

Benefits Book

How your dental plan works

Independence

Using your dental benefits

Oral health is an important part of overall health. It not only helps keep teeth healthy but can also help detect serious medical conditions, like high blood pressure and diabetes.

Your dental coverage encourages prevention, early diagnosis, and treatment. You have access to a robust and expanding dental network, so you can find a dentist that is convenient to your location.

Plan features

All plans are designed for prevention and savings. Plans feature coverage for most diagnostic and preventive services, such as cleanings and exams. You'll also benefit from unique value-adds that will help you save on out-of-pocket expenses.

Most plans offer both in- and out-of-network benefits, but you will save time and pay lower out-of-pocket costs if you use in-network providers. Check your dental plan benefits in this book to see if you have out-of-network benefits.

Using your ID card

You and your covered dependents will each receive a dental ID card. It is important to take your ID card with you and present it prior to receiving care because it contains important information for your provider.



View your benefits online

Log in at ibx.com to:

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

Your dental network

To find an in-network provider, follow these steps:

1. Go to ibx.com/findadentist.
2. Under *Your Plan*, select *Dental – Employer Plans*.
3. Then select your dental network.

With our online directory you can:

- Search by dentist or practice name, location, or specialty
- Compare dentists
- Get more information, such as languages spoken, ages treated, if they are accepting new patients, gender, and handicap accessibility
- Create and print, download, or email a personalized directory
- View a dentist's location on a map and get directions

Group Certificate of Coverage

PPO Plan

Notice

This Certificate provides dental benefits only and does not participate in any divisible surplus of premiums.

QCC Insurance Company (hereinafter referred to as "Plan") certifies that the Subscriber is covered under and subject to all the provisions, definitions, limitations and conditions of this Certificate for the benefits approved herein, and is eligible for benefits stated in the ***Coverage Schedule*** as of the date indicated in the letter accompanying the ID Card.

The address of the principal administrative office of the Plan is:

QCC Insurance Company
9001 Market Street
Philadelphia, PA 19103

This is a Limited Policy - Read It Carefully

Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Taglines as of 11/4/2024

Discrimination is Against the Law

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

This plan:

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

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

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

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

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

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

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

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

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

COVERAGE SCHEDULE

AmeriHealth Caritas - Platinum Plan

The dental plan is underwritten by the Plan.

Benefit Period		Calendar Year (1/1 - 12/31)			
Service Class	**Service Description**	**In-Network**		**Out-of-Network**	
		Plan Pays	**Waiting Period**	**Plan Pays[1]**	**Waiting Period**
1	Diagnostic & Preventive Services	100%	None	100%	None
2	Basic Services	100%	None	100%	None
3	Major Services	90%	None	90%	None
4	Orthodontic Services	60%	None	60%	None
Annual Deductible		**In-Network**		**Out-of-Network**	
Amount		$50		$50	
Max Per Family		$150		$150	
Applies To		Class 2, Class 3, Class 4		Class 2, Class 3, Class 4	
Note for Annual Deductible shown above: Each Member must pay the Annual Deductible amount for dental services before the Plan will begin to cover the Member's dental procedures. The Annual Deductible is combined for all applicable services for each Benefit Period per Member.					

Maximums	In-Network	Out-of-Network
Annual	$3,000	$3,000
Applies To	Class 2, Class 3	Class 2, Class 3
Lifetime Orthodontic	$2,000	$2,000
Note for Maximums shown above: The maximum listed is the dollar amount that the Plan will pay towards the cost of dental care within the specified period per Member. The Annual Maximum is combined for In-Network and Out-of-Network services.		
Out-of-Network Allowance	**In-Network**	**Out-of-Network**
	N/A	
1. Unlike In-Network (INN) providers that have agreed to negotiated fees for services, Out-of-Network (OON) providers have no contract with the Plan's leased dental networks. As such, OON providers set their own fees and the Plan only reimburses the Member based on the established , which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than the Plan's , the Member will be billed the remaining balance to cover the OON provider's fee.		

- If course of treatment is to exceed $300, prior review is recommended.

This Plan will pay either the In-Network dentist's negotiated fee or the Out-of-Network (subject to service coverage percentage) for dental procedures and services as shown below, after any required Annual Deductible.

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period	Does a deductible apply?	Plan Pays	Waiting Period	Does a deductible apply?
1	Oral Evaluations (Exams)	*One (1) of these services per 6 months.* Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more years.	100%	None	No	100%	None	No
1	Emergency or problem focused exam	One per Benefit Period	100%	None	No	100%	None	No
1	Prophylaxis (cleaning, scaling and polishing teeth)	Two per Benefit Period; one additional cleaning is covered for expecting mothers or diabetics	100%	None	No	100%	None	No
1	Topical fluoride	One (1) per 6 months under age nineteen (19).	100%	None	No	100%	None	No
1	Bitewing x-rays	Two per Benefit Period	100%	None	No	100%	None	No
1	Periapical x-rays		100%	None	No	100%	None	No
1	Full mouth or panoramic x-ray	One per 60 months	100%	None	No	100%	None	No
1	Emergency palliative treatment	No limitations	100%	None	No	100%	None	No
1	Sealants	One per tooth per three Benefit Periods, to age 16, limited to permanent 1st and 2nd molars	100%	None	No	100%	None	No

