Highmark Inc., d/b/a
HIGHMARK BLUE SHIELD
(“the Plan”)

A Pennsylvania non-profit corporation whose
home office address is 1800 Center Street, Camp Hill, Pennsylvania, 17011

Comprehensive Major Medical Preferred Provider High
Deductible Subscription Agreement for Individual Members Utilizing
the PremierBlue Shield Professional Provider Network and the
Highmark Blue Shield Participating Facility Provider Network, Without a Gatekeeper

identified as

“PPO Blue℠”

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.

Except for a newborn child of a member, enrollment under the Agreement is subject to medical underwriting.
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); services for mastectomy and breast cancer reconstructive surgery; diabetes treatment for all types of diabetes; 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 Services** - Coverage is provided for the treatment of bodily injuries resulting from an accident or the treatment of a medical condition with acute symptoms of sufficient severity or severe pain 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 and which the absence of immediate medical attention could reasonably result in: a) placing the member’s health in jeopardy, b) causing serious impairment to bodily functions, c) causing serious dysfunction of any bodily organ or part or d) causing other serious medical consequences.

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

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

In the event that the member requires Emergency Care Services, benefits will be provided at the network services benefit levels. The member will not be responsible for any difference between the Plan payment and the provider’s charge.

**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 Provider’s Reasonable Charge (PRC) for covered services. The Provider’s Reasonable Charge is defined as the allowance or payment that the Plan has determined is reasonable for covered services provided to a member based on the provider who renders such services. The Provider’s Reasonable Charge 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.
i) **Network Facility Provider**: the Provider’s Reasonable Charge is the amount agreed to by the network facility provider as payment in full as set forth in the agreement between the network facility provider and the Plan.

ii) **Highmark Managed Care Facility Provider**: the Provider’s Reasonable Charge is the amount agreed to by the Highmark managed care facility provider and Highmark Inc. as payment in full as set forth in the agreement between the Highmark managed care facility provider and Highmark Inc.

iii) **Participating Facility Provider**: the Provider’s Reasonable Charge is the amount agreed to by the participating facility provider and the local licensee of the Blue Cross and Blue Shield Association as payment in full, as set forth in the agreement between the participating facility provider and the local licensee of the Blue Cross and Blue Shield Association.

iv) **Non-Participating Facility Provider**: the Provider’s Reasonable Charge is 60% of billed charges for inpatient Services and 40% of billed charges for outpatient services. The member will be responsible for any difference between the non-participating facility provider’s billed charge and the Plan’s payment.

v) **Network Professional Provider and Network Supplier**: the Provider’s Reasonable Charge is the amount agreed to by the network professional provider or network supplier as payment in full, as set forth in the agreement between the network professional provider or network supplier and the Plan.

vi) **Highmark Managed Care Professional Provider and Highmark Managed Care Supplier**: the Provider’s Reasonable Charge is the amount agreed to by the Highmark managed care professional provider or Highmark managed care supplier as payment in full, as set forth in the agreement between the Highmark managed care professional provider or Highmark managed care supplier and Highmark Inc.

vii) **PremierBlue Shield Professional Provider and Preferred Supplier (within the Highmark Managed Care Network Service Area)**: the Provider’s Reasonable Charge is the amount paid to a network professional provider or a network supplier. The member will be responsible for the difference between the PremierBlue Shield professional provider’s or preferred supplier’s billed charge and the Plan’s payment.

However, if the PremierBlue Shield professional provider or preferred supplier is also a participant in the Highmark managed care network, the Provider’s Reasonable Charge is the amount paid to a Highmark managed care professional provider or a Highmark managed care supplier as payment in full,
as set forth in the agreement between the Highmark managed care professional provider or Highmark managed care supplier and Highmark Inc.

viii) **PremierBlue Shield Professional Provider and Preferred Supplier (Out-of-Area):** the Provider’s Reasonable Charge is the amount agreed to by the PremierBlue Shield professional provider or preferred supplier as payment in full, as set forth in the agreement between the PremierBlue Shield professional provider or preferred supplier and the Plan.

