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 Agreement 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, comprehensive major medical coverage for 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 for most benefits at network and out-of-network benefit levels with cost-sharing options such as deductibles, coinsurance, copayments and annual and lifetime maximums. However, benefits for certain services are only available if received from a network provider. 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, whether natural born, adopted or placed for adoption, enrollment under this Agreement is subject to medical underwriting.
C. *A brief description of the benefits contained in the Agreement is 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 forty (40) and over, and for any physician recommended mammograms for members under age forty (40); services for mastectomy and breast cancer reconstructive surgery; and diabetes treatment for all types of diabetes.

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. **Prescription Drugs Outpatient Non-Facility** - coverage is provided, upon satisfaction of the prescription drug deductible, for covered medications when prescribed by a physician, podiatrist or dentist in connection with a covered service and when purchased at a participating pharmacy provider upon presentation of a valid identification card and dispensed on or after the member’s effective date for outpatient use.

a. **Covered Medications**

i) Prescription drugs listed in the closed formulary;

ii) Over-the-counter drugs listed in the closed formulary, upon presentation of a written prescription order;

iii) Maintenance prescription drugs obtained though a mail service program for up to 90-day supply; and

iv) Selected prescription drugs within, but not limited to, the following drug classifications only when such drugs are covered medications and are dispensed through an exclusive pharmacy provider:

a) Oncology related therapies

b) Interferons

c) Agents for multiple sclerosis and neurological related therapies

d) Antiarthritic therapies

e) Anticoagulants

f) Hematinic agents

g) Immunomodulators

h) Growth hormones

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

Once the prescription drug deductible has been satisfied, benefits will be provided for prescription drugs in the amounts specified in Section C.11.c of this Outline.
b. **Limitations:**

   i) Except in emergency situations, no coverage is provided for prescription drugs or over-the-counter drugs purchased at a non-participating pharmacy provider.

   ii) Each prescription drug and over-the-counter drug from a participating pharmacy provider is limited to a 34-day supply. Maintenance prescription drugs available through a mail service program are limited to a 90-day supply.

   iii) Insulin syringes, needles, and/or disposable diabetic testing materials will be covered by the same copayment as the insulin, if dispensed in days supply corresponding to the amount of insulin dispensed. Insulin syringes, needles, and/or disposable diabetic testing material dispensed without insulin will require a copayment when dispensed.

   iv) The participating pharmacy provider will dispense generic drugs in accordance with State and Federal laws, unless a generic equivalent is not available, regardless of whether the prescription order specifies a brand drug. If the member will not accept a generic substitution when the generic substitution is available, the member will be required to pay the difference between the price for a brand drug and any available generic equivalent, for each separate prescription order or refill. This amount is in addition to the brand drug or over-the-counter drug copayment stipulated in Section C.11.c.N. of this Outline.

   v) Coverage is limited to those prescription drugs and over-the-counter drugs listed in the closed formulary.

   vi) Oral or injectable contraceptive drugs are covered only when prescribed for purposes other than birth control.

   vii) Benefits provided under this Subsection are not subject to the provisions of SECTION GP – GENERAL PROVISIONS, COORDINATION OF BENEFITS Section of the Agreement.

   viii) The selected prescription drugs dispensed through an exclusive pharmacy provider are subject to the cost sharing provisions for retail covered medications set forth in Section C.11.c, COVERED SERVICES, Paragraph N. PRESCRIPTION DRUGS OUTPATIENT NON-FACILITY, and the day supply quantity limitations for non-maintenance prescription drugs as set forth in this Section C.8. Prescription Drugs Outpatient Non-Facility, Subsection b. Limitations, Paragraph ii).

   c. **Exclusions:**

   i) Drugs and supplies, not listed on the closed formulary, which can be purchased without a prescription order;

   ii) Prescription drugs and over-the-counter drugs not listed in the closed formulary;
iii) Topical antifungals;

iv) Antitussives (cough/cold);

v) Charges for administration of prescription drugs and/or injectable insulin whether by a physician or other person;

vi) Charges for a prescription drug, including drugs on the closed formulary, when such drug or medication is used for unlabeled or unapproved indications where such use has not been approved by the Food and Drug Administration (FDA);

vii) Any drug or medication, which is otherwise excluded under the terms of this Agreement;

viii) Antihemophilia drugs;

ix) Any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes;

x) Any drug requiring refrigeration (if delivered through the mail) or injectables, except insulin and other injectables used to treat diabetes; and

xi) The topical acne cream Retin-A, for those members who are over the age of thirty (30).

Important: See Section D. 7, Exclusions, of this Outline for additional conditions and limitations, which affect a member’s prescription drug coverage.

9. 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.

10. Emergency Care - coverage is provided for the treatment of a medical condition or injury 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.