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period	Does a deductible apply?	Plan Pays	Waiting Period	Does a deductible apply?
1	Space maintainers	One (1) per three (3) year period for Members under age nineteen (19) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.	100%	None	Yes	100%	None	Yes
2	Simple extraction of teeth		100%	None	Yes	100%	None	Yes
2	Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations)	Per tooth, per surface, every 24 months	100%	None	Yes	100%	None	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	100%	None	Yes	100%	None	Yes
2	Antibiotic injections administered by a dentist		100%	None	Yes	100%	None	Yes
2	Oral surgery, including postoperative care for coronectomy, intentional partial tooth removal	One per tooth per lifetime	100%	None	Yes	100%	None	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period	Does a deductible apply?	Plan Pays	Waiting Period	Does a deductible apply?
2	Oral surgery, including postoperative care for: removal of teeth, including impacted teeth; extraction of tooth root; alveolectomy, alveoplasty and frenectomy; excision of periocoronal gingiva, exostosis or hyper plastic tissue and excision of oral tissue for biopsy; tooth reimplantation and/or stabilization; tooth transplantation; excision of a tumor or cyst and incision and drainage of an abscess or cyst		100%	None	Yes	100%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to root canal therapy	No limitations	100%	None	Yes	100%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: pulpotomy; apicoectomy		100%	None	Yes	100%	None	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period	Does a deductible apply?	Plan Pays	Waiting Period	Does a deductible apply?
2	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to retrograde fillings	No limitations	100%	None	Yes	100%	None	Yes
2	Periodontic services, limited to periodontal maintenance	Periodontal maintenance following active periodontal therapy - Two, per 12 months in addition to routine prophylaxis	100%	None	Yes	100%	None	Yes
2	Periodontic services, limited to root scaling and planing	One per quadrant per 24 months	100%	None	Yes	100%	None	Yes
2	Periodontic services, limited to: occlusal adjustment performed with covered surgery; gingivectomy; osseous surgery including flap entry and closure		100%	None	Yes	100%	None	Yes
2	Periodontic services, limited to pedicle or free soft tissue graft	One per 24 months per area of the mouth	100%	None	Yes	100%	None	Yes
2	Periodontic services, limited to occlusal guard (night guards)	No limitations	100%	None	Yes	100%	None	Yes
2	Periodontic services, limited to full mouth debridement	No limitations	100%	None	Yes	100%	None	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period	Does a deductible apply?	Plan Pays	Waiting Period	Does a deductible apply?
2	Periodontic services, limited to scaling in presence of generalized moderate or severe gingival inflammation	Full mouth, after oral evaluation and in lieu of a covered Prophylaxis (cleaning, scaling and polishing teeth), limited to one per two years	100%	None	Yes	100%	None	Yes
2	General anesthesia and analgesia, including intravenous sedation	No limitations	100%	None	Yes	100%	None	Yes
3	Infiltration of sustained release therapeutic drug - single or multiple sites		90%	None	Yes	90%	None	Yes
3	Diagnostic cast (study model)	One per 36 months	90%	None	Yes	90%	None	Yes
3	Crown build-up for non-vital teeth		90%	None	Yes	90%	None	Yes
3	Recementing bridges, inlays, onlays and crowns	After first 12 months of insertion and per 12 months per tooth thereafter	90%	None	Yes	90%	None	Yes
3	Repair of dentures or fixed bridgework		90%	None	Yes	90%	None	Yes
3	Restoration services, limited to cast metal, resin-based, or porcelain/ceramic inlay, onlay, and crown	Limited to a tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling	90%	None	Yes	90%	None	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period	Does a deductible apply?	Plan Pays	Waiting Period	Does a deductible apply?
3	Restoration services, limited to replacement of existing inlay, onlay, or crown	Single crowns, inlays, onlays - not within 5 Benefit Periods of previous placement of any of the procedures in this category. Replacement of natural tooth/teeth in an arch - not within 5 Benefit Periods of a fixed partial denture, full denture or partial removable denture.	90%	None	Yes	90%	None	Yes
3	Restoration services, limited to stainless steel crowns	Up to age 14 (one per tooth per lifetime)	90%	None	Yes	90%	None	Yes
3	Restoration services, limited to post and core	Buildups and post and cores - not within 5 Benefit Periods of previous placement of any of the procedures in this category.	90%	None	Yes	90%	None	Yes
3	Prosthetic services, limited to initial placement of removable dentures or fixed bridges		90%	None	Yes	90%	None	Yes
3	Prosthetic services, limited to replacement of removable dentures or fixed bridges	That cannot be repaired after 5 years from the date of last placement	90%	None	Yes	90%	None	Yes
3	Prosthetic services, limited to addition of teeth to existing partial denture		90%	None	Yes	90%	None	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period	Does a deductible apply?	Plan Pays	Waiting Period	Does a deductible apply?
3	Prosthetic services, limited to relining or rebasing of existing removable dentures	One per 24 months (only after 24 months from date of last placement)	90%	None	Yes	90%	None	Yes
3	Prosthetic services, limited to tissue conditioning	One treatment 7 years (not covered when performed within 6 months of any denture)	90%	None	Yes	90%	None	Yes
3	Implants and related services	No limitations	90%	None	Yes	90%	None	Yes
3	Endosteal implant, a devise surgically inserted into the bone to provide support for a single restoration when used in lieu of a three unit bridge and adjacent abutment teeth are not to be restored		90%	None	Yes	90%	None	Yes
3	Occlusal orthotic device for TMD, by report	One per 5 years	Not Covered	None	Yes	Not Covered	None	Yes
4	Orthodontic services, up to age 19		60%	None	N/A	60%	None	N/A
4	Orthodontic services, age 19 and older		60%	None	N/A	60%	None	N/A

An Alternate Benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the Member to the less costly treatment. However, if the Member and the dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed under this ABP.

