SC - SCHEDULE OF MAXIMUMS AND LIMITATIONS**.

12. HEARING DEVICES AND EXAMINATIONS

a. Benefits are provided for Audiometric Examinations, Hearing Aid Evaluation Tests and Hearing Aids when provided or prescribed by an Audiologist, Physician or Hearing Aid Dealer/Fitter. The Member must first obtain a medical examination of the ear by a Physician and such examination, in conjunction with the Audiometric Examination, must result in a determination that a Hearing Aid will improve hearing acuity.

b. Limitations

   i) The Hearing Aid Evaluation Test and/or Hearing Aid must be provided within sixty (60) days of an Audiometric Examination;

   ii) No Benefits are payable after the Member's coverage terminates, except for Hearing Aids ordered prior to the termination date and delivered within sixty (60) days of that date.

iii) Repairs and maintenance (except batteries) are only covered if provided after the expiration of the warranty.

c. Excluded from coverage under this Benefit

1) batteries and cords for Hearing Aids;

ii) dispensing fees for Hearing Aids;

iii) replacement of lost or stolen Hearing Aids; and

iv) insurance premiums protecting against Hearing Aid loss. See **SECTION SC - SCHEDULE OF MAXIMUMS AND LIMITATIONS**.

13. **HEARING CARE SERVICES**

Hearing aids and devices and the fitting and adjustment of such devices are covered when determined to be medically necessary and appropriate.

14. HOME HEALTH CARE

a. Benefits are provided for the following when Services are rendered by a Home Health Care Agency or a Hospital program for Home Health Care and may require Preauthorization from FPH:

i) Skilled Nursing Services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN), including private duty nursing Services;

ii) Habilitative, Therapy and Rehabilitation Services;

iii) medical and surgical supplies provided by the Home Health Care Agency or Hospital program for Home Health Care;

iv) oxygen and its administration;

v) medical social service consultations;

vi) health aide Services to a Member who is receiving covered nursing or Habilitative, Therapy and Rehabilitation Services.

b. Exception - No Home Health Care Benefits will be provided for:

i) dietitian services;

ii) homemaker services;

iii) maintenance therapy;
iv) Custodial Care; and

v) food or home delivered meals.

15. **HOME VISITS**

Benefits are provided for PCP or Specialist Visits to a Member's home within the Service Area.

16. **HOSPICE CARE**

Benefits provided for Home Health Care are also available when the Services are rendered by a Hospice program. Respite Care and family counseling related to the Member's terminal condition are Covered Services.

17. **INJECTIONS**

Benefits are provided for injectable medication for the treatment of an injury or illness when provided by the PCP or other Network Specialist and administered in the Physician's office.

18. **MASTECTOMY AND BREAST CANCER RECONSTRUCTION**

Benefits are provided for a mastectomy performed on an Outpatient basis and for the following:

a. Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to, augmentation, mammoplasty, reduction mammoplasty, mastopexy, and surgery and reconstruction to the other breast to produce a symmetrical appearance.

b. initial and subsequent prosthetic devices to replace the removed breast or portions thereof; and

c. physical complications of all stages of mastectomy, including lymphedemas.

Coverage is also provided for one (1) home health care Visit, as determined by the Member's Physician, received within forty-eight (48) hours after discharge, if such discharge occurs within forty-eight (48) hours after an admission for a mastectomy.

19. **MATERNITY CARE**

Pregnant Members must notify FPH and will be referred to Medicaid to determine eligibility for Medicaid coverage. If the Member is not eligible for Medicaid, Benefits

will be provided under this Agreement for obstetrical care, including prenatal and postnatal care, sonograms, complications of pregnancy (physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section), childbirth and newborn care received on an Outpatient basis. Maternity Care can be provided by a Network obstetrician, Network Nurse-Midwife, or a Network PCP who has been credentialed to provide routine obstetrical care.

NOTE: Under federal law, FPH may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, FPH may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Coverage is also provided for at least one (1) home health care visit following an inpatient release for maternity care when the Member is released prior to forty-eight (48) hours for a normal delivery and ninety-six (96) hours for a caesarean delivery in consultation with the mother and provider, or in the case of a newborn, in consultation with the mother or the newborn's authorized representative. Home health care visits include, but are not limited to: parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests, and the performance of any necessary maternal and neonatal physical assessments. A licensed health care Provider whose scope of practice includes postpartum care must make such home health care visits. At the mother's sole discretion, the home health care visit may occur at the facility of the Provider. Home health care visits following an Inpatient stay for maternity services are not subject to Copayments.

20. MEDICAL SUPPLIES

Benefits are provided for Medical Supplies which are necessary for the essential function of Durable Medical Equipment, Prosthetic Appliances, or Orthotic Devices and for the follow-up care and treatment required as a result of Emergency Accident Care, Emergency Medical Care, Home Health Care or following Inpatient care.

21. MENTAL HEALTH CARE

Benefits are provided for the treatment of Mental Illness. Benefits include, but are not limited to, individual psychotherapy, group psychotherapy, psychological testing, family counseling and convulsive therapy treatment. A Mental Illness Service provided on a Partial Hospitalization basis will be deemed to be an Outpatient Service Visit.

22. NEWBORN CARE

Benefits are provided for the care of a newborn child of a Member for a Maximum period of thirty-one (31) days following birth. Such care shall include routine nursery care, prematurity services, preventive care services, as well as coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

23. ORAL SURGERY

Benefits are provided for the following limited oral surgical procedures in an Outpatient setting. Services require Preauthorization by FPH:

a. extraction of teeth in preparation for cardiac Surgery, organ transplantation or radiation therapy;

b. Facility Provider, and Anesthesia Services rendered in conjunction with non-covered dental procedures when determined by FPH to be Medically Necessary and Appropriate due to the age and/or medical condition of the Member;

c. accidental injury to the jaw or structures contiguous to the jaw except teeth;

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

e. treatment for tumors and cysts requiring pathological examination and for infections of the jaw, cheeks, lips, tongue, roof and floor of mouth;

f. orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft Surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus;

g. mandibular staple implant, provided the procedure is not done in preparation of the mouth for dentures;

h. lingual frenectomy, frenotomy or frenoplasty (to correct tongue-tie) and mandibular frenectomy; and

i. extraction of impacted teeth when partially or totally covered by bone.

24. ORTHOTIC DEVICES

Benefits will be provided for the purchase, fitting, necessary adjustment, repairs, and replacements, if necessitated because of normal wear and not neglect, of Orthotic Devices determined to be the standard to restore basic function, when prescribed by a Professional Provider. If more than one (1) type of Orthotic Device exists FPH will

provide coverage for only the Orthotic Device Medically Necessary and Appropriate to restore basic function. This includes shoes permanently attached to a brace or when prescribed in connection with the treatment of diabetes. Medical Supplies which are necessary for the essential function of the Orthotic Device and are Primarily Medical in Nature, not a Comfort/Convenience Item, and used for therapeutic purposes are also eligible under this Benefit.

25. OSTEOPORSIS SCREENING (Bone Mineral Density Testing or BMDT)

Coverage is provided for Bone Mineral Density Testing (BMDT) using a U.S. Food and Drug approved method. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength which is the aggregate of bone density and bone quality. Bone quality refers to architecture, turnover and mineralization of bone. The BMDT must be prescribed by a Professional Provider legally authorized to prescribe such items under applicable law.

26. OUTPATIENT SERVICE VISITS

Benefits are provided for Covered Services received on an outpatient basis during a Visit with a Professional Provider. Benefits are also provided for a Specialist Virtual Visit when a Member communicates with the Specialist from any location such as their home, office or another mobile location, or the Member travels to a Provider-based location referred to as the "Provider originating site." The physical site from which the Member communicates with the Specialist is referred to as the "originating site." Benefits will not be paid for a Specialist Virtual Visit if such Visit is related to the treatment of Mental Illness or Substance Abuse.

27. PRESCRIPTION DRUGS

a. Benefits are provided for the following drugs when prescribed by a licensed practitioner in connection with a Covered Service and when purchased at a Participating Pharmacy Provider upon presentation of a valid Member Identification Card.

   i) Prescription Drugs listed on the Formulary.

   ii) Over-the-Counter Drugs listed on the Formulary, upon presentation of a written Prescription Order.

   iii) Maintenance Prescription Drugs when purchased from a retail Participating Pharmacy Provider. The Copayment for each Prescription Order or refill is described in SECTION SC - SCHEDULE OF MAXIMUMS AND LIMITATIONS.

   iv) Specialty Prescription Drugs purchased from a retail Participating Pharmacy Provider or an Exclusive Pharmacy Provider.

Benefits under this Prescription Drug benefit or other benefits provided under this Contract include Food and Drug Administration-approved contraceptive methods, including contraceptive devices; injectable contraceptives; IUDs and implants; voluntary sterilization procedures; and patient education and counseling, not including abortifacient drugs. Copayments do not apply to these Covered Services, Drugs and Supplies. Contraception drugs and devices are also covered under this Prescription Drug benefit.

Benefits are provided for continuous glucose monitoring devices when prescribed by a Professional Provider in connection with a Covered Service, when purchased at a Participating Pharmacy Provider upon presentation of a valid Identification Card and when dispensed on or after the Member's Effective Date.

b. Limitations

i) Except in Emergency situations, no coverage is provided for Prescription Drugs purchased at a non-Participating Pharmacy Provider.

ii) Each Prescription Drug purchased from a retail Participating Pharmacy Provider is limited to a 31-day supply per Prescription Order or refill. Maintenance Prescription Drugs purchased from a retail Participating Pharmacy Provider are limited to a 90-day supply per Prescription Order or refill. All Specialty Prescription Drugs, including those which must be obtained from an Exclusive Pharmacy Provider, are limited to a 31-day supply per Prescription Order or refill. Members may contact FPH at the toll-free telephone number or the website appearing on the back of the Member's Identification Card to verify that a particular Prescription Drug is a Specialty Prescription Drug, and whether it may be purchased from a retail Participating Pharmacy Provider or must be obtained through an Exclusive Pharmacy Provider.

iii) The Participating Pharmacy Provider will dispense Generic Drugs in accordance with State and Federal laws unless a generic equivalent is not available. If the Member cannot or will not accept a generic substitution when the generic equivalent is available, the Member will be required to pay the difference between the price for a Brand Drug and any available generic equivalent, for each separate Prescription Order or refill. This amount is in addition to the applicable Brand Drug Copayment stipulated in **SECTION SC- SCHEDULE OF MAXIMUMS AND LIMITATIONS**. If the prescribing Physician indicates that the Brand Name Drug is medically necessary and appropriate, it should be dispensed and the Brand Name Drug will be covered and the Member will only be responsible for the Generic Drug Copayment amount.

iv) Quantity level limits may be imposed on certain Prescription Drugs by FPH. Such limits are based on the manufacturer's recommended daily dosage or as determined by FPH. Quantity level limits control the quantity covered each

time a new Prescription Order or refill is dispensed for selected Prescription Drugs. Each time a new Prescription Order or refill is dispensed, the Participating Pharmacy may limit the amount dispensed.

v) Benefits are provided for selected Prescription Drugs within, but not limited to, the following drug classifications only when such drugs are dispensed through an Exclusive Pharmacy Provider:

- Oncology related therapies;

- Interferons;

- Agents for multiple sclerosis and neurological related therapies;

- Antiarthritic therapies;

- Anticoagulants;

- Hematinic agents;

- Immunomodulators;

- Growth hormones; and

- Hemophilia related therapies.

