Highmark Inc., d/b/a

HIGHMARK BLUE CROSS BLUE SHIELD*

Fifth Avenue Place, 120 Fifth Avenue
Pittsburgh, Pennsylvania 15222-3099

WHOLE HEALTH BALANCE SUBSCRIPTION AGREEMENT

("Agreement")

RENEWABLE AT OPTION OF COMPANY/PREMIUM
SUBJECT TO CHANGE ON A CLASS BASIS
(see Page 5 of this Agreement)

DESCRIPTION OF COVERAGE: This Agreement sets forth a program of limited dental, fitness and wellness education, hearing and vision care benefits. Cost-sharing in the form of Copayments applies to certain benefits. Maximums also apply to certain benefits. Maximums may apply in the form of maximum program Plan Allowances and/or benefit frequencies. When provider charges exceed an applicable maximum Plan Allowance, the Member will be responsible for additional amounts not covered by the Plan. Benefits provided for certain covered services or products are only available when performed by or received from a Network or Participating Provider, as designated by the Plan. Benefits for dental services are only available when covered services are received from a Network, United Concordia Advantage Plus Provider Network provider. Hearing services and aids are only available from a TruHearing Provider. Benefits for vision care services and products are only available from a Davis Vision Network provider. A gatekeeper is not required to access benefits. This Agreement is non-participating in any divisible surplus of premium.

This Is A Limited Policy - Read It Carefully

Member's Right to Examine Agreement for Ten (10) Days

The Member shall have the right to return the Agreement within ten (10) days of its delivery and to have the premium rate refunded if, after examination of the Agreement, the Member is not satisfied for any reason.

HIGHMARK.

Alexis Miller, Senior Vice President, Senior Markets

*An independent licensee of the Blue Cross Blue Shield Association

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

    If a Member needs these services, the Member should contact [Name of Civil Rights Coordinator].

If a Member believes that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, the Member can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. The Member can file a grievance in person or by mail, fax, or email. If the Member needs help filing a grievance, the Civil Rights Coordinator is available to help the Member. The Member can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

LANGUAGE ASSISTANCE SERVICES

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意： 如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY： 711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان **فارسی** صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

WHB/WN-DP

WHOLE HEALTH BALANCE SUBSCRIPTION AGREEMENT

TABLE OF CONTENTS

Highmark Blue Cross Blue Shield

(hereinafter called "the Plan")

Whole Health Balance Subscription Agreement

In consideration for and upon payment of the appropriate premium, the person covered under this Agreement is entitled to health care and other benefits set forth herein in accordance with the terms and conditions of this Agreement.

Renewable at Option of Company/Premium Subject to Change on a Class Basis

Subject to the approval of the Pennsylvania Insurance Department, the Plan may adjust premiums on a class basis. Premium amounts due under this Agreement are based on the applicable amount as of the Effective Date and on the date of each subsequent renewal. Premiums are payable in advance on a monthly basis. Members may submit amounts in excess of the specific premium amount. However, such excess amounts will be applied on a monthly basis and the application of such excess amounts will not guarantee the continuation of coverage in the event of the loss of eligibility in accordance with **SECTION SE - SCHEDULE OF ELIGIBILITY** of this Agreement. Coverage will be subject to premium increases on the date the increase becomes effective.

Coverage begins on the Effective Date and continues until the end of the month. Thereafter, the coverage renews monthly. The Agreement will remain in effect until terminated by the Member or the Plan in accordance with Subsection O. **TERMINATION OF THE MEMBER'S COVERAGE UNDER THE AGREEMENT** of **SECTION GP - GENERAL PROVISIONS**. Non-renewal shall not be based on the deterioration of mental or physical health of any individual covered under this Agreement.

SECTION DE - DEFINITIONS

1. **AGREEMENT -** this Agreement, including the application and endorsements, if any, between the Plan and the Member, the Member's enrollment confirmation letter, the Member's current Identification Card and the Outline of Coverage.

2. **CLAIM -** a request made by or on behalf of a Member for the payment or reimbursement of the charges or costs associated with a Covered Service or product that has been received by a Member.

3. **CONTACT LENSES** - lenses made of various materials, either rigid or flexible, that fit over the cornea and may extend to the sclera of the eye in order to correct refractive errors.

4. **COPAYMENT** - a specified dollar amount of eligible expenses which the Member is required to pay for a specified Covered Service and which will be deducted from the Plan Allowance before the determination of the benefits payable under this Agreement is made.