Exclusions

- Services which are covered under worker's compensation or employer's liability laws or the Pennsylvania Motor Vehicle Responsibility Law.
- Services which are not necessary for the patient's dental health as determined by the Plan.
- Reconstructive, plastic, cosmetic, elective, or aesthetic dentistry.
- Oral surgery requiring the setting of fractures and dislocations.
- Services with respect to malignancies, cysts, or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
- Dispensing of drugs (with the exception of antibiotic injections administered by a dentist).
- Hospitalization for any dental procedure.
- Treatment required for conditions resulting from major disaster, epidemic, war, acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
- Replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
- Diagnosis or treatment of temporomandibular disorder (TMD) syndromes, problems and/or occlusal disharmony.
- Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth including third molars.
- Procedures not listed as covered services under this plan.
- Replacement of lost, stolen, or damaged prosthetic or orthodontic appliances.
- Athletic mouthguards.
- Precision or semi-precision attachments.
- Denture duplication.
- Periodontal splinting of teeth by any method.
- Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
- Procedures that in the opinion of the plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the member's condition.
- Preventive restorations.
- For which, in the absence of insurance, the Member would incur no charge.
- For:
  - Plaque control programs;
  - Tobacco counseling;
  - Oral hygiene; and
  - Dietary instructions.
- Incomplete treatment (For Example, patient does not return to complete treatment) and temporary services (For Example, temporary restorations).
- Procedures that are:
  - Part of a service, but are reported as separate services;
  - Reported in a treatment sequence that is not appropriate;
  - Misreported or that represent a procedure other than the one reported.
- Fees for broken appointments.

PRE-EXISTING CONDITION

There will be no pre-existing condition that will apply to this dental plan. The Covered Services as shown in this dental plan will apply as of the effective date of this coverage. All Benefits are subject to the ***Exclusions*** section of this Certificate of Coverage.

DEFINITIONS

Accredited Educational Institution
A publicly or privately operated academic institution of higher learning which:
- Provides recognized courses or a course of instruction.
- Confers any of the following, when a student completes the course of study:
  - A diploma;
  - A degree; or
  - Another recognized certification of completion.
- Is duly recognized, and declared as such, by the appropriate authority, as follows:
  - An authority of the state in which such institution must also be accredited by a nationally recognized accrediting association as recognized by the United States Secretary of Education.

The definition may include, but is not limited to Colleges and Universities; and Technical or specialized schools.

Annual Deductible
The amount set forth in the ***Coverage Schedule*** which each Member must pay each Benefit Period before Benefits will be paid by the Plan.

Annual Maximum
The total amount of Benefits set forth in the ***Coverage Schedule*** that will be paid to the Member in a Benefit Period.

Benefit Period
The specified period of time as shown in the ***Coverage Schedule*** within which the Member has to use Covered Services in order to be eligible for payment by the Plan.

Benefits
The amount payable by the Plan, as set forth in the ***Coverage Schedule***, for a Covered Service.

Covered Service
A procedure listed in the ***Coverage Schedule***.

Dependent
- The Subscriber's spouse under a legally valid existing marriage, the Subscriber's child(ren), including any stepchild, legally adopted child, a child placed for adoption or any child whose coverage is the Subscriber's responsibility under the terms of a qualified release or court order. The limiting age for covered children is the first of the month following the month in which they reach age 26. Eligibility will be continued past the limiting age for unmarried children, regardless of age, who are incapable of self-support because of mental or physical incapacitation and who are dependent on the Subscriber for over half of their support. The Plan may require proof of eligibility under the prior Plan 's plan and also from time to time under this dental plan. In addition, a full-time student will be considered eligible for coverage when they are on a medically necessary leave of absence from an Accredited Educational Institution. The Dependent child will be eligible for coverage until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate. The limiting age referenced above will be applicable regardless of the status of the medically necessary leave of absence.

- A full-time student who is eligible for coverage under this dental plan who is:
  - A member of the Pennsylvania National Guard or any reserve component of the U.S. armed forces and who is called or ordered to active duty, other than active duty for training for a period of 30 or more consecutive days; or
  - A member of the Pennsylvania National Guard who is ordered to active state duty, including duty under Pa. C.S. Ch. 76 (relates to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

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

  As proof of eligibility, the Subscriber must submit a form to the Plan approved by the Department of Military & Veterans Affairs (DMVA):
  - Notifying the Plan that the Dependent has been placed on active duty;
  - Notifying the Plan that the Dependent is no longer on active duty; or
  - Showing that the Dependent has re-enrolled as a full-time student in an Accredited Educational Institution for the first term or semester starting 60 or more days after their release from active duty.
- A Domestic Partner, as long as a Domestic Partnership exists, the child or children of a Domestic Partner shall be considered for eligibility under the dental plan as if they were the Member's own child or children. If the Member enrolls their Domestic Partner, the Member has an affirmative obligation to notify the Plan immediately if the Domestic Partnership terminates. Upon termination of the Domestic Partner relationship, coverage of the former Domestic Partner and the children of the former Domestic Partner shall terminate at the end of the current monthly term. The former Domestic Partner, and any of their previously covered children, shall be entitled, by applying within 60 days of such termination, to direct pay coverage of the type for which the former Domestic Partner and children are then qualified, at the rate then in effect. This direct pay coverage may be different from the coverage provided under this Certificate.
- The newborn child(ren) of the Subscriber or the Subscriber's Dependent shall be entitled to the benefits provided by this dental plan from the date of birth for a period of 31 days. Coverage of newborn children within such 31 days shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. To be eligible for Dependent coverage beyond the 31 day period, the Subscriber must enroll the newborn child within such 31 days. To continue coverage beyond 31 days for a newborn child, who does not otherwise qualify for coverage as a Dependent, the Subscriber must apply within 31 days after the birth of the newborn and the appropriate rate, calculated from the 32nd day after birth, must be paid when billed.
- A newly acquired Dependent shall be eligible for coverage under this dental plan on the date the Dependent is acquired provided that the Subscriber applies to the Plan for addition of the Dependent within 31 days after the Dependent is acquired and the Subscriber makes timely payment of the appropriate rate. If application is made later than 31 days after the Dependent is acquired, coverage shall become effective on the first billing date following 30 days after the Subscriber's application is accepted by the Plan.
- A Dependent child of a custodial parent covered under this dental plan may be enrolled under the terms of a qualified medical release or court order, as required by law.
- No Dependent may be eligible for coverage as a Dependent of more than one Member of the enrolled Group. No individual may be eligible for coverage hereunder as a Member and as a Dependent of a Member at the same time.