Coverage includes emergency accident services (the treatment of bodily injuries resulting from an accident) and emergency medical services (the treatment of a medical condition). This shall not include treatment for an occupational injury for which benefits are provided under any Worker’s Compensation Law or any similar Occupational Disease Law.
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.

11. 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. A charge shall be considered incurred on the date a member receives the service or supply for which the charge is made.

b. Payment of Benefits - subject to the provisions of the Agreement, a member is responsible for payment of any cost-sharing amounts due to the provider after the amounts paid by the Plan hereunder.

The Provider’s Reasonable Charge (PRC) 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.

The Plan’s coinsurance liability arises after the member’s deductible or copayment obligation is subtracted from the Provider’s Reasonable Charge. At that time, the Plan will pay a percentage of the remaining amount and the member’s coinsurance obligation will be a percentage of the remaining amount, as set forth in SECTION SB - SCHEDULE OF BENEFITS. The member is obligated to pay the coinsurance amount as well as any deductible and/or copayment amounts.

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 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.

iv) **Non-Participating Facility Provider:** the Provider’s Reasonable Charge is sixty percent (60%) of billed charges for inpatient services and forty percent (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 the 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 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 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 that non-participating professional provider’s or non-contracting supplier’s billed charge and the Plan’s payment.

c.  

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>NETWORK SERVICES</th>
<th>OUT-OF-NETWORK SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEDUCTIBLE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. <strong>INDIVIDUAL</strong></td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>B. <strong>FAMILY</strong></td>
<td>3 times individual deductible</td>
<td>3 times individual deductible</td>
</tr>
</tbody>
</table>

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

| C. **PRESCRIPTION DRUG** | $100 | Not Covered |

**MAXIMUMS**

**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.

**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 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. <strong>AMBULANCE SERVICE</strong></td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>B. <strong>DENTAL SERVICES RELATED TO ACCIDENTAL INJURY</strong></td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>C. <strong>DIABETES TREATMENT</strong></td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Equipment and Supplies</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Outpatient Diabetes Education</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>
</tr>
<tr>
<td>G. <strong>HOME HEALTH CARE SERVICES</strong></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>H. <strong>HOSPICE CARE SERVICES</strong></td>
<td>90% PRC</td>
<td>70% PRC</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>HOSPITAL SERVICES</strong></td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Unlimited days per benefit period</td>
<td>90 days per benefit period</td>
<td></td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>NETWORK SERVICES</td>
<td>OUT-OF-NETWORK SERVICES</td>
</tr>
<tr>
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</tr>
<tr>
<td>Private Room Allowance</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td></td>
<td>for the most common semiprivate room charge.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Private room covered when Medically Necessary and Appropriate.</td>
<td></td>
</tr>
<tr>
<td>Emergency Accident Services</td>
<td>90% PRC</td>
<td>Same as network services</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>Emergency Medical Services</td>
<td>90% PRC</td>
<td>Same as network services</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>Surgery</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Pre-Admission Testing</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
</tbody>
</table>

K. MATERNITY SERVICES

K.1. Maternity Home Health Care Visit

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.

L. ORTHOTIC DEVICES

M. MEDICAL/SURGICAL SERVICES

Surgical Services

- Surgery                          | 90% PRC          | 70% PRC                 |
- Special Surgery                  | 90% PRC          | 70% PRC                 |
- Assistant at Surgery             | 90% PRC          | 70% PRC                 |
- Anesthesia                       | 90% PRC          | 70% PRC                 |
- Second Surgical Opinion Services | 90% PRC          | 70% PRC                 |
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>NETWORK SERVICES</th>
<th>OUT-OF-NETWORK SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Medical Care Services</td>
<td>Inpatient medical care visits and intensive medical care 90% PRC 70% PRC</td>
<td></td>
</tr>
<tr>
<td>Concurrent Care</td>
<td>90% PRC 70% PRC</td>
<td></td>
</tr>
<tr>
<td>Consultation</td>
<td>90% PRC 70% PRC</td>
<td></td>
</tr>
<tr>
<td>Newborn Care</td>
<td>90% PRC 70% PRC</td>
<td></td>
</tr>
<tr>
<td>Outpatient Medical Care Services</td>
<td>90% PRC 70% PRC</td>
<td></td>
</tr>
<tr>
<td>Emergency Accident Services</td>
<td>90% PRC Same as network services</td>
<td></td>
</tr>
<tr>
<td>Emergency Medical Care</td>
<td>90% PRC Same as network services</td>
<td></td>
</tr>
</tbody>
</table>