5. **COVERED SERVICE** - a Service or product specified in this Agreement which is eligible for payment.

6. **DENTIST** - a person who is a doctor of dental surgery (D.D.S.) or doctor of medical dentistry (D.M.D.), licensed where required and performing services within the scope of such licensure.

7. **DESIGNATED AGENT** - an entity that has contracted with the Plan, either directly or indirectly, to perform a function and/or Service in the administration of this Agreement.

8. **EFFECTIVE DATE** - according to **SECTION SE - SCHEDULE OF ELIGIBILITY**, the date on which coverage for a Member begins under this Agreement.

9. **HIGHMARK INC. (HIGHMARK)** - an independent licensee of the Blue Cross Blue Shield Association. Highmark Blue Cross Blue Shield is a d/b/a of Highmark Inc.

10. **IDENTIFICATION CARD** - the currently effective card issued to the Member by the Plan.

11. **INCURRED** - a charge is considered Incurred on the date a Member receives the Service or product for which the charge is made.

12. **MAXIMUM** - the greatest amount and/or frequency with which the Plan may be liable for a Covered Service within a prescribed period of time. This will be expressed in terms of (i) dollar amounts or (ii) number of services or products covered under the Agreement within a specified period of time.
13. **MAXIMUM ALLOWABLE CHARGE (MAC)** - the maximum amount that the Plan will allow for a specific Covered Service. Maximum Allowable Charge may vary

depending upon the contract between the Plan or its Designated Agent and the particular Network Dental Provider rendering the Covered Service, provider specialty and geographic location.

14. **MEDICARE** - the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

15. **MEMBER** - an individual who meets the eligibility requirements specified in **SECTION SE - SCHEDULE OF ELIGIBILITY** of this Agreement.

16. **NETWORK DENTAL PROVIDER** - a Dentist who has entered into a network participation agreement, either directly or indirectly, with the Plan pertaining to payment for Covered Services rendered to a Member. Network Providers have agreed to accept the Plan's Maximum Allowable Charge as payment in full for Covered Services

17. **NETWORK SERVICE** - a Service, treatment or care that is provided by a Network Dental Provider, Network Vision Provider, Participating Fitness Center or Participating Hearing Aid Provider.

18. **NETWORK VISION PROVIDER** - a vision provider that has entered into a network participation agreement, either directly or indirectly, with the Plan pertaining to payment for Covered Services rendered to a Member.

19. **OUTLINE OF COVERAGE** - the document provided by the Plan to the Member summarizing some of the more significant provisions of the Agreement and which set forth applicable cost-sharing for benefits.

20. **PARTICIPATING FITNESS CENTER** - a gym or other facility designed for the purpose of providing individuals with the opportunity to exercise for the purpose of improving and maintaining personal fitness that has an agreement, either directly or indirectly, with the Plan pertaining to the payment of covered fitness benefits to a Member.

21. **PARTICIPATING HEARING AID PROVIDER** - a hearing aid device and service provider that has an agreement, either directly or indirectly, with the Plan pertaining to the payment of covered hearing aid benefits to a Member. Hearing aid evaluation and fitting services rendered by such providers are performed by licensed or registered audiologists, hearing instrument specialists, hearing aid fitters or other professionals permitted to provide such services under applicable state law.

22. **PHYSICIAN** - a person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed and legally entitled to practice medicine in all of its branches, perform surgery and dispense drugs.
23. **PLAN** - refers to Highmark Blue Cross Blue Shield, which is an independent licensee of the Blue Cross Blue Shield Association. Any reference to the Plan may also include its Designated Agent as defined herein and with whom the Plan has contracted to perform a function or service in the administration of this Agreement.

24. **PLAN ALLOWANCE** - the amount used to determine payment by the Plan for Covered Services provided to a Member and to determine Member liability. Plan Allowance is based on the type of Provider who renders such Services or as required by law.

In the case of a Network Provider, the Plan Allowance is the contractual allowance for Covered Services rendered by a Network Provider in a specific geographic region. A Network Provider will accept the Plan Allowance, plus any Member liability, as payment in full for Covered Services.

In the case of a Network Dental Provider, the Plan Allowance is expressed in terms of the Maximum Allowable Charge.

25. **PROVIDER** - a fitness center, hearing aid, dental or vision Provider licensed where required and performing within the scope of such licensure.

