Highmark Inc., d/b/a

HIGHMARK BLUE SHIELD

An independent licensee of the Blue Cross Blue Shield Association
(hereinafter called "the Plan")

1800 Center Street
Camp Hill, Pennsylvania 17011

WHOLE HEALTH BALANCE SUBSCRIPTION AGREEMENT

("Agreement")

Required Outline of Coverage

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 the 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

If you speak English, language assistance services, free of charge, are available to you. Call 1-800-876-7639.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-800-876-7639.

如果您说中文，可向您提供免费语言协助服务。 請致電 1-800-876-7639.

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-800-876-7639.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-800-876-7639 로 전화.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-800-876-7639.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-800-876-7639.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-800-876-7639.

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-800-876-7639.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-800-876-7639.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-800-876-7639.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-800-876-7639.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-800-876-7639.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.

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。 1-800-876-7639 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-800-876-7639 .

I. **READ YOUR AGREEMENT CAREFULLY** - This outline provides a very brief description of the important features of your Agreement. This is not the insurance contract and only the actual Agreement provisions will control. The Agreement itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR AGREEMENT CAREFULLY!

II. **LIMITED BENEFIT PLAN COVERAGE** - Agreements of this category are designed to provide limited benefits. Coverage is subject to cost-sharing in the form of copayments. Some benefits are also subject to dollar or benefit frequency limitations.

Under this Agreement, benefits for covered dental services must be received from the United Concordia Advantage Plus Provider Network. Covered vision services and products must be received from the Davis Vision Provider Network. Covered hearing aids and services must be received from TruHearing and fitness and wellness education services are only available from participating fitness centers as identified by the Plan.

III. **A BRIEF DESCRIPTION OF THE BENEFITS COVERED UNDER THE AGREEMENT IS AS FOLLOWS:**

A. ***Dental*** - includes routine dental examination and cleanings. X-ray examinations are also covered.

B. ***Fitness and Wellness Education*** - include access to participating fitness centers and wellness educational programs designed to promote better health, injury prevention and other healthy daily living habits.

C. ***Hearing Aids and Services*** - includes annual routine hearing examination, hearing aids and batteries.

D. ***Vision Services*** – includes annual vision examination and eyeglasses or contact lenses.

E. ***Benefit Amounts, Durations, Limits, Deductibles and Coinsurance for Benefits Under the Agreement*** -

1. **Payment of Benefits**

   Benefit amounts are determined based on the plan allowance for covered services. The plan allowance is the allowance that the Plan utilizes to represent the value of covered services provided to a member based on the type of service and the provider who renders such service, or as required by law. The plan allowance is the portion of the provider's billed charge that is used by the Plan to calculate the Plan's payment to that provider.

2. **Schedule**

   Subject to the exclusions, conditions, and limitations of the Agreement, a Member is entitled to benefits for covered services as set forth in this Schedule during a benefit period. Benefits are subject to applicable copayments and/or dollar or frequency maximums apply in the amounts described in this Paragraph.

   a. *Benefit Period* - the specified period of time during which charges for covered services must be incurred in order to be eligible for payment by the Plan. For this program, the benefit period is a calendar year. A member's effective date is the date on which coverage under this program commences for the member.

   b. *Covered Services*

      Benefits for covered services are based upon the Plan Allowance for those covered services and products listed in this Schedule. See **SECTION SB - SCHEDULE OF BENEFITS** and **SECTION DB - DESCRIPTION OF BENEFITS** in the Agreement for further explanation and additional limitations.

      Subject to the provisions of the Agreement, a Member is responsible for payment of any copayment amounts due to the Provider after the amounts paid by the Plan hereunder.

      The payment amount is based on the Plan Allowance at the time Services or products are rendered or received. The payments to a provider may be adjusted from time to time based on settlements with the providers. Such adjustments will not affect the member's copayment obligation or applicable benefit maximums.

COVERED SERVICES	NETWORK SERVICES
1) **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
2) **FITNESS AND WELLNESS EDUCATION**	100% Plan Allowance
3) **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

COVERED SERVICES	NETWORK SERVICES
	$699 Copayment for each covered TruHearing Advanced level hearing aid device
	$999 Copayment for each covered TruHearing 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
4) **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
	Limited to the choice between one (1) pair of standard plastic eyeglass lenses and frames or a supply of contact lenses every calendar year
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

IV. EXCEPTIONS, REDUCTIONS, AND LIMITATIONS OF THE AGREEMENT

A. ***Maximums*** **-**

B. ***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 and products covered under the Agreement. Plan allowance is set forth in Section III, Subsection *E.* ***Benefit Amounts, Durations, Limits, Deductibles and Coinsurance for Benefits Under the Agreement***.

1. **Plan Payment**

   The Plan's payment is determined by first subtracting any copayment from the plan allowance, subject to any applicable dollar maximum.

2. **Member Liability**

   The member's total liability is the sum of any copayment and/or the amount by which charges exceed any dollar benefit maximum. 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.

C. ***Exclusions*** - Except as specifically provided in the 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 in the Agreement;
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.

V. TERMS AND CONDITIONS OF THE RENEWABILITY OF THE AGREEMENT

A. ***Renewable at Option of Company*** - The Agreement is renewable at the option of the Plan. 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 Subscriber or the Plan in accordance with the terms of the Agreement. Non-renewal shall not be based on the deterioration of mental or physical health of any individual covered under this Agreement.

B. ***Termination -***

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 the 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.

C. ***Modification/Premium Subject to Change*** - The Plan, subject to the approval of the Pennsylvania Insurance Department, may alter or revise the terms of the Agreement or the premiums. Any such alteration or revision of the terms of the Agreement shall become applicable for all members on the effective date of the alteration or revision, whether or not the subscriber has paid the premium in advance.