**N. PRESCRIPTION DRUGS OUTPATIENT NON-FACILITY**

<table>
<thead>
<tr>
<th>Covered Medications</th>
<th>Network Services</th>
<th>Out-of-Network Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Covered Medications (Closed Formulary)</td>
<td>100% provider’s allowable price</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Generic Drugs and Over-the-Counter Drugs</td>
<td>$10 copayment or a copayment equal to 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 copayment or a copayment equal to the provider’s allowable price per prescription order or refill, whichever is less.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Mail Order Maintenance Covered Medications (Closed Formulary)</td>
<td>100% provider’s allowable price</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Generic Drugs and Over the Counter Drugs</td>
<td>$20 copayment or a copayment equal to the provider’s allowable price for each 90-day supply, whichever is less.</td>
<td>Not Covered</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>Brand Drugs</td>
<td>$40 copayment or a copayment equal to 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

- **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 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

- **Mammographic Screening**
  - 90% PRC
  - Not Covered

**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. THERAPY AND REHABILITATION SERVICES**

- **Radiation Therapy**
  - 90% PRC
  - 70% PRC

- **Chemotherapy**
  - 90% PRC
  - 70% PRC

- **Dialysis Treatment**
  - 90% PRC
  - 70% PRC
### Covered Services

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Network Services</th>
<th>Out-of-Network Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Medicine</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Respiration Therapy</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
<tr>
<td>Occupational and Speech Therapy</td>
<td>90% PRC</td>
<td>70% PRC</td>
</tr>
</tbody>
</table>

**Physical Medicine** 90% PRC 70% PRC 15 visit maximum per calendar year.

**Infusion Therapy** 90% PRC 70% PRC

**Cardiac Rehabilitation** 90% PRC 70% PRC

**Respiration Therapy** 90% PRC 70% PRC

**Occupational and Speech Therapy** 90% PRC 70% PRC

Combined 15 visit maximum per calendar year.

### U. Transplant Services

<table>
<thead>
<tr>
<th>Transplant Services</th>
<th>90% PRC</th>
<th>70% PRC</th>
</tr>
</thead>
</table>

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

1. **Pre-existing Condition Exclusion Period** - “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 immediately preceding the effective date of the coverage of the member. During an exclusion period of twelve (12) months following the member’s effective date, no benefits are provided under the Agreement for care related to (a) Pre-Existing Condition(s). The Pre-Existing Condition Exclusion Period will not be imposed on a newborn or adopted child, or a child placed for adoption, during the first thirty-one (31) days from the date of birth, adoption or placement for adoption, subject to the **BENEFITS AFTER TERMINATION OF COVERAGE** provision 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.

2. **Medically Necessary and Appropriate** - “Medically Necessary and Appropriate” means that the benefits under this Agreement for services received from a Network provider will be provided only when and so long as such services are determined by the Plan or its designated agent to be: 1) appropriate for the symptoms and diagnosis or treatment of the member’s condition, illness, disease or injury; and 2) provided for the diagnosis, of the direct care and treatment of the member’s condition, illness, disease or injury; and 3) in accordance with standards of good medical practice; and 4) not primarily for the convenience of the member, or the member’s physician and/or other provider; and 5) 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 a bed patient 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, Highmark managed care facility providers, network professional providers and PremierBlue Shield professional providers (out-of-area) will accept this determination of medical necessity. Out-of-network providers may not 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.

   a. **Covered Services Received From A Network Provider**

      i) **Network Facility Provider**

      The Plan’s coinsurance liability arises after the member 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 and/or copayment amounts.
The network facility provider will accept the Plan’s payment, plus the member’s coinsurance and/or deductible and/or copayment 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 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 and/or copayment amounts. The network professional provider or the network supplier will accept the Plan’s payment, plus the member’s coinsurance and/or deductible and/or copayment 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 and/or copayment amounts to the network professional provider in a timely manner. The member shall remit or make arrangements to pay any coinsurance and/or deductible and/or copayment 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.

b. 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 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 and/or copayment amounts. The Highmark managed care facility provider will accept the Plan’s payment, plus the member’s coinsurance and/or deductible and/or copayment 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 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 and/or copayment amounts. The participating facility provider will accept the Plan’s
payment, plus the member’s coinsurance and/or deductible and/or copayment, 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 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 and/or copayment 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 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 and/or copayment 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 and/or copayment 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 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 and/or copayment 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 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 and/or copayment amounts. The PremierBlue Shield professional provider or preferred
supplier will accept the Plan’s payment plus the member’s coinsurance and/or deductible and/or copayment 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 and/or copayment 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 and/or copayment 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 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 and/or copayment amounts. The participating professional provider or contracting supplier will accept the Plan’s payment, plus the member’s coinsurance and/or deductible and/or copayment 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 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 and/or copayment amounts. The member is also responsible for any difference between the non-participating professional provider’s or non-contracting supplier’s billed charges and the Plan’s payment.
### 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>
</tbody>
</table>