ix) **Participating Professional Provider and Contracting Supplier (Out-of Area):** the Provider’s Reasonable Charge is the amount agreed to by the participating professional provider or contracting supplier as payment in full, as set forth in the agreement between the participating professional provider or contracting supplier and the local licensee of the Blue Cross and Blue Shield Association located Out-of-Area.

x) **Non-Participating Professional Provider and Non-Contracting Supplier (within or outside of Pennsylvania):** the Provider’s Reasonable Charge is the amount paid to a network professional provider or network supplier. The member will be responsible for any difference between the non-participating professional provider’s or non-contracting supplier’s billed charge and the Plan’s payment.

3. **Payment of Outpatient Prescription Drug Benefits** - Benefit amounts are determined based on the Provider’s Allowable Price (PAP) for covered medications. The Provider’s Allowable Price is defined as 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 this Agreement.

i) **Participating Pharmacy Provider:** The Provider’s Allowable Price is the amount agreed to by the participating pharmacy provider as payment in full, as set forth in the agreement between the participating pharmacy provider and the Plan.

ii) **Non-Participating Pharmacy Provider:** The member will be responsible for the entire amount of the billed charge.
4. **Schedule**

   i) **DEDUCTIBLE**

<table>
<thead>
<tr>
<th>Network and Out-of-Network Services</th>
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</thead>
<tbody>
<tr>
<td>Individual</td>
</tr>
<tr>
<td>Family</td>
</tr>
<tr>
<td>$3,500</td>
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<tr>
<td>$7,000</td>
</tr>
</tbody>
</table>

   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.

   ii) **PROGRAM MAXIMUMS**

   A. $5,000,000 for network services, including prescription drugs, per lifetime per member.

   B. $300,000 for out-of-network services per lifetime per member.

   C. $1,000,000 for network services, excluding prescription drugs, per contract year per member.

   D. $50,000 for prescription drugs when purchased at a participating pharmacy provider per contract year.

   E. Amounts applied to the maximum for out-of-network services are also applied to the maximum for network services.
iii) **OUT-OF-POCKET LIMIT**

A. **GENERAL**

<table>
<thead>
<tr>
<th></th>
<th>NETWORK SERVICES</th>
<th>OUT-OF-NETWORK SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

The dollar amounts specified shall not include any amounts paid for deductibles or amounts in excess of the Provider’s Reasonable Charge.

B. **INDIVIDUAL OUT-OF-POCKET LIMIT**

1) **Network Covered Services**

When a member incurs $1,500 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 Provider’s Reasonable Charge.

The dollar amount specified shall not include any amounts paid for deductibles or amounts in excess of the Provider’s Reasonable Charge.

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 Provider’s Reasonable Charge.

The dollar amount specified shall not include any amounts paid for deductibles or amounts in excess of the Provider’s Reasonable Charge.
C. FAMILY OUT-OF-POCKET LIMIT

1) Network Covered Services

When members under the same family coverage have incurred $3,000 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 Provider’s Reasonable Charge.

In the case of family coverage, benefits for any individual will not increase to one hundred percent (100%) of the Provider’s Reasonable Charge 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 Provider’s Reasonable Charge.

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 Provider’s Reasonable Charge.

In the case of family coverage, benefits for any individual will not increase to one hundred percent (100%) of the Provider’s Reasonable Charge 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 Provider’s Reasonable Charge.

