

**HIGHMARK BLUE CROSS BLUE SHIELD**  
**(“the Plan”)**

whose home office address is 1800 Center Street, Camp Hill, Pennsylvania, 17011  
and whose mailing address is 120 Fifth Avenue, Fifth Avenue Place  
Pittsburgh, PA 15222-3099

**COMPREHENSIVE MAJOR MEDICAL COVERAGE**

**\$1,000 DEDUCTIBLE**  
**\$5,000,000 SUBSCRIPTION AGREEMENT**

**REQUIRED OUTLINE OF COVERAGE**

**A. *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!**

**B. *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, outpatient prescription drug coverage and transplant services.

Coverage is subject to cost-sharing provisions such as deductibles, coinsurance, and annual and lifetime maximums. Benefits are maximized by the use of participating providers, and are subject to the Health Care Management Service Provision with penalties and possible loss of benefits for non-compliance.

*Except for a newborn child of a subscriber, enrollment under this Agreement is subject to medical underwriting.*

**C. Benefit Amounts, Durations, Limits, Deductibles and Coinsurance for Benefits Under the Agreement:**

**1. Benefit Period**                      Contract Year.

**2. Deductible**

**a. Individual**                              \$1,000 per benefit period per subscriber. The deductible applies to all covered services, except for coverage for enteral formula, maternity home health care visit, pediatric immunizations, and gynecological examinations and papanicolau smears. The deductible is not applicable toward satisfaction of the out-of-pocket limits

specified in this Outline. Any penalties assessed amounts for which the subscriber is responsible under the Health Care Management Service Program will not be used to satisfy the deductible as defined herein.

**b. Family** \$3,000 per benefit period for the applicant and dependents covered under this Agreement. However, no subscriber will contribute more than the individual deductible of \$1,000 in a benefit period toward satisfaction of the family deductible.

**c. Prescription Drug** \$100 per subscriber per calendar year.

The Prescription Drug Deductible is applicable to covered medications provided on an outpatient basis, except where exempted by law or otherwise indicated herein, but is not applicable toward the satisfaction of the Out-of-Pocket Limits specified in this Outline.

### **3. Maximums**

**a. Contract year** \$1,000,000 per subscriber. This Maximum does not include expenses for covered medications provided on an outpatient basis.

**b. Lifetime** \$5,000,000 per subscriber. This Maximum includes the \$1,000,000 maximum per contract year, but does not include expenses for covered medications provided on an outpatient basis.

**c. Prescription Drug** \$50,000 per subscriber per calendar year in expenses for covered medications provided on an outpatient basis.

### **4. Out-Of-Pocket Limit**

**a. Individual** When a subscriber incurs \$1,000 of coinsurance expense for covered services in one benefit period, the benefits payable for that subscriber during the remainder of the benefit period will increase from 80% to 100% of the Provider's Reasonable Charge.

The dollar amounts specified shall not include any expense incurred for the deductible amounts specified in this Outline, covered medications provided on an outpatient basis, any penalties associated with the Health Care Management Service Program, or charges in excess of the Provider's Reasonable Charge.

**b. Family**

When subscribers enrolled under this Agreement have incurred a total of \$3,000 of coinsurance expense for covered services in one benefit period, the benefits payable for all subscribers enrolled under the Agreement during the remainder of the benefit period will be increased from 80% to 100% of the Provider's Reasonable Charge.

The dollar amounts specified shall not include any expense incurred for the deductible amounts specified in this Outline, covered medications provided on an outpatient basis, any penalties associated with the Health Care Management Service Program, or charges in excess of the Provider's Reasonable Charge.