(a) These selected Prescription Drugs are subject to the day supply quantity limitations as set forth in this Subparagraph b. (2) Limitations.

(b) These selected Prescription Drugs may be ordered by a Network Provider on behalf of the Member or the Member may submit the Prescription Order directly to the Exclusive Pharmacy Provider. In either situation, the Exclusive Pharmacy Provider will deliver the Prescription Drug to the Member.

(c) For a complete listing of those Prescription Drugs that must be obtained through an Exclusive Pharmacy Provider, Members may call Member Service at the toll-free telephone number appearing on the back of the Member's Identification Card or visit FPH's website at www.highmarkbcbs.com.

vi) Coverage is limited to those Prescription Drugs and Over-the-Counter Drugs listed on the Formulary.

vii) The quantity level limit for each initial Prescription Order may be reduced, dependent upon the particular medication, to a quantity level necessary to establish that the Member can tolerate the Prescription Drug. Consequently, the amounts set forth in **SECTION SC - SCHEDULE OF MAXIMUMS AND**

LIMITATIONS will be prorated based upon the initial quantity dispensed. If the Member is able to tolerate the Prescription Drug the remainder of the available days supply for the initial Prescription Order will be filled and the Member will be charged the balance of the amount applicable to the initial Prescription Order.

viii) Benefits are provided for certain specified drugs when dispensed to Members (on a "stepped basis", referred to as the "Step Therapy" Program. Within selected drug categories, benefits are only provided for specified Prescription Drugs when one (1) or more alternative drugs prove ineffective or intolerable and the following criteria are met: (1) the Member has used alternative drug(s) within the same therapeutic class/category as the specified Prescription Drug; (2) the Member has used the alternative drugs for a length of time necessary to constitute an adequate trial; and (3) the specified Prescription Drug is being used for an FDA approved indication. If these criteria are met, the Participating Pharmacy Provider will dispense the specified Prescription Drug to the Member. The Member shall be responsible for any cost-sharing amounts and will be subject to any quantity limit requirements or other limitations set forth in this Agreement. When these criteria are not met, the treating Physician may submit a request for authorization to dispense a specified Prescription Drug to the Member for the FPH's consideration.

c. Excluded from coverage under this Benefit

i) weight control drugs;

ii) drugs and supplies which can be purchased without a Prescription Order;

iii) drugs whose labeled indications are for cosmetic purposes only;

iv) injectable drugs that require administration and/or monitoring by a health care professional, and charges related to such administration and/or monitoring;

v) fertility drugs;

vi) drug therapy associated with tobacco cessation programs for members under age 18;

vii) impotency treatment drugs;

viii) antihemophiliac drugs, when purchased from other than an Exclusive Pharmacy Provider;

ix) any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes;

xi) Prescription Drugs used for unlabeled or unapproved indications where such use has not been approved by the Food and Drug Administration (FDA);

xii) Prescription Drugs and Over-the-Counter Drugs not listed on the Formulary;

xii) Prescription Drugs and Over-the-Counter Drugs that have not demonstrated efficacy; and

xiii) any drug or medication which is otherwise excluded under the terms of this Agreement.

28. PREVENTIVE SERVICES

Benefits are provided for prevention, early detection and minimization of the ill effects and causes of disease or disability based on the Member's health assessment by the PCP or Network Specialist. The PCP or Network Specialist determines the frequency of these exams and procedures based on FPH's guidelines in conjunction with the Member's age, sex, and medical history. Unless otherwise indicated, Preventive Services are covered when provided by the PCP or Network Specialist. Copayments do not apply to Preventive Services involving family planning, women's health and contraceptives.

Well Woman Care preventive health services covered under this Agreement includes all services and supplies as described under the Women's Preventive Services provision of the Patient Protection and Affordable Care Act.

Covered Preventive Services and supplies include, but are not limited to, the following:

a. Allergy Testing and Treatment

   Benefits are provided for allergy tests, testing materials, and treatment, including serums.

b. Immunizations

   Benefits are provided for immunizations, including the immunizing agent, when required for the prevention of disease (except those required for foreign travel or employment). This includes the meningitis immunization when required for college admission and influenza vaccinations administered by a Participating Pharmacy provider for Members age 9 and older, with parental consent, in accordance with Pennsylvania Act 8 or 2015.

   Coverage will be provided for those pediatric immunizations, including the immunizing agents, which, as determined by the Pennsylvania Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and the U.S. Department of Health and Human Services, when provided by the PCP. Benefits for pediatric immunizations are exempt from any applicable dollar limits. Pediatric and adult Immunization ACIP

schedules may be found by accessing the following link: http://www.cdc.gov/vaccines/recs/schedules/default.htm.

c. Mammograms

Coverage will be provided for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service Provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992. Copayments, if any, do not apply to this benefit.

d. Routine Gynecological Services

Benefits are provided for one (1) routine gynecological examination, including a pelvic examination and clinical breast examination and one (1) routine Papanicolaou (PAP) Smear per calendar year for all female Members when provided by the PCP or Network gynecologist or Network Nurse-Midwife of the Member's choice. This includes a pelvic exam and clinical breast exam; and routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists. Female Members have direct access to care by an Obstetrician or Gynecologist. This means there is no Primary Care Physician referral needed. A female Member may select a participating Provider of gynecological services without a referral or Preauthorization.

e. Routine Physical Examinations

Benefits are provided for routine physical examinations, regardless of Medical Necessity and Appropriateness, when performed by the PCP and in accordance with a predefined schedule* based on age and sex.

f. Well Baby Care

Benefits are provided for well baby visits, including medical history, height and weight measurement, physical examination and counseling.

Benefits also include an oral health risk assessment and application of fluoride varnish for member age five (5) months to five (5) years old as recommended by the U.S. Preventive Service Task Force.

g. Blood Testing (Pediatric)

Benefits are provided for:

*This schedule is reviewed and updated periodically by FPH based on the advice of the American Academy of Pediatrics, U.S. Preventive Task Force, the Blue Cross and Blue Shield Association, and medical consultants. Accordingly, the frequency and eligibility of services is subject to change.

i) blood lead testing and lead testing; and

ii) blood testing to measure size, shape, number and content of red blood cells (Hemoglobin/Hematocrit).

h. Well Woman Care

Additional well woman care benefits covered under this Contract include the following breastfeeding or other related Services:

i) comprehensive support and counseling from trained Providers;

ii) lactation support and counseling provided during postpartum hospitalization; and

iii) Mother's Option Visits, and obstetrician or pediatrician visits for pregnant and nursing women. No Copayment required.

Benefits for breastfeeding supplies, including coverage for rental of hospital-grade breastfeeding pumps require Preauthorization and are provided under the Durable Medical Equipment benefit of this Contract.

i. Diabetes Prevention Program

Benefits are provided for those Members meeting certain medical criteria of having a high risk of developing type 2 diabetes when enrolled in a Diabetes Prevention Program that is offered through a Network Diabetes Prevention Provider. Coverage is limited to one (1) enrollment in a Diabetes Prevention Program per year, regardless of whether the Member completes the Diabetes Prevention Program.

29. PROSTHETIC APPLIANCES

Benefits are provided for the purchase, fitting, necessary adjustment, repairs, and replacements, if necessitated because of normal wear and not neglect, of Prosthetic Appliances determined to be the standard to restore basic function and related Medical Supplies when prescribed by a Professional Provider. Replacements are also covered when required due to the normal growth of a child. If more than one (1) type of Prosthetic Appliance exists FPH will provide coverage for only the Prosthetic Appliance Medically Necessary and Appropriate to replace the basic function of the missing or malfunctioning body limb or organ. This includes prosthetic shoes for a person with a partial amputation of the foot or feet, and the initial and subsequent prosthetic devices to replace the removed breast or portions thereof as provided under the **MASTECTOMY AND BREAST CANCER RECONSTRUCTION** Benefit in this Section. Medical Supplies which are necessary for the essential function of the Prosthetic Appliance and

are Primarily Medical in Nature, not a Comfort/Convenience Item, and used for therapeutic purposes are also eligible under this Benefit.

Reconstructive Surgery will only be covered when required to restore function following accidental injury, result of a birth defect, infection, or malignant disease in order to achieve reasonable physical or bodily function; in connection with congenital disease or anomaly through the age of eighteen (18); or in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment; or breast reconstruction following a mastectomy.

30. ROUTINE PATIENT COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS

Routine patient costs incurred in connection with the Member's participation in a Qualifying Clinical Trial, including all items and services received on an Outpatient basis consistent with the coverage provided under this Agreement that are typically covered for a Member who is not enrolled in a clinical trial.

31. SUBSTANCE ABUSE

Benefits are provided for Outpatient Service Visits for the treatment of Substance Abuse. Covered Services must be Preauthorized by FPH.

The following Services are covered:

a. Physician, Psychologist, nurse, Master Level Therapist and Social Worker Services;

b. Detoxification, rehabilitation, therapy and counseling;

c. family counseling and intervention;

d. psychiatric, psychological and medical laboratory tests; and

e. drugs, medicines, equipment use and supplies.

A Parent, guardian, or Member as young as fourteen (14) years old can self-refer.

32. SURGERY

Benefits are provided for covered surgical Services required for treatment of disease, illness or injury. See **SECTION SC - SCHEDULE OF MAXIMUMS AND LIMITATIONS.**

33. TELEMEDICINE SERVICES

Benefits are provided for covered Telemedicine Services for the examination, diagnosis and treatment of an injury or illness.

