Exhibit B

This provides an outline of the benefit package that Healthy PA Private Coverage Organizations are responsible to provide in calendar year 2015. This information is current as of June 5, 2014 and is subject to change.

- **Physician Services**
  - Primary Care Physician Visits
  - Specialist Office Visits
  - Pre-Natal Maternity
  - Maternity – Delivery and Post-Partum Care
  - Allergy Treatment
  - Allergy Testing

- **Preventative Care**
  - Routine Adult Physical Exams/Immunizations
    (Limited to one exam every 12 months.)
  - Routine Gynecological Exams
    (Limited to one routine exam and pap smear per 365 days.)
  - Routine Mammograms
    (Recommended: One annual mammogram for covered females age 40 and over.)
  - Women's Health
    (Includes: Screening for gestational diabetes;
    HPV (Human Papillomavirus) DNA testing;
    counseling for sexually transmitted infections;
    counseling and screening for human immunodeficiency virus;
    screening and counseling for interpersonal and domestic violence;
    breastfeeding support, supplies and counseling; and
    contraceptive methods and counseling.
    Limitations may apply.)
  - Routine Digital Rectal Exams/Prostate Specific Antigen Test
    (Recommended for covered males age 40 and over.
    Age and frequency schedules may apply.)
  - Colorectal Cancer Screening
    (For all members age 50 and over. Frequency schedule applies.)
  - Routine Eye Exam at Specialist
    (Limited to one routine exam per 24 months.)
  - Routine Hearing Screening at PCP
    (Covered only as part of a physical exam.)

❖ Diagnostic Procedures

- Diagnostic Laboratory
- Diagnostic X-ray for Complex Imaging Services
  (Includes MRA/MRS, MRI, PET and CAT scans.)

❖ Emergency Medical Care

- Urgent Care Provider
  (Non-Urgent use of Urgent Care Provider is not covered)
- Emergency Room
  (Non-Emergency care in an Emergency Room is not covered)
- Emergency Ambulance
  (Non-Emergency Ambulance is not covered)

❖ Hospital Care

- Inpatient Coverage
  (Including maternity and transplants)
- Outpatient Surgery

❖ Mental Health Services

- Inpatient Psychiatric Services
  (except at State Mental Hospitals)
- Outpatient Psychiatric Services: Licensed Provider or Licensed Practitioner
  - Counseling:
    - Individual
    - Group
    - Family
- Partial Hospitalization
- Intensive Outpatient Psychiatric Services
- Medication Management
- Psychological Testing
- Laboratory and Diagnostic Studies and Procedures for the Purpose of Determining Response to Behavioral Health Medication and/or Treatment Ordered by Behavioral Health Service Provider within the Scope of their Practice

❖ Alcohol/Drug Abuse Services

- Inpatient Drug and Alcohol Rehabilitation
- Inpatient Detoxification
- Non-hospital Drug and Alcohol Rehabilitation
- Non-hospital Detoxification
- Outpatient Drug and Alcohol Services
  - Individual
  - Group
  - Partial
- Intensive Outpatient
- Medication Assisted Treatment

❖ Other Services

- Skilled Nursing Facility
  (Limited to 120 days per member per calendar year.)
- Home Health Care
  (Limited to 60 visits per member per calendar year,
  no more than 3 intermittent visits per day by a Home Health Care Agency,
  1 visit equals a period of 4 hours or less.)
- Infusion Therapy
- Hospice Care – Inpatient
- Hospice Care – Outpatient
- Outpatient Physical and Occupational Therapy
  (Physical and Occupational Therapy limited to 30 visits [combined]
  per member per calendar year.)
- Outpatient Speech Therapy
  (Limited to 30 visits per member per calendar year.)
- Subluxation (Chiropractic)
  (Limited to 20 visits per member per calendar year.)
- Treatment of Autism
  (Includes coverage for habilitative care and Applied Behavioral Analysis.)
- Vision Corrective Lenses/Contact Lenses Allowance
  ($100 per 24-month period)
- Durable Medical Equipment
  (Maximum benefit of $2,500 per member per calendar year.)

❖ Family Planning

- Infertility Treatment
  (Coverage for only the diagnosis and surgical treatment of the underlying medical cause. Comprehensive Infertility Services are not covered. Advanced Reproductive Technology [ART] is not covered. This includes In-Vitro Fertilization (IVF), Zygote Intra-Fallopian Transfer [ZIFT], Gamete Intra-embryo transfers [GIFT], Intra-Cytoplasmic Sperm Injection [ICSI] or ovum microsurgery.)
- Vasectomy
- Tubal Ligation

- **Pharmacy = Prescription Drug Benefits**
  - Prescription Drugs
    Up to a 30-day supply
  - Prescription Drugs (Retail or Mail Order)
    31-90 supply
  - Specialty Care Drugs
    (Self-injectable, infused and oral specialty drugs)
  - Diabetic supplies, oral fertility drugs, contraceptive drugs and devices obtainable from a pharmacy.
  - Formulary generic FDA-approved Women's Contraceptives

What's Not Covered

This plan does not cover all health care expenses and includes exclusions and limitations. The following is a partial list of services and supplies that are generally not covered.

1. Cosmetic surgery, including breast reduction.
2. Custodial care.
3. Dental care and x-rays.
4. Donor egg retrieval.
5. Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for Members participating in a cancer clinical trial.)
6. Hearing aids
7. Home births
8. Immunizations for travel or work.
9. Implantable drugs and certain injectable drugs, including injectable infertility drugs.
10. Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents.
11. Non-medically necessary services or supplies
12. Orthotics, except diabetic orthotics.
13. Over-the-counter medications (except as provided in a hospital) and supplies
14. Redial keratotomy or related procedures
15. Reversal of Sterilization
16. Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs.
17. Special duty nursing
18. Therapy or rehabilitation other than those listed as coved in the plan documents.
19. Weight control services and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.