**5. Provider Reimbursement and Subscriber Liability**

- a. The Plan reserves the right to make payment directly to the subscriber.
- b. Covered services under the Agreement are paid as follows:
  - i) Participating Hospital or Facility Other Provider: Services are covered at 80% of the Provider's Reasonable Charge which is based on the amount agreed to by the Plan and the participating hospital or facility other provider as payment in full, less any subscriber deductible obligation.
  - ii) Non-Participating Hospital or Facility Other Provider Located Within the 29-County Area Served by the Plan: Services are covered at 80% of the Provider's Reasonable Charge which is based on the amount agreed to by the Plan and a participating hospital or facility other provider, less any subscriber deductible obligation. The subscriber is responsible for the difference between the Plan payment and the non-participating hospital or facility other provider's billed charge.
  - iii) Non-Participating Hospital or Facility Other Provider Located Outside the 29-County Area Served by the Plan: Services are covered at 80% of the Provider's Reasonable Charge, which is based on the lesser of the non-participating hospital or facility other provider's billed charge for the covered services or the negotiated rate that the Plan pays the local Blue Cross and/or Blue Shield plan through the BlueCard Program, less any subscriber deductible obligation.
  - iv) Participating Professional Provider: Services are covered at 80% of the Provider's Reasonable Charge which is based on the Usual, Customary, and Reasonable Allowance as defined in this Subsection 5, and that the participating professional provider has agreed to accept as payment in full for covered services, less any subscriber deductible obligation.
  - v) Non-Participating Professional Provider Located in Pennsylvania: Services are covered at 80% of the Provider's Reasonable Charge which is based on the Usual, Customary, and Reasonable Allowance as defined in this Subsection 5, less any subscriber deductible obligation. The subscriber is responsible for the difference between the Plan payment and the non-participating professional provider's billed charge.

- vi) Non-Participating Professional Provider Located Outside Pennsylvania: Services are covered at 80% of the Provider's Reasonable Charge which is based on the lower of the non-participating professional provider's billed charge for the covered services or the negotiated rate that the Plan pays the local Blue Cross and/or Blue Shield plan through the BlueCard Program, less any subscriber deductible obligation.
  - vii) Supplier: Services are covered at 80% of the Provider's Reasonable Charge which is the supplier's billed charge, less any subscriber deductible obligation.
  - viii) Participating Pharmacy Provider: Prescription drugs and over-the-counter drugs are covered at 80% of the Providers Allowable Price, with the subscriber's coinsurance liability never less than \$10 or greater than \$100, unless the covered medications are "Brand Drugs" or "Mail Order Maintenance Prescription Drugs."
- c. Provider's Reasonable Charge. The charge that the Plan determines is reasonable for covered services provided to a subscriber. In the case of a participating hospital or facility other provider, the Provider's Reasonable Charge is the amount agreed to as payment in full, as set forth in the agreement between the participating hospital or facility other provider and the Plan. In the case of a non-participating hospital or facility other provider, the Provider's Reasonable Charge is the amount that is paid by the Plan to a participating hospital or facility other provider. In the case of physicians and professional other providers, the Provider's Reasonable Charge is the Usual, Customary and Reasonable Allowance as determined by the Plan and as defined in this Outline.
- d. Provider's Allowable Price. The amount at which the participating pharmacy provider has agreed with the Plan, or its designated agent, to provide covered medications to subscribers under the Agreement.
- e. Usual, Customary, and Reasonable (UCR) Allowance. An amount for Covered Services determined by the Plan by applying one or more of the following criteria:
- i) *Usual* - the allowed amount determined by the Plan for a Professional Provider based upon that individual Provider's charges for the procedure performed.
  - ii) *Customary* - the allowed amount determined by the Plan by considering relevant professional, economic, and market factors, including but not limited to: the degree of professional involvement, charges of Professional Providers of the same or similar specialty for the procedure performed, the actual cost of equipment and facilities, or other factors which contribute to the cost of the procedure.
  - ii) *Reasonable* - the allowed amount (which may differ from the Usual or Customary allowed amounts) determined by the Plan by considering unusual clinical circumstances.

Allowed amounts are updated periodically to respond to changing economic and market circumstances. The timing of updates and methodology employed are subject to approval by the Insurance Department of the Commonwealth of Pennsylvania.