34. THERAPY AND REHABILITATION SERVICES

Benefits are provided for specific Therapy and Rehabilitation Services when Preauthorized by FPH and performed by a Professional Provider. Covered Services for therapies, such as Cardiac Rehabilitation, must be expected to make measurable or sustainable improvement in the level of functioning within a reasonable period of time as determined by FPH. The following Therapy and Rehabilitation Services are Covered Services when Preauthorized:

a. Cardiac Rehabilitation Therapy

b. Chemotherapy

c. Infusion Therapy

Benefits will be provided when Covered Services are performed by a Provider on an Outpatient basis or if the components are furnished and billed by a Provider. Covered Services include pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with Infusion Therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with Infusion Therapy. Benefits for certain Infusion Therapy Prescription Drugs as identified by FPH and which are appropriate for self-administration, will be provided only when received from a Participating Pharmacy Provider as set forth under the **PRESCRIPTION DRUGS** paragraph of this Subsection.

d. Pulmonary Therapy

e. Radiation Therapy

f. Respiratory Therapy

The following Therapy and Rehabilitation Services are Covered Services and do not require Preauthorization:

g. Occupational Therapy

h. Physical Medicine

i. Speech Therapy

See **SECTION SC - SCHEDULE OF MAXIMUMS AND LIMITATIONS**.

35. VISION CARE SERVICES

Vision care services and products are provided under this Agreement as set forth in the Member Handbook.

36. VISION SCREENING

Benefits are provided for vision screening when provided by the PCP.

37. FAMILY PLANNING SERVICES

Benefits are provided for voluntary family planning services when provided by the PCP, a Network gynecologist or Network Nurse-Midwife. Coverage will be provided for contraceptive devices and oral, injectable, transdermal and intravaginal contraceptive Prescription Drugs when obtained from a Participating Pharmacy Provider. Coverage will also be provided for counseling, education and related Services to prevent and address the consequences of at-risk behavior related to sexually transmitted diseases ("STDs") and pregnancy when such Services are provided by the PCP, a Network gynecologist or Network Nurse-Midwife.

38. HOSPITAL OUTPATIENT SERVICES

a. Ancillary Services

Hospital services and supplies including, but not restricted to:

i) Use of operating and treatment rooms and equipment;

ii) Drugs and medicines provided to a Member who is an Outpatient in a Facility Provider. However, benefits for certain therapeutic injectables and Infusion Therapy Prescription Drugs as identified by FPH and which are appropriate for self-administration, will be provided only when received from a Participating Pharmacy Provider as set forth under the **PRESCRIPTION DRUGS** paragraph of this Subsection;

iii) Whole blood, administration of blood, blood processing, and blood derivatives;

iv) Anesthesia, Anesthesia supplies and Services rendered in a Facility Provider by an employee of the Facility Provider, including the administration of Anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at surgery;

v) Medical and surgical dressings, supplies, casts, and splints;

vi) Diagnostic Services;

vii) Habilitative Services; and

viii) Rehabilitative and Therapy Services.

b. Pre-Admission Testing

Tests and studies, including those set forth in the Basic Diagnostic Services paragraph of Paragraph G. **DIAGNOSTIC SERVICES** of this Section**,** when such Services are required in connection with the Member's admission and are rendered or accepted by a Hospital on an Outpatient basis prior to a scheduled admission to the Hospital as an Inpatient.

c. Surgery

Hospital services and supplies for Outpatient surgery including removal of sutures, Anesthesia, Anesthesia supplies and Services rendered by an employee of the Facility Provider other than the surgeon or assistant at Surgery.

39. **HOSPITAL MEDICAL CARE SERVICES**

Medical care rendered by a Professional Provider to a Member who is an Outpatient for a condition not related to Surgery, pregnancy or Mental Illness, except as specifically provided, including allergy extracts, allergy injections, medical care Visits, Telemedicine Services, therapeutic injections and consultations for the examination, diagnosis and treatment of an injury or illness, and Covered Services provided by Professional Providers at a Retail Clinic or Urgent Care Center. However, benefits for certain therapeutic injectables as identified by FPH and which are appropriate for self-administration, will be provided only when received from a Participating Pharmacy Provider as set forth under the **PRESCRIPTION DRUGS** paragraph of this Subsection.

Benefits for outpatient Hospital Medical Care Services is covered subject **SECTION SC - SCHEDULE OF MAXIUMUMS AND LIMITATIONS.**

Surgical Services

a. Anesthesia

Administration of Anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at surgery. Benefits are also provided for the administration of Anesthesia for covered oral surgical procedures in an Outpatient setting when ordered and administered by the attending Professional Provider.

b. Assistant at Surgery

Services of a Physician who actively assists the operating surgeon in the performance of covered Surgery. Benefits will be provided for an assistant at surgery only if an intern, resident, or house staff member is not available.

c. Second Surgical Opinion

i) Services

A consulting opinion and directly related Diagnostic Services to confirm the need for recommended elective Surgery.

ii) Specifications

(a) The second opinion consultant must not be the Physician who first recommended elective Surgery.

(b) Elective Surgery is covered Surgery that may be deferred and is not an emergency.

(c) Use of a second surgical opinion is at the Member's option.

(d) If the first opinion for elective Surgery and the second opinion conflict, then a third opinion and directly related Diagnostic Services are Covered Services.

(e) If the consulting opinion is against elective Surgery and the Member decides to have the elective Surgery, the Surgery is a Covered Service. In such instances, the Member will be eligible for a maximum of two (2) such consultations involving the elective surgical procedure in question, but limited to one (1) consultation per consultant.

d. Special Surgery

i) Oral Surgery

Benefits are provided for the following limited oral surgical procedures in an Outpatient setting when Preauthorized by FPH or in an Inpatient setting if determined to be Medically Necessary and Appropriate:

(a) Extraction of impacted teeth when partially or totally covered by bone;

(b) Extraction of teeth in preparation for cardiac Surgery, organ transplantation or radiation therapy;

(c) Mandibular staple implant, provided the procedure is not done in preparation of the mouth for dentures;

(d) Lingual frenectomy, frenotomy or frenoplasty (to correct tongue-tie) and Mandibular frenectomy;

(e) Facility Provider and Anesthesia services rendered in conjunction with non-covered dental procedures when determined by FPH to be Medically Necessary and Appropriate due to the age and/or medical condition of the Member;

(f) Accidental injury to the jaw or structures contiguous to the jaw except teeth;

(g) The correction of a non-dental physiological condition which has resulted in a severe functional impairment;

(h) Treatment for tumors and cysts requiring pathological examination and for infections of the jaw, cheeks, lips, tongue, roof and floor of mouth; and

(i) Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft Surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

ii) Mastectomy and Breast Cancer Reconstruction

Benefits are provided for a mastectomy performed on an Inpatient or Outpatient basis for the following:

(a) Surgery to reestablish symmetry or alleviate functional impairment including, but not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy;

(b) Initial and subsequent prosthetic devices to replace the removed breast or portions thereof; and

(c) Physical complications of all stages of mastectomy, including lymphedemas.

Benefits are also provided for one (1) home health care visit, as determined by the Member's Physician, when received within forty-eight (48) hours after discharge, if such discharge occurred within forty-eight (48) hours after an admission for a mastectomy.

e. Surgery

i) Surgery performed by a Professional Provider. Separate payment will not be made for pre- and post-operative Services.

ii) If more than one (1) surgical procedure is performed by the same Professional Provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure, plus fifty percent (50%) of the amount that would have been payable for each of the additional procedures, had those procedures been performed alone.

40. Therapeutic Injections

Benefits are provided for injectable medication for the treatment of an injury or illness when provided by the PCP or other Network Specialist and administered in the Physician's office.

41. Tobacco Cessation Counseling

Benefits are provided for tobacco cessation counseling for symptomatic individuals.

B. INPATIENT BENEFITS

1. ANESTHESIA

Benefits are provided for Anesthesia Services when performed in connection with Covered Services, except as provided in connection with the **ORAL SURGERY** Benefit set forth in this Section.

2. DIAGNOSTIC SERVICES

Benefits are provided in a Hospital for the following Diagnostic Services:

a. diagnostic X-ray consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine;

b. diagnostic pathology consisting of laboratory and pathology tests;

c. diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by FPH; and

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

3. HOSPICE CARE

Benefits are provided for Hospital Services for a Member who is enrolled in a program for Hospice Care.

4. HOSPITAL SERVICES

Benefits are provided for the following Services when provided in a Facility Provider:

a. semi-private room and board (or private or specialty accommodations when certified as Medically Necessary and Appropriate by the attending Physician or the PCP, and FPH);

b. general nursing care;

c. drugs, medications, and biologicals;

d. meals (including special diets or Enteral Formulae when Medically Necessary and Appropriate);

e. use of the operating room and related facilities;

f. use of intensive care or cardiac units or related services;

g. oxygen services;

h. whole blood, blood derivatives, blood plasma and blood components; the administration and processing of blood; the storage of blood when done in preparation for a scheduled surgical procedure, and transfusion supplies and equipment when administered in connection with Covered Services;

i. Medical Supplies, Durable Medical Equipment, Prosthetic Appliances, Orthotic Devices; and

j. Dialysis Treatments.

5. INPATIENT PROFESSIONAL SERVICES

Benefits are provided for generally accepted, Medically Necessary and Appropriate Covered Services performed, prescribed, or supervised by a Professional Provider for an Inpatient, within a Facility Provider. Covered Services includes Physician consultations. See **SECTION SC - SCHEDULE OF MAXIMUMS AND LIMITATIONS.**

6. MASTECTOMY AND BREAST CANCER RECONSTRUCTION

Benefits are provided for a mastectomy, and for the following when performed on an Inpatient basis:

a. Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy, and surgery and reconstruction of the other breast to produce a symmetrical appearance.

b. initial and subsequent prosthetic devices to replace the removed breast or portions thereof; and

c. physical complications of all stages of mastectomy, including lymphedemas.

Coverage is also provided for one home health care Visit, as determined by the Member's Physician, received within forty-eight (48) hours after discharge.

7. **MATERNITY CARE**

Pregnant Members must notify FPH and will be referred to Medicaid to determine eligibility for Medicaid coverage. If the Member is not eligible for Medicaid, Benefits will be provided under this Agreement for obstetrical care, including prenatal and postnatal care, sonograms, complications of pregnancy (physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section), childbirth and newborn care in the Facility Provider. Maternity Care can be provided by a Network obstetrician, Network Nurse-Midwife or a Network PCP who has been credentialed to provide routine obstetrical care, and is subject to all the terms of this Agreement. Coverage is provided out of the Service Area, in the event of an emergency.

