

Highmark Inc., d/b/a
HIGHMARK BLUE CROSS BLUE SHIELD
("the Plan")

A Pennsylvania non-profit corporation whose
address is 120 Fifth Avenue, Fifth Avenue Place
Pittsburgh, PA 15222-3099

**Comprehensive Major Medical Preferred Provider High Deductible
Subscription Agreement for Individual Members Utilizing the
Keystone Health Plan West Network of Providers, Without a Gatekeeper**

identified as the

"PPOBlue"

Required Outline of Coverage

- I. **READ YOUR AGREEMENT CAREFULLY** - This outline provides a very brief description of the important features of your Subscription Agreement ("Agreement"). This is not the insurance contract and only the actual Agreement provisions will control. The Agreement itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR AGREEMENT CAREFULLY!

- II. **COMPREHENSIVE MAJOR MEDICAL EXPENSE COVERAGE** - Agreements of this category are designed to provide, to persons covered under the Agreement, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, out-of-hospital care, prosthetic appliances and durable medical equipment, preventive services, emergency services and transplant services. Outpatient prescription drug coverage is provided for prescription drugs when purchased at a participating pharmacy provider.

Coverage is provided at network and out-of-network benefit levels with cost-sharing options such as deductibles, coinsurance, and annual and lifetime maximums. Benefits are subject to the Health Care Management Services Provision with possible loss of benefits for non-compliance. Benefits for emergency care are provided at the network benefit level. A gatekeeper is not required to access benefits from providers.

III. **A BRIEF DESCRIPTION OF THE BENEFITS CONTAINED IN THE AGREEMENT IS AS FOLLOWS:**

- A. **Daily Hospital Room and Board** - which includes a room with two (2) or more beds or a private room, when medically necessary and appropriate, and general nursing services.

- B. Miscellaneous Hospital Services** - including the use of medical equipment and specialty rooms, transplant services, services related to surgery and other usual and customary covered services such as drugs and medicines, diagnostic services and therapy and rehabilitation services, not specifically excluded by the Agreement.
- C. Surgical Services** - including pre- and post-operative services, assistant at surgery, second surgical opinion and special surgical procedures which include oral surgery and mastectomy and breast cancer reconstruction.
- D. Anesthesia Services** - coverage is provided for the administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery. Benefits are provided for the administration of anesthesia for oral surgical procedures in an outpatient setting when ordered and administered by the attending preferred professional provider.
- E. In-Hospital Medical Services** - including inpatient medical care visits, intensive medical care, concurrent care, consultation and routine newborn care.
- F. Out-of-Hospital Care** - including follow-up care for accidental injury for physical medicine, speech therapy, and occupational therapy services; surgery of a non-dental nature; diagnostic services; chemotherapy; radiation therapy; physical medicine, speech therapy or occupational therapy services for the continuing treatment of a traumatic condition or illness or injury following a covered inpatient stay or following covered outpatient surgery; infusion therapy; oral surgery; pediatric immunizations; routine gynecological examinations and papanicolaou smears; annual screening mammograms for members age forty (40) and over, and for any physician recommended mammograms for members under age forty (40); well-woman care; services for mastectomy and breast cancer reconstructive surgery; diabetes treatment for all types of diabetes; the Dr. Dean Ornish Program (for Reversing Heart Disease); and prescription drugs when purchased at a participating pharmacy provider.
- G. Prosthetic Appliances** - including the purchase, fitting, necessary adjustments, repairs and replacements of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses); initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof; the purchase, fitting, necessary adjustments, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part; and the rental (but not to exceed the total cost of purchase) or, at the option of the Plan, the purchase, adjustment, repairs and replacement of durable medical equipment when prescribed by a professional provider within the scope of their license and required for therapeutic use.
- H. Other Benefits** - including home health agency covered services for eligible members; inpatient care in a skilled nursing facility; and birthing center coverage for prenatal, labor, delivery and postpartum care.

- I. Emergency Care Services** - Coverage is provided for the treatment of bodily injuries resulting from an accident, following the sudden onset of a medical condition or, following, in the case of a chronic condition, a sudden and unexpected medical event that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: i) placing the member's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, ii) causing serious impairment to bodily functions, or iii) causing serious dysfunction of any bodily organ or part and for which care is sought as soon as possible after the medical condition becomes evident to the Member, or the Member's parent or guardian.