26. **VISION PROVIDER** - a Physician, person or practitioner licensed where required and performing services within the scope of such licensure relating to the examination, diagnosis and treatment of conditions of the eye and associated structures. Vision Providers under this Agreement include ophthalmologists, optometrists and opticians.

SECTION SE - SCHEDULE OF ELIGIBILITY

A. **ELIGIBILITY**

Eligible Member

To be eligible to enroll as a Member for coverage under this Agreement, an individual must:

a. be currently enrolled as a policyholder of a Medigap Blue plan issued by the Plan; and

b. reside in the geographic area in which the product represented by this Agreement is available from the Plan.

B. **NOTICE OF INELIGIBILITY**

It shall be the responsibility of the Member to immediately notify the Plan of any changes that will affect his or her eligibility for coverage under this Agreement.

C. **ENROLLMENT**

The Plan must receive a completed application for coverage and the applicable premium payment by the Member before coverage will be provided under this Agreement.

Eligible individuals may apply for coverage under this Agreement at any time.

Coverage under this Agreement shall become effective the first day of the first month following receipt of the Member's application.

The Effective Date of coverage under this Agreement shall appear in the enrollment confirmation letter issued by the Plan to the applicant. Upon enrollment in this coverage, the Plan shall issue to the Member an Identification Card evidencing coverage under this Agreement.

SECTION SB - SCHEDULE OF BENEFITS

Subject to exclusions, conditions and limitations of this Agreement, a Member is entitled to benefits for Covered Services as set forth in this Section, subject to the applicable Copayment, Maximums and/or benefit frequency limitations specified in this Section.

COVERED SERVICES	NETWORK SERVICES
A. **DENTAL CARE SERVICES**	
Routine Dental Examination and Cleaning	100% Plan Allowance $30 Copayment for each Visit Services are limited to one (1) Visit every six (6) calendar months
X-Ray Examinations	100% Plan Allowance $25 Copayment for each set of x-rays Services are limited to one (1) set of bitewing x-rays every calendar year and one (1) set of full mouth x-rays every five (5) years
B. **FITNESS AND WELLNESS EDUCATION**	100% Plan Allowance
C. **HEARING AIDS AND SERVICES**	
Hearing Services	100% Plan Allowance $40 Copayment per Visit Services are limited to one (1) Visit to assess hearing aid needs each calendar year and up to three (3) additional Visits received within the first year following purchase of the hearing aid

	Hearing Aid Devices	100% Plan Allowance $699 Copayment for each covered Advanced level hearing aid device $999 Copayment for each covered Premium level hearing aid device Covered hearing aids are limited to two (2) hearing aid devices every calendar year
	Hearing Aid Batteries	100% Plan Allowance Covered hearing aid batteries are limited to forty-eight (48) batteries for each covered hearing aid purchase

D. **VISION CARE SERVICES AND PRODUCTS**

Vision Examination	100% Plan Allowance $0 Copayment for each Visit Services are limited to one (1) Visit every calendar year
Eyeglass Lenses and Frames or Contact Lenses	
Davis Vision Fashion Collection	100% Plan Allowance

Other than Davis Vision Fashion Collection	Covered subject to $100 Maximum for each purchase
	Limited to the choice between one (1) pair of standard plastic eyeglass lenses and frames or a supply of Contact Lenses every calendar year

SECTION DB - DESCRIPTION OF BENEFITS

Subject to the exclusions, conditions, and limitations of this Agreement, a Member is entitled to the benefits of this Section.

A. **DENTAL CARE SERVICES**

Benefits will be provided for the following dental care Services not covered by Medicare only when received from a Network Dental Provider:

1. **Routine Dental Examination and Cleaning**

   Routine preventive oral examination and cleaning.

2. **X-Ray Examinations**

   Radiographic examinations consisting of the following:

   a. bitewing x-rays; and

   b. full mouth x-rays.

Benefits for covered dental examinations, cleanings and x-ray examinations are subject to applicable Copayments and Maximums as set forth in **SECTION SB - SCHEDULE OF BENEFITS** of this Agreement.

B. **FITNESS AND WELLNESS EDUCATION**

1. **Fitness Center Access**

   The Plan will identify and arrange for Members to have access to Participating Fitness Centers where they may personally exercise and receive exercise instruction. Depending upon which of these locations the Member selects, additional fitness classes and/or other fitness center amenities may also be available to the Member.