## 6. Covered Services

**Plan Coinsurance:** 80% of the Provider's Reasonable Charge.

80% of the Provider's Allowable Price for covered medications (provided on an outpatient basis).

**Subscriber Coinsurance:** 20% of the Provider's Reasonable Charge.

20% of the Provider's Allowable Price for covered medications (provided on an outpatient basis).

### **Benefit Limits:**

Physical Medicine: Limited to fifteen (15) visits per calendar year.

Speech and Occupational Therapy: Limited to a combined total of fifteen (15) visits per calendar year.

### **Covered Services:**

- a. Diagnostic Services:
  - i) Diagnostic X-Ray, consisting of Radiology, Ultrasound and Nuclear Medicine;
  - ii) Diagnostic Pathology, consisting of Laboratory and Pathology Tests;
  - iii) Diagnostic medical procedures, consisting of ECG, EEG, and other diagnostic medical procedures approved by the Plan; and
  - iv) Allergy Testing, consisting of Percutaneous, Intracutaneous, Patch and In Vitro Tests.
- b. Hospital Services (Inpatient or Outpatient):
  - i) Room and board;
  - ii) General nursing; and
  - iii) Ancillary services.
- c. Medical Care Services:
  - i) Medical Care;
  - ii) Concurrent Care; and
  - iii) Consultations.
- d. Surgical Services:
  - i) Anesthesia;
  - ii) Assistant at Surgery;
  - iii) Surgery; and
  - iv) Voluntary Second Surgical Opinions.
- e. Therapy and Rehabilitation Services:
  - i) Chemotherapy;
  - ii) Dialysis Treatment;

- iii) Infusion Therapy;
  - iv) Occupational Therapy;
  - v) Physical Medicine;
  - vi) Radiation Therapy;
  - vii) Respiratory Therapy; and
  - viii) Speech Therapy.
- f. Other Covered Services:
- i) Adult Care
  - ii) Adult Immunizations
  - iii) Allergy Extract/Injections
  - iv) Ambulance Services;
  - v) Anesthesia Services;
  - vi) Dental Services Related to Accidental Injury;
  - vii) Dr. Dean Ornish Program (For Reversing Heart Disease);
  - viii) Durable Medical Equipment;
  - ix) Emergency Care;
  - x) Enteral Formulae;
  - xi) Home Health Care Services;
  - xii) Home Infusion Therapy Services;
  - xiii) Hospice Care Services;
  - xiv) Mammography Screening;
  - xv) Mastectomy and Breast Reconstruction (including prosthetic devices);
  - xvi) Maternity Services;
  - xvii) Orthotic Devices;
  - xviii) Outpatient Diabetes Education Program;
  - xix) Pediatric Care
  - xx) Pediatric Immunizations;
  - xxi) Prescription Drugs;
  - xxii) Prosthetic Appliances;
  - xxiii) Routine Gynecological Exam and Pap Smear;
  - xxiv) Skilled Nursing Facility; and
  - xxv) Transplant Services.
- g. Prescription Drugs (provided on an outpatient basis):

Upon satisfaction of the prescription drug deductible, benefits will be provided for covered medications provided on an outpatient basis when prescribed by a physician, podiatrist or dentist in connection with a covered service and when purchased at a participating pharmacy provider upon presentation of a valid Identification Card and dispensed on or after the subscriber's effective date, as follows:

- i) Retail Covered Medications
  - a) Generic Drugs and Over-the-Counter Drugs      80% of the Provider's Allowable Price per prescription order or refill. The subscriber's coinsurance liability will never be less than \$10 or more than \$100.