Domestic Partner
A person who is at least 18 years old, is not related to the Subscriber by blood or marriage within four degrees of consanguinity under civil law rule, is not married or in a civil union or domestic partnership with another individual, has been financially interdependent with the Subscriber for at least six consecutive months prior to enrollment in the dental plan in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely, and shares a primary residence with the Subscriber. In order to obtain coverage for a Domestic Partner, the Subscriber must sign an Affidavit of Domestic Partnership form provided by the Plan.

Eligible Expenses
Covered dental services and procedures described in this Certificate of Coverage.

Group
The organization or employing unit with which the Subscriber is associated and which has executed the Contract.

Member
Any individual Subscriber or their eligible family Dependent entitled to receive services by reason of the Contract.

Non-Participating Dentist
Shall mean an independent licensed dentist who is not a Participating Dentist.

Participating Dentist
Those independent licensed dentists who have contracted with the Plan to provide dental services at negotiated fees for Members of the dental plan. Participating Dentists are not employees of, nor supervised by the Plan.

Premiums
Amounts payable on a regular prepayment basis by or for the Subscriber to the Plan.

Subscriber
An individual who has paid the Premiums for services of the Plan prior to the effective date, including payments for Dependents as hereinafter defined.

Waiting Periods
Shall mean the period between employment or enrollment for coverage and the date when a Member becomes eligible for a given Covered Service.

EFFECTIVE DATE OF BENEFITS
When the Group provides its annual open enrollment period, it will begin at least 30 days prior to the 1st day of the Benefit Period. The open enrollment period will extend for a minimum of 30 days. During the annual open enrollment period, a Member may enroll, discontinue, or change enrollment in this dental plan offered by the Group. The Group will let the Member know when the open enrollment period begins and ends. Member’s effective date of coverage will be indicated on communications provided by the Plan, which will be sent either electronically or via regular mail.

TERMINATION OR CANCELLATION
Benefits shall cease upon the earliest of the following events:

- **Termination by Group**
  - If the Group terminates the Contract with the Plan for any reason, all eligible Member's enrollment in the dental plan ends on the same date that the Group terminates the Contract. In the event of termination or upon receipt of notice of termination from the dental plan, the Group shall provide written notice to the Subscriber no later than 15 days after receipt of the notice of termination.

- **Termination by the** Plan
  - The Member is entitled to coverage only for the period for which the Plan has received the appropriate Premium from the Group. If the Group fails to pay the appropriate Premiums, the Plan will terminate the Members under the dental plan. The Group shall provide written notice to the Subscriber no later than 15 days after receipt of the notice of termination.
  - Upon the date of the Dependents attaining the age of 26 or marriage prior to that date (Subject to the provisions contained in the definition of Dependent).
  - If after reasonable efforts to establish and maintain a satisfactory dentist-patient relationship, the Participating Dentist is unable to do so, the Plan reserves the right to transfer the Subscriber and Dependents to a second and then third Participating Dentist of their choice. If the third Participating Dentist is also unable to establish a satisfactory dentist-patient relationship, the Plan reserves the right to terminate the membership of said Subscriber and Dependents. Termination shall be effective on the last day of the month after 31 days of which termination notice occurs. In case of termination by the Plan, and if services have been rendered, no refund will be given to the Subscriber.
  - Upon violation of the terms of the Contract, fraud or deception in the use of services, coverage will be canceled after the 31st day after written notice is mailed to the Subscriber.

EXTENSION OF BENEFITS
Upon termination of coverage, an extension of benefits shall be provided for any treatment in progress at the time of termination, provided the treatment requires two or more visits on separate days to the dentist's office. Extension of benefits will be limited to 90 days for all care other than orthodontics, and 60 days for orthodontics (if covered under this dental plan), if the orthodontist has agreed to or is receiving monthly payments when coverage terminates, or to the end of the quarter in progress or 60 days, whichever is longer, if the orthodontist is receiving quarterly payments. An extension of benefits will not be provided if termination was due to a failure of the Subscriber to pay the Premiums or fraud or material misrepresentation by the Subscriber or Dependent.

PREMIUMS
Members are entitled to dental coverage for the period for which the Plan has received the appropriate Premium from the Group. The Subscriber is responsible to pay any required contribution to the Premium, as determined and required by the Group. The Group will tell the Subscriber the amount owed and how the Subscriber will pay the Premium to the Group (For Example: A payroll deduction).

BENEFITS AND COVERAGES

Eligible Expenses

The Plan will pay for Eligible Expenses incurred by a Member. Eligible Expenses must be incurred while the Contract is in force or under extension of benefits provision in the ***Extension of Benefits*** section of this Certificate of Coverage. The description of Eligible Expenses is shown in the ***Coverage Schedule***. All Benefits will be paid to the Subscriber unless otherwise designated by the claimant. Benefits will be paid after the Member complies with any Waiting Periods and deductibles as specified in the ***Coverage Schedule***. All Benefits are subject to the ***Exclusions*** section of this Certificate of Coverage. Benefit amounts will vary depending on whether the Member obtains services from a Participating Dentist or a Non-Participating Dentist. To be considered an Eligible Expense, the service must be performed by a dentist, a physician, or a dental hygienist, and be deemed by the treating dentist to be necessary for the patient's dental health. An Eligible Expense is considered incurred on the following dates:

- Dentures: on the date the final impression is taken.
- Fixed bridges, crowns, inlays and onlays: on the date the teeth are initially prepared.
- Root canal therapy: on the date the pulp chamber is opened.
- Periodontal surgery: on the date the surgery is performed.
- All other services: on the date the service is performed.