2. **Wellness Education**

   The Plan will provide information to Members concerning opportunities to attend classes, programs and other events designed to promote the Member's health, injury prevention and other healthy daily living habits. Members will decide which wellness education opportunities they want to attend and which they do not.

C.

HEARING AIDS AND SERVICES

Benefits include coverage for:

1. an annual routine examination to assess the Member's hearing aid needs;

2. additional Visits to fit and, when necessary, adjust the purchased hearing aid device within the first year following purchase; and

3. hearing aid devices and batteries.

All covered hearing aid services, devices and batteries must be received from a Participating Hearing Aid Provider.

Benefits for hearing services and aids are subject to applicable Copayments and Maximums as set forth in **SECTION SB - SCHEDULE OF BENEFITS** of this Agreement**.**

D. VISION CARE SERVICES AND PRODUCTS

Benefits will be provided for the following vision care Services and products not covered by Medicare only when received from a Network Vision Provider:

1. **Vision Examinations**

   An annual routine eye examination, including refraction, received from a Network Vision Provider.

   When a Member elects to purchase Contact Lenses from a Network Vision Provider, both the routine eye examination and any additional evaluation, fitting and other services relating to that purchase of Contact Lenses will be included and paid under this vision examination benefit subject to any Copayment or limitations set forth in **SECTION SB - SCHEDULE OF BENEFITS** of this Agreement.

2. **Vision Products (Eyeglass Lenses, Frames and Contact Lenses)**

   a. Pair of standard eyeglass frames and plastic lenses; and

   b. Supply of Contact Lenses, planned replacement or disposable.

   Eyeglass frames, eyeglass lenses and Contact Lenses must be purchased from a Network Vision Provider. Choice of Contact Lenses brand and/or manufacturer based on product formulary of the Network Vision Provider in effect at the time of purchase.

   The amount of the benefit paid by the Plan for covered eyeglass frames vary depending upon whether the frames selected by the Member are from the Standard Davis Vision

Fashion Collection. See **SECTION SB - SCHEDULE OF BENEFITS** of this Agreement.

Vision care benefits are subject to applicable Copayments and Maximums as set forth in **SECTION SB - SCHEDULE OF BENEFITS** of this Agreement.

SECTION EX - EXCLUSIONS

Except as specifically provided in this Agreement, or as the Plan is mandated or required to pay based on state or federal law, no benefits will be provided for Services, supplies or charges:

1. Rendered by other than Providers identified herein;

2. Rendered prior to the Member's Effective Date;

3. Incurred after the date of termination of the Member's coverage;

4. For which a Member would have no legal obligation to pay;

5. Rendered by a Provider who is a Member of the Member's immediate family;

6. For any dental, fitness and wellness education, hearing and vision services, except as provided herein or as mandated by law;

7. For dental Services not received from a Network Dental Provider;

8. For fitness and wellness education Services not received from a Participating Fitness Center;

9. For hearing Services and aids not received from a Participating Hearing Aid Provider;

10. For vision Services and products not received from a Network Vision Provider;

11. For the following services or charges related to dental Services:

    a. For dental treatment started prior to the Member's Effective Date or after the termination date of coverage under this Agreement, (including, but not limited to, multi-visit procedures such as endodontics, crowns, fixed partial dentures, inlays, onlays, and dentures);

    b. For house or hospital calls for dental services and for hospitalization costs (including, but not limited to, facility-use fees);

    c. Cosmetic in nature as determined by the Plan (including, but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures);

    d. for elective procedures (including, but not limited to, the prophylactic extraction of third molars);

e. For congenital mouth malformations or skeletal imbalances (including, but not limited to, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment);

f. For diagnostic services and treatment of jaw joint problems. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint;

g. For treatment of fractures and dislocations of the jaw;

h. For treatment of malignancies or neoplasms;

i. For Services and/or appliances that alter the vertical dimension (including, but not limited to, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method;

j. For replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances;

k. For periodontal splinting of teeth by any method;

l. For duplicate dentures, prosthetic devices or any other duplicative device;

m. For maxillofacial prosthetics;

n. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions;

o. For treatment and appliances for bruxism (night grinding of teeth);

p. For any claims submitted to the Plan by the Member or on behalf of the Member in excess of twelve (12) months after the date of service;

q. For incomplete treatment (including, but not limited to, patient does not return to complete treatment) and temporary services (including, but not limited to, temporary restorations);

r. For procedures that are:

i) part of a service but are reported as separate Services;

ii) reported in a treatment sequence that is not appropriate; or

iii) misreported or which represent a procedure other than the one reported.;

s. For specialized procedures and techniques (including, but not limited to, precision attachments, copings and intentional root canal treatment);

t. For Services not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Plan will apply;

u. For fees for broken appointments;

v. For other dental services, except as provided herein; and

w. For orthodontic services.