- b) Brand Drugs 80% of the Provider's Allowable Price per prescription order or refill. The subscriber's coinsurance liability will never be less than \$20 or more than \$100.
- ii) Mail Order Maintenance Prescription Drugs
  - a) Generic Drugs and Over-the-Counter Drugs 2 times the Retail Covered Medications coinsurance amount for a Generic or Over-the-Counter Drug, for each 90-day supply. The subscriber's coinsurance liability will never be less than \$20 or more than \$200.
  - b) Brand Drugs 2 times the Retail Covered Medications coinsurance amount for a Brand Drug, for each 90-day supply. The subscriber's coinsurance liability will never be less than \$40 or more than \$200.
- iii) Limitations:
  - a) Except in emergency care situations, no coverage is provided for prescription drugs or over-the-counter drugs purchased at a non-participating pharmacy provider.
  - b) Each covered medication purchased from a participating pharmacy provider is limited to a 31-day supply. Maintenance prescription drugs available through a mail service program are limited to a 90-day supply.
  - c) Insulin syringes, needles, and/or disposable diabetic testing materials will be covered by the same coinsurance as the insulin, if dispensed in days supply corresponding to the amount of insulin dispensed. Insulin syringes, needles, and/or disposable diabetic testing material dispensed without insulin will require a separate coinsurance when dispensed.
  - d) The participating pharmacy provider will dispense generic drugs in accordance with State and Federal laws, unless a generic equivalent is not available, regardless of whether the prescription order specifies a brand drug. If the Subscriber will not accept a generic substitution when the generic substitution is available, the subscriber will be required to pay the difference between the price for a brand drug and any available generic equivalent, for each separate prescription order or refill. This amount is in addition to the applicable coinsurance amounts set forth in this Outline.
  - e) Selected prescription drugs within, but not limited to, the following drug classifications only when such drugs are covered medications and are dispensed through an exclusive pharmacy provider:

- i) Oncology related therapies
- ii) Interferons
- iii) Agents for multiple sclerosis and neurological related therapies
- iv) Antiarthritic therapies
- v) Anticoagulants
- vi) Hematinic agents
- vii) Immunomodulators
- viii) Growth hormones

The selected prescription drugs may be ordered by a physician or other health care provider on behalf of the subscriber or the subscriber may submit the prescription order directly to the exclusive pharmacy provider. In either situation, the exclusive pharmacy provider will deliver the prescription drug to the subscriber.

The selected prescription drugs are subject to the cost-sharing provisions for Retail Covered Medications set forth in Section C.6. **Covered Services**, Paragraph g. Prescription Drugs (provided on an outpatient basis), Subparagraph i) Retail Covered Medications of this Outline, and the day supply quantity limitations for non-maintenance prescription drugs as set forth in this Subparagraph iii) Limitations, item b).

- f) Coverage is limited to those prescription drugs or over-the-counter drugs listed in the closed formulary.
- g) Oral or injectable contraceptive drugs are covered only when prescribed for purposes other than birth control.
- h) Benefits provided under this Section are not subject to the provisions of **ARTICLE V - GENERAL PROVISIONS**, Section V. **COORDINATION OF BENEFITS** in the Agreement.

***D. Exceptions, Reductions, and Limitations of the Agreement***

1. **Pre-existing Conditions** - During an exclusion period of 12 months following the subscriber's effective date, no benefits are provided under the Agreement for care related to (a) Pre-Existing Condition(s). The Pre-Existing Condition exclusion period will not be imposed on a newborn or adopted child, or a child placed for adoption, during the first 31 days from the date of birth, adoption or placement for adoption.
2. **Medically Necessary and Appropriate** - "Medically Necessary and Appropriate" means that the benefits under this Agreement for services received from a participating provider will be provided only when and so long as such services are determined by the Plan or its designated agent to be: 1) appropriate for the symptoms and diagnosis or treatment of the subscriber's

condition, illness, disease or injury; and 2) provided for the diagnosis, of the direct care and treatment of the subscriber's condition, illness, disease or injury; and 3) in accordance with standards of good medical practice; and 4) not primarily for the convenience of the subscriber, or the subscriber's physician and/or other provider; and 5) the most appropriate supply or level of service that can safely be provided to the subscriber. When applied to hospitalization, this further means that the subscriber requires acute care as a bed patient due to the nature of the services rendered or the subscriber's condition, and the subscriber cannot receive safe or adequate care as an outpatient.