Transportation and related emergency services provided by an ambulance service shall constitute emergency ambulance service if the injury or the condition satisfies the criteria above.

Use of an ambulance as transportation to an emergency room of a Facility Provider for an injury or condition that does not satisfy the criteria above will not be covered as emergency ambulance services.

Treatment for an occupational injury for which benefits are provided under any Workers' Compensation Law or any similar Occupational Disease Law is not covered.

J. Benefit Amounts, Durations, Limits, Deductibles and Coinsurance for Benefits Under the Agreement -

1. **Benefit Period** - the specified period of time during which charges for covered services must be incurred in order to be eligible for payment by the Plan. For this program, the benefit period is the period of twelve (12) consecutive months beginning on the member's effective date and renewing on each effective date thereafter until termination. A member's effective date is the date on which coverage under this program commences for the member.
2. **Payment of Benefits** - Benefit amounts are determined based on the plan allowance for covered services. The plan allowance is the allowance that the Plan utilizes to represent the value of covered services provided to a member based on the type of service and the provider who renders such service, or as required by law. The plan allowance is the portion of the provider's billed charge that is used by the Plan to calculate the Plan's payment to that provider and the member's liability.

Benefit amounts for outpatient prescription drugs are determined based on the provider's allowable price for covered medications. The provider's allowable price is the amount at which the participating pharmacy provider has agreed with the Plan to provide covered medications and covered maintenance prescription drugs to members covered under the Agreement.

3. Schedule

<u>DEDUCTIBLE</u>	<u>NETWORK AND OUT-OF-NETWORK SERVICES</u>
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Individual	\$1,500
Family	\$3,000

- A. Unless otherwise indicated, deductible amounts are applicable to covered services furnished to a member per benefit period.
- B. The deductible applies to all covered services, except where exempted by law or indicated herein. The deductible is not applicable toward the satisfaction of the out-of-pocket limit specified in this section.
- C. In the case of family coverage, the entire family deductible must be satisfied in one (1) benefit period by one (1) or more family members in order for the family to satisfy the family deductible before benefits are payable.
- D. In the case of family coverage, benefits for any individual will not be payable until the family deductible has been satisfied.

OUT-OF-POCKET LIMIT

A. GENERAL	<u>NETWORK SERVICES</u>	<u>OUT-OF-NETWORK SERVICES</u>
Individual	\$4,000	\$3,000
Family	\$8,000	\$6,000

B. INDIVIDUAL OUT-OF-POCKET LIMIT

1) Network Covered Services

When a member incurs \$4,000 in coinsurance expense for network covered services furnished to the member in one (1) benefit period, the benefits payable for claims received by the Plan for that member during the remainder of the benefit period will increase to one hundred percent (100%) of the plan allowance.

The dollar amount specified shall not include any amounts paid for deductibles or amounts in excess of the plan allowance.

2) Out-of-Network Covered Services

When a member incurs \$3,000 in coinsurance expense for out-of-network covered services furnished to the member in one (1) benefit period, the benefits payable for claims received by the Plan for that member during the remainder of the benefit period will increase to one hundred percent (100%) of the plan allowance.

The dollar amount specified shall not include any amounts paid for deductibles or amounts in excess of the plan allowance.

C. FAMILY OUT-OF-POCKET LIMIT

1) Network Covered Services

When members under the same family coverage have incurred \$8,000, in coinsurance expense for network covered services furnished to the members in one (1) benefit period, the benefits payable for claims received by the Plan thereafter for all members under that same family coverage during the remainder of the benefit period will increase to one hundred percent (100%) of the plan allowance.

In the case of family coverage, benefits for any individual will not increase to one hundred percent (100%) of the plan allowance until the entire Family Out-of-Pocket Limit has been satisfied.

The dollar amount specified shall not include any amounts paid for deductibles or amounts in excess of the plan allowance.

2) Out-of-Network Covered Services

When members under the same family coverage have incurred \$6,000 in coinsurance expense for out-of-network covered services furnished to the members in one (1) benefit period, the benefits payable for claims received by the Plan thereafter for all members under that same family coverage during the remainder of the benefit period will increase to one hundred percent (100%) of the plan allowance.

In the case of family coverage, benefits for any individual will not increase to one hundred percent (100%) of the plan allowance until the entire Family Out-of-Pocket Limit has been satisfied.