12. For ear molds;

13. For hearing aid accessories;

14. For hearing aid batteries, except as provided herein;

15. For hearing aid returns and related fees;

16. For hearing aid service Visits, except as provided herein;

17. For non-prescription industrial safety glasses and safety goggles;

18. For sports glasses;

19. For any lenses which do not require a prescription;

20. For non-prescription (Plano) lenses;

21. For special lens designs or coatings;

22. For replacement of broken frames and eyeglass lenses that are not supplied by Davis Vision's ophthalmic laboratories;

23. For additives for eyeglass lenses or Contact Lenses; and

24. For sales tax and shipping charges that may be associated with purchases of vision care products as covered under this Agreement.

SECTION GP - GENERAL PROVISIONS

A. APPEAL PROCEDURE

Internal Appeal Process

a. The Plan maintains an internal appeal process involving one (1) level of review.

b. At any time during the appeal process, a Member may choose to designate an authorized representative to participate in the appeal process on the Member's behalf. The Member or the Member's authorized representative shall notify the Plan, in writing, of the designation. For purposes of the appeal process, authorized representative includes designees, legal representatives and, in the case of a minor, parents of a Member entitled or authorized to act on the Member's behalf. The Plan reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member.

   At any time during the appeal process, a Member may contact the Member Service Department at the toll-free telephone number listed on the Member's Identification Card to inquire about the filing or status of an appeal.

c. If a Member has received notification that a claim has been denied by the Plan, in whole or in part, the Member may appeal the decision. For purposes of this Subsection, determinations made by the Plan to rescind a Member's coverage or to deny the enrollment request of an individual that the Plan has determined is ineligible for coverage under this Agreement, can also be appealed in accordance with the procedures set forth in this Subsection. The Member's appeal must be submitted within one hundred eighty (180) days from the date of the Member's receipt of notification of the adverse decision.

d. The Member, upon request to the Plan, may review all documents, records and other information relevant to the appeal and shall have the right to submit or present additional evidence or testimony which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of the appeal.

e. The appeal will be reviewed by a representative from the Member Grievance and Appeals Department. The representative shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the claim or matter which is the subject of the Member's appeal. In rendering a decision on the appeal, the Member Grievance and Appeals Department will take

   into account all evidence, comments, testimony, documents, records and other information submitted by the Member without regard to whether such information was previously submitted to or considered by the Plan. The Member Grievance and

Appeals Department will afford no deference to any prior adverse decision on the claim which is the subject of the appeal.

f. Each appeal will be promptly investigated and the Plan will provide written notification of its decision within a reasonable period of time not to exceed thirty (30) days following receipt of the appeal.

g. If the Plan fails to provide notice of its decision within the above-stated time frames or otherwise fails to strictly adhere to these appeal procedures, the Member shall be permitted to pursue any applicable right to arbitration.

h. In the event that the Plan renders an adverse decision on the internal appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding the right of the Member to pursue any applicable right to arbitration.

B. BENEFITS TO WHICH MEMBERS ARE ENTITLED

1. The benefit liability of the Plan is limited to the benefits specified in this Agreement.

2. No person other than a Member is entitled to receive benefits under this Agreement. Such right to benefits and coverage is not transferable.

C. COMPLIANCE WITH THE LAW; AMENDMENT

Anything contained herein to the contrary notwithstanding, the Plan shall have the right to modify this Agreement, including any endorsements hereto, at any time during the term of this Agreement to comply with the provisions of any law, regulation or lawful order.

These amendments may include, but are not limited to, the:

1. modification of premium rates and/or applicable Copayments;

2. required increase of the benefits provided herein; or

3. the reduction or elimination of any of the benefits provided herein.

Each party hereby agrees to any amendment of this Agreement which is necessary in order to accomplish such purpose.

D. GOVERNING LAW

This Agreement is entered into and is subject to the laws of the Commonwealth of Pennsylvania. The invalidity or unenforceability of any terms or conditions hereof shall in no way affect the validity or enforceability of any other terms or provisions. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

E. IDENTIFICATION CARDS

The Plan shall furnish to the Member an Identification Card to be presented to Providers when a service or product for which benefits are provided under this Agreement is requested.

