HIGHMARK BLUE CROSS BLUE SHIELD
(“the Plan”)

whose address 120 Fifth Avenue, Fifth Avenue Place
Pittsburgh, PA 15222-3099

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

identified as the

“DirectBlue Individual Comprehensive Major Medical
Preferred Provider Program”

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 and transplant services. Outpatient prescription drug coverage is
provided for those prescription drugs listed in the closed formulary.

Coverage is provided at Network and Out-of-Network benefit levels with cost-sharing
options such as deductibles, coinsurance, copayments and annual and lifetime
maximums. Benefits are subject to the Health Care Management Services Provision with
penalties and 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 this Agreement is subject to
medical underwriting.
C. *A brief description of the benefits contained in the Agreement are as follows:*

1. **Daily Hospital Room and Board** – which includes a room with two or more beds or a private room, when medically necessary and appropriate, and general nursing services.

2. **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.

3. **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.

4. **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.

5. **In-Hospital Medical Services** – including inpatient medical care visits, intensive medical care, concurrent care, consultation and routine newborn care.

6. **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 of illness or injury following a covered inpatient stay or following covered outpatient surgery; infusion therapy; oral surgery; pediatric immunizations; routine gynecological exams and pap smears; annual screening mammograms for members age 40 and over, and for any physician recommended mammograms for members under age 40; services for mastectomy and breast cancer reconstructive surgery; diabetes treatment for all types of diabetes; the Dr. Dean Ornish Program (for Reversing Heart Disease); and prescription drugs listed on the closed formulary.

7. **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; the purchase, fitting, necessary adjustments, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminated 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.

8. *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.

9. *Emergency Care* – Coverage is provided for the initial treatment of a sudden onset of a medical condition or injury that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the health of the member or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

Benefits are provided for emergency accident services (the initial treatment of bodily injuries resulting from an accident) and emergency medical services (the initial treatment after the sudden onset of a medical condition). Treatment for an occupational injury for which benefits are provided under any Workers’ Compensation Law or any similar Occupational Disease Law is not covered.

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.

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

a. 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 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.

b. 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.

ii) **Participating Facility Provider (within the Plan Service Area):** the Provider’s Reasonable Charge is the amount paid to a Network Facility Provider. The Member will be responsible for any difference between the Participating Facility Provider’s billed charge and the Plan’s payment.

iii) **Participating Facility Provider (within the Highmark Blue Shield Service Area):** the Provider’s Reasonable Charge is the amount agreed to by the Participating Facility Provider (within the Highmark Blue Shield Service Area) as payment in full, as set forth in the agreement between the Participating Facility Provider and Highmark Blue Shield.

iv) **Participating Facility Provider (Out-of-Area):** the Provider’s Reasonable Charge is the amount agreed to by the Participating Facility Provider (Out-of-Area) and the local licensee of the Blue Cross 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 Blue Shield Association.

v) **Non-Participating Facility Provider:** the Provider’s Reasonable Charge is an average of the amount paid to comparable Participating Facility Providers located in the same geographic region as the Non-Participating Facility Provider. The Member will be responsible for any difference between the Non-Participating Facility Provider’s billed charge and the Plan’s payment.

vi) **Preferred Professional Provider and Network Supplier:** the Provider’s Reasonable Charge is the amount agreed to by the Preferred Professional Provider or Network Supplier as payment in full.

vii) **Participating Professional Provider, PremierBlue Shield Professional Provider and Contracting Supplier (within the Plan Service Area):** the Provider’s Reasonable Charge is the amount paid to a Preferred Professional Provider or Network Supplier. The Member will be responsible for any difference between the Participating Professional Provider’s, PremierBlue Shield Professional Provider’s or Contracting Supplier’s billed charge and the Plan’s payment.
viii) **PremierBlue Shield Professional Provider (within Pennsylvania, outside the Plan Service Area):** the Provider’s Reasonable Charge is the amount agreed to by the PremierBlue Shield Professional Provider as payment in full, as set forth in the agreement between the PremierBlue Shield Professional Provider and Highmark Blue Shield.

ix) **Participating Professional Provider (within Pennsylvania, outside the Plan Service Area):** the Provider’s Reasonable Charge is the amount paid to a Preferred Professional Provider. The Member will be responsible for any difference between the Participating Professional Provider’s billed charge and the Plan’s payment.