Participating hospitals, facility other providers and professional providers will accept this determination of medical necessity. Non-participating providers are not obligated to accept this determination and may bill the subscriber for services determined not to be medically necessary and appropriate. See the Agreement for further explanation.

3. **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 subscriber's physician performs such experimental procedure, the subscriber is responsible for charges for services considered to be experimental or investigative. The subscriber or the subscriber's physician may contact the Plan to determine whether a service is considered experimental or investigative. See the Agreement for further explanation.
4. **Health Care Management Service** - A complete Health Care 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.

The subscriber will be held harmless and will NOT be financially responsible for payment for admissions to a participating hospital or facility other provider or for home health care services which have been determined to not be medically necessary and appropriate, EXCEPT when the Plan provides prior written notice to the subscriber that the admission or services will not be covered. In such case, the subscriber is financially responsible for charges for such admission or services.

For a proposed inpatient admission to a non-participating hospital or facility other provider, or for services from a non-participating home health agency, the subscriber is responsible to contact the Plan, or its designated agent, prior to a proposed admission or receipt of home health care services, to determine the medical necessity and appropriateness of the proposed admission.

- a. If pre-certification for a medically necessary and appropriate inpatient admission, or for home health care services, has been obtained as required under this Agreement, benefits will be paid in accordance with this Agreement, and the subscriber will be financially responsible for the difference between the payment by this Agreement and the non-participating provider's full charge.
- b. If a subscriber elects to be admitted or to receive home health care services, after receiving written notification from the Plan, or its designated agent, that any portion of the proposed admission or services is not medically necessary and appropriate, then the subscriber will be financially responsible for all charges associated with care that has been determined not to be medically necessary and appropriate.
- c. If a subscriber DOES NOT contact the Plan for pre-certification as required under the Agreement, any claim for benefits will be reviewed for medical necessity and appropriateness. If the admission or services are determined to be medically necessary and appropriate, benefits will be paid in accordance with the Agreement and the subscriber will be financially responsible for the difference between the payment by the Agreement and the full amount of the non-participating provider's charge. If such admission or services are determined to not be medically necessary and appropriate, no benefit will be provided and the subscriber will be financially responsible for the full amount of the non-participating provider's charge.

## **5. Exclusions:**

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

- a. Rendered prior to the subscriber's effective date of coverage under the Agreement;
- b. Rendered after the date of termination of the subscriber's coverage except for an inpatient admission or in the case of total disability that commenced prior to the date the subscriber's coverage terminates or for maternity care for a pregnancy which commenced prior to the termination date of the subscriber's coverage in accordance with Section E., Subsection 2 of this Outline;
- c. For any services furnished to a subscriber for a pre-existing condition during the first 12 months following the date on which the subscriber is most recently enrolled under the Agreement;
- d. For any illness or injury suffered after the subscriber's effective date as a result of any act of war;
- e. For which a subscriber would have no legal obligation to pay in the absence of this or any similar coverage;
- f. Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;

- g. To the extent benefits are paid or payable under Medicare;
- h. For an illness or injury covered by any Worker's Compensation Act or Occupational Disease Law or by the United States Longshoreman's Harbor Worker's Compensation Act;
- i. To the extent benefits are provided to members of the armed forces or to patients in Veteran's Administration facilities for service-connected illness or injury;
- j. For treatment 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;
- k. Which are not prescribed by or performed by or upon the direction of a physician or professional provider;
- l. Rendered by other than hospitals, physicians, and other providers as defined in the Agreement;
- m. Performed by a non-licensed health care professional;
- n. Which are submitted by a certified registered nurse when a physician or professional provider has submitted a claim for the same services performed on the same date for the same patient;
- o. Rendered by a provider who is a member of the subscriber's immediate family;
- p. Performed by a physician or professional provider enrolled in an education or training program when such services are related to the education or training program;
- q. Which are not medically necessary and appropriate;
- r. Which are experimental/investigative in nature;
- s. For the treatment of Alcohol Abuse, Drug Abuse, and/or Mental or Nervous Disorders, including Prescription Drugs prescribed for such treatment;
- t. Furnished by a private duty nurse;
- u. Furnished in connection with research studies;