iv) COVERED SERVICES

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>NETWORK SERVICES</th>
<th>OUT-OF-NETWORK SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. AMBULANCE SERVICE</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>B. DENTAL SERVICES RELATED TO ACCIDENTAL INJURY</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>NETWORK SERVICES</td>
<td>OUT-OF-NETWORK SERVICES</td>
</tr>
<tr>
<td>-----------------------------------------</td>
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</tr>
<tr>
<td>C. <strong>DIABETES TREATMENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equipment and Supplies</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Diabetes Education Program</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>D. <strong>DIAGNOSTIC SERVICES</strong></td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>E. <strong>DURABLE MEDICAL EQUIPMENT</strong></td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>F. <strong>ENTERAL FORMULAE</strong></td>
<td>90% PRC</td>
<td>70% PRC</td>
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<tr>
<td>G. <strong>FAMILY PLANNING AND INFERTILITY SERVICES</strong></td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>H. <strong>HOME HEALTH CARE SERVICES</strong></td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td></td>
<td>100 Visit Maximum per Benefit Period</td>
<td></td>
</tr>
<tr>
<td>I. <strong>HOME INFUSION THERAPY SERVICES</strong></td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>J. <strong>HOSPICE CARE SERVICES</strong></td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>K. <strong>HOSPITAL SERVICES</strong></td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td></td>
<td>Unlimited days per Benefit Period</td>
<td>90 days per Benefit Period</td>
</tr>
<tr>
<td></td>
<td>Private Room Allowance</td>
<td>90% PRC</td>
</tr>
<tr>
<td></td>
<td>for the most common semiprivate room charge</td>
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<tr>
<td></td>
<td>Private Room covered when Medically Necessary and Appropriate.</td>
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<tr>
<td></td>
<td>Emergency Accident Services</td>
<td>90% PRC</td>
</tr>
<tr>
<td></td>
<td>Emergency Medical Services</td>
<td>90% PRC</td>
</tr>
<tr>
<td></td>
<td>Pre-Admission Testing</td>
<td>90% PRC</td>
</tr>
<tr>
<td></td>
<td>Surgery</td>
<td>90% PRC</td>
</tr>
<tr>
<td>Service Description</td>
<td>Covered Services</td>
<td>Network Services</td>
</tr>
<tr>
<td>---------------------</td>
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</tr>
<tr>
<td><strong>L. MATERNITY SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity Home Health Care Visit</td>
<td></td>
<td>90% PRC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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 or Deductible amounts.</td>
</tr>
<tr>
<td><strong>M. MEDICAL/SURGICAL SERVICES</strong></td>
<td>Inpatient Medical Care Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient Medical Care Visits and Intensive Medical Care</td>
<td>90% PRC</td>
</tr>
<tr>
<td></td>
<td>Concurrent Care</td>
<td>90% PRC</td>
</tr>
<tr>
<td></td>
<td>Consultation</td>
<td>90% PRC</td>
</tr>
<tr>
<td></td>
<td>Newborn Care</td>
<td>90% PRC</td>
</tr>
<tr>
<td></td>
<td>Outpatient Medical Care Services</td>
<td>90% PRC</td>
</tr>
<tr>
<td></td>
<td>Emergency Accident Services</td>
<td>90% PRC</td>
</tr>
<tr>
<td></td>
<td>Emergency Medical Care</td>
<td>90% PRC</td>
</tr>
<tr>
<td>Surgical Services</td>
<td>Anesthesia</td>
<td>90% PRC</td>
</tr>
<tr>
<td></td>
<td>Assistant at Surgery</td>
<td>90% PRC</td>
</tr>
<tr>
<td></td>
<td>Second Surgical Opinion Services</td>
<td>90% PRC</td>
</tr>
<tr>
<td></td>
<td>Special Surgery</td>
<td>90% PRC</td>
</tr>
<tr>
<td></td>
<td>Surgery</td>
<td>90% PRC</td>
</tr>
<tr>
<td></td>
<td>Therapeutic Injections</td>
<td>90% PRC</td>
</tr>
<tr>
<td><strong>N. ORTHOTIC DEVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td><strong>O. PRESCRIPTION DRUGS (OUTPATIENT)</strong></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>90% PAP</td>
<td>Not Covered</td>
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</tbody>
</table>
## COVERED SERVICES