x) **Participating Vision Provider:** the Provider’s Reasonable Charge is the amount agreed to by the Participating Vision Provider as payment in full, as set forth in the agreement between the Participating Vision Provider and the Plan or its designated agent.

xi) **Contracting Supplier (within the Highmark Blue Shield Service Area):** the Provider’s Reasonable Charge is the amount agreed to by the Contracting Supplier (within the Highmark Blue Shield Service Area) as payment in full, as set forth in the agreement between the Contracting Supplier and Highmark Blue Shield.

xii) **Contracting Supplier (within Pennsylvania, Out-of-Area):** the Provider’s Reasonable Charge is the amount paid to a Network Supplier. The Member will be responsible for any difference between the Contracting Supplier’s billed charge and the Plan’s payment.

xiii) **Participating Professional Provider and Contracting Supplier (outside Pennsylvania):** 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 Blue Shield Association outside Pennsylvania.

xiv) **Non-Participating Professional Provider and Non-Contracting Supplier (within Pennsylvania):** the Provider’s Reasonable Charge is the amount paid to a Preferred Professional Provider or Network Supplier. The Member will be responsible for any difference between that Non-Participating Professional Provider’s or Non-Contracting Supplier’s billed charge and the Plan’s payment.
xv) Non-Participating Professional Provider and Non-Contracting Supplier (outside Pennsylvania): the Provider’s Reasonable Charge is the Usual, Reasonable and Customary (UCR) Allowance. 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. However, the Plan reserves the right to establish threshold amounts at which the Plan may pay Non-Participating Professional Providers or Non-Contracting Suppliers at their billed charge. In this instance, the Provider’s Reasonable Charge for Non-Participating Professional Providers or Non-Contracting Suppliers will be the billed charge and there will be no resulting liability to the Member.

c. Schedule

<table>
<thead>
<tr>
<th>DEDUCTIBLE</th>
<th>NETWORK SERVICES</th>
<th>OUT-OF-NETWORK SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>$500</td>
<td>$500</td>
</tr>
</tbody>
</table>

1. Unless otherwise indicated, deductible amounts are applicable to covered services furnished to a member per Benefit Period.

2. The deductible applies to all covered services, except covered medications provided on an outpatient basis and 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.

3. Each of three (3) members under one family coverage must satisfy their individual deductibles in one benefit period.

B. PRESCRIPTION DRUG DEDUCTIBLE

<table>
<thead>
<tr>
<th>NETWORK SERVICES</th>
<th>OUT-OF-NETWORK SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

1. Unless otherwise indicated, prescription drug deductible amounts are applicable to covered medications furnished to a member per calendar year on an outpatient basis.

2. The prescription drug deductible applies to all covered medications provided on an outpatient basis, except where exempted by law or indicated herein, but is not applicable toward satisfaction of the Out-of-Pocket Limit specified in this Section.
MAXIMUMS

A. PROGRAM MAXIMUMS

1. $1,000,000 for Network and Out-of-Network Services per Benefit Period per member.

2. $5,000,000 for Network Services per lifetime per member.

3. $300,000 for Out-of-Network Services per lifetime per member.

4. Amounts applied to the program maximum for Out-of-Network Services are also applied to the program maximum for Network Services.

5. The program maximums do not include expenses for covered medications provided on an outpatient basis.

B. PRESCRIPTION DRUG MAXIMUM

$50,000 per calendar year per member for covered medications provided on an outpatient basis.

OUT-OF-POCKET LIMIT

A. INDIVIDUAL $1,500

B. FAMILY $4,500 for Network and Out-of Network covered services.

The dollar amounts specified shall not include any expenses for covered medications provided on an outpatient basis, private duty nursing, amounts paid for copayments and deductibles or amounts in excess of the Provider’s Reasonable Charge.

<table>
<thead>
<tr>
<th>NETWORK SERVICES</th>
<th>OUT-OF-NETWORK SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAXIMUM</td>
<td>$5,000,000</td>
</tr>
<tr>
<td></td>
<td>$300,000 per member per lifetime.</td>
</tr>
</tbody>
</table>