F. MEMBER/PROVIDER RELATIONSHIP

1. The choice of a Provider is solely that of the Member.

2. The Plan does not furnish Covered Services but only makes payment for Covered Services received by Members. The Plan is not liable for any act or omission of any Provider. The Plan has no responsibility for a Provider's failure or refusal to render Covered Services to a Member.

3. The use or non-use of an adjective such as network, out-of-network, participating or non-participating in modifying any Provider is not a statement as to the ability of the Provider.

4. Providers maintain their own relationship with Members and are solely responsible to Members for all Covered Services that they provide. The relationship between the Plan and any Network or Participating Provider is an independent contract relationship. Providers are not agents or employees of the Plan, nor is any employee of the Plan an employee or agent of a Provider. The Plan shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any Provider.

G. OVERPAYMENT OF PLAN BENEFITS

The Plan and the Member will cooperate fully to make every reasonable effort under the circumstances, considering the chances of successful recovery and costs thereof, to recover any payment made to a Member, Provider which is in excess of the amount entitled to be received under the Plan.

H. PAYMENT OF BENEFITS

1. The Plan is authorized by the Member to make payments directly to Providers furnishing Covered Services for which benefits are provided under this Agreement. However, the Plan reserves the right to make the payments directly to the Member. The right of a Member to receive payment is not assignable, except to the extent required by law, nor may benefits of this Agreement be transferred either before or after Covered Services are rendered.

2. Once Covered Services are rendered by a Provider, the Plan will not honor the Member's requests not to pay the claims submitted by the Provider. The Plan will have no liability to any person because of its rejection of the request.

I. PLAN PAYMENT AND MEMBER LIABILITY

The Plan uses the Plan Allowance to calculate the benefit payable and the financial liability of the Member for Services covered under this Agreement. See **SECTION DE - DEFINITIONS** of this Agreement for the definitions of "Plan Allowance".

1. **Plan Payment**

   The Plan's payment is determined by first subtracting any Copayment liability from the Plan Allowance. This amount represents the Plan's payment.

2. **Member Liability**

   The Member's total liability is the sum of any applicable Copayment obligations. Network and Participating Providers, will accept the Plan's payment plus the Member's total liability as payment in full for the Covered Services provided to the Member.

3. **Plan Payment for Dental, Hearing and Vision Care Services**

   The Plan Allowance for Network or Participating Providers within or outside Pennsylvania is the amount agreed to by such Provider as payment in full, as set forth in the agreement between the Provider and the Plan.

J. PREMIUM/MODIFICATION

1. Each Agreement is maintained at a premium for which the Member is eligible.

2. The amount of the premium for the Member at any time is the rate set forth in the schedule of rates on file with and approved by the Insurance Department of the Commonwealth of Pennsylvania.

3. Coverage under this Agreement begins on the Effective Date and continues until the end of the calendar month. Thereafter, this coverage renews monthly. The premium is payable in advance directly to the Plan on a monthly basis. Members may, for their convenience, submit amounts in excess of the specific monthly premium. However, such excess amounts will only be applied on a monthly basis by the Plan. Acceptance of the excess remittance by the Plan does not convert the term of this Agreement from a monthly contract to some other term.

4. 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 premiums. Any such alteration or revision of the terms of this Agreement shall become effective for all Members on the effective date of the alteration or revision whether or not the Member has paid the premium in advance.

   Any change in the premiums shall become applicable for Members upon the expiration of the period covered by the Member's current payment at the time of such change. In the event of such alteration or revision of the premium, the Member 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 Member at the address on the records of the Plan.

K. RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD PLANS

The Member is hereby notified:

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

L. RELEASE AND PROTECTION OF MEMBER INFORMATION

All personally identifiable information about individual Members ("Protected Health Information") is subject to various statutory privacy standards, including state insurance regulations implementing Title V of the Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and regulations adopted thereunder by the Department of Health and Human Services (45 CFR Parts 160, 162, 164). In accordance with those standards, the Plan may use and disclose Protected Health

Information to facilitate payment, treatment and health care operations as described in the Highmark Notice of Privacy Practices ("NPP"). Copies of Highmark's current NPP are available on the Highmark internet site or from the Highmark Privacy Office.

