

AMENDMENT TO YOUR PPO AGREEMENT

QCC INSURANCE COMPANY

This Notice of Change is issued to form part of your Benefit Booklet that describes Health Benefit Plan's or Claims Administrator's (as applicable) PPO Health Benefits Program, a Preferred Provider Organization Health Care Program.

This Notice changes the language that describes the provisions, conditions or other terms of the Benefit Booklet as detailed below.

Effective January 1, 2015:

- I. If applicable, the last sentence of the last paragraph of the Cover page of your Benefit Booklet is replaced with the following:

Failure to obtain Precertification for services provided by a BlueCard PPO Provider (excluding Inpatient Admissions) or an Out-of-Network Provider will result in a 20% reduction in benefits.

- II. If applicable, the sentence which begins "When the Member seeks treatment from an Out-of-Network..." contained in the **INFORMATION ABOUT PROVIDER REIMBURSEMENT** subsection of the **GENERAL INFORMATION** section is replaced with the following:

When the Member seeks treatment from an Out-of-Network Provider or a BlueCard PPO Provider (excluding Inpatient Admissions), the Member is responsible for initiating the Precertification process.

- III. If applicable, the sentence which begins "When the Member seeks medical treatment that requires Precertification..." contained in the **INFORMATION ABOUT PROVIDER REIMBURSEMENT** subsection of the **GENERAL INFORMATION** section is replaced with the following:

When the Member seeks medical treatment that requires Precertification (excluding Inpatient Admissions), the Member must ask their Provider to initiate the Precertification process.

- IV. The sentence which begins "For Member's located outside the..." contained in the first paragraph of the **Precertification Review** provisions of the **SERVICES AND SUPPLIES REQUIRING PRECERTIFICATION** subsection of the **GENERAL INFORMATION** section is replaced with the following:

For Member's located outside the Health Benefit Plan's or Claims Administrator's (as applicable) PPO Network who are accessing BlueCard PPO Providers, the Member is responsible for initiating or requesting the Provider to initiate the Precertification review (excluding Inpatient Admissions).

- V. The sentence which begins "However, the Member, not the Hospital..." contained in the "Inpatient Pre-Admission Review, In-Network Inpatient Admissions" item of the **Precertification Review** provisions of the **SERVICES AND SUPPLIES REQUIRING**

PRECERTIFICATION subsection of the **GENERAL INFORMATION** section is replaced with the following:

The Hospital, Skilled Nursing Facility or other Facility Provider, is responsible to Precertify an Inpatient Admission under the BlueCard PPO Program.

- VI. The sentence which begins "For an Out-of-Network Inpatient Admission..." contained in the "Inpatient Pre-Admission Review, Out-of-Network Inpatient Admissions" item of the **Precertification Review** provisions of the **SERVICES AND SUPPLIES REQUIRING PRECERTIFICATION** subsection of the **GENERAL INFORMATION** section is replaced with the following:

For an Out-of-Network Inpatient Admission, the Member is responsible to have the admission (other than for an Emergency or maternity admission) certified in advance as an approved admission.

- VII. The "Out-of-Network and BlueCard PPO Provider Admissions" subsection contained in the "Emergency Admission Review" item of the **Precertification Review** provisions of the **SERVICES AND SUPPLIES REQUIRING PRECERTIFICATION** subsection of the **GENERAL INFORMATION** section is replaced with the following:

- Out-of-Network Provider Admissions
 - Members are responsible for notifying the Health Benefit Plan or Claims Administrator (as applicable) of an Out-of-Network Provider Emergency admission within two business days of the admission, or as soon as reasonably possible, as determined by the Health Benefit Plan or Claims Administrator (as applicable).
 - Failure to initiate Emergency admission review will result in a reduction in Covered Expense for Out-of-Network services. Such Penalty, as shown below, will be the sole responsibility of, and payable by, the Member.
 - If the Member elects to remain hospitalized after the Health Benefit Plan or Claims Administrator (as applicable) and the attending Physician have determined that an Inpatient level of care is not Medically Necessary, the Member will be financially liable for non-covered Inpatient charges from the date of notification.

- VIII. The first paragraph of the "In-Network Care" item of the **Other Precertification Requirements** provisions of the **SERVICES AND SUPPLIES REQUIRING PRECERTIFICATION** subsection of the **GENERAL INFORMATION** section is replaced with the following:

In-Network Providers in the Personal Choice Network must contact the Health Benefit Plan or Claims Administrator (as applicable) to initiate Precertification. The Health Benefit Plan or Claims Administrator (as applicable) will verify the results of the Precertification with the Member and with the In-Network Provider. If the In-Network Provider is a BlueCard PPO Provider, however, the Member must initiate Precertification (excluding Inpatient Admissions).