The dollar amount specified shall not include any amounts paid for deductibles or amounts in excess of the plan allowance.

COVERED SERVICES

EXCEPT AS OTHERWISE INDICATED, PAYMENT FOR THE FOLLOWING COVERED SERVICES IS BASED ON THE PLAN ALLOWANCE:

<u>COVERED SERVICES</u>	<u>NETWORK SERVICES</u>	<u>OUT-OF-NETWORK SERVICES</u>
A. AMBULANCE SERVICE		
Emergency Ambulance Services	80%	Same as Network Services
Non Emergency Ambulance Services	80%	60%
B. DENTAL SERVICES RELATED TO ACCIDENTAL INJURY	80%	60%
C. DIABETES TREATMENT		
<u>Equipment and Supplies</u>	80%	60%
<u>Diabetes Education Program</u>	80%	60%
D. DIAGNOSTIC SERVICES	80%	60%
E. DR. DEAN ORNISH PROGRAM (For Reversing Heart Disease)	80%	60%
	Maximum of one (1) enrollment per lifetime	
F. DURABLE MEDICAL EQUIPMENT	80%	60%
G. EMERGENCY CARE SERVICES	80%	Same as Network Services
	Benefits for Emergency Care Services rendered by an out-of-network provider will be paid at the network services level. The Plan will pay 80% of the plan allowance and the member will be responsible for the remaining 20% of the plan allowance plus any deductible that would have been applicable to network services. The member will not be responsible for any amounts billed by the out-of-network provider that are in excess of the plan allowance.	
H. ENTERAL FORMULAE	80%	60%
I. FAMILY PLANNING AND INFERTILITY SERVICES	80%	60%
J. HOME HEALTH CARE SERVICES	80%	60%
	100 visit maximum per benefit period	

<u>COVERED SERVICES</u>	<u>NETWORK SERVICES</u>	<u>OUT-OF-NETWORK SERVICES</u>
K. HOSPICE CARE SERVICES	80%	60%
L. HOSPITAL SERVICES	80%	60%
	Unlimited days per benefit period	90 days per benefit period
<u>Private Room Allowance</u>	80%	60%
	for the most common semiprivate room charge	
	Private room covered when Medically Necessary and Appropriate.	
<u>Pre-Admission Testing</u>	80%	60%
<u>Surgery</u>	80%	60%
M. MATERNITY SERVICES	80%	60%
<u>Maternity Home Health Care Visit</u>	One (1) maternity home health care visit within forty-eight (48) hours of discharge when discharge occurs prior to (a) forty-eight (48) hours of inpatient care following a normal vaginal delivery; or (b) ninety-six (96) hours of inpatient care following a Caesarean delivery. Such visit is exempt from any coinsurance amount.	
N. MEDICAL/SURGICAL SERVICES		
<u>Inpatient Medical Care Services</u>		
Inpatient Medical Care Visits and Intensive Medical Care	80%	60%
Concurrent Care	80%	60%
Consultation	80%	60%
Newborn Care	80%	60%
<u>Outpatient Medical Care Services</u>	80%	60%
<u>Allergy Extract/Injections</u>	80%	60%
<u>Surgical Services</u>		

<u>COVERED SERVICES</u>	<u>NETWORK SERVICES</u>	<u>OUT-OF-NETWORK SERVICES</u>
Anesthesia	80%	60%
Assistant at Surgery	80%	60%
Second Surgical Opinion Services	80%	60%
Special Surgery	80%	60%
Surgery	80%	60%
<u>Therapeutic Injections</u>	80%	Not Covered
O. ORTHOTIC DEVICES	80%	60%

P. PRESCRIPTION DRUGS (OUTPATIENT)

PAYMENT FOR OUTPATIENT PRESCRIPTION DRUGS IS BASED ON THE PROVIDER'S ALLOWABLE PRICE

<u>Covered Medications</u>	80% of the provider's allowable price	Not Covered
<u>Preventive Medications (Outpatient)</u>	100% of the provider's allowable price	Not Covered

Q. PREVENTIVE SERVICES

*Benefits are provided in accordance with a predefined schedule based on age and sex. The preventive schedule is reviewed and updated periodically by the Plan based on the requirements of the Patient Protection and Affordable Care Act of 2010, as amended, and the advice of the American Academy of Pediatrics, U.S. Preventive Services Task Force, the Blue Cross and Blue Shield Association, and medical consultants. Accordingly, the frequency and eligibility of services is subject to change.