### P. PREVENTIVE SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Services</th>
<th>Out-of-Network Services</th>
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</thead>
<tbody>
<tr>
<td>Adult Care</td>
<td>90% PRC</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(Routine physical examinations are exempt from all deductibles.)</td>
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</tr>
<tr>
<td>Adult Immunizations</td>
<td>90% PRC</td>
<td>Not Covered</td>
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<tr>
<td>(Adult immunizations are exempt from all deductibles.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Extract/Injections</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Mammographic Screening</td>
<td>90% PRC</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(Routine mammographic screenings are exempt from all deductibles.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric Care</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Pediatric Immunizations</td>
<td>90% PRC</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(Pediatric immunization benefits are exempt from all deductibles or dollar limits.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Gynecological Examination and Papanicolaou Test</td>
<td>90% PRC</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(Routine gynecological examinations and papanicolaou smear benefits are exempt from all deductibles or maximums.)</td>
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</table>

### Q. PRIVATE DUTY NURSING SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Services</th>
<th>Out-of-Network Services</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>90% PRC</td>
<td>70% PRC</td>
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</table>

### R. PROSTHETIC APPLIANCES

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Services</th>
<th>Out-of-Network Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>90% PRC</td>
<td>70% PRC</td>
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</table>

### S. SKILLED NURSING FACILITY SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Services</th>
<th>Out-of-Network Services</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>90% PRC</td>
<td>70% PRC</td>
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</tbody>
</table>

- Limited to 100 days per Benefit Period
- Up to 50 days may be used Out-of-Network

### T. SPINAL MANIPULATIONS

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Services</th>
<th>Out-of-Network Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
</tbody>
</table>

- 10 Visit Maximum per contract year
U. THERAPY AND REHABILITATION SERVICES

Cardiac Rehabilitation 90% PRC 70% PRC
Chemotherapy 90% PRC 70% PRC
Dialysis Treatment 90% PRC 70% PRC
Infusion Therapy 90% PRC 70% PRC
Occupational and Speech Therapy 90% PRC 70% PRC

Combined 15 Visit maximum per contract year

Physical Medicine 90% PRC 70% PRC
Radiation Therapy 90% PRC 70% PRC
Respiratory Therapy 90% PRC 70% PRC

V. TRANSPLANT SERVICES

90% PRC 70% PRC

IV. EXCEPTIONS, REDUCTIONS, AND LIMITATIONS OF THE AGREEMENT

A. Pre-Existing Condition Exclusion Period - During an exclusion period of twelve (12) months following the member’s effective date, no benefits are provided under the Agreement for pregnancy and any condition 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 thirty-one (31) days from the date of birth, adoption or placement for adoption, subject to Subsection B. BENEFITS AFTER TERMINATION OF COVERAGE of SECTION GP - GENERAL PROVISIONS of the Agreement. The pre-existing condition exclusion period will not be applied thereafter provided that such child is enrolled within thirty-one (31) days from the date of birth, adoption or placement for adoption.

B. Medically Necessary and Appropriate - “Medically necessary and appropriate” means that the benefits under the Agreement for services received from a network provider will be provided only when and so long as such services are determined by the Plan to be: a) appropriate for the symptoms and diagnosis or treatment of the member’s condition, illness, disease or injury; and b) provided for the diagnosis, or the direct care and treatment of the member’s condition, illness, disease or injury; and c) in accordance with standards of good medical practice; and d) not primarily for the convenience of the member.
member, or the member’s physician and/or other provider; and e) the most appropriate supply or level of service that can safely be provided to the member. When applied to hospitalization, this further means that the member requires acute care as an inpatient due to the nature of the services rendered or the member’s condition, and the member cannot receive safe or adequate care as an outpatient.

Network facility providers, network professional providers and PremierBlue Shield professional providers (out-of-area) 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. Health Care Management Services - 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 or services.