At its sole discretion, the Plan may make available, either directly or through a designated vendor, Member identity theft protection services. Any decision to accept or not accept such services will not affect the continued eligibility, benefits, premiums or cost-sharing of the Member under this Agreement. The Plan shall not be liable for, and the Member shall hold the Plan harmless from, any matters arising from or relating to such services.

M. REPORTS AND RECORDS

Each Member, in connection with the administration of, or delivery or receipt of benefits under this Agreement a) authorizes any insurer, employer, organization and health care service Provider to release to the Plan all personal health information relating to past, present and future health care examinations, treatments and diagnoses and b) authorizes the Plan to release the personal health information described above, including medical records, claims, benefits and other administrative data to insurers, health care service providers, and outside vendors.

The information will only be released in connection with the following purposes: treatment decisions, appeals, complaints and grievances, coordination of care, quality assessment and measurement, quality improvement, preventive measures, audits, utilization management, case management, pharmacy management, physician review, research, fraud investigations, reviews by regulatory and accrediting bodies, claims processing, billing and reimbursement.

Each Member further agrees that approval by the Plan of benefits for any services rendered under this Agreement is contingent upon the furnishing of such information or records or copies of records.

The Member is responsible for maintaining all claims information and correspondence. If the Member requests claims information from the Plan with an incurred date of more than twelve (12) months prior to the request, it will be the Member's responsibility to pay for the cost of retrieval of such information.

N. REQUIRED PROVISIONS

1. Entire Agreement; Changes

This Agreement, the Member's application and any Endorsements, the Outline of

Coverage, the Member's enrollment confirmation letter and the Member's current Identification Card constitute the entire Agreement between the Member and the Plan. No change in this benefit agreement shall be valid until approved by an executive officer of the Plan and unless such approval be endorsed hereon or attached hereto. No agent or representative of the Plan, other than a Plan officer, may otherwise change this Agreement or waive any of its provisions. All statements made by a Member shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to a claim under this Agreement, unless it is contained in a written instrument signed by and furnished to the Member.

2. **Time Limit On Certain Defenses**

After three (3) years from the date of issue of this Agreement, no misstatements, except intentional misrepresentations of material fact or fraudulent misstatements, made by the Member in the application for such Agreement shall be used to void the Agreement or to deny a claim for loss incurred or disability commencing after the expiration of such three (3)-year period.

Intentional misrepresentations of material fact or fraudulent misstatements will, at the option of the Plan, render this Agreement void from inception, provided such material misrepresentations or misstatements are discovered by the Plan within three (3) years of the Effective Date. In the event the Plan elects to void this Agreement, the Member will be given at least thirty (30) days advance written notice and will forfeit any charges paid to the extent of any liability incurred by the Plan.

3. **Grace Period**

A grace period of thirty-one (31) days from the due date will be granted for the payment of each premium. During the grace period, the Agreement will stay in force; however, no benefits will be paid for services Incurred subsequent to the Agreement's then current paid date. If appropriate payment is not received at the end of thirty-one (31) days, this Agreement automatically terminates as of the then current paid date without written notification to the Member.

4. **Reinstatement**

If this Agreement is terminated due solely to nonpayment of the premium, coverage will be reinstated if the Member, within thirty-six (36) days from the end of the Grace Period, tenders and the Plan receives payment of the premium required for reinstatement. The Member(s) and the Plan have the same rights under the reinstated Agreement as they had under the Agreement immediately before the due date of the defaulted premium. The right of the Member to have this Agreement reinstated is limited to one (1) reinstatement during any twelve (12)-month period and to two (2) reinstatements during the Member's lifetime.

5. **Notice of Claim and Proof of Loss**

Network and Participating Providers have entered into an agreement with the Plan pertaining to the payment for Covered Services rendered to a Member. When a Member receives Covered Services from a Network or Participating Provider, it is the responsibility of the Network or Participating Provider to submit its claim to the Plan in accordance with the terms of its participation agreement. Should the Network or Participating Provider fail to submit its claim in a timely manner or otherwise satisfy the Plan's requirements as they relate to the filing of claims, the Member will not be liable and the Network or Participating Provider shall hold the Member harmless relative to payment of the Covered Services received by the Member. If for any reason the Member is required to submit a claim to the Plan, the Member must submit that claim in accordance with the following procedures:

a. Notice of Claim

The Plan will not be liable for any claims under this Agreement unless proper notice is furnished to the Plan that Covered Services in this Agreement have been rendered to a Member. Written notice of a claim must be given to the Plan within twenty (20) days or as soon as reasonably possible after Covered Services have been rendered to the Member. Notice given by or on behalf of the Member to the Plan that includes information sufficient to identify the Member that received the Covered Services shall constitute sufficient notice of a claim to the Plan. The Member can give notice to the Plan by writing to the Member Service Department. The address of the Member Service Department can be found on the Member's Identification Card. A charge shall be considered Incurred on the date a Member receives the Service or product for which the charge is made.