(All Preventive Services benefits are exempt from deductibles)

<u>Adult Care</u>	100%	Not Covered
<u>Adult Immunizations</u>	100%	Not Covered

(Adult immunizations required by an employer are subject to the deductible.)

<u>Mammographic Screening (Routine)</u>	100%	Not Covered
<u>Pediatric Care</u>	100%	60%
<u>Pediatric Immunizations</u>	100%	Not Covered
<u>Routine Gynecological Examination and Papanicolaou Smear</u>	100%	Not Covered

<u>COVERED SERVICES</u>	<u>NETWORK SERVICES</u>	<u>OUT-OF-NETWORK SERVICES</u>
<u>Well-Woman Care</u>	100%	Not Covered
R. PROSTHETIC APPLIANCES	80%	60%
S. SKILLED NURSING FACILITY SERVICES	80%	60%
	Limited to 100 days per benefit period Up to 50 days may be used out-of-network	
T. SPINAL MANIPULATIONS	80%	60%
	10 visit maximum per contract year	
U. THERAPY AND REHABILITATION SERVICES		
<u>Cardiac Rehabilitation</u>	80%	60%
<u>Chemotherapy</u>	80%	60%
<u>Dialysis Treatment</u>	80%	60%
<u>Infusion Therapy</u>	80%	60%
<u>Occupational and Speech Therapy</u>	80%	60%
	Combined 15 visit maximum per contract year	
<u>Physical Medicine</u>	80%	60%
	15 visit maximum per contract year	
<u>Radiation Therapy</u>	80%	60%
<u>Respiratory Therapy</u>	80%	60%
V. TRANSPLANT SERVICES	80%	60%

IV. **EXCEPTIONS, REDUCTIONS, AND LIMITATIONS OF THE AGREEMENT**

- A. **Pre-existing Condition** - A “Pre-existing Condition” means a condition for which medical advice or treatment was recommended by a physician or received from a physician within a five-year period preceding the effective date of coverage of the member. Benefits are not available under this Agreement for services furnished to a member for a pre-existing condition during an exclusion period of 12 months following the member’s effective date. The pre-existing condition exclusion period will not be imposed on any member under the age of nineteen (19).

B. Medically Necessary and Appropriate - “Medically necessary and appropriate” means services or supplies that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: 1) in accordance with generally accepted standards of medical practice; and 2) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and 3) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

Benefits under the Agreement for services or supplies will be provided only when the Plan, utilizing the criteria set forth in the paragraph above, determines that such service or supply is medically necessary and appropriate. Network facility providers and preferred professional providers will accept this determination of medical necessity. Out-of-network providers are not obligated to accept this determination and may bill the member for services determined not to be medically necessary and appropriate. See the Agreement for further explanation.

C. Experimental/Investigative Treatments - The Plan does not cover services which it determines are experimental or investigative in nature because those services are not accepted by the medical community as effective treatments. However, the Plan acknowledges that situations exist when a patient and his or her physician agree to pursue an experimental treatment. If the member’s physician performs such an experimental procedure, the member is responsible for charges for services considered to be experimental or investigative. The member or the member’s physician may contact the Plan to determine whether a service is considered experimental or investigative. See the Agreement for further explanation.

D. Healthcare Management Services - A complete Healthcare Management Service (HMS) Program requires review prior to non-emergency and non-delivery related admissions to determine the medical necessity and appropriateness for the proposed admission or services.

E. Plan Payment and Member Liability - The Plan uses the plan allowance to calculate the benefit payable and the financial liability of the member for Medically Necessary and Appropriate Services covered under the Agreement. In the case of prescription drug (outpatient) benefits, the Plan uses the provider’s allowable price for this calculation. See Section III, Subsection **J. Benefit Amounts, Durations, Limits, Deductibles and Coinsurance for Benefits Under the Agreement.**

1. Plan Payment

The Plan’s payment is determined by first subtracting any deductible liability from the plan allowance. The coinsurance percentage of the plan allowance set forth in Section III, Subsection **J. Benefit Amounts, Durations, Limits, Deductibles and Coinsurance for Benefits Under the Agreement,** Paragraph 3. Schedule, within this

Outline of Coverage is then applied to that amount. This amount represents the Plan's payment. Any remaining coinsurance amount is the member's responsibility.