In-Network Benefits

The Plan will pay a percentage of the Participating Dentist's charge for each Covered Service up to the Participating Dentist's negotiated fee. The percentage of payment by the Plan is determined by procedure classification as set forth in the ***Coverage Schedule***. For example, if a procedure is covered at 80%, the Plan will pay 80% and the Member will pay the remaining balance of 20%, up to the Participating Dentist's negotiated fee. The Member may be required to remit payment for the remaining balance at the time of service. Billing arrangements are between the Member and the Participating Dentist. Participating Dentists are listed in the dentist directory. The Member should confirm continued participation of a Participating Dentist prior to receiving treatment. Members can find a current list of Participating Dentists online by visiting https://www.ibx.com/findadentist or by contacting Customer Service at 1-866-615-4956.

Out-of-Network Benefits

A Member may choose to receive treatment from a Non-Participating Dentist. Benefit percentages for out-of-network Benefits, if applicable, are listed in the ***Coverage Schedule*** according to procedure classification. Benefits are calculated using . The Member is responsible for any amount charged which exceeds the per procedure. Billing arrangements are between the Member and the Non-Participating Dentist. If a Member receives treatment from a Non-Participating Dentist, the Member may be required to make payment in full at the time of service. The Member may then submit a claim to the Plan for Benefit payment.

Pre-Authorization of Benefits

If the charge for treatment is expected to exceed $300, the Plan recommends that the treating dentist to submit a treatment plan prior to initiating services. In accordance with its review guidelines, the Plan may request x-rays, periodontal charting or other dental records, prior to issuing the pre-authorization. The proposed services will be reviewed and a pre-authorization will be issued to the Subscriber or dentist, specifying coverage. The pre-authorization is not a guarantee of coverage and is considered valid for 180 days.

Clinical Review
The Plan may review requests for payment to ensure that care and services were necessary and provided in accordance with generally accepted dental practice. Clinical review is performed when the Plan receives a claim for payment of services that have already been provided. The Member may obtain a copy of the Plan s Utilization Review Guidelines through the Plan website or by calling Customer Service Department toll-free at 1-866-615-4956.

COORDINATION OF BENEFITS AND SERVICES
A Member may be covered for health Benefits or services by more than one Plan. For instance, the Member may be covered by this Certificate as an employee and by another Plan as a dependent of their spouse. If the Member is covered by more than one Plan, this provision allows QCC Insurance Company (QCC) to coordinate what QCC pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the primary Plan and which is the secondary Plan. Coordination of Benefits is intended to avoid duplication of Benefits while at the same time preserving certain rights to coverage under all Plans under which the Member is covered.

DEFINITIONS
The words shown below have special meanings when used in this provision. Please read these definitions carefully.

Allowable Expense
The charge for any health care service, supply or other item of expense for which the Member is liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below. When this Certificate is coordinating Benefits with a Plan that provides Benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense. QCC will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is medically necessary and appropriate services. When this Certificate is coordinating Benefits with a Plan that restricts coordination of Benefits to a specific coverage, QCC will only consider corresponding services, supplies or items of expense to which coordination of Benefits applies as an Allowable Expense.

Claim Determination Period
A Benefit Period, or any portion of a Benefit Period, during which a Member is covered by this Certificate and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

Plan
Coverage with which coordination of Benefits is allowed. Plan includes:
- Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
- Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
- Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
- Group hospital indemnity benefit amounts that exceed $150.00 per day;
- Medicare or other governmental Benefits, except when, pursuant to law, the Benefits must be treated as in excess of those of any private insurance plan or non- governmental plan.

Plan does not include:
- Individual or family insurance contracts or subscriber contracts;
- Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
- Group or group-type coverage where the cost of coverage is paid solely by the Member except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
- Group hospital indemnity benefit amounts of $150.00 per day or less;
- School accident-type coverage;
- A State plan under Medicaid.

Primary Plan
A Plan whose Benefits for a Member's health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either of the bullet points below exist:
- The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
- All Plans which cover the Member use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the Plan determines its Benefits first.

Reasonable and Customary
An amount that is not more than the Usual, Customary and Reasonable Fees for the service or supply as determined by QCC, based on a standard which is most often charged for a given service by a provider within the same geographic area.

Secondary Plan
A Plan which is not a Primary Plan. If a Member is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the Benefits payable under the multiple Secondary Plans are paid in relation to each other. The Benefits of each Secondary Plan may take into consideration the Benefits of the Primary Plan or Plans and the Benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its Benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN
QCC considers each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of Benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the Benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each claim determination period the Secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the "Procedures to be Followed by the Secondary Plan to Calculate Benefits" section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for medically necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or - second surgical opinion procedures were not followed.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The Benefits of the Plan that covers the Member as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the Member as a dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The Benefits of the Plan that covers the Member as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers the Member as a laid off or retired employee, or as such a person's dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The Benefits of the Plan that covers the Member as an employee, member, subscriber or retiree, or dependent of such person, shall be determined before those of the Plan that covers the Member under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

- The Benefits of the Plan of the parent whose birthday falls earlier in the calendar year shall be determined before those of the parent whose birthday falls later in the calendar year.
- If both parents have the same birthday, the Benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the plan which covered the other parent for a shorter period of time.
- "Birthday," as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
- If the other Plan contains a provision that determines the order of Benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

- The Benefits of the Plan of the parent with custody of the child shall be determined first.
- The Benefits of the Plan of the spouse of the parent with custody shall be determined second.
- The Benefits of the Plan of the parent without custody shall be determined last.
- If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the Benefits of that Plan shall be determined first. The Benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of Benefits does not establish which Plan is the Primary Plan, the Benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the Benefits of the Plan(s) that covered the person for a shorter period of time.

