ENDORSEMENT TO THE  
MEDICAL – SURGICAL BENEFITS  
CONTRACT FOR DIRECT  
PAYMENT SUBSCRIBERS  

Providing for the Amendment of this contract to  
conform with the provisions of the  
Patient Protection and Affordable Care Act of 2010.  

This Endorsement is issued to be attached to and form part of the Highmark Blue Shield Medical – Surgical Benefits Contract for Direct Payment Subscribers identified as the “SpecialCare Program” (“Contract”), Form No. 7122-3A, Form No. 7122-1B, and Form No. 4122-B.

Notwithstanding any provisions to the contrary, said Contracts are modified as indicated:

I. Medical–Surgical Expense Coverage, Required Outline of Coverage, is hereby amended as follows:

A. By adding the following Professional Providers to the enumerated list of providers in Subsection (3):

   “clinical social worker, marriage and family therapist, professional counselor, and occupational therapist.”

B. By adding the following paragraphs to Subsection (3)(r) Preventive Benefits:

   “Adult Care. Routine adult physical examination benefits are exempt from all Deductibles.

   Adult Immunizations. Adult immunization benefits are exempt from all Deductibles; however, adult immunizations required by an employer are subject to the Deductible.

   Mammographic Screening. Mammographic screening benefits are exempt from all Deductibles and Maximums.

   Pediatric Care. Routine pediatric physical examination benefits are exempt from all Deductibles."
Pediatric Immunizations. Pediatric immunization benefits are exempt from all Deductibles and Maximums.

Routine Gynecological Examination and Papanicolaou Smear. Routine gynecological benefits are exempt from all Deductibles.”

C. By adding the following new language to Subsection (4)(o):

“The Pre-existing Condition Exclusion Period will not be imposed on any Subscriber or Dependent under the age of nineteen (19).”

D. By deleting Subsection (4)(t), in its entirety, and replacing it with the following:

“Treatment of obesity, except for surgical treatment of morbid obesity when weight is at least twice the ideal weight specified for frame, age, height and sex or as otherwise provided in the predefined schedule described in Section III. PREVENTIVE BENEFITS.”

E. By deleting Subsection (4)(y), in its entirety, and replacing it with the following.

“Preventive pediatric care, except for the benefits set forth in Section III. PREVENTIVE BENEFITS.”

F. By deleting Subsection (5)(a)2, in its entirety, and replacing it with the following.

“2. if it is proven that the Subscriber committed fraud or made a material intentional misrepresentation in the application for coverage under this Contract. However, the Plan will not terminate this Contract because of the Subscriber’s Medically Necessary and Appropriate utilization of services covered under this Contract;”

II. Pre-Policy Section, IMPORTANT, PRE-EXISTING CONDITION, is hereby deleted, in its entirety, and replaced with the following:

“Benefits for pre-existing conditions will not be available for services furnished to a Subscriber during the twelve-month period following the date on which such Subscriber is first covered under the Contract except for a Child under the age of nineteen (19) and Group Conversion Subscribers who have been continuously enrolled under the Contract from the date the Contract was effective for the Applicant. However, if such Subscriber was covered under another contract issued by the Plan which the Contract replaces without lapse, the twelve-month waiting period shall be reduced by any period of time during which the Subscriber was enrolled under such previous contract. The term pre-existing means a condition for which medical advise or treatment was recommended by a physician or received from a physician within a one-year time period preceding the effective date of the coverage of the Subscriber.”
III. **Pre-Policy Section, IMPORTANT, ENROLLMENT ELIGIBILITY PROVISIONS,**
is hereby deleted, in its entirety, and replaced with the following:

“This program of health care benefits is available to Pennsylvania residents who reside within the geographical area served by the Plan. Eligibility for the program is based on family income guidelines established by the Plan. Except for a Child under the age of twenty-six (26), any individual eligible for any governmental program is ineligible for enrollment under Special Care. Any Individual, regardless of age, enrolled in any private group health care plan or program is ineligible for enrollment under Special Care except in cases where an individual’s income does not exceed guidelines and such individual would otherwise be uninsured.

As a requirement of initial enrollment into this program, the Applicant and the spouse of the Applicant agree to provide certification to the Plan that their income does not exceed the income established by the Plan for their corresponding family size. Additionally, the Applicant and the spouse of the Applicant must provide written certification that they, as well as their eligible dependents, are not enrolled or eligible for any other health plan, as defined above.

The Applicant and the spouse of the Applicant also agree to submit any documentation as may be reasonably requested by the Plan to periodically re-certify their (and their Dependents’, if applicable) income. The Applicant further agrees to notify the Plan at the time of any change in income that would change such eligibility status so the Plan may determine eligibility for the appropriate subscription rate.

Determination by the Plan of enrollment eligibility and the applicable subscription rate is conclusive.”

IV. **Section I. DEFINITIONS,** is hereby amended as follows:

A. By deleting Subsection 30. **PROFESSIONAL PRE-SURGICAL CERTIFICATION**, in its entirety, and replacing it with the following:

“**CLAIM**

“Claim” means a request made by or on behalf of a Subscriber for pre-certification or prior approval of a Covered Service, as required under this Contract for the payment or reimbursement of the charges or costs associated with a Covered Service that has been received by a Subscriber. Claims for benefits provided under this Contract include:

A. Pre-service Claim:

“Pre-service Claim” means a request for pre-certification or prior approval of a Covered Service which, as a condition to