2. Member Liability

The member's total liability is the sum of any deductible and member coinsurance obligation. Network providers will accept the Plan's payment plus the member's total liability as payment in full for the covered services provided to the member. However, out-of-network providers are not required to accept the Plan's payment as payment in full. Out-of-network providers may bill the member for the difference between the out-of-network provider's billed amount and the Plan's payment. This is in addition to any deductible and member coinsurance obligations. If a member receives services which are not covered under the Agreement, the member is responsible for all charges associated with those services.

In the event that a member requires non-emergency covered services that are not available within the network, the Plan may refer the member to a provider who is not a network provider. In such cases, services will be covered at the network service benefit level and the liability of the member will be limited to the network service deductible and member coinsurance amount. The member will not be responsible for any difference between the Plan payment and the provider's charge.

3. The Plan's payment for covered medications purchased from a participating pharmacy provider is determined by first subtracting any deductible liability from the provider's allowable price. The coinsurance percentage as set forth in Section III, Subsection **J. Benefit Amounts, Durations, Limits, Deductibles and Coinsurance for Benefits Under the Agreement**, Paragraph 3. Schedule within this Outline of Coverage is then applied to that amount once the deductible has been satisfied. Any remaining coinsurance amount is the member's responsibility. The member's total liability for covered medications is the sum of any deductible and coinsurance obligations. However, until the member has satisfied their deductible, the participating pharmacy provider is entitled to collect from the member 100% of the provider's allowable price for the covered medication at the time of purchase. Preventive medications are exempt from any deductible or coinsurance obligation.

F. BlueCard Program - When a member obtains covered health care services through BlueCard outside the geographic area the Plan serves, the amount a member pays for covered services is calculated on the **lower** of:

- The billed charges for a member's covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to the Plan.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with a member's health care provider or with a specified

group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with a member's health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount a member pays is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating member liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, the Plan would then calculate a member's liability for any covered services in accordance with the applicable state statute in effect at the time a member received care.

G. Exclusions - Except as specifically provided the Agreement, no benefits will be provided for services, supplies or charges:

1. Which are not medically necessary and appropriate as determined by the Plan;
2. Which are not prescribed by or performed by or upon the direction of a professional provider;
3. Rendered by other than hospitals, facility providers, professional providers, professional other providers and suppliers;
4. Which are experimental/investigative in nature;
5. Rendered prior to the member's effective date;
6. Incurred after the date of termination of the member's coverage except as provided in **SECTION GP - GENERAL PROVISIONS, BENEFITS AFTER TERMINATION OF COVERAGE** Subsection, in the Agreement;
7. For a pre-existing condition, but only during the exclusion period as specified in Section **IV** of this Outline of Coverage;;
8. For loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of an act of war whether declared or undeclared;
9. For which a member would have no legal obligation to pay;
10. Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;

11. To the extent payment has been made under Medicare when Medicare is primary;
12. For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease, or similar type legislation. This exclusion applies whether or not the member files a claim for said benefits or compensation;
13. To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service-connected illness or injury, unless the member has a legal obligation to pay;
14. For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act;
15. For prescription drugs which were paid or are payable under a freestanding prescription drug program;
16. For nicotine cessation support programs, classes and prescription drugs prescribed for nicotine cessation purposes; except as otherwise provided in the predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule within this Outline of Coverage;
17. Which are submitted by a certified registered nurse and another professional provider or professional other provider for the same services performed on the same date for the same member;
18. Rendered by a provider who is a member of the member's immediate family;
19. Performed by a professional provider or professional other provider enrolled in an education or training program when such services are related to the education or training program;
20. For ambulance services, except as provided in Section **III** of this Outline of Coverage;
21. For a cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body or performed for psychological or psychosocial reasons, and from which no improvement in physiological function can be expected, except: as otherwise required by law; when necessitated by a covered sickness or injury; when required to correct a condition directly resulting from an accident; or to correct a congenital birth defect;

22. For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
23. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or “barrier free” home modifications, whether or not specifically recommended by a professional provider or professional other provider;
24. For inpatient admissions which are primarily for diagnostic studies or for physical medicine services;
25. For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care;
26. For respite care;
27. For treatment of all mental illness, including prescription drugs prescribed for the treatment of mental illness;
28. Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses otherwise covered because of accidental bodily injury to sound natural teeth and for orthodontic treatment for congenital cleft palates as provided in Section **III** of this Outline of Coverage;
29. For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma;
30. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone Surgery), calluses, toe nails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes;
31. For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;
32. For any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery;