Procedures to be followed by the Secondary Plan to Calculate Benefits:

In order to determine which procedure to follow it is necessary to consider:
- The basis on which the Primary Plan and the Secondary Plan pay Benefits; and
- Whether the provider who provides or arranges the services and Supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge, or some similar term. This means that the provider bills a charge and the Member may be held liable for the full amount of the billed charge. In this section, a Plan that bases Benefits on a reasonable and customary charge is called Reasonable and Customary Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the Member may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases Benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the Member uses the services of a non-network provider, the Plan will be treated as a Reasonable and Customary Plan even though the Plan under which they are covered allows for a fee schedule.

Payment to the provider may be based on a "capitation." This means that the HMO or other Plan pays the provider a fixed amount per Member. The Member is liable only for the applicable deductible, coinsurance or copayment. If the Member uses the services of a non-network provider, the HMO or other Plan will only pay Benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is Reasonable and Customary Plan and Secondary Plan is Reasonable and Customary Plan:

The Secondary Plan shall pay the lesser of:
- The difference between the amount of the billed charges and the Amount paid by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

When the Benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan:
If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:
- The amount of any deductible, coinsurance or copayment required by The Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary Plan, the Secondary Plan and the

Member shall not exceed the fee schedule of the Primary Plan. In no event shall the Member be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Reasonable and Customary Plan and Secondary Plan is Fee Schedule Plan:

If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

- The difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

The Member shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the Member has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event shall the Member be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Reasonable and Customary Plan:

If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Reasonable and Customary Plan or Fee Schedule Plan:

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Member receives from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay Benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or Reasonable and Customary Plan:

If the Member receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

- The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or Reasonable and Customary Plan and Secondary Plan is Capitation Plan:

If the Member receives services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, coinsurance or copayment imposed by the Primary Plan. The Member shall not be liable to pay any deductible, coinsurance or copayments of either the Primary Plan or the Secondary Plan.

Primary Plan is an HMO and Secondary Plan is an HMO:

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Member receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay Benefits as if it were the Primary Plan, except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

DENTAL RECORDS
The dental records of all Members concerning services performed hereunder shall remain the property of the treating dentist. Information related to the number, cost, and delivery of services provided under the dental plan to Members may be made available to the Plan by dentists for purposes of review, investigation, or evaluation of care.

CHANGE IN SERVICE
The Plan reserves the right to change the Premiums and/or dental plan Benefits after completion of the term of the Contract. No change will be made without giving the Member 30 days prior written notice and without approval by the Pennsylvania Insurance Department.

CLAIMS

Payment of Claims
If the Plan provides coverage of a Member as a Dependent of a parent who has legal responsibility for the Dependent's dental care, and such parent does not have custody of the Dependent, the Plan may, upon request of the custodial parent, make the payments directly to the treating dentist. Any payments so made will release the Plan from all further liability to the Member to the extent of the payments made. Benefits for other losses are paid to the Member. However, the Plan has the right to pay all or part of the benefits due to the treating dentist. This is true whether or not the Member is alive. If the Member has died and the Plan does not pay accrued benefits to the treating dentist, benefits will be paid to the Member's estate.

Consistent with pre-authorization of benefits, the Plan may request supporting documentation in accordance with its review guidelines in order to make a benefit determination.

Emergency Services
When a Member is more than 50 miles from their home, they may have emergency services rendered by any licensed dentist. Emergency services is defined as ‘palliative care of injury, toothache, or accident requiring the immediate attention of a dentist or hospital/ambulatory surgical care center.’ For purposes of calculating any amount payable under the dental plan by the Member, the Plan will treat services received as if services were provided by a Participating Dentist. All policy provisions, limitations and exclusions will be applied.

Claim Forms
If the Plan receives a notice of claim, it will provide claim forms for filing proof of loss. If such forms are not sent within 15 days after notice of claim is received, the claimant will be deemed to have complied with the requirements of this Contract as to proof of loss.

Notice of Claim
The Plan must receive written notice of the claim within 20 days after the occurrence or commencement of any loss covered by the dental plan, or as soon thereafter as is reasonably

possible. Notice given by or on behalf of the Member to the Plan's dental administrator at Dominion National, P.O. Box 21522, Eagan, MN, 55121, to any authorized agent of the Plan, with information sufficient to identify the Member, shall be deemed notice to the Plan.

Proof of Loss
The Plan must receive written proof of loss within 180 days of treatment. Failure to provide proof of loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the claimant, not later than one year from the time proof is otherwise required. Instructions for submitting proof of loss to the Plan can be obtained by calling the Customer Service Department at 1-866-615-4956.

Explanation of Benefits
The Plan will make available to the Member notice of the Plan's claims processing, called an Explanation of Benefits. The Explanation of Benefits explains the Plan's payment or the Plan's reason(s) for nonpayment of the claim.

Time of Payment of Claim
Benefits payable under this Certificate of Coverage for any loss will be paid immediately or within the time required by state regulations. If the Plan fails to pay claim within the time required by state regulations that contains the required supporting documentation, it will pay interest from the date on which payment is required to the date the claim is paid.