- v. For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise required by law or as provided in **ARTICLE III - BENEFITS** of the Agreement. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; b) surgery to correct congenital birth defects; and c) surgery to correct functional impairment which results from a covered disease or injury;
- w. For inpatient admissions which are primarily for diagnostic studies which can be appropriately performed on other than an inpatient basis;
- x. For inpatient admissions which are primarily for physical medicine services when the patient is capable of receiving such care on an outpatient basis;
- y. For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
- z. For local anesthetic when billed for by a physician or professional provider;
- aa. For the first three pints of whole blood or blood components, and blood derivatives which are not classified as drugs in the official formularies;
- bb. For biofeedback training or equipment;
- cc. For automatic ambulatory blood pressure monitoring;
- dd. For devices intended primarily for communication which are not incorporated into the body habitus;
- ee. For custodial care, domiciliary care or rest cures;
- ff. For treatment of temporomandibular joint syndrome with intra-oral devices, or any other method to alter vertical dimensions;
- gg. For oral surgery procedures except: i) surgical removal of full bony impactions; ii) maxillary or mandibular frenectomy; and iii) the orthodontic treatment of congenital cleft palate involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.
- hh. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, 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 services are related to the treatment of diabetes;
- ii. For hearing aids or examinations for the prescription or fitting of hearing aids and all related services;

- jj. For any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery;
- kk. Related to treatment provided specifically for the purpose of assisted fertilization;
- ll. For routine neonatal circumcision;
- mm. For nutritional counseling and services intended to produce weight loss;
- nn. For dietary or food supplements, except enteral formulae;
- oo. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, physical fitness equipment, stair glides, elevators/lifts or “barrier free” home modifications, whether or not specifically recommended or prescribed by a physician or professional provider;
- pp. Performed on high cost technological equipment such as, but not limited to, computed tomography scanners (CT scanners), lithotriptors, and magnetic resonance imaging (MRI) scanners, as defined by the Plan, which is not approved through the certificate of need process, if applicable and/or is not approved by the Plan;
- qq. For the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment or subluxation of or in the vertebral column;
- rr. For diapers and other incontinence supplies which are not billed as a component to an inpatient stay;
- ss. For music therapy;
- tt. For recreational therapy;
- uu. For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses;
- vv. For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;
- ww. For preventive care services, wellness services or programs, except as provided in **ARTICLE III - BENEFITS** of the Agreement, or as mandated by law;
- xx. For 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, except as provided in **ARTICLE III - BENEFITS** of the Agreement, or as mandated by law;
- yy. For allergy testing, except as provided in **ARTICLE III - BENEFITS** of the Agreement, or as mandated by law;
- zz. For immunizations required for foreign travel or employment;