**NETWORK BENEFIT SERVICE LEVEL**
- (90% PRC with No Balance Billing)
- (70% PRC with Balance Billing)

**OUT-OF-NETWORK BENEFIT SERVICE LEVEL**
- (90% PRC with No Balance Billing)
- (70% PRC with Balance Billing)

<table>
<thead>
<tr>
<th>Network Professional Provider (PremierBlue Shield Professional Provider)</th>
<th>Non-Participating Professional Provider</th>
<th>Highmark Managed Care Professional Provider ▲</th>
<th>PremierBlue Shield Professional Provider ▲</th>
<th>Participating Professional Provider ▲</th>
<th>Non-Participating Professional Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Facility Provider</td>
<td>Non-Participating Facility Provider</td>
<td>Highmark Managed Care Facility Provider ▲</td>
<td>Non-participating Facility Provider</td>
<td>Participating Facility Provider ▲</td>
<td>Non-Participating Facility Provider</td>
</tr>
<tr>
<td>Network Supplier</td>
<td>Non-Contracting Supplier</td>
<td>Highmark Managed Care Supplier ▲</td>
<td>Preferred Supplier</td>
<td>Contracting Supplier ▲</td>
<td>Non-Contracting Supplier</td>
</tr>
</tbody>
</table>

**Network Facility Provider**
- Non-Participating Facility Provider
- Highmark Managed Care Facility Provider ▲
- Non-participating Facility Provider
- Participating Facility Provider ▲
- Non-Participating Facility Provider

**Network Supplier**
- Non-Contracting Supplier
- Highmark Managed Care Supplier ▲
- Preferred Supplier
- Contracting Supplier ▲
- Non-Contracting Supplier

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.

### 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 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 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;
   
   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 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 by the Agreement. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; b) surgery to correct a 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 all 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, alveolectomy 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, toe 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;

c. For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;

d. 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;

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 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);

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 allergy testing, except as provided in the Agreement, or as mandated by law;

pp. 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;

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

rr. For immunizations required for foreign travel;

ss. 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;

tt. For treatment of sexual dysfunction not related to organic disease or injury;
uu. For any care that is provided for a condition which has no demonstrable organic origin or which extends beyond traditional medical management. This includes the following: a) 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; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services provided for purposes of behavioral modification and/or training; d) services related to learning disorders or learning abilities; e) 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 g) services provided for which, based on medical standards, there is no established expectation of achieving measurable improvement in a reasonable and predictable period of time;

vv. For the 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 the Agreement or as mandated by law; and

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 member rate within thirty-one (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:

a. The Agreement may be terminated by the member by giving thirty (30) days written notice to the Plan.

b. The Agreement is guaranteed renewable and cannot be terminated by the Plan except in the following instances:

1. if payment of the appropriate member rate is not made when due, or during the grace period;

2. 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;

3. 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 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 area served by the Plan;

4. in the event the member no longer lives in the area served by the Plan. Should the member change his or her residence to a geographic area outside the area served by the Plan and the member wishes to continue coverage, the member 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

5. 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 subscriber.

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

c. If the Agreement is terminated at the option of either party, the Plan shall refund to the member the amount of any unearned prepaid member rate held by the Plan.
3. **Conversion Privilege**

   a. **Conversion due to ineligibility**

      A dependent who becomes ineligible for coverage pursuant to the terms set out in the Agreement may apply within thirty (30) days thereafter to continue coverage under this program, as an individual subscriber, without proof of insurability, or under another program of the type for which the dependent then qualifies.

   b. **Conversion due to death of member**

      Upon the death of the subscriber, coverage under this Agreement shall continue for the surviving dependents for any period for which the member rate 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 the Agreement.

4. **Modification/Member Rate Subject to Change** - Member rates 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 member rate for the age, which the member has then attained.

   The Plan, subject to the approval of the Insurance Department of the Commonwealth of Pennsylvania, may alter or revise the terms of this Agreement or the member rates. Any such alteration or revision of the terms of this Agreement shall become effective for all members on the applicable renewal date.

   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 member shall be notified in advance of the new member rate and the effective date. Payment of the new member rate shall be considered receipt of notice and acceptance of the change in member rate.

   Any notice shall be considered to have been given when mailed to the subscriber at the address on the records of the Plan.
F. Relationship to Blue Cross and Blue Shield Plans

The Agreement is between the member(s) and Highmark Blue Shield only. Highmark 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 Shield to use the familiar Blue Shield word and symbol. Highmark Blue Shield, upon entering into the Agreement, is not contracting as an Agent of the national Association. Highmark Blue Shield shall be liable to the members for any of Highmark Blue Shield’s obligations under this Agreement. This paragraph does not add any obligations to the Agreement.