OUT-OF-POCKET LIMIT

A. INDIVIDUAL $1,500

B. FAMILY $4,500 for Network and Out-of Network Covered Services.

The dollar amounts specified shall not include any expenses for prescription drugs, private duty nursing, amounts paid for copayments and deductibles or amounts in excess of the Provider’s Reasonable Charge.
<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 ACCIDENTUAL INJURY</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>C. DIABETES TREATMENT</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Equipment and Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Diabetes Education</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>D. DIAGNOSTIC SERVICES</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>E. DR. DEAN ORNISH PROGRAM (For Reversing Heart Disease)</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>F. DURABLE MEDICAL EQUIPMENT</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>G. ENTERAL FORMULAE</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>H. HOME HEALTH CARE SERVICES</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>100 visit maximum per benefit period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. HOSPICE CARE SERVICES</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>J. HOME INFUSION THERAPY SERVICES</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>K. HOSPITAL SERVICES</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Unlimited days</td>
<td>90 days per benefit period</td>
<td></td>
</tr>
<tr>
<td>Private Room Allowance</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>for the most common semiprivate room charge.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private room covered when medically necessary and appropriate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Accident Services</td>
<td>90% PRC</td>
<td>90% PRC</td>
</tr>
<tr>
<td>$40 copayment per visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copayment is waived if member is admitted as inpatient.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Payers (90% PRC)</td>
<td>Payers (70% PRC)</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Emergency Medical Services</strong></td>
<td>90% PRC</td>
<td>90% PRC</td>
</tr>
<tr>
<td></td>
<td>$40 copayment per visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Copayment is waived if member is admitted as inpatient.</td>
<td></td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td><strong>Pre-Admission Testing</strong></td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td><strong>L. MATERNITY SERVICES</strong></td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Maternity Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Care Visit</td>
<td>One (1) Maternity Home Health Care Visit within 48 hours of discharge when discharge occurs prior to (a) 48 hours of inpatient care following a normal vaginal delivery; or (b) 96 hours of inpatient care following a caesarean delivery. Such visit is exempt from any copayment, coinsurance or deductible amounts.</td>
<td></td>
</tr>
<tr>
<td><strong>M. ORTHOTIC DEVICES</strong></td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td><strong>N. PRESCRIPTION DRUGS OUTPATIENT NON-FACILITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Covered Medications (Closed Formulary)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drugs and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over-the-Counter Drugs</td>
<td>$10 or the Provider’s Allowable Price per Prescription Order or refill, whichever is less.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Brand Drugs</td>
<td>$20 or the Provider’s Allowable Price per Prescription Order or refill, whichever is less.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Mail Order Maintenance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Medications (Closed Formulary)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drugs and</td>
<td>$20 or the Provider’s Allowable Price for each 90-day supply, whichever is less.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Over the Counter Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brand Drugs</td>
<td>$40 or the Provider’s Allowable Price for each 90-day supply, whichever is less.</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
O. PREVENTIVE SERVICES

Pediatric Care 90% PRC 70% PRC

(Routine physical examination benefits are exempt from all deductibles.)

Pediatric Immunizations 90% PRC Not Covered

(Pediatric immunization benefits are exempt from all deductibles or dollar limits.)

Routine Physical Examinations 90% PRC Not Covered

(Routine physical examination benefits are exempt from all deductibles.)

Routine Gynecological Examination and Pap Test 90% PRC Not Covered

(Routine gynecological examinations and papanicolaou smear benefits are exempt from all deductibles or maximums.)

Allergy Extract/Injections 90% PRC 70% PRC

Adult Immunizations and Therapeutic Injections 90% PRC Not Covered

(Adult immunization benefits, except those required by an employer, are exempt from all deductibles.)

Mammographic Screening 90% PRC Not Covered

(Routine mammographic screening benefits are exempt from all deductibles.)

P. PRIVATE DUTY NURSING SERVICES 90% PRC 70% PRC

Q. PROSTHETIC APPLIANCES 90% PRC 70% PRC

R. SKILLED NURSING FACILITY SERVICES 90% PRC 70% PRC

Limited to 100 days per Benefit Period, and up to 50 days may be used Out-of-Network.

S. SPINAL MANIPULATIONS 90% PRC 70% PRC

10 visit maximum per calendar year.
### T. SURGICAL/MEDICAL SERVICES

#### Surgical Services

<table>
<thead>
<tr>
<th>Service</th>
<th>90% PRC</th>
<th>70% PRC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Surgery</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Assistant at Surgery</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Second Surgical Opinion Services</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
</tbody>
</table>

#### Inpatient Medical Care Services

<table>
<thead>
<tr>
<th>Service</th>
<th>90% PRC</th>
<th>70% PRC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Medical Care Visits and Intensive Medical Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concurrent Care</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Consultation</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Newborn Care</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
</tbody>
</table>

#### Outpatient Medical Care Services

<table>
<thead>
<tr>
<th>Service</th>
<th>90% PRC</th>
<th>70% PRC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Accident Services</td>
<td>90% PRC</td>
<td>90% PRC</td>
</tr>
<tr>
<td>Emergency Medical Care</td>
<td>90% PRC</td>
<td>90% PRC</td>
</tr>
</tbody>
</table>

$40 copayment per visit.