33. Related to treatment provided specifically for the purpose of assisted fertilization; including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law;
34. For sterilization, except as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule in this Outline of Coverage;
35. For impotency treatment drugs or fertility drugs;
36. For oral impotency drugs;
37. For contraceptive services including contraceptive prescription drugs, contraceptive devices, implants and injections, and all related services, except as otherwise set forth in the predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule in this Outline of Coverage;
38. For reversal of sterilization;
39. For weight control drugs and services intended to produce weight loss, except as otherwise provided in the predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule within this Outline of Coverage;
40. For nutritional counseling, except as provided herein or as otherwise provided in the predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule within this Outline of Coverage;
41. For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless Medically Necessary and Appropriate or as otherwise provided in the predefined schedule in the **PREVENTIVE SERVICES** benefit schedule within this Outline of Coverage;
42. For treatment of obesity, except for medical and surgical treatment of morbid obesity or as otherwise provided in the predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule within this Outline of Coverage;
43. For prescription vitamins, except vitamins prescribed during pregnancy, and fluoride legend vitamins, or as otherwise provided in the predefined schedule described in the **PREVENTIVE SERVICES** benefit schedule within this Outline of Coverage;
44. For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, (except for aphakic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury);
45. For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial

keratotomy, corneal ring implants, laser-assisted in situ keratomileusis (LASIK) and all related services;

46. For any food including, but not limited to, enteral formulae, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis. This does not include enteral formulae prescribed solely for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria;
47. For preventive care services, wellness services or programs, except as provided in Section **III** of this Outline of Coverage, or as mandated by law;
48. For allergy testing, except as provided in Section **III** of this Outline of Coverage, or as mandated by law;
49. For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not Medically Necessary and Appropriate, except as provided in Section **III** of this Outline of Coverage, or as mandated by law;
50. For immunizations required for foreign travel or employment, except as otherwise provided in the predefined schedule in the **PREVENTIVE SERVICES** benefit schedule within this Outline of Coverage;
51. For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur; unless medically necessary and appropriate;
52. For treatment of sexual dysfunction not related to organic disease or injury;
53. For any care that is related to conditions such as autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change. Care which extends beyond traditional medical management or for inpatient confinement for environmental change includes the following: i) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; ii) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; iii) services provided for purposes of behavioral modification and/or training; iv) services related to the treatment of learning disorders or learning disabilities; v) services provided primarily for

social or environmental change or for respite care; vi) developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the member has not yet attained; and vii) services provided for which, based on medical standards, there is no established expectation of achieving measurable sustainable improvement in a reasonable and predictable period of time;

54. For the treatment of substance abuse, including prescription drugs prescribed for the treatment of substance abuse;
55. For any care, treatment, or service which has been disallowed under the provisions of the Health Care Management Services Program;
56. For any care, treatment or service for any loss sustained or contracted in consequence of the member's being intoxicated, or under the influence of any narcotic unless administered on the advice of a physician;
57. For any care, treatment or service for any loss to which a contributing cause was the member's commission of or attempt to commit a felony or to which a contributing cause was the member's being engaged in an illegal occupation;
58. For private duty nursing services;
59. For services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, prenatal/delivery/postnatal services;
60. For otherwise covered services ordered by a court or other tribunal unless Medically Necessary and Appropriate or the reimbursement of such services is required by law; and
61. For any other medical or dental service or treatment except as provided in Section **III** of this Outline of Coverage, or as mandated by law.

V. **TERMS AND CONDITIONS OF THE RENEWABILITY OF THE AGREEMENT**

A. **Guaranteed Renewable** - The Agreement is guaranteed renewable and may be renewed by payment of the premium within thirty-one (31) days after the first day of the month for which payment must be made. Coverage continues for one (1) month from the effective date of the Agreement and from month to month thereafter until terminated in accordance with the Agreement. Non-renewal shall not be based on the deterioration of the mental or physical health of any individual covered under the Agreement.