8. **MENTAL HEALTH CARE**

Benefits are provided for the treatment of Mental Illness in a Facility Provider. Benefits include but are not limited to individual psychotherapy, group psychotherapy, psychological testing, family counseling and convulsive therapy treatment. See **SECTION SC - SCHEDULE OF MAXIMUMS AND LIMITATIONS**.

9. **NEWBORN CARE**

Benefits are provided for a newborn child of a Member for a period of thirty-one (31) days following birth. Covered Services shall include routine nursery care, prematurity services, preventive care services, as well as coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

10. **ORAL SURGERY**

When Medically Necessary and Appropriate to be performed in an Inpatient setting, and Preauthorized by FPH benefits are provided for the following limited oral surgical procedures:

a. extraction of teeth in preparation for cardiac Surgery, organ transplantations or radiation therapy;

b. Facility Provider and Anesthesia services rendered in conjunction with non-covered dental procedures when determined by FPH to be Medically Necessary and Appropriate due to the age and/or medical condition of the Member;

c. accidental injury to the jaw or structures contiguous to the jaw except teeth;

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

e. treatment for tumors and cysts requiring pathological examination and for infections of the jaws, cheeks, lips, tongue, roof and floor of mouth;

f. orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft Surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus**;**

g. mandibular staple implant, provided the procedure is not done in preparation of the mouth for dentures;

h. lingual frenectomy, frenectomy or frenoplasty (to correct tongue-tie) and mandibular frenectomy; and

i. extraction of impacted teeth when partially or totally covered by bone.

11. **ROUTINE PATIENT COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS**

Routine patient costs incurred in connection with the Member's participation in a Qualifying Clinical Trial, including all items and services received on an Inpatient basis consistent with the coverage provided under this Agreement that are typically covered for a Member who is not enrolled in a clinical trial.

12. **SKILLED NURSING FACILITY SERVICES**

Benefits are provided for Skilled Nursing Facility Services when Preauthorized by FPH. No Benefits are payable: (a) after the Member has reached the maximum level of recovery possible for a particular condition and no longer requires definitive treatment other than routine supportive care; (b) when confinement in a Skilled Nursing Facility is intended solely to provide Custodial Care to the Member; and (c) for the treatment of Substance Abuse.

13. **SUBSTANCE ABUSE SERVICES**

Benefits are provided for the treatment of Substance Abuse, including Detoxification and rehabilitation therapy Services in a Hospital or Substance Abuse Treatment Facility. Members may seek these Services directly by calling the telephone number listed on their Member Identification Card for Substance Abuse Services. Covered Services require no Preauthorization. Members as young as fourteen (14) years old can self-refer. The following Services are covered:

a. lodging and dietary services;

b. Physician, Psychologist, nurse, Master Level Therapist and Social Worker services;

c. rehabilitation, therapy and counseling;

d. family counseling and intervention;

e. psychiatric, psychological and medical laboratory tests; and

f. drugs, medicines, equipment use and supplies.

14. **SURGERY**

Benefits are provided for covered surgical Services required for the treatment of disease, illness or injury.

15. **THERAPY AND REHABILITATION SERVICES**

Benefits are provided for Therapy and Rehabilitation Services when the admission is Preauthorized by FPH and Covered Services are performed by a Professional Provider. For admissions primarily for therapies such as Physical Medicine, Occupational Therapy, Speech Therapy and Cardiac Rehabilitation, the Member is expected to make measurable or sustainable improvement in the level of functioning within a reasonable period of time as determined by FPH. The following Therapy and Rehabilitation Services are Covered Services:

a. Cardiac Rehabilitation Therapy

b. Chemotherapy

c. Infusion Therapy

d. Occupational Therapy

e. Physical Medicine

f. Pulmonary Rehabilitation Therapy

g. Radiation Therapy

h. Respiratory Therapy

i. Speech Therapy

Inpatient rehabilitation admissions primarily for Physical Medicine, Speech Therapy and/or Occupational Therapy Services may be subject to limitations. Refer to **SECTION SC- SCHEDULE OF MAXIMUMS AND LIMITATIONS**.

16. **TRANSPLANT SERVICES**

Subject to the provisions of this Agreement, Benefits will be provided for Covered Services furnished by a Hospital which are directly and specifically related to the transplantation of organs, bones, tissue or blood stem cells.

If a human organ, bone, tissue or blood stem cell transplant is provided from a living donor to a human transplant recipient:

a. when both the recipient and the donor are Members, each is entitled to the Benefits of their Agreement;

b. when only the recipient is a Member, both the donor and the recipient are entitled to the Benefits of this Agreement subject to the following additional limitations:

i) 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, other Blue Cross or Blue Shield coverage, or any government program; and

ii) Benefits provided to the donor will be charged against the recipient's coverage under this Agreement to the extent that Benefits remain and are available under this Agreement after Benefits for the recipient's own expenses have been paid;

c. when only the donor is a Member, the donor is entitled to the Benefits of this Agreement, subject to the following additional limitations:

i) the Benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this Agreement; and

ii) no Benefits will be provided to the non-member transplant recipient;

d. if any organ, tissue or blood stem cell is sold rather than donated to the Member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered.

17. **Tobacco Cessation Counseling**

Benefits are provided for tobacco cessation counseling for symptomatic individuals.

C. EMERGENCY CARE SERVICES

Emergency Care Services are available seven (7) days a week, twenty-four (24) hours a day. In the event that the Member requires Emergency Care Services, the Member should immediately proceed to the nearest emergency services Provider. All reasonably necessary costs for Emergency Care Services, including evaluation, testing, and if necessary, stabilization of the Member's condition, will be paid whether provided within or outside the Network Service Area. The Member should notify the PCP or Network Specialist of the receipt of Emergency Care Services to coordinate any follow-up care. This includes the initial treatment for psychiatric emergencies. **No prior authorization is needed for Emergency Care Services.**

Treatment for an occupational injury for which benefits are provided under any Workers' Compensation Law or any similar Occupational Disease Law is not covered.

Transportation and related emergency services provided by an Ambulance Service shall constitute an Emergency Care Service if the injury or the condition satisfies the criteria set forth in the definition of Emergency Care Services in **SECTION DE - DEFINITIONS**.

Use of an ambulance as transportation to an emergency Facility Provider for an injury or condition that is not an emergency, will not be covered as an Emergency Care Service.

D. COVERAGE FOR NON-EMERGENCY SERVICES WHILE TRAVELING OUTSIDE THE NETWORK SERVICE AREA

1. BLUECARD PROGRAM

In the event that a Member is traveling outside the Service Area, coverage is provided for the following: a) medical care for an unexpected illness or injury that is not life threatening, but which cannot reasonably be postponed until the Member returns home ("Urgent Care"); or b) medical care necessary to treat an illness or injury that originated in the Service Area ("Follow-up Care"). Members should call the toll-free telephone number listed on their Member Identification Card or refer to the Member Handbook for details. In an emergency, the Member should go directly to the nearest Provider.

2. BLUE CROSS BLUE SHIELD GLOBAL CORE PROGRAM

Coverage is provided through the Blue Cross Blue Shield Global Core Program when a Member requires non-routine medical care while traveling outside the United States. Members may call the Blue Cross Blue Shield Global Core toll-free telephone number appearing in the Member Handbook or on their Member Identification Card for assistance. In an emergency, the Member should go directly to the nearest Provider. All medical Services are covered in accordance with this Agreement. When Covered Services are rendered in a Hospital that participates in the Blue Cross Blue Shield Global Core Program, Members are responsible for any Copayment amount appearing in this Agreement. However, for Outpatient Hospital care or Physician services, or if Covered Services are rendered in a Hospital that does not participate in the Blue Cross Blue Shield Global Core Program, Members may be responsible for full payment at the time Covered Services are received. In the event that full payment for Covered Services is made by the Member, reimbursement may be obtained upon submission of the appropriate claim form(s). Information regarding Blue Cross Blue Shield Global Core may be obtained by calling the Member Service telephone number listed on the Member Identification Card.

SECTION EX - EXCLUSIONS

Except as specifically provided in this Agreement, no Benefits will be provided for services, supplies or charges as follows:

KEY WORD	DESCRIPTION
1. **Abortion**	For Elective Abortions, except those abortions necessary to avert the death of the Member, or terminate pregnancies caused by rape or incest. This includes all related surgical procedures or Prescription Drugs provided for the purpose of terminating pregnancy. Coverage includes medical services and care necessary to treat the complications of an abortion performed and not covered under this Agreement or performed by other than a Provider.
2. **Allergy testing**	For allergy testing, except as provided herein or as mandated by law.
3. **Ambulance**	For Ambulance Services, except as provided herein.
4. **Autism Spectrum Disorders**	For any care that is related to Autism Spectrum Disorders which extends beyond traditional medical management, except as otherwise provided in SECTION DB - DESCRIPTION OF BENEFITS of this Contract. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education and vocational training including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; and c) services provided primarily for Respite Care.
5. **Bariatric Surgery**	For Bariatric Surgery, including reversal, revision, repeat and staged Surgery, except for the treatment of sickness or injury resulting from such Bariatric Surgery, or unless required by law.
6. **Blood**	For whole blood, blood derivatives, blood plasma, blood components, the administration and processing of blood, and the storage of blood, except as provided in **SECTION DB - DESCRIPTION OF BENEFITS**.

KEY WORD	DESCRIPTION
7. **Circumcision**	For routine neonatal circumcision.
8. **Comfort/Convenience Items**	For personal or Comfort/Convenience Items as defined herein.
9. **Complementary alternative medicine**	For complementary alternative care services such as, but not limited to, acupuncture, massage therapy, hypnotherapy, holistic medicine, herbal treatments and naturopathic services, except as provided herein.
10. **Cosmetic procedures**	For a cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body or performed for psychological or psychosocial reasons, and from which no improvement in physiological function can be expected, except: as otherwise required by law; when necessitated by a covered sickness or injury; when required to correct a condition directly resulting from an accident; or to correct a congenital birth defect.
11. **Custodial Care**	For Custodial Care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care.
12. **Court ordered services**	For otherwise Covered Services ordered by a court or other tribunal unless Medically Necessary and Appropriate or if the reimbursement of such services is required by law.
13. **Dental care:** **Teeth** **Temporomandibular joint syndrome (TMJ)**	 For treatment directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, including but not limited to apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease except as provided in **SECTION DB - DESCRIPTION OF BENEFITS**. (Please read the "CHIP Dental Benefit Book" for information regarding dental coverage.) For the treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimension and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.