- IX. The first paragraph of the "Out-of-Network Care" item of the **Other Precertification Requirements** provisions of the **SERVICES AND SUPPLIES REQUIRING PRECERTIFICATION** subsection of the **GENERAL INFORMATION** section is replaced with the following:

For Out-of-Network Care and care provided by BlueCard PPO Providers (excluding Inpatient Admissions), the Member is responsible to have the Provider performing the service contact the Health Benefit Plan or Claims Administrator (as applicable) to initiate Precertification. The Health Benefit Plan or Claims Administrator (as applicable) will verify the results of the Precertification with the Member and the Provider.

- X. The first paragraph of the **Precertification Penalty**: provisions of the **SERVICES AND SUPPLIES REQUIRING PRECERTIFICATION** subsection of the **GENERAL INFORMATION** section is replaced with the following:

If the Provider is a BlueCard® PPO Provider of another Blue Plan (excluding Inpatient Admissions) or the Member uses an Out-of-Network Provider, the Member must obtain Precertification if required. The Member will be subject to a 20% reduction in benefits if Precertification is not obtained.

- XI. The **Subrogation** provisions of the **COORDINATION OF BENEFITS** subsection of the **GENERAL INFORMATION** section is replaced with the following:

SUBROGATION AND REIMBURSEMENT RIGHTS

By accepting benefits for Covered Services, the Member agrees that the Health Benefit Plan or Claims Administrator (as applicable) has the right to enforce subrogation and reimbursement rights. This section explains these rights and the responsibilities of each Member pertaining to subrogation and reimbursement. The term Member includes Eligible Dependents. The term Responsible Third Party refers to any person or entity, including any insurance company, health benefits plan or other third party, that has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to the Member for an injury or illness.

The Health Benefit Plan or Claims Administrator (as applicable) or the Plan Administrator, as applicable, retains full discretionary authority to interpret and apply these subrogation and reimbursement rights based on the facts presented.

Subrogation Rights

Subrogation rights arise when the Health Benefit Plan or Claims Administrator (as applicable) pays benefits on behalf of a Member and the Member has a right to receive damages, compensation, benefits or payments of any kind (whether by a court judgment, settlement or otherwise) from a Responsible Third Party. The Health Benefit Plan or Claims Administrator (as applicable) is subrogated to the Member's right to recover from the Responsible Third Party. This means that the Health Benefit Plan or Claims Administrator (as applicable) "stands in your shoes" - and assumes the Member's right to pursue and receive the damages, compensation, benefits or payments from the Responsible Third Party to the full extent that the Health Benefit Plan or Claims Administrator (as applicable) has reimbursed the Member for medical expenses or paid medical expenses on the Member's behalf, plus the costs and fees that are incurred by the Health Benefit Plan or Claims Administrator (as applicable) to enforce these rights. The right to pursue a subrogation claim is not contingent upon whether or not the Member pursues the Responsible Third Party for any recovery.

Reimbursement Rights

If a Member obtains any recovery - regardless of how it's described or structured - from a Responsible Third Party, the Member must fully reimburse the Health Benefit Plan or Claims Administrator (as applicable) for all medical expenses that were paid to the Member or on the Member's behalf, plus the costs and fees that are incurred by the Health Benefit Plan or Claims Administrator (as applicable) to enforce these rights. The Health Benefit Plan or Claims Administrator (as applicable) has a right to full reimbursement.

Lien

By accepting benefits for Covered Services from the Health Benefit Plan or Claims Administrator (as applicable), the Member agrees to a first priority equitable lien by agreement on any payment, reimbursement, settlement or judgment received by the Member, or anyone acting on the Member's behalf, from any Responsible Third Party. As a result, the Member must repay to the Health Benefit Plan or Claims Administrator (as applicable) the full amount of the medical expenses that were paid to the Member or on the Member's behalf out of the amounts recovered from the Responsible Third Party (plus the costs and fees that are incurred by the Health Benefit Plan or Claims Administrator (as applicable) to enforce these rights) first, before funds are allotted toward any other form of damages, whether or not there is an admission of fault or liability by the Responsible Third Party. The Health Benefit Plan or Claims Administrator (as applicable) has a lien on any amounts recovered by the Member from a Responsible Third Party, regardless of whether or not the amount is designated as payment for medical expenses. This lien will remain in effect until the Health Benefit Plan or Claims Administrator (as applicable) is reimbursed in full.