Time Limit on Certain Defenses
In the absence of fraud, all statements made by a Member shall be considered representations and not warranties and no statement shall be the basis for voiding coverage or denying a claim after the Contract has been in force for three years from its effective date. During the three year period, contests by the Plan are limited to material misstatements made in a written application.

Physical Examinations
The Plan at the Plan's own expense shall have the right and opportunity to examine a Member when and as often as it may reasonably require during the pendency of a claim hereunder.

Legal Actions
No action at law or in equity shall be brought to recover on this Contract prior to the expiration of 60 days after written proof of loss has been furnished in accordance with this Contract. No such action will be brought after the expiration of three years after written proof of loss is required to be furnished.

Misstatement of Age
If the age of the Member has been misstated, all benefits payable under this Contract shall be such as the Premium paid would have purchased at the correct age.

APPEALS OF AN ADMINISTRATIVE DENIAL AND MEDICAL NECESSITY APPEAL PROCESS

Important Information Regarding Your Insurance
The following definitions apply only to this section:

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

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

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

- **Medical Necessity Appeal**
  An appeal of an Adverse Benefit Determination that the request for a benefit under a health insurance policy does not meet the Plan's requirement for Medical Necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental/Investigative. This includes an Adverse Benefit Determination that does any of the following:
  - Disapproves full or partial payment for a requested health care service;
  - Approves the provision of a requested health care service for a lesser scope or duration than requested; or
  - Disapproves payment of the provision of a requested health care service but approves payment for the provision of an alternative health care service.

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

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

General Correspondence
1901 Market Street
Philadelphia, PA 19103

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

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

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

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

Except in the case of an expedited appeal, the Plan must receive completed, valid authorization forms before the Member's appeal can be processed. (For information on expedited appeals, see the definition below and the references in the Appeal of an Administrative Denial Process and the Medical Necessity Appeal Process sections below.) The Member has the right to withdraw or rescind authorization of an authorized representative at any time during the process.

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

Information for the Appeal Review:

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

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

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

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

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

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

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

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

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

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

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

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

Appeals are also subject to the following classifications:

A **pre-service appeal** is any appeal for benefits with a coverage requirement that preapproval or Precertification by the Plan must be obtained before Medical Care and services are received.

A **post-service appeal** includes any appeal regarding benefits for Medical Care or services that a Member has already received or any appeal for a service that does not require preapproval or Precertification by the Plan.

Internal Standard Appeal of an Administrative Denial
The Member or authorized representative may file an Appeal of an Administrative Denial for an

unresolved dispute or objection. The Appeal of an Administrative Denial process consists of two internal levels of review by the Plan, and one external level of review by the Pennsylvania Insurance Department.

Internal Standard First Level Appeal of an Administrative Denial

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

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

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

The internal standard first level Appeal of an Administrative Denial is decided by a Plan employee who has no previous involvement with the case and who is not the subordinate of anyone previously involved with the case. The decision notification is sent to the Member or authorized representative within:

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

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

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

Internal Standard Second Level Appeal of an Administrative Denial

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

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

Upon receipt of the Member's appeal, the Member or authorized representative will be notified

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

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

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

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

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

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

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

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

The Member's request for external review of an Appeal of an Administrative Denial should

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

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

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

Internal Standard Medical Necessity Appeal Process

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

The appeal process consists of one (1) internal review by the Plan and if appealed further, an external review conducted by an accredited private Independent Review Organization (IRO). The external review is coordinated by the Pennsylvania Insurance Department’s HCA3. There is also an internal and external expedited Medical Necessity Appeal process in the event the Member's condition involves an urgent issue.

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

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

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

The Member's one level of internal appeal is reviewed by a Plan Medical Director, who is the decision-maker. This individual holds an active unrestricted license to practice medicine, has had no previous involvement in the case, and is not a subordinate of the person who made the original determination. Additionally, the Plan Medical Director is a same or similar specialist, or

the decision-maker receives input from an independent consultant who is a same or similar specialist. A same or similar specialist or "same or similar specialty Physician" is a licensed Physician or Psychologist who is in the same or similar specialty as typically manages the case under review. Additionally, the physician consultant:

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

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

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

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

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

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

Internal Expedited Medical Necessity Appeals

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

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

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

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

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

EXTERNAL REVIEW INDEPENDENT REVIEW ORGANIZATION (IRO) PROCESS

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

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

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

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

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

Preliminary Review of an External Review Request

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

- The individual is or was a Member under the health insurance policy at the time the health care service was requested, or in the case of a retrospective utilization review, at the time the health care service was provided.
- The health care service that is the subject of the external review request is covered under the Member's health insurance policy, except for determinations by the Plan that a health care service is not covered because it does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

- The Member has exhausted the Plan's internal Medical Necessity Appeal process.
- The Member has not provided all required information and forms to process an external review.

For an external review of denial of coverage of an Experimental/Investigative treatment, the Plan's preliminary review will also include a determination of whether:

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

External Review Process

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

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

Within one business day of the HCA3's receipt of the Plan's notification that the external review is eligible based on the Plan's preliminary review, the HCA3 assigns an IRO to review

the case file and notifies the Plan of the assignment.

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

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

Reconsideration by the Plan

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

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

Standard External Review IRO Decision

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

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

Expedited External Review

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

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

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

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

A Member/authorized representative may request an expedited external review at the same time as the expedited internal Medical Necessity Appeal process in the following circumstances:
- The Member has an Urgent Care condition for which the timeframe for completion of an expedited internal review of the Adverse Benefit Determination would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function.
- The final Adverse Benefit Determination involves a determination that the recommended or requested health care service is Experimental/Investigative, and the Member's treating health care Provider certifies in writing that the recommended or requested health care service that is the subject of the Adverse Benefit Determination would be significantly less effective if not promptly initiated.