KEY WORD	DESCRIPTION
14. **Diabetes Prevention**	For a Diabetes Prevention Program offered by other than a Network Diabetes Prevention Provider.
15. **Duplicate services**	For charges submitted by a certified registered nurse or other Professional Provider for the same services performed on the same date for the same Member.
16. **Effective Date**	Rendered prior to the Member's Effective Date of coverage.
17. **Enteral Foods**	For any food including, but not limited to, Enteral Foods, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an Outpatient basis, except as provided in **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement.
18. **Experimental/ Investigative**	Which is Experimental/Investigative in nature, except for routine patient costs associated with participation in a Qualified Clinical Trial described elsewhere in this Agreement.
19. **Eyeglass and contact lenses**	For eyeglass or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, except for aphakic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury.
20. **Felony**	For any illness or injury suffered during the Member's commission of a felony.
21. **Foot care (routine)**	For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of incomplete or partial dislocation of a bone in a joint (subluxations) of the foot, care of corns, bunions (except capsular or bone Surgery), calluses, toe nails (except Surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
22. **Hair**	For hair growth stimulants, hair replacement Surgery or wigs.
23. **Health care management program**	For any care, treatment or service which has been disallowed under the provisions of the Managed Health Care program.

KEY WORD	DESCRIPTION
24. **Immunizations**	For immunizations required for foreign travel or employment.
25. **Infertility**	For all services with the diagnosis of Infertility, including counseling, testing and treatment.
26. **Inpatient admissions for diagnostic purposes**	For Inpatient admissions which are primarily for diagnostic studies.
27. **Legal obligation**	For which a Member would have no legal obligation to pay.
28. **Medically Necessary and Appropriate**	Which are not Medically Necessary and Appropriate.
29. **Mental health**	For any care that is provided for a condition which has no demonstrable organic origin or which extends beyond traditional medical management. This includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services provided for purposes of behavioral modification and/or training; d) services related to learning disorders or learning disabilities; e) services provided primarily for social or environmental change unrelated to medical treatment; f) developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the Member has not yet attained; and g) services provided for which, based on medical standards, there is no established expectation of achieving measurable improvement in a reasonable and predictable period of time.
30. **Methadone**	For methadone hydrochloride treatment for which no additional functional progress is expected to occur.
31. **Military service**	To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service-connected illness or injury, unless the Member has a legal obligation to pay.
32. **Miscellaneous**	For any medical or dental service or treatment, except as provided herein.

KEY WORD	DESCRIPTION
33. **Motor vehicle accident**	For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such medical treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.
34. **Non-covered care, treatments, services and prescription drugs**	For any medical, dental, vision or other care or treatments or for Prescription Drugs except as provided herein or mandated by law.
35. **Non-prescribed treatments and services**	For treatments and services not prescribed by or performed by or upon the direction of a Professional Provider.
36. **Nutritional counseling**	For nutritional counseling, except as provided herein.
37. **Obesity**	For the treatment of obesity, except as provided herein.
38. **Oral surgery**	For oral Surgery procedures, except as provided herein.
39. **Organ donation**	Required by a Member related to organ donation where the Member serves as the organ donor. Expenses for donors donating organs to Members are covered only as provided in this Agreement. No payment will be made for human organs/tissue/blood which are sold rather than donated.
40. **Physical examinations**	For routine or periodic physical examinations, the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports, or travel, which are not Medically Necessary and Appropriate, except as provided herein or as mandated by law.
41. **Preventive and wellness services**	For preventive services, wellness services and programs, except as provided herein.
42. **Private duty nursing**	For private duty nursing when provided on an Inpatient basis and not determined to be Medically Necessary and Appropriate.
43. **Provider of service**	Rendered by a Provider who is a member of the patient's Immediate Family.

KEY WORD	DESCRIPTION
44. **Providers training programs**	For services and treatments performed by a Professional Provider enrolled in an education or training program when such Services are related to the education or training program.
45. **Public Facility**	Care for conditions that federal, state or local law requires to be treated in a public facility.
46. **Services performed by other than providers**	For services, treatments and care performed by other than Facility Providers, Professional Providers or Suppliers as defined herein.
47. **Sexual dysfunction**	For the treatment of sexual dysfunction that is not related to organic disease or injury.
48. **Smoking (tobacco)**	For tobacco cessation support programs and/or classes, except as provided herein.
49. **Sterilization, reversal of**	For the reversal of voluntary sterilization.
50. **Surrogate motherhood**	For Services and supplies associated with surrogate motherhood, including but not limited to, all Services and supplies relating to the conception and prenatal through postnatal care of a Member acting as a surrogate mother.
51. **Telephone consultations and other provider charges**	For telephone consultations which do not involve covered Telemedicine services, charges for failure to keep a scheduled Visit, or charges for completion of a claim form.
52. **Termination date**	Incurred after the date of termination of the Member's coverage, except as provided herein.
53. **Vision correction (radial keratotomy)**	For the correction of myopia, hyperopia or presbyopia, including, but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants and Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.
54. **War**	For a loss sustained or expenses Incurred while on active duty as a member of the armed forces of any nation or losses sustained or expenses Incurred as a result of any act of war whether declared or undeclared.
55. **Weight Reduction**	For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless Medically Necessary and Appropriate.

KEY WORD	DESCRIPTION
56. **Well baby care**	For well-baby care visits, except as provide herein.
57. **Workers' Compensation**	For any illness or injury eligible for or covered by any federal, state or local government Workers' Compensation Act, Occupational Disease Law or similar type legislation.

SECTION GP - GENERAL PROVISIONS

A. BENEFITS AFTER TERMINATION OF COVERAGE

When this Agreement is terminated, except for termination by fraud or intentional misrepresentation of a material fact, and a Member is receiving Inpatient Covered Services in a Hospital or Skilled Nursing Facility on the date of termination, coverage shall be extended until the Member is discharged from the Hospital or Skilled Nursing Facility. If a Member is pregnant on the date coverage terminates, no additional coverage will be provided, unless the Member is in her second or third trimester of the pregnancy in which case the Member will continue to remain covered under this Agreement through the period of post-partum care.

B. BENEFITS TO WHICH MEMBERS ARE ENTITLED

1. The Benefit liability of FPH is limited to the Benefits specified in this Agreement.

2. Except as provided in Subsection B, Paragraph 16. **TRANSPLANT SERVICES** of **SECTION DB - DESCRIPTION OF BENEFITS**, no person other than a Member is entitled to receive Benefits under this Agreement. Such right to Benefits and coverage is not transferable.

3. Benefits for Covered Services specified in this Agreement will be provided only for Services and supplies rendered by a Provider as defined in **SECTION DE - DEFINITIONS** of this Agreement and regularly included in such Provider's charges.

4. FPH will make payment directly to the Network Provider furnishing the Covered Services provided for in this Agreement. However, FPH reserves the right to make payment directly to the Member or the Member's family. In situations where payment is made to the Member or the Member's family, the Member or the Member's family is responsible for payment to the Provider.

C. COMPLAINT AND GRIEVANCE PROCESSES

FPH maintains complaint and grievance processes, each involving two (2) levels of review. A Member or a health care Provider may contact the Pennsylvania Department of Health ("Department of Health") to complain that FPH's administrative processes or time frames are being applied in such a manner as to discourage or disadvantage the Member or health care Provider in utilizing the complaint and grievance processes. Referral of the allegations to the Department of Health will not operate to delay the processing of the complaint or grievance review.

At any time during the internal complaint or grievance process, a Member may choose to designate an authorized representative to participate in the complaint or grievance process on his/her behalf. The Member or the Member's authorized representative shall notify FPH, in

writing, of the designation. FPH reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member. Such procedures as adopted by FPH shall, in the case of an Urgent Care Claim, permit a Professional Provider with knowledge of the Member's medical condition to act as the Member's authorized representative.

For purposes of the complaint and grievance processes, Member includes designees, legal representatives and, in the case of a minor, parents of a Member entitled or authorized to act on the Member's behalf.

At any time during the internal complaint or grievance process, at the request of the Member, FPH will appoint a person from its Member Service Department to assist the Member, at no charge, in preparing the complaint or grievance. The FPH employee made available will not have participated in any previous decisions to deny coverage for the issue in dispute.

At any time during the internal complaint or grievance process, a Member may contact the Member Service Department at the toll-free telephone number listed on his/her Identification Card to inquire about the filing or status of a complaint or grievance.

1. **Complaint Process**

a. Internal Complaint Process

FPH maintains a complaint process for the resolution of disputes or objections by a Member regarding a Network Provider or the coverage (including contract exclusions and non-covered benefits), operations or management policies of FPH, delivery of services and the breach or termination of the Agreement. A complaint does not include a grievance.

Members have the right to have complaints internally reviewed through the two (2) level process described in this Internal Complaint Process. However, when a complaint involves an Urgent Care Claim, a single level review process is available as provided in Paragraph 3. **Expedited Review** of this Subsection.

Members must exhaust this two (2) level process before seeking further administrative review of a complaint by the Department of Health or Pennsylvania Insurance Department.

i) Initial Review

The Member's initial complaint shall be directed to the Member Service Department. This complaint, which may be oral or in written form, must be submitted within sixty (60) days from the date of the Member's receipt of the notification of an adverse decision or the occurrence of the issue which is the subject of the complaint. Upon receipt of the complaint, FPH will provide

written confirmation to the Member that the request has been received, and that FPH has classified it as a complaint for purposes of internal review. If a Member disagrees with FPH's classification of a request for an internal review, he/she may directly contact the Department of Health or the Pennsylvania Insurance Department for consideration and intervention with FPH in regards to the classification that has been made.

The Member, upon request to FPH, may review all documents, records and other information relevant to the complaint and shall have the right to submit any written comments, documents, records, information, data or other material in support of the complaint. The initial level complaint review will be performed by an Initial Review Committee which shall include one (1) or more employees of FPH. The members of the Committee shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the Member's complaint.

In rendering a decision on the complaint, the Initial Review Committee will take into account all comments, records and other information submitted by the Member without regard to whether such information was previously submitted to or considered by FPH. The Initial Review Committee will afford no deference to any prior adverse decision on the Claim which is the subject of the complaint.

Each complaint will be promptly investigated and a decision rendered within the following time frames:

(a) When the complaint involves a non-urgent care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances not to exceed thirty (30) days following receipt of the complaint;

(b) When the complaint involves an Urgent Care Claim, within the period of time provided in Paragraph 3. **Expedited Review** of this Subsection; or

(c) When the complaint involves a Post-service Claim, within a reasonable period of time not to exceed thirty (30) days following receipt of the complaint.