Constructive Trust

If the Member (or anyone acting on the Member's behalf) receive damages, compensation, benefits or payments of any type from a Responsible Third Party (whether by a court judgment, settlement or otherwise), the Member agrees to maintain the funds in a separate, identifiable account and that the Health Benefit Plan or Claims Administrator (as applicable) has a lien on the monies. In addition the Member agrees to serve as the trustee over the monies for the benefit of Health Benefit Plan or Claims Administrator (as applicable) to the full extent that the Health Benefit Plan or Claims Administrator (as applicable) has reimbursed the Member for medical expenses or paid medical expenses on the member's behalf, plus the attorney's fees and the costs of collection incurred by the Health Benefit Plan or Claims Administrator (as applicable).

- These subrogation and reimbursement rights apply regardless of whether money is received through a court decision, settlement, or any other type of resolution.
- These subrogation and reimbursement rights apply even if the recovery is designated or described as covering damages other than medical expenses (such as property damage or pain and suffering).
- These subrogation and reimbursement rights apply with respect to any recoveries made by the Member, including amounts recovered under an uninsured or underinsured motorist policy.
- The Health Benefit Plan or Claims Administrator (as applicable) is entitled to recover the full amount of the benefits paid to the Member or on the Member's behalf plus the costs and fees that are incurred by the Health Benefit Plan or Claims Administrator (as applicable) to enforce these rights without regard to whether the Member has been made whole or received full compensation for other damages (including property damage or pain and suffering). The recovery rights of the Health Benefit Plan or

Claims Administrator (as applicable) will not be reduced by the "made whole" doctrine or "double recovery" doctrine.

- The Health Benefit Plan or Claims Administrator (as applicable) will not pay, offset any recovery, or in any way be responsible for attorneys' fees or costs associated with pursuing a claim against a Responsible Third Party unless the Health Benefit Plan or Claims Administrator (as applicable) agrees to do so in writing. The recovery rights of the Health Benefit Plan or Claims Administrator (as applicable) will not be reduced by the "common fund" doctrine.
- In addition to any Coordination of Benefits rules described in this Benefit Booklet, the benefits paid by the Health Benefit Plan or Claims Administrator (as applicable) will be secondary to any no-fault auto insurance benefits and to any worker's compensation benefits (no matter how any settlement or award is characterized) to the fullest extent permitted by law.
- These subrogation and reimbursement rights apply and will not be decreased, restricted, or eliminated in any way if the Member receives or has the right to recover no-fault insurance benefits. All rights under this section are enforceable against the heirs, estate, legal guardians or legal representatives of the Member.
- The Health Benefit Plan or Claims Administrator (as applicable) is entitled to recover the full amount of the medical benefits paid without regard to any claim of fault on the Member's part.

Obligations of Member

- Immediately notify the Health Benefit Plan or Claims Administrator (as applicable) or its designee in writing if the Member asserts a claim against a Responsible Third Party, whether informally or through judicial or administrative proceedings.
- Immediately notify the Health Benefit Plan or Claims Administrator (as applicable) or its designee in writing whenever a Responsible Third Party contacts the Member or the Member's representative - or the Member or the Member's representative contact a Responsible Third Party - to discuss a potential settlement or resolution.
- Refuse any offer to settle, adjust or resolve a claim for damages, benefits or compensation that involves an injury, illness or medical expenses in any way, unless and until the Member receives written authorization from the Health Benefit Plan or Claims Administrator (as applicable) or its delegated representative.
- Fully cooperate with the Health Benefit Plan or Claims Administrator (as applicable) and its designated representative, as needed, to allow for the enforcement of these subrogation and reimbursement rights and promptly supply information/documentation when requested and promptly execute any and all forms/documents that may be needed.
- Avoid taking any action that may prejudice or harm the Health Benefit Plan's or Claims Administrator's (as applicable) ability to enforce these subrogation and reimbursement rights to the fullest extent possible.
- Fully reimburse the Health Benefit Plan or Claims Administrator (as applicable) or its designated representative immediately upon receiving compensation of any kind (whether by court judgment, settlement or otherwise) from a Responsible Third Party.
- Serve as trustee for any and all monies paid to (or payable to) the Member or for the Member's benefit by any Responsible Third Party to the full extent the Health Benefit Plan or Claims Administrator (as applicable) paid benefits for an injury or illness.
- All of these Obligations apply to the heirs, estate, legal guardians or legal representatives of the Member.

Applicable to Self-Insured groups only:

IMPORTANT: Failure to Cooperate

If the Member fails or refuses to sign forms or documents as requested or otherwise fail or refuse to cooperate or abide by any of the obligations described above, the Claims Administrator or Plan Administrator, as applicable, has full discretion and authority to reduce or withhold benefit payments to recover subrogation/reimbursement amounts that are owed and/or to terminate the Member's participation in the Program.

All other terms of your Benefit Booklet shall remain in effect.

A handwritten signature in black ink, appearing to read "Brian Lobley", with a horizontal line underneath the signature.

Brian Lobley
Senior Vice President
Marketing & Consumer Business