Preliminary Review of an Expedited External Review Request

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

Expedited External Review Process

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

The Plan forwards all documents from an Adverse Benefit Determination or final Adverse Benefit Determination to the assigned IRO by the following methods:
- Electronically (typically via the assigned IRO portal).
- By any other available expedited method, if no IRO portal is available.

Expedited External Review IRO Decision

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

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

Binding Decision for External Reviews

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

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

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

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

This is a Limited Policy - Read It Carefully

INDEPENDENCE BLUE CROSS NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

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

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

We protect your privacy by:

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

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

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

[2] For purposes of this Notice, "Independence Blue Cross" refers to the following companies: Independence Blue Cross, Keystone Health Plan East, QCC Insurance Company, and Vista Health Plan, Inc. – independent licensees of the Blue Cross and Blue Shield Association.

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

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

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

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

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

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

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

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

Health Care Operations: We may use and disclose your PHI to conduct and support our business and management activities as a health insurance issuer. For example, we may use and disclose your PHI to determine our premiums for your health plan, to conduct quality assessment and improvement activities, to conduct business planning activities, to conduct fraud detection programs,

to conduct or arrange for medical review, or to engage in care coordination of health care services.

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

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

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

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

- We may disclose "summary health information" to your plan sponsor to use to obtain premium bids for providing health insurance coverage or to modify, amend or terminate its group health plan. "Summary health information" is information that summarizes claims history, claims expenses, or types of claims experience for the individuals who participate in the plan sponsor's group health plan;
- We may disclose PHI to your plan sponsor to verify enrollment/disenrollment in your group health plan;
- We may disclose your PHI to the plan sponsor of your group health plan so that the plan sponsor can administer the group health plan; and
- If you are enrolled in a group health plan, your plan sponsor may have met certain requirements of the HIPAA Privacy Rule that will permit us to disclose PHI to the plan sponsor. Sometimes the plan sponsor of a group health plan is the employer. In those circumstances, we may disclose PHI to your employer. You should talk to your employer to find out how this information will be used.

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

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

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

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

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

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

Lawsuits and Other Legal Disputes: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process once we have met all administrative requirements of the HIPAA Privacy Rule.
Law Enforcement: We may disclose your PHI to law enforcement officials under certain conditions. For example, we may disclose PHI:

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

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

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

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

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

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

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

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

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

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

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

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

Health Information Exchanges

We share your health information electronically through certain Health Information Exchanges ("HIEs"). A HIE is a secure electronic data sharing network. In accordance with applicable federal and state privacy and security requirements, regional health care providers participate in HIEs to exchange patient information in real-time to help facilitate delivery of health care, avoid duplication of services, and more efficiently coordinate care. As a participant in HIEs, Independence shares your health information we may have received when a claim has been submitted for services you have received among authorized participating providers, such as physicians, hospitals, and health systems for the purpose of treatment, payment and health care operations as permitted by law. During an emergency, patients and their families may forget critical portions of their medical history which may be very important to the treating physician who is trying to make a quick, accurate diagnosis in order to treat the sick patient. Independence, through its participation in an HIE, makes

pertinent medical history, including diagnoses, studies, lab results, medications and the treating physicians we may receive on a claim available to participating emergency room physicians while the patient is receiving care. This is invaluable to the physician, expediting the diagnosis and proper treatment of the patient.

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

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

Right to Provide an Authorization for Other Uses and Disclosures

- Other uses and disclosures of your PHI that are not described above will be made only with your written authorization.
- You may give us written authorization permitting us to use your PHI or disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your PHI that are not identified by this Notice, or are not otherwise permitted by applicable law.

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

Your authorization must be in writing and contain certain elements to be considered a valid authorization. For your convenience, you may use our approved Independence Blue Cross Authorization Form. To request the Independence Blue Cross Authorization Form, please contact

Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at www.ibx.com, or write us at the address at the end of this Notice.

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

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

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

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

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

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

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

Right to Request Restrictions: You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to your request. However, if we do agree, we will be bound by our agreement except when required by law, in

emergencies, or when information is necessary to treat you. An approved restriction continues until you revoke it in writing, or until we tell you that we are terminating our agreement to a restriction.

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

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

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

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

You will not be penalized for filing a complaint.

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

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

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

NOTICE OF PROTECTION PROVIDED BY PENNSYLVANIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** regarding the protections provided to policyholders by the Pennsylvania Life and Health Insurance Guaranty Association ("the Association"). This protection was created under Pennsylvania law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to $300,000 (or $500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

Life insurance:
- Up to $300,000 in death benefits including up to $100,000 in net cash surrender or withdrawal value.

Accident, accident and health, or health insurance (including HMOs):
- Up to $500,000 for health benefit plans, with some exceptions.
- Up to $300,000 for disability income benefits.
- Up to $300,000 for long-term care insurance benefits.
- Up to $100,000 for all other types of health insurance.

Individual annuities:
- Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:

- any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;
- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contractholder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract
- If the person is provided coverage by the guaranty association of another state
- A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

NOTICES

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

Pennsylvania Insurance Department
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388
www.insurance.pa.gov

The summary information provided by this notice and on the Association's web site do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's web site are for general information purposes and should not be relied upon as legal advice.

Dental Plans are underwritten by QCC Insurance Company, a subsidiary of Independence Blue Cross – independent licensees of the Blue Cross and Blue Shield Association. IBX dental plans are administered by Dominion Dental Services, Inc. an independent company.

Independence Blue Cross offers products through its subsidiaries Independence Assurance Company, Independence Hospital Indemnity Plan, Keystone Health Plan East, and QCC Insurance Company — independent licensees of the Blue Cross and Blue Shield Association.

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