FPH will provide written notification of its decision within five (5) business days of the decision, not to exceed thirty (30) days from FPH's receipt of the Member's complaint. In the event that FPH renders an adverse decision on the complaint, the notification shall include, among other items, the specific reason or reasons for the adverse decision, the procedure for appealing the decision and a statement regarding the right of the Member to pursue legal action.

ii) Second Level Review

If the Member is dissatisfied with the decision following the initial review of his/her complaint, including a non-urgent care Pre-service Claim or Post-service Claim complaint, he/she may request to have the decision reviewed by a Second Level Review Committee. The request to have the decision reviewed must be submitted in writing (or communicated orally under special circumstances) within forty-five (45) days from the date an adverse decision is received and may include any written information from the Member or any party in interest. The Second Level Review Committee shall be comprised of three (3) individuals who were not involved or the subordinate of any individual that was previously involved in the matter under review. At least one (1) individual of the Committee will not be an employee of FPH or of any FPH related subsidiary or affiliate. The Committee will hold an informal hearing to consider the Member's complaint. When arranging the hearing, FPH will notify the Member in writing of the hearing procedures and rights at such hearing, including the right of the Member to be present at the review. If a Member cannot appear in person at the second level review, FPH shall provide the Member the opportunity to communicate with the Committee by telephone or other appropriate means.

The hearing will be held and a decision rendered within thirty (30) days of FPH's receipt of the Member's request for review. This applies to both the second level review of a non-urgent care Pre-service Claim complaint and the second level review of a Post-service Claim complaint.

FPH will provide written notification of its decision within five (5) business days of the decision, not to exceed thirty (30) days from FPH's receipt of the Member's request for review. In the event that FPH renders an adverse decision, the notification shall include, among other items, the specific reason or reasons for the adverse decision, the procedure for appealing the decision and a statement regarding the right of the Member to pursue legal action.

b. Appeal of Complaint

A Member will have fifteen (15) days from the receipt of the notice of the decision of the Second Level Review Committee to appeal the decision to the Department of Health or the Pennsylvania Insurance Department, as appropriate depending on the nature of the dispute. The appeal shall be in writing unless the Member requests to file the appeal in an alternative format.

Appeals may be filed at the following addresses:

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, Pennsylvania 17120

Department of Health
Bureau of Managed Care
Room 912 Health & Welfare Building
625 Forster Street

Harrisburg, Pennsylvania 17120-0701All records from the initial review and the second level review shall be forwarded to the Department of Health or the Pennsylvania Insurance Department, as appropriate. Additional material related to the complaint may be submitted by the Member, the health care Provider or FPH. Each shall provide to the other, copies of additional documents provided. The Member may be represented by an attorney or other individual before the appropriate Department.

2. **Grievance Process**

a. Internal Grievance Process

FPH maintains an internal grievance process by which a Member or a health care Provider, with the written consent of the Member, shall be able to file a grievance regarding the denial of payment for a health care service on the basis of Medical Necessity and Appropriateness. Any Member who consents to the filing of a grievance by a health care Provider may not file a separate grievance. This consent may be rescinded by the Member at any time during the grievance process. In the event that the health care Provider fails to file or pursue a grievance, the consent shall be deemed as having been automatically rescinded without further action on the part of the Member.

A grievance may be filed regarding a decision that: (a) disapproves full or partial payment for a requested health care service; (b) approves the provision of a requested health care service for a lesser scope or duration than requested; or (c) disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service. A grievance does not include a complaint. Members have the right to have grievances internally reviewed through the two (2) level process described in this Internal Grievance Process. However, when a grievance involves an Urgent Care Claim, a single level review process is available as provided in Paragraph 3. **Expedited Review** of this Subsection.

Members must exhaust this two (2) level process before seeking further administrative review of a grievance by the Department of Health.

i) Initial Review

The Member's initial grievance shall be directed to the Member Service Department. This grievance, which may be oral or in written form, must be submitted within sixty (60) days from the date of the Member's receipt of the notification of an adverse decision or occurrence of the issue which is the subject of the grievance. Upon receipt of the grievance, FPH will provide

written confirmation to the Member and the health care Provider that the request has been received, and that FPH has

classified it as a grievance for purposes of internal review. If a Member disagrees with FPH's classification of a request for an internal review, he/she may directly contact the Department of Health or the Pennsylvania Insurance Department for consideration and intervention with FPH in regards to the classification that has been made.

The Member or health care Provider, upon request to FPH, may review documents, records and other information relevant to the grievance and shall have the right to submit any written comments, documents, records, information, data or other material in support of the grievance. The initial level grievance review will be performed by an Initial Review Committee which shall include one (1) or more individuals selected by FPH. The members of the Committee shall not have been involved or be the subordinate of any individual that was involved in any previous decision relating to the Member's grievance. The Member or the health care Provider may specify the remedy or corrective action being sought. The initial review will include a licensed Physician or, where appropriate, an approved licensed Psychologist in the same or similar specialty that typically manages or consults on the health care service at issue.

In rendering a decision on the grievance, the Initial Review Committee will take into account all comments, records and other information submitted by the Member without regard to whether such information was previously submitted to or considered by FPH. The Initial Review Committee will afford no deference to any prior adverse decision on the Claim which is the subject of the grievance.

Each grievance will be promptly evaluated and a decision rendered within the following time frames:

(a) When the grievance involves a non-urgent care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances not to exceed thirty (30) days following receipt of the grievance;

(b) When the grievance involves an Urgent Care Claim, within the period of time provided in Paragraph 3. **Expedited Review** of this Subsection; or

(c) When the grievance involves a Post-service Claim, within a reasonable period of time not to exceed thirty (30) days following receipt of the grievance.

FPH will provide written notification of its decision within five (5) business days of the decision, not to exceed thirty (30) days from FPH's receipt of the Member's grievance. In the event that FPH renders an adverse decision on the grievance, the notification shall include, among other items, the specific reason or reasons for the adverse decision including clinical rationale, the procedure for appealing the decision and a statement regarding the right of the Member to pursue legal action.

ii) Second Level Review

If the Member is dissatisfied with the decision following the initial review of his/her grievance, including a non-urgent care Pre-service Claim or Post-service Claim grievance, he/she may request to have the decision reviewed by a Second Level Review Committee. The request to have the decision reviewed by the Second Level Review Committee must be submitted in writing (or communicated orally under special circumstances) within forty-five (45) days from the date an adverse decision is received and may include any written information from the Member or health care Provider. The Second Level Review Committee shall be comprised of three (3) FPH employees who were not involved or the subordinate of any individual that was previously involved in any decision to deny coverage or payment for the health care service. The Committee will include a licensed Physician or, where appropriate, an approved licensed Psychologist in the same or similar specialty that typically manages or consults on the health care service at issue. The Committee will hold an informal hearing to consider the Member's grievance. When arranging the hearing, FPH will notify the Member or the health care Provider in writing of the hearing procedures and rights at such hearing, including the right of the Member or the health care Provider to be present at the review and to present a case. If a Member or health care Provider cannot appear in person at the second level review, FPH shall provide the Member or health care Provider the opportunity to communicate with the Committee by telephone or other appropriate means.

The hearing will be held and a decision rendered within thirty (30) days of FPH's receipt of the Member's request for review. This applies to both the second level review of a non-urgent care Pre-service Claim grievance and the second level review of a Post-service Claim grievance.

FPH will provide written notification of its decision within five (5) business days of the decision, not to exceed thirty (30) days from FPH's receipt of the Member's request for review. In the event that FPH renders an adverse decision, the notification shall include, among other items, the specific reason or reasons for the adverse decision including clinical rationale, the procedure for appealing the decision and a statement regarding the right of the Member to pursue legal action.

b. External Grievance Process

A Member or a health care Provider, with the written consent of the Member, may within fifteen (15) days from the receipt of the notification of the decision of the Second Level Review Committee, appeal the denial resulting from the Internal Grievance Process. This can be done by filing a request for an external grievance with FPH. The Member should include any material justification and all reasonably necessary supporting information as part of the external grievance filing.

Within five (5) business days of the filing of the appeal, FPH will notify the Department of Health, the Member or the health care Provider, as appropriate, that an external grievance has been filed. FPH's notification to the Department of Health shall include a request for assignment of a Certified Utilization Review Entity (CRE). FPH shall forward copies of all written documentation regarding the denial, including the decision, all reasonably necessary supporting information, a summary of applicable issues and the basis and clinical rationale for the decision to the CRE conducting the external grievance within fifteen (15) days of the receipt of notice that the external grievance was filed. Within this same period, FPH shall provide the Member or the health care Provider with a list of documents forwarded to the CRE for the external review. The Member or the health care Provider may supply additional written information, with copies to FPH, to the CRE for consideration on the external review within fifteen (15) days of receipt of notice that the external grievance was filed.

The external grievance review will be conducted by a CRE selected by the Department of Health. The Department of Health will notify the Member or the health care Provider, and FPH of the name, address and telephone number of the CRE assigned within two (2) business days following receipt of the request for assignment. If the Department of Health fails to select a CRE within two (2) business days of receiving the request, FPH has the right to designate and notify a CRE to conduct the external review.

The CRE conducting the external grievance shall review all the information considered in reaching any prior decisions to deny payment for the health care service and any other written submission by the Member or the health care Provider.

Within sixty (60) days of the filing of the external grievance, the CRE conducting the external grievance shall issue a written notification of the decision to FPH, the Member or the health care Provider, including the basis and clinical rationale for the decision.

The external grievance decision may be appealed to a court of competent jurisdiction within sixty (60) days of receipt of the notification of the external grievance decision.

FPH shall authorize any health care Service or pay a Claim determined to be Medically Necessary and Appropriate based on the decision of the CRE regardless of whether an appeal to a court of competent jurisdiction has been filed.

3. **Expedited Review**

In those cases involving an Urgent Care Claim, there is a procedure for expedited review. In order to obtain an expedited review, the Member shall identify the particular need for an expedited review to the Member Service Department. A Member shall provide FPH with a certification, in writing, from the Member's Physician that the Member's life, health or ability to regain maximum function would be placed in jeopardy or in the opinion of a Physician with knowledge of the Member's medical condition would subject the Member to severe pain that cannot be adequately managed without the service requested as a result of the delay occasioned by the review process. The certification shall include clinical rationale and facts to support the Physician's opinion. FPH shall accept the Physician's certification, and provide an expedited review.