### U. THERAPY AND REHABILITATION SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>90% PRC</th>
<th>70% PRC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Medicine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15 visit maximum per calendar year.

<table>
<thead>
<tr>
<th>Service</th>
<th>90% PRC</th>
<th>70% PRC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infusion Therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Cardiac Rehabilitation  
Occupational and Speech Therapy
Respiration Therapy

Combined 15 visit maximum per calendar year.

V. TRANSPLANT SERVICES

W. VISION CARE SERVICES

One (1) comprehensive, routine eye examination every twenty-four (24) consecutive months

(Covered Vision Care Services are exempt from all Deductibles, Coinsurance, Copayments and dollar limits.)

D. Exceptions, Reductions, and Limitations of the Agreement

1. Pre-existing Conditions - A “Pre-existing Condition” means a condition for which medical advice or treatment was recommended by a physician or received from a physician within a five-year period preceding the effective date of coverage of the member. Benefits are not available under this Agreement for services furnished to a member for a Pre-existing Condition as defined in SECTION DE - DEFINITIONS of the Agreement, during an exclusion period of 12 months following the member’s effective date. 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 services or supplies that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: a) in accordance with generally accepted standards of medical practice; and b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.
Benefits under the Agreement for services or supplies will be provided only when the Plan or its designated agent, utilizing the criteria set forth in the paragraph above, determines that such service or supply is medically necessary and appropriate. Network facility providers and preferred professional providers will accept this determination of medical necessity. Out-of-Network providers are not obligated to accept this determination and may bill the member for services determined not to be medically necessary and appropriate. See the Agreement for further explanation.

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 member’s physician performs such 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.

4. **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.

5. **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 this 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 this 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 10. *Benefit Amounts, Durations, Limits, Deductibles, Coinsurance and Copayments for Benefits Under the Agreement* of this Outline for the definition of “Provider’s Reasonable Charge”.

a. **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 90% of the remaining amount and the Member’s Coinsurance obligation will be 10% of the remaining amount. The
Member is obligated to pay the Coinsurance amount as well as any Deductible and/or Copayment amounts. The Network Facility Provider will accept the Plan’s payment, plus the Member’s Coinsurance, Deductible and/or Copayment as payment in full for Covered Services rendered to the Member.

ii) Preferred 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 90% of the remaining amount and the Member’s Coinsurance obligation will be 10% of the remaining amount. The Member is obligated to pay the Coinsurance amount as well as any Deductible and/or Copayment amounts. The Preferred Professional Provider or Network Supplier will accept the Plan’s payment, plus the Member’s Coinsurance, Deductible and/or Copayment as payment in full for Covered Services rendered to the Member.

b. Covered Services Received from an Out-Of-Network Provider

i) Participating Facility Provider (within the Plan 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 70% of the remaining amount and the Member’s Coinsurance obligation will be 30% of the remaining amount. The Member is obligated to pay the Coinsurance amount as well as any Deductible and/or Copayment amounts. The Member, in addition to Coinsurance, Deductible and/or Copayment obligations, is also responsible for any difference between the Participating Facility Provider’s billed charge and the Plan’s payment.

ii) Participating Facility Provider (within the Highmark Blue Shield 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 90% of the remaining amount and the Member’s Coinsurance obligation will be 10% of the remaining amount. The Member is obligated to pay the Coinsurance amount as well as any Deductible and/or Copayment amounts. The Participating Facility Provider will accept the Plan’s payment, plus the Member’s Coinsurance, Deductible and/or Copayment obligations, as payment in full for Covered Services rendered to the Member.
iii) 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 70% of the remaining amount and the Member’s Coinsurance obligation will be 30% of the remaining amount. The Member is obligated to pay the Coinsurance amount as well as any Deductible and/or Copayment amounts. The Participating Facility Provider will accept the Plan’s payment, plus the Member’s Coinsurance, Deductible and/or Copayment obligations, as payment in full for Covered Services rendered to the Member.