- aaa. For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, which extends beyond traditional medical management, or for inpatient confinement for environmental change;
- bbb. For any other medical or dental services or treatment except as listed in Section 6., Subsection 5. Covered Services in this Outline;
- ccc. Which has been disallowed under the provisions of the Health Care Management Service Program;
- ddd. For any loss sustained or contracted in consequence of the subscriber's being intoxicated, or under the influence of any narcotic unless administered on the advice of a physician;
- eee. For any loss to which a contributing cause was the subscriber's commission of or attempt to commit a felony, or to which a contributing cause was the subscriber's being engaged in an illegal occupation;
- fff. 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 orthodontic treatment for congenital cleft palates;
- ggg. 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; and
- hhh. Prescription Drugs:
  - i) Drugs and supplies, not listed on the closed formulary, which can be purchased without a prescription order;
  - ii) Prescription Drugs or Over-the-Counter Drugs not listed on the closed formulary;
  - iii) Charges for administration of prescription drugs and/or injectable insulin whether by a physician or other person;
  - iv) Charges for a Prescription Drug or Over-the-Counter Drug, including drugs on the closed formulary, when such drug or medication is used for unlabeled or unapproved indications and where such use has not been approved by the Food and Drug Administration (FDA);
  - v) Any drug or medication which is otherwise excluded under the terms of this Agreement;
  - vi) Antihemophiliac drugs when purchased from a pharmacy provider;
  - vii) Any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes;
  - viii) Any drug requiring refrigeration (if delivered through the mail) or injectables, except insulin and other injectables used to treat diabetes;

- ix) The topical acne cream Retin-A, for those subscribers who are over the age of thirty (30); and
- x) For impotency treatment Prescription Drugs.

***E. Terms and Conditions of the Renewability of the Agreement***

1. **Guaranteed Renewable** - The Agreement is guaranteed renewable and may be renewed by payment of the subscription rate within 31 days after the first day of the month for which payment must be made. Coverage continues for one 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 mental or physical health of any individual covered under the Agreement.
2. **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:
  - a. The Agreement may be terminated by the subscriber by giving thirty (30) days written notice to the Plan.
  - b. The Agreement is guaranteed renewable and cannot be terminated by the Plan except in the following instances:
    - i. if payment of the appropriate subscription rate is not made when due, or during the grace period;
    - ii. if a subscriber 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 subscriber ID Card). However, the Plan will not terminate the Agreement because of a subscriber'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 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 29-county area served by the Plan;

- iv. in the event the subscriber no longer lives in the 29-county area served by the Plan. Should the subscriber change his or her residence to a geographic area outside the area served by the Plan and the subscriber wishes to continue coverage, the subscriber must transfer his or her coverage to the Blue Cross and Blue Shield Plan that serves the area of his or her new residence; or
- v. as of the end of the month in which either of the following events occurs:
  - (i) a child ceases to meet any of the requirements of the definition of child as follows: the child is the applicant's son or daughter, a stepchild dependent upon the applicant, legally adopted child (including a child during the period of probation), or child for whom the applicant is legal guardian, who is unmarried and under 19 years of age, or 19 years of age or older provided the child is certified by a physician to be incapable of self-support by reason of physical disability or mental retardation and provided such dependent became so incapable before reaching age 19; or
  - (ii) a spouse becomes divorced from the subscriber.

However, if the Plan accepts payment of the subscription rate 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 subscription rate was accepted, except where such acceptance was predicated on a misstatement of age.

- c. If the Agreement is terminated at the option of either party, the Plan shall refund to the subscriber the amount of any unearned prepaid subscription rate held by the Plan.

**3. Modification/Subscription Rates Subject to Change** - Subscription rates will be charged to subscribers based upon their attained age at the time the application for coverage is approved by the Plan and the Agreement will renew every month thereafter at the subscription 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 subscription rates. Any such alteration or revision of the terms of the Agreement shall become applicable for all subscribers on the effective date of the alteration or revision. Any change in the subscription rates shall become applicable for subscribers 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 subscription rates and the effective date, and payment of the new subscription rates shall be considered receipt of notice and acceptance of the change in rates. Any notice shall be considered to have been given when mailed to the subscriber at the address on the records of the Plan.

***F. Relationship to Blue Cross and Blue Shield Plans***

The subscriber is hereby notified:

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 and 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 Plans' obligations under the Agreement. This paragraph does not add any obligations to the Agreement.

### ***G. BlueCard Program***

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

- The billed charges for a subscriber'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 subscriber'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 subscriber'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 subscriber pays is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating subscriber 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 subscriber 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 subscriber's liability for any covered services in accordance with the applicable state statute in effect at the time a subscriber received care.







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