E. Provider/Supplier Reimbursement and Member Liability - The Provider’s Reasonable Charge is the allowance or payment that the Plan has determined is reasonable for covered services provided to a member based upon the provider who renders such services. Specifically, it is the portion of the provider’s billed charge that will be recognized by the Plan and used to calculate the benefit payable and the financial liability of the member under the Agreement. In the event that a provider has not agreed to accept the Provider’s Reasonable Charge as payment in full, any amounts billed by the provider in excess of the Provider’s Reasonable Charge are not covered under the Agreement and shall be the financial responsibility of the member. Deductible and coinsurance amounts shall be applied to the Provider’s Reasonable Charge to determine the benefit amount payable by the Plan. See Section II. COMPREHENSIVE MAJOR MEDICAL EXPENSE COVERAGE, Subsection J. Benefit Amounts, Durations, Limits, Deductibles and Coinsurance for Benefits Under the Agreement of this Outline for the definition of “Provider’s Reasonable Charge”.
1. Covered Services Received from a Network Provider

i) **Network Facility Provider**:

The Plan’s coinsurance liability arises after the member’s deductible obligation is subtracted from the Provider’s Reasonable Charge. At that time, the Plan will pay ninety percent (90%) of the remaining amount and the member’s coinsurance obligation will be ten percent (10%) of the remaining amount. The member is obligated to pay the coinsurance amount as well as any deductible amounts.

The network facility provider will accept the Plan’s payment, plus the member’s coinsurance and/or deductible as payment in full for covered services rendered to the member.

ii) **Network Professional Provider and Network Supplier**:

The Plan’s coinsurance liability arises after the member’s deductible obligation is subtracted from the Provider’s Reasonable Charge. At that time, the Plan will pay ninety percent (90%) of the remaining amount and the member’s coinsurance obligation will be ten percent (10%) of the remaining amount. The member is obligated to pay the coinsurance amount as well as any deductible amounts. The network professional provider or network supplier will accept the Plan’s payment, plus the member’s coinsurance and/or deductible as payment in full for covered services rendered to the member.

The network professional provider is not obligated to accept such payment as payment in full if the member fails to remit the coinsurance and/or deductible amounts to the network professional provider in a timely manner. The member shall remit or make arrangements to pay any coinsurance and/or deductible amounts directly to the network professional provider within sixty (60) days of the Plan’s finalization of the claim. Otherwise, the member will also be responsible for the difference between the network professional provider’s billed charge and the Plan’s payment.

2. Covered Services Received from an Out-of-Network Provider

i) **Highmark Managed Care Facility Provider (within the Highmark Managed Care Network Service Area)**:

The Plan’s coinsurance liability arises after the member’s deductible obligation is subtracted from the Provider’s Reasonable Charge. At that time, the Plan will pay ninety percent (90%) of the remaining amount and the member’s coinsurance obligation will be ten percent (10%) of the remaining amount. The
member is obligated to pay the coinsurance amount as well as any deductible amounts. The Highmark managed care facility provider will accept the Plan’s payment, plus the member’s coinsurance and/or deductible amount as payment in full for covered services rendered to the member.

ii) Participating Facility Provider (Out-of-Area):

The Plan’s coinsurance liability arises after the member’s deductible obligation is subtracted from the Provider’s Reasonable Charge. At that time, the Plan will pay seventy percent (70%) of the remaining amount and the member’s coinsurance obligation will be thirty percent (30%) of the remaining amount. The member is obligated to pay the coinsurance amount as well as any deductible amounts. The participating facility provider will accept the Plan’s payment, plus the member’s coinsurance and/or deductible obligations, as payment in full for covered services rendered to the member.

iii) Non-Participating Facility Provider:

The Plan’s coinsurance liability arises after the member’s deductible obligation is subtracted from the Provider’s Reasonable Charge. At that time, the Plan will pay seventy percent (70%) of the remaining amount and the member’s coinsurance obligation will be thirty percent (30%) of the remaining amount. The member is obligated to pay the coinsurance amount as well as any deductible amounts. The member is also responsible for any difference between the non-participating facility provider’s billed charges and the Plan’s payment.

iv) Highmark Managed Care Professional Provider and Highmark Managed Care Supplier (within the Highmark Managed Care Network Service Area):

The Plan’s coinsurance liability arises after the member’s deductible obligation is subtracted from the Provider’s Reasonable Charge. At that time, the Plan will pay ninety percent (90%) of the remaining amount and the member’s coinsurance obligation will be ten percent (10%) of the remaining amount. The member is obligated to pay the coinsurance amount as well as any deductible amounts. The Highmark managed care professional provider or Highmark managed care supplier will accept the Plan’s payment, plus the member’s coinsurance and/or deductible as payment in full for covered services rendered to the member.