b. Claim Forms

Proof of loss for benefits under this Agreement must be submitted to the Plan on the appropriate claim form. The Plan, upon receipt of a notice of a claim will, within fifteen (15) days following the date a notice of a claim is received, furnish to the Member claim forms for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of such notice, the Member shall be deemed to have complied with the requirements of this Paragraph as to filing a proof of loss upon submitting, within the time fixed in this Paragraph for filing proofs of loss, itemized bills for Covered Services as described below. The proof of loss may be submitted to the Plan at the address appearing on the Member's Identification Card.

c. Proof of Loss

Claims cannot be paid until a written proof of loss is submitted to the Plan. Written proof of loss must be provided to the Plan within ninety (90) days after the date of such loss. Proof of loss must include all data necessary for the Plan to determine benefits. Failure to submit a proof of loss to the Plan within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss was submitted

as soon as reasonably possible, but in no event, except in the absence of legal capacity, will the Plan be required to accept a proof of loss later than one (1) year from the time proof is otherwise required.

d. Submission of Claim Forms

The completed claim form, with all itemized bills attached, must be forwarded to the Plan at the address appearing on the Member's Identification Card in order to satisfy the requirement of submitting a written proof of loss and to receive payment for benefits provided under this Agreement.

To avoid delay in handling Member-submitted claims, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing:

Person or organization providing the Service or product
Type of Service or product
Date of Service or product
Amount charged
Name of patient

Professional Provider bills must show specific treatment dates. The Member's Provider must certify that he/she prescribed all Services by signing his/her name on all bills. Itemized bills cannot be returned.

A request for payment of a claim will not be reviewed and no payment will be made unless all of the information and evidence of payment required on the claim form has been submitted in the manner described above. The Plan reserves the right to require additional information and documents as needed to support a claim that a Covered Service has been rendered.

Notice of the Plan's claim determination will be issued within a reasonable period of time not to exceed thirty (30) days following the receipt of a proper proof of loss. This period of time may be extended one (1) time by the Plan for an additional period of time not to exceed fifteen (15) days provided the extension is due to matters outside the control of the Plan and a written explanation for the delay is provided to the Member.

In the event that the Plan renders an adverse decision on the claim, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement describing the right of the Member to file an appeal.

e. Time of Payment of Claims

Claim payments for benefits payable under this Agreement will be processed immediately upon receipt of a proper proof of loss.

f. Authorized Representative

Nothing in this Paragraph shall preclude a duly authorized representative of the Member from filing or otherwise pursuing a claim on behalf of the Member. The Plan reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of the Member.

6. **Physical Examinations and Autopsy**

The Plan, at its own expense, shall have the right and opportunity to examine the person of the Member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

7. **Legal Actions**

No action at law or in equity shall be brought to recover on this Agreement prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Agreement. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

O. TERMINATION OF THE MEMBER'S COVERAGE UNDER THE AGREEMENT

1. This Agreement may be terminated by the Member by giving appropriate written notice to the Plan. In such case, the termination effective date shall be the first of the month following the date of the request for termination. The right of the Member to terminate this Agreement may only be made once the period of enrollment under this Agreement has been in effect for a minimum of six (6) months.

2. This Agreement is renewable at the option of the Plan. The Plan may notify the Member, in writing, of its decision not to renew coverage under the Agreement in which case coverage shall terminate on the last day of the month for which premium has been accepted.

3. This Agreement may also be terminated by the Plan in the following instances:

   a. If payment of the appropriate premium is not made when due, or during the grace period, coverage will terminate on the last day of the grace period unless an earlier date is required by law.

   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), coverage will terminate immediately.

c. If the Member is no longer eligible for coverage as set forth in **SECTION SE – SCHEDULE OF ELIGIBILITY** of this Agreement.

4. If this Agreement is terminated at the option of either party, the Plan shall refund to the Member the amount of any unearned prepaid premium held by the Plan. Unearned prepaid premium in any amount less than one ($1.00) dollar shall not be refunded unless specifically requested by the Member.