In general, FPH's internal expedited review process shall be bound by the same rules and procedures as the second level grievance review process. Any exceptions to those rules and procedures will be provided, in writing, upon receipt by FPH of the Member's request for an expedited review. FPH shall conduct an expedited internal review and notify the Member of its decision as soon as possible taking into account the medical exigencies involved but not later than forty-eight (48) hours following the receipt of the Member's request for an expedited review accompanied by a Physician's statement. The notification to the Member and health care Provider shall include, among other items, the specific reason or reasons for the adverse decision including any clinical rationale, the procedure for obtaining an expedited external review and a statement regarding the right of the Member to pursue legal action.

The Member has two (2) business days from the receipt of the expedited internal review decision to contact FPH to request an expedited external review. Within twenty-four (24) hours of receipt of the Member's request for an expedited external review, FPH shall submit a request for an expedited external review to the Department of Health. The Department of Health will assign a CRE within one (1) business day of receiving the request for an expedited review. The CRE shall have two (2) business days to issue a decision.

D. **COMPLIANCE WITH LAW; AMENDMENT**

Anything contained herein to the contrary notwithstanding, FPH shall have the right, for the purpose of complying with the provisions of any law or lawful order of a regulatory authority, to amend this Agreement, including any Amendatory Riders hereto, or to increase, reduce or eliminate any of the Benefits provided for in this Agreement for any one (1) or more eligible Members enrolled under this Agreement, and each party hereby agrees to any amendment of this Agreement which is necessary in order to accomplish such purpose.

E. CONVERSION PRIVILEGE

A Member who becomes ineligible for coverage under this Agreement in accordance with **SECTION SE - SCHEDULE OF ELIGIBILITY** may apply within 31 days thereafter to continue coverage under a program of the type for which the Member then qualifies.

F. ENTIRE CONTRACT; CHANGES

This Agreement (along with the appropriate premium rate, if applicable), the Application and any Amendatory Riders and/or Schedules is the entire contract between FPH and the Member. No change in this Agreement shall be effective until approved by an authorized officer of FPH. This approval must be noted on or attached to this Agreement. No agent or representative of FPH, other than an officer of FPH, may otherwise change this Agreement or waive any of its provisions. In the event of any conflict or inconsistency, the Agreement and any attached Amendatory Riders, shall be the controlling document.

G. GOVERNING LAW

This Agreement is entered into in and is subject to the laws of the Commonwealth of Pennsylvania. The invalidity or unenforceability of any terms or conditions hereof shall in no way affect the validity or enforceability of any other terms or provisions. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof. Where applicable, the interpretation of this Agreement shall be guided by the direct-service nature of FPH's operations as opposed to a fee-for-service indemnity basis.

H. IDENTIFICATION CARD

FPH will provide an Identification Card to all Members. This Identification Card must be presented when a Service is requested.

I. INTER-PLAN ARRANGEMENTS

1. Out of Area Services

FPH has a variety of relationships with other Blue Cross and/or Blue Shield Licensees, referred to generally as "Inter-Plan Arrangements". These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Members access health care services outside the geographic area FPH serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area FPH serves, Members obtain care from health care providers that have a contractual agreement ("participating

providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from health care providers in the Host Blue geographic area that do not have a contractual agreement ("non-participating providers") with the Host Blue. FPH remains responsible for fulfilling its contractual obligations to the Member. FPH payment practices in both instances are described below.

2. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services outside the geographic area FPH serves, the Host Blue will be responsible for contracting and handling all interactions with its participating health care providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar copayment, the calculation of the Member liability on claims for Covered Services will be based on the lower of the participating provider's billed charges for Covered Services or the negotiated price made available to FPH by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's health care provider contracts. The negotiated price made available to FPH by the Host Blue may be represented by one of the following:

i) an actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases, or

ii) an estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

iii) an average price. An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e. prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by FPH in determining your premiums.

3. Return of Overpayments

Recoveries of overpayments from a Host Blue or its participating and non-participating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/health care provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to FPH, they will be credited to your account. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to you as a percentage of the recovery.

4. Non-Participating Providers Outside of the FPH Service Area

a. Member Liability Calculation

When Covered Services are provided outside of the FPH service area by non-participating providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable law. In these situations, the Member may be responsible for the difference between the amount that the non-participating provider bills and the payment FPH will make for the Covered Services as set forth in this Subsection. Payments for out-of-network emergency services are governed by applicable federal and state law

b. Exceptions

In some exception cases, FPH may pay claims from non-participating health care providers outside of the FPH service area based on the provider's billed charge. This may occur in situations where a Member did not have reasonable access to the participating provider, as determined by FPH in FPH's sole and absolute discretion or by applicable law. In other exception cases, FPH may pay such claims based on the payment FPH would make if FPH were paying a non-participating provider inside the FPH service area. This may occur where the Host Blue's corresponding payment would be more than the FPH in-service area non-participating provider payment. FPH may choose to negotiate a payment with such provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the non-participating health care provider bills and payment FPH will make for the Covered Services as set for in this Subsection.

5. Blue Cross Blue Shield Global Core

a. General Information

If Members are outside the United States (hereinafter "BlueCard service area"), they may be able to take advantage of the Blue Shield Blue Cross 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 Members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

b. Inpatient Services

In most cases, if Members contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-sharing amounts. In such cases, the hospital will submit Member claims to the BlueCard Worldwide Service Center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for Covered Services. **Members must contact FPH to obtain precertification for non-emergency inpatient services.**

c. Outpatient Services

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

d. Submitting a Blue Cross Blue Shield Global Core Claim

When Members pay for Covered Services outside the Blue Card service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the BlueCard Worldwide Service Center address on the form to initiate claims processing. The claim form is available from FPH, the Blue Cross Blue Shield Global Core Service Center or online at **www.bcbsglobalcore.com**. If Members need assistance with their claim submissions, they should call the BlueCard Worldwide Service Center at 1-(800)-810-BLUE (2583) or call collect at 1-(804)-673-1177, 24 hours a day, seven days a week.

J. LEGAL ACTIONS

No legal action may be taken to recover Benefits within sixty (60) days after Notice of Claim has been given as specified in this Agreement, nor may such action be taken later than three (3) years after the expiration of the time within which Notice of Claim is required by this Agreement.

K. LIMITATIONS

In the event that, due to circumstances not within the control of FPH, including but not limited to a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, or similar causes, the rendition of Covered Services provided under this Agreement is delayed or rendered impractical, FPH shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, FPH shall provide Covered Services under this Agreement in so far as practical, and according to its best judgment; but neither FPH nor Providers shall incur liability or obligation for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such event(s).

L. MODIFICATION

By this Agreement, coverage is made available to Members who are eligible under **SECTION SE - SCHEDULE OF ELIGIBILITY**. However, this Agreement shall be subject to amendment, modification, and termination in accordance with any provision hereof without the consent or concurrence of the Members. By electing this coverage or accepting Benefits provided in this Agreement, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof. No change in this Agreement shall be valid until approved by an authorized officer of FPH, and such approval is endorsed hereon or attached hereto. FPH may unilaterally modify the terms of this Agreement if notice of such modification is given at least thirty (30) days prior to the effective date of the modification.

M. NOTICE OF CLAIM AND PROOF OF LOSS
(Applies to Post-service Claims Only)

1. Notice of Claim

FPH will not be liable for any claims under this Agreement unless proper notice is furnished to FPH that Covered Services in this Agreement have been rendered to a Member. Written notice of a claim must be given to FPH within twenty (20) days, or as soon as reasonably possible after Covered Services have been rendered to the Member. Notice given by or on behalf of the Member to FPH that includes information sufficient to identify the Member that received the Covered Services, shall constitute sufficient notice of a claim to FPH. The Member can give notice to FPH by calling or writing to the Member Service Department. The telephone number and address of the Member Service Department can be found on the Member's Identification Card. A charge shall

be considered Incurred on the date a Member receives the Covered Service for which the charge is made.

2. Proof of Loss

Claims cannot be paid until a written proof of loss is submitted to FPH. Written proof of loss must be provided to FPH within ninety (90) days after the charge for a Covered Service is Incurred. Proof of loss must include all data necessary for FPH to determine Benefits. Failure to submit a proof of loss to FPH within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will FPH be required to accept a proof of loss later than twelve (12) months from the time proof is otherwise required.

3. Claim Forms

If a Member (or his/her personal representative) is required to submit a proof of loss for Benefits under this Agreement, it must be submitted to FPH on the appropriate claim form. FPH, upon receipt of a notice of claim will, within fifteen (15) days following the date notice of claim is received, furnish to the Member claim forms for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of such notice, the Member shall be deemed to have complied with the requirements of this Subsection as to filing a proof of loss upon submitting, within the time fixed in this Subsection for filing proofs of loss, itemized bills for Covered Services as described below. Itemized bills may be submitted to FPH at the address appearing on the Member's Identification Card. Itemized bills cannot be returned.

4. Submission of Claim Forms

For Member-submitted claims, the completed claim form, with all itemized bills attached, must be forwarded to FPH at the address appearing on the claim form in order to satisfy the requirement of submitting a written proof of loss and to receive payment for Benefits provided under this Agreement.

To avoid delay in handling Member-submitted claims, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing all of the following information:

Person or organization providing the service or supply
Type of service or supply
Date of service or supply
Amount charged
Name of patient

A request for payment of a claim will not be reviewed and no payment will be made unless all of the information and evidence of payment required on the claim form has been submitted in the manner described above. FPH reserves the right to require additional information and documents as needed to support a claim that a Covered Service has been rendered.

5. Time of Payment of Claims

Claim payments for Benefits payable under this Agreement will be processed immediately upon receipt of a proper proof of loss. Notice of FPH's claim determination will be issued within a reasonable period of time not to exceed thirty (30) days following the receipt of a proper proof of loss. This period of time may be extended one (1) time by FPH for an additional period of time not to exceed fifteen (15) days provided the extension is due to matters outside the control of FPH and the Member is notified of the extension.

In the event that FPH renders an adverse decision on the claim, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement describing the right of the Member to file a complaint or grievance appeal.

6. Authorized Representative

Nothing in this Subsection shall preclude a duly authorized representative of the Member from filing or otherwise pursuing a claim on behalf of the Member. FPH reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of the Member.

N. OVERPAYMENT OF BENEFITS

FPH reserves the right to seek reimbursement from the Member for payments made for any excluded services or supplies through inadvertence or errors.

O. PHYSICAL EXAMINATION AND AUTOPSY

FPH, at its own expense, shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

P. POLICIES AND PROCEDURES

FPH may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Agreement, with which Members shall comply.

Q. REINSTATEMENT

Any individual Member whose membership shall have been terminated may be reinstated at the discretion of FPH and, if applicable, upon payment of any retroactive premium due.