iv) 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 70% of the remaining amount and the Member’s Coinsurance obligation will be 30% of the remaining amount. The Member is obligated to pay the Coinsurance amount as well as any Deductible and/or Copayment amounts. The Member, in addition to Coinsurance, Deductible and/or Copayment obligations, is also responsible for any difference between the Non-Participating Facility Provider’s billed charge and the Plan’s payment.

v) Participating Professional Provider, PremierBlue Shield Professional Provider and Contracting Supplier (within the Plan 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 70% of the remaining amount and the Member’s Coinsurance obligation will be 30% of the remaining amount. The Member is obligated to pay the Coinsurance amount as well as any Deductible and/or Copayment amounts. The Member, in addition to Coinsurance, Deductible and/or Copayment obligations, is also responsible for any difference between the Participating Professional Provider’s, PremierBlue Shield Professional Provider’s, or Contracting Supplier’s billed charge and the Plan’s payment.

vi) PremierBlue Shield Professional Provider (within Pennsylvania, outside the Plan 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 90% of the remaining amount and the Member’s Coinsurance obligation will be 10% of the remaining amount. The Member is obligated to pay the Coinsurance amount as well as any
Deductible and/or Copayment amounts. The PremierBlue Shield Professional Provider will accept the Plan’s payment, plus the Member’s Coinsurance, Deductible and/or Copayment as payment in full for Covered Services rendered to the Member.

vii) Participating Professional Provider (within Pennsylvania, outside the Plan 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 70% of the remaining amount and the Member’s Coinsurance obligation will be 30% of the remaining amount. The Member is obligated to pay the Coinsurance amount as well as any Deductible and/or Copayment amounts. The Member, in addition to Coinsurance, Deductible and/or Copayment obligations, is also responsible for any difference between the Participating Professional Provider’s billed charge and the Plan’s payment.

viii) Participating Vision Provider (within or outside of Pennsylvania)

Covered vision care services are exempt from all Deductibles, Coinsurance, Copayments and dollar limits. The Plan will pay 100% of Provider’s Reasonable Charge. The Participating Vision Provider will accept the Plan’s payment as payment in full.

ix) Contracting Supplier (within the Highmark Blue Shield 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 90% of the remaining amount and the Member’s Coinsurance obligation will be 10% of the remaining amount. The Member is obligated to pay the Coinsurance amount as well as any Deductible and/or Copayment amounts. The Contracting Supplier will accept the Plan’s payment, plus the Member’s Coinsurance, Deductible and/or Copayment as payment in full for Covered Services rendered to the Member.

tax) Contracting Supplier (within Pennsylvania, 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 70% of the remaining amount and the Member’s Coinsurance obligation will be 30% of the remaining amount. The Member is obligated to pay the Coinsurance amount as well as any Deductible and/or Copayment amounts. The Member, in addition to Coinsurance, Deductible and/or Copayment obligations, is also
responsible for any difference between the Contracting Supplier’s billed charge and the Plan’s payment.

xi) Participating Professional Provider and Contracting Supplier (outside Pennsylvania)

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 70% of the remaining amount and the Member’s Coinsurance obligation will be 30% of the remaining amount. The Member is obligated to pay the Coinsurance amount as well as any Deductible and/or Copayment amounts. The Participating Professional Provider or Contracting Supplier will accept the Plan’s payment, plus the Member’s Coinsurance, Deductible and/or Copayment obligations, as payment in full for Covered Services rendered to the Member.

d) Non-Participating Professional Provider and Non-Contracting Supplier (within or outside Pennsylvania)

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 70% of the remaining amount and the Member’s Coinsurance obligation will be 30% of the remaining amount. The Member is obligated to pay the Coinsurance amount as well as any Deductible and/or Copayment amounts. The Member, in addition to Coinsurance, Deductible and/or Copayment obligations, 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.

6. 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.