v) PremierBlue Shield Professional Provider and Preferred Supplier (within the Highmark Managed Care Network Service Area):

The Plan’s coinsurance liability arises after the member’s deductible obligation is subtracted from the Provider’s Reasonable Charge. At that time, the Plan will
pay seventy percent (70%) of the remaining amount and the member’s coinsurance obligation will be thirty percent (30%) of the remaining amount. The member is obligated to pay the coinsurance amount as well as any deductible amounts. The member is also responsible for any difference between the PremierBlue Shield professional provider’s or preferred supplier’s billed charges and the Plan’s payment.

vi) PremierBlue Shield Professional Provider and Preferred Supplier (Out-of-Area):

The Plan’s coinsurance liability arises after the member’s deductible obligation is subtracted from the Provider’s Reasonable Charge. At that time, the Plan will pay ninety percent (90%) of the remaining amount and the member’s coinsurance obligation will be ten percent (10%) of the remaining amount. The member is obligated to pay the coinsurance amount as well as any deductible amounts. The PremierBlue Shield professional provider or preferred supplier will accept the Plan’s payment plus the member’s coinsurance and/or deductible as payment in full for covered services rendered to the member.

The PremierBlue Shield professional provider is not obligated to accept such payment as payment in full if the member fails to remit the coinsurance and/or deductible amounts to the PremierBlue Shield professional provider in a timely manner. The member shall remit or make arrangements to pay any coinsurance and/or deductible amounts directly to the PremierBlue Shield professional provider within sixty (60) days of the Plan’s finalization of the claim. Otherwise, the member will also be responsible for the difference between the PremierBlue Shield professional provider’s billed charge and the Plan’s payment.

vii) Participating Professional Provider and Contracting Supplier (Out-of-Area):

The Plan’s coinsurance liability arises after the member’s deductible obligation is subtracted from the Provider’s Reasonable Charge. At that time, the Plan will pay seventy (70%) of the remaining amount and the member’s coinsurance obligation will be thirty percent (30%) of the remaining amount. The member is obligated to pay the coinsurance amount as well as any deductible amounts. The participating professional provider and the contracting supplier will accept the Plan’s payment plus the member’s coinsurance and/or deductible as payment in full for covered services rendered to the member.

viii) Non-Participating Professional Provider and Non-Contracting Supplier:

The Plan’s coinsurance liability arises after the member’s deductible obligation is subtracted from the Provider’s Reasonable Charge. At that time, the Plan will
pay seventy percent (70%) of the remaining amount and the member’s
coinsurance obligation will be thirty percent (30%) of the remaining amount.
The member is obligated to pay the coinsurance amount as well as any
deductible amounts. The member is also responsible for any difference between
the non-participating professional provider’s or non-contracting supplier’s
billed charge and the Plan’s payment.

3. Summary of Provider/Supplier and Member Liability

<table>
<thead>
<tr>
<th>NETWORK SERVICE AREA</th>
<th>HIGHMARK MANAGED CARE NETWORK SERVICE AREA</th>
<th>OUT-OF-AREA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twenty-One (21) County Central Region Area</td>
<td>Twenty-Nine (29) County Western Region Area</td>
<td>Outside of the Twenty-One (21) County Central and Twenty-Nine (29) County Western Region Areas</td>
</tr>
<tr>
<td><strong>NETWORK BENEFIT SERVICE LEVEL</strong></td>
<td><strong>OUT-OF-NETWORK BENEFIT SERVICE LEVEL</strong></td>
<td><strong>OUT-OF-NETWORK BENEFIT SERVICE LEVEL</strong></td>
</tr>
<tr>
<td>(90% PRC with No Balance Billing)</td>
<td>(70% PRC with Balance Billing)</td>
<td>(90% PRC with No Balance Billing)</td>
</tr>
<tr>
<td>Network Professional Provider (PremierBlue Shield Professional Provider)</td>
<td>Non-Participating Professional Provider</td>
<td>Highmark Managed Care Professional Provider ▲</td>
</tr>
<tr>
<td>Network Facility Provider</td>
<td>Non-Participating Facility Provider</td>
<td>Highmark Managed Care Facility Provider ▲</td>
</tr>
<tr>
<td>Network Supplier</td>
<td>Non-Contracting Supplier</td>
<td>Highmark Managed Care Supplier ▲</td>
</tr>
</tbody>
</table>

Note: ▲ Except for any applicable Coinsurance and/or Deductible, the Member will incur no additional cost-sharing if the Member seeks Services from this Provider within the specified service area. Members must utilize this Provider in this indicated service area in order to maximize benefits.
4. Outpatient Pharmacy Benefits

The Plan will reimburse participating pharmacy providers ninety percent (90%) of the Provider’s Allowable Price for covered medications provided on an outpatient basis. The participating pharmacy provider is also entitled to collect the prescription drug deductible or any other financial obligation due from the member as set forth in Section II. COMPREHENSIVE MAJOR MEDICAL EXPENSE COVERAGE, Subsection J. Benefit Amounts, Durations, Limits, Deductibles and Coinsurance for Benefits Under the Agreement, Paragraph 4. Schedule, of this Outline of Coverage. The participating pharmacy provider must accept the Plan’s payment, plus the member’s coinsurance and/or deductible payment as payment in full for covered medications. No coverage is provided for prescription drugs purchased at a non-participating pharmacy provider.

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 in 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 SE - SCHEDULE OF ELIGIBILITY** in the Agreement;

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;

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 DB - DESCRIPTION OF BENEFITS in the Agreement;

21. 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 SECTION DB - DESCRIPTION OF BENEFITS in the Agreement. Other exceptions to this exclusion are: i) surgery to correct a condition resulting from an accident; ii) surgery to correct a congenital birth defect; and iii) surgery to correct functional impairment which results from a covered disease or injury;

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 DB - DESCRIPTION OF BENEFITS** in the Agreement;

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 and reversal of sterilization;

35. For impotency treatment drugs or fertility drugs;

36. For oral impotency drugs;
37. For oral or injectable contraceptive medication except when prescribed for purposes other than birth control;

38. For contraceptive devices and contraceptive implants, including services related to the provision of such devices or implants;

39. For weight control drugs and services intended to produce weight loss;

40. For nutritional counseling, except as provided herein;

41. For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate;

42. For treatment of obesity, except for medical and surgical treatment of morbid obesity;

43. For prescription vitamins, except vitamins prescribed during pregnancy, and fluoride legend vitamins;

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 DB - DESCRIPTION OF BENEFITS in the Agreement or as mandated by law;

48. For allergy testing, except as provided in SECTION DB - DESCRIPTION OF BENEFITS in the Agreement, 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 DB - DESCRIPTION OF BENEFITS in the Agreement or as mandated by law;

50. For immunizations required for foreign travel or employment;

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 any other medical or dental service or treatment except as provided in SECTION DB - DESCRIPTION OF BENEFITS in the Agreement 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-one (21) 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-one (21) county area served by the Plan;

iv) in the event the subscriber no longer lives in the twenty-one (21) 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 e., 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.

C. Conversion Privilege

1. Conversion 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. Conversion due to death of subscriber

Upon the death of the subscriber, coverage under the Agreement shall continue for the surviving dependents for any period for which the premium has been paid. A surviving spouse, if covered under the Agreement, shall become the subscriber upon
notice to the Plan of the subscriber’s death. A dependent child may make application during this period to continue coverage under the Agreement.

D. Modification/Premium Subject to Change - Premiums 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 premium for the age which the member has then attained. For family coverage, the premium rate will be based upon the attained age of the oldest member covered under the agreement and whether any member of the family smokes.

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 Shield only. Highmark 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 Shield to use the familiar Blue Shield words and symbol. Highmark Blue Shield, upon entering into the Agreement, is not contracting as an agent of the national Association. Only Highmark 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.