R. RELATIONSHIP OF PARTIES

Network Professional Providers maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services. The relationship between FPH and any Network Provider is an independent contract relationship. Network Providers are not agents or employees of FPH, nor is any employee of FPH an employee or agent of a Network Provider. FPH shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any Network Professional Provider, or from any Provider to whom the Member has been referred.

S. RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD PLANS

The Member is hereby notified:

This Agreement is between the Member and FPH only. FPH is a licensed controlled affiliate operating under a license from the Blue Cross Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield Plans throughout the United States. Although all of these independent Blue Cross and Blue Shield Plans operate under licenses from the Association, each of them is a separate and distinct corporation. The Association allows FPH to use the familiar Blue Cross and Blue Shield words and symbols. FPH, which is entering into this Agreement, is not contracting as an agent of the national Association. Only FPH shall be liable to the Member for any obligations in this Agreement. This paragraph does not add any obligations to this Agreement.

T. RELEASE AND PROTECTION OF MEMBER INFORMATION

All personally identifiable information about individual Members ("Protected Health Information") is subject to various statutory privacy standards, including state insurance regulations implementing Title V of the Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and regulations adopted thereunder by the Department of Health and Human Services (45 CFR Parts 160, 162, 164). In accordance with those standards, FPH may use and disclose Protected Health Information to facilitate payment, treatment and health care operations as described in FPH's Notice of Privacy Practices (NPP). Copies of FPH’s current NPP are available on FPH's internet site, or from FPH's Privacy Office.

At its sole discretion and starting January 1, 2016, FPH may make available, either directly or through a designated vendor, Member identity theft protection services. Any decision to accept or not accept such services will not affect the continued eligibility, benefits, premiums or cost-sharing of the Member under this Contract. FPH shall not be liable for, and the Member shall hold FPH harmless from, any matters arising from or relating to such services.

U. SUBROGATION

1. To the extent that Benefits for Covered Services are provided or paid under this Agreement, FPH shall be subrogated and succeed to any rights of recovery of a Member as permitted by law for expenses Incurred against any person, firm or organization except insurers on policies or health insurance issued to and in the name of the Member.

2. The Member shall execute and deliver such instruments and take such other reasonable action as FPH may require to secure such rights, as permitted by law. The Member shall do nothing to prejudice the rights given FPH by this Paragraph without its consent.

3. This Subsection does not apply where subrogation is specifically prohibited by law.

V. TERMINATION OF GROUP AGREEMENT

This Agreement may be terminated in the following instances:

1. The Group may cancel this Agreement on any Agreement anniversary date by giving written notice to FPH at least sixty (60) days in advance.

2. Either the Group or FPH may request a change in the rates or the terms of this Agreement on any anniversary date by giving written notice to the other party at least sixty (60) days in advance of the Agreement anniversary date. If the parties are unable to agree on such requested change(s), the Group may terminate this Agreement at the end of the then-current Agreement term, unless the parties agree in writing to an extension hereof.

3. This Agreement shall be terminated, at FPH's option, if the Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact.

4. A grace period of thirty (30) days from the due date will be granted for the payment of the premium from the Group. During the grace period, the Agreement will stay in force. If the appropriate payment is not received within the grace period, this Agreement automatically terminates at the end of the grace period and coverage ceases at that time. FPH may seek payment of premium from the Group for coverage provided during the grace period. The Member shall remain liable for any Copayments owed including those for Services Incurred during the grace period. Members of a discontinued Group may become conversion Members as set forth in Subsection F. **CONVERSION PRIVILEGE** of this Section.

5. This Agreement may be terminated, at FPH's option, in the event no member of the Group lives, resides or works in the FPH Service Area.

6. This Agreement may be terminated if FPH ceases to offer group coverage in the Service Area.

7. This Agreement may be terminated if FPH ceases to offer coverage in the Service Area.

W. TERMINATION OF MEMBER COVERAGE

Subject to the right of FPH to terminate coverage, and to any amendment permitted under applicable law, the Agreement will remain in effect continually until terminated by the Member and FPH in accordance with the following:

1. The Agreement may be terminated by the Member by giving thirty (30) days written notice to FPH.

2. The Agreement may be terminated by FPH:

   a. if payment of any applicable premium rate is not made when due, or during the grace period;

   b. if a Member in obtaining coverage, or in connection with coverage hereunder, has performed an act or practice constituting fraud or intentional misrepresentation of a material fact (e.g., misuse of the Member Identification Card). However, FPH will not terminate the Agreement because of a Member's Medically Necessary and Appropriate utilization of services covered under the Agreement;
   c. upon ninety (90) days notice to the Member when FPH discontinues this coverage, and offers to each individual the option to purchase any other individual health insurance coverage currently being offered by FPH to individuals within the Service Area, or upon one hundred eighty (180) days notice to the Member when FPH discontinues all individual coverage within the Service Area;
   d. in the event the Member no longer resides in the Service Area (regardless of whether the Member still resides in the Commonwealth of Pennsylvania). Should the Member change his or her residence to a geographic area outside the Service Area and the Member wishes to continue coverage, the Member may transfer his or her coverage to the CHIP contractor that serves the area of his or her new residence; or

   e. in the event the Member no longer meets the eligibility requirements set forth in **SECTION SE - SCHEDULE OF ELIGIBILITY**.

3. Termination of the contractual arrangement between FPH and the Group automatically terminates the coverage of all the Members. It is the responsibility of the Group to notify all the Members of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given to the Members by the Group.

X. TIME LIMIT ON CERTAIN DEFENSES

After three (3) years from the date of issue of this Contract, no misstatements, except intentional misrepresentations of material fact or fraudulent misstatements, made by the Group in the application for such Contract shall be used to void the Contract or to deny a claim for loss incurred or disability commencing after the expiration of such three (3)-year period.

Intentional misrepresentations of material fact or fraudulent misstatements will, at the option of FPH Plan, render this Contract void from inception, provided such material misrepresentations or misstatements are discovered by FPH within three (3) years of the Effective Date. In the event FPH elects to void this Contract, the Group will be given at least thirty (30) days advance written notice and will forfeit any charges paid to the extent of any liability incurred by FPH.

SECTION SC - SCHEDULE OF MAXIMUMS AND LIMITATIONS

BENEFIT/PROVISION	**MAXIMUM/LIMITATION *VISITS***
PCP Office/Home Visit and Retail Clinic Visit	Visit limits do not apply
Free CHIP Coverage	No Copayment required
Low-Cost CHIP Coverage	$5 Copayment per Visit*
Full-Cost CHIP Coverage	$15 Copayment per Visit*
	*Does not apply to well-child Visits
Specialist Office/Home Visit, Applied Behavioral Analysis, Specialist Virtual Visit, Urgent Care Center Visit for non-emergency care	Visit limits do not apply
Free CHIP Coverage	No Copayment required
Low-Cost CHIP Coverage	$10 Copayment per Visit
Full-Cost CHIP Coverage	$25 Copayment per Visit
Annual Routine Gynecological Exam Visit	Limited to one (1) Visit every twelve (12) consecutive months
	No Copayment required
SERVICES	
EMERGENCY ROOM CARE	Day/Visit limits do not apply.
Free CHIP Coverage	No Copayment required
Low-Cost CHIP Coverage	$25 Copayment per Visit, except waived if admitted to the Hospital
Full-Cost CHIP Coverage	$50 Copayment per Visit, except waived if admitted to the Hospital

BENEFIT/PROVISION	MAXIMUM/LIMITATION
HABILITATIVE SERVICES*	
Physical Therapy	Limited to thirty (30) Visits per calendar year+
Occupational Therapy	Limited to thirty (30) Visits per calendar year+
Speech Therapy	Limited to thirty (30) Visits per calendar year+
	*Habilitative Services is limited to ninety (90) Visits per calendar. This is a combined limit and includes Physical Therapy, Occupational Therapy and Speech Therapy services covered under this benefit.
	+Limit does not apply when services are prescribed for treatment of Mental Illness or Substance Abuse
HEARING CARE SERVICES	
Audiometric Exam	Limited to one (1) per Benefit Period
Hearing Aid Evaluation Test	Limited to one (1) per Benefit Period
Hearing Aid	Limited to one (1) Hearing Aid or device per ear every two (2) Benefit Periods
Routine Exam	Limited to one (1) per Benefit Period
	No Copayment required
INPATIENT PHYSICIAN CONSULTATIONS	Limited to one (1) consultation per Hospital admission
MAMMOGRAMS	Limited to one (1) routine screening per twelve (12) consecutive months
PRESCRIPTION BRAND DRUGS	
Free CHIP Coverage	No Copayment required

BENEFIT/PROVISION	MAXIMUM/LIMITATION
Low-Cost CHIP Coverage	$9 Copayment for each Prescription Order or refill for up to a 31 day supply
	$18 Copayment for each Prescription Order or refill for between 32 days and 60 days supply
	$27 Copayment for each Prescription Order or refill for between 61 days and 90 days supply
Full-Cost CHIP Coverage	$18 Copayment for each Prescription Order or Refill for up to a 31 day supply
	$36 Copayment for each Prescription Order or refill for between 32 days and 60 days supply
	$54 Copayment for each Prescription Order or refill for between 61 days and 90 days supply
PRESCRIPTION GENERIC DRUGS	
Free CHIP Coverage	No Copayment required
Low-Cost CHIP Coverage	$6 Copayment for each Prescription Order or refill for up to a 31 day supply
	$12 Copayment for each Prescription Order or refill for between 32 days and 60 days supply
	$18 Copayment for each Prescription Order or refill for between 61 days and 90 days supply
Full-Cost CHIP Coverage	$10 Copayment for each Prescription Order or refill for up to a 31 day supply
	$20 Copayment for each Prescription Order or refill for between 32 days and 60 days supply
	$30 Copayment for each Prescription Order or refill for between 61 days and 90 days supply
SECOND SURGICAL OPINIONS	Two (2) consultations per elective surgical procedure, limited to one (1) consultation per Physician

BENEFIT/PROVISION	**MAXIMUM/LIMITATION**
REHABILITATION THERAPY SERVICES	
Outpatient Services	
Occupational Therapy	Limited to sixty (60) Visits per calendar year
Physical Medicine	Limited to sixty (60) Visits per calendar year
Speech Therapy	Limited to sixty (60) Visits per calendar year
DEVICES AND EQUIPMENT	
Continuous Glucose Monitoring Devices	
Receiver kits	Limited to one (1) kit per calendar year
Sensor kits	Limited to one (1) refill every thirty (30) days
Transmitter kits	Limited to one (1) refill every ninety (90) days

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