B. **Termination** - Subject to the right of the Plan to terminate coverage, and to any amendment permitted under applicable law, the Agreement will remain in effect continually until terminated by the subscriber or the Plan in accordance with the following:

1. The Agreement may be terminated by the subscriber by giving thirty (30) days written notice to the Plan.
 2. The Agreement is guaranteed renewable and cannot be terminated by the Plan except in the following instances:
 - i) if payment of the appropriate premium is not made when due, or during the grace period;
 - ii) if a member in obtaining coverage, or in connection with coverage hereunder, has performed an act or practice constituting fraud or intentional misrepresentation of a material fact (e.g., misuse of the member identification card). However, the Plan will not terminate the Agreement because of a member's medically necessary and appropriate utilization of services covered under the Agreement;
 - iii) upon ninety (90) days notice to the subscriber when the Plan discontinues this coverage, and offers to each individual the option to purchase any other individual health insurance coverage currently being offered by the Plan to individuals within the twenty-nine (29) county area served by the Plan, or upon one hundred eighty (180) days notice to the subscriber when the Plan discontinues all individual coverage within the twenty-nine (29) county area served by the Plan;
 - iv) in the event the subscriber no longer lives in the (twenty-nine (29) county) area served by the Plan; or
 - v) as of the end of the month in which either of the following events occurs:
 - a. a child ceases to meet any of the requirements for dependent coverage set forth in **SECTION SE - SCHEDULE OF ELIGIBILITY** in the Agreement; or
 - b. a spouse becomes divorced from the subscriber.
- However, if the Plan accepts payment of the premium for coverage extending beyond the date determined in this subparagraph v)., then coverage as to such person shall continue during the period for which an identifiable premium was accepted, except where such acceptance was predicated on a misstatement of age.
3. If the Agreement is terminated at the option of either party, the Plan shall refund to the subscriber the amount of any unearned prepaid premium held by the Plan. Unearned prepaid premium in any amount less than one (\$1.00) dollar shall not be refunded unless specifically requested by the Subscriber.

C. Continuation of Coverage

1. Continuation due to ineligibility

A dependent who becomes ineligible for coverage pursuant to the terms set out in **SECTION SE - SCHEDULE OF ELIGIBILITY** in the Agreement may apply within thirty (30) days thereafter to continue coverage under this program as an individual subscriber or under another program of the type for which the dependent then qualifies.

2. Continuation upon termination of subscriber's coverage or death of subscriber

Upon termination of the subscriber's coverage under the Agreement due to enrollment in a Medicare supplemental or Medicare Advantage plan, or due to the death of the subscriber, coverage may continue for the covered dependents for any period for which the premium has been paid. The subscriber's spouse, if covered under the Agreement, shall become the subscriber upon notice to the Plan of the termination of the subscriber's coverage or the subscriber's death. If the subscriber's spouse was not covered under the Agreement, a dependent child may become a subscriber under his or her own Agreement.

D. Modification/Premium Subject to Change -

Premium rates are based upon the age of the oldest member covered under this Agreement. The Agreement will renew every month for all members thereafter at the premium rate for the age which the subscriber has then attained.

The Plan, subject to the approval of the Pennsylvania Insurance Department, may alter or revise the terms of the Agreement or the premiums. Any such alteration or revision of the terms of the Agreement shall become applicable for all members on the effective date of the alteration or revision whether or not the subscriber has paid the premium in advance. Any change in the premiums shall become applicable for members upon the expiration of the period covered by the subscriber's current payment at the time of such change. In the event of such alteration or revision, the subscriber shall be notified in advance of the new premium and the effective date, and payment of the new premium shall be considered receipt of notice and acceptance of the change in premium. Any notice shall be considered to have been given when mailed to the subscriber at the address on the records of the Plan.

VI. RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD PLANS

The Agreement is between the subscriber and Highmark Blue Cross Blue Shield only. Highmark Blue Cross Blue Shield is an independent corporation operating under a license from the Blue Cross Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield plans throughout the United States. Although all of these independent Blue Cross and Blue Shield plans operate from a license

with the Association, each of them is a separate and distinct corporation. The Association allows Highmark Blue Cross Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Highmark Blue Cross Blue Shield, upon entering into the Agreement, is not contracting as an agent of the national Association. Only Highmark Blue Cross Blue Shield shall be liable to the subscriber for any of the Plan's obligations under the Agreement. This paragraph does not add any obligations to the Agreement.



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Blue Cross, Blue Shield, BlueCard and the Cross and Shield symbols are registered marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.