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

   a. Which are not medically necessary and appropriate as determined by the Plan;

   b. Which are not prescribed by or performed by or upon the direction of a professional provider;

   c. Rendered by other than hospitals, facility other providers, professional providers, professional other providers and suppliers;

   d. Which are experimental/investigative in nature;

   e. Rendered prior to the member’s effective date;

   f. Incurred after the date of termination of the member’s coverage except as provided in the Agreement;

   g. For a Pre-Existing Condition, but only during the exclusion period as specified in the Agreement;

   h. For any illness or injury suffered after the member’s effective date as a result of any act of war;

   i. For which a member would have no legal obligation to pay;

   j. 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;
k. To the extent payment has been made under Medicare when Medicare is primary;

l. 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.

m. To the extent benefits are provided to members of the armed forces and the National Health Service or to patients in Veteran’s Administration facilities for service-connected illness or injury, unless the member has a legal obligation to pay;

n. 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;

o. 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.

p. Rendered by a provider who is a member of the member’s immediate family;

q. 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;

r. For ambulance services, except as provided in the Agreement;

s. 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 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;
t. For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;

u. 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;

v. For inpatient admissions which are primarily for diagnostic studies or for physical medicine services;

w. For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care;

x. For respite care;

y. For treatment of mental illness, including prescription drugs prescribed for the treatment of mental illness;

z. 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, alveolecctomy and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates as provided in the Agreement;

aa. 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;

bb. 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, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;

cc. For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;
dd. For any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery;

e. Related to treatment provided specifically for the purpose of assisted fertilization including, but not limited to, artificial insemination, in vitro fertilization, and including pharmacological or hormonal treatments used in conjunction with assisted fertilization;

ff. For sterilization and reversal of sterilization;

gg. For impotency treatment drugs or fertility drugs;

hh. Weight control drugs, or for nutritional counseling and services intended to produce weight loss;

ii. Prescription vitamins, except vitamins prescribed during pregnancy, and fluoride legend vitamins;

jj. For eyeglasses or contact lenses (except for aphakic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury);

kk. For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;

ll. 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.

mm. For preventive care services, wellness services or programs, except as provided in the Agreement, or as mandated by law;

nn. For the detection and correction by manual or mechanical means (including incidental x-rays) of structural imbalance or subluxation for the purpose of removing nerve interference resulting from or related to distortion, misalignment or subluxation of or in the vertebral column.

oo. For well-baby care visits, except as provided in the Agreement;
pp. For allergy testing, except as provided in the Agreement, or as mandated by law;

qq. 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 the Agreement, or as mandated by law;

rr. For screening examinations including x-ray examinations made without film, except as specified in the Agreement;

ss. For immunizations required for foreign travel;

tt. For treatment of sexual dysfunction not related to organic disease or injury;

uu. For any care related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, and mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change;

vv. For treatment of drug and alcohol abuse, including prescription drugs prescribed for the treatment of drug and alcohol abuse;

ww. For care, treatment, or service which has been disallowed under the provisions of the Health Care Management Services Program;

xx. 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;

yy. 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;

zz. For any other medical or dental service or treatment except as provided in this Agreement or as mandated by law.

aaa. 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.
bbb. For any eye examinations or vision care services, except as provided herein, or rendered by a physician or Professional Provider who is not a Participating Vision Provider.

ccc. For otherwise covered services ordered by a court or other tribunal unless Medically Necessary and Appropriate or if the reimbursement of such services is required by law.

**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 premium 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 member or the Plan in accordance with the following:

   1. The Agreement may be terminated by the member 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:

      a. if payment of the appropriate premium is not made when due, or during the grace period;

      b. 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;

      c. upon ninety (90) days notice to the member 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 member when the Plan discontinues all individual coverage within the 29 County area served by the Plan;
d. 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

e. 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 for Dependent coverage set forth the Agreement; or

ii) a spouse becomes divorced from the member.

However, if the Plan accepts payment of the premium rate 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.

3. **Conversion Privilege**

1. **Conversion due to ineligibility**

A dependent who becomes ineligible for coverage pursuant to the terms set out in the Agreement may apply within 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 this Agreement shall continue for the surviving Dependents for any period for which the premium has been paid. A surviving spouse, if covered under this 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 this Agreement.
4. **Modification/Premium Subject to Change** - Premiums will be charged to members 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.

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. 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.

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

The Agreement is between the member(s) and Highmark Blue Cross Blue Shield only. Highmark Blue Cross Blue Shield is an independent corporation operating under license from the Blue Cross Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield Plans throughout the United States. Although all of these independent Blue Cross and Blue Shield Plans operate from a license with the Association, each of them is a separate and distinct corporation. The Association allows Highmark Blue Cross Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Highmark Blue Cross Blue Shield, upon entering into the Agreement, is not contracting as an Agent of the national Association. Highmark Blue Cross Blue Shield shall be liable to the members for any of Highmark Blue Cross Blue Shield’s obligations under this Agreement. This paragraph does not add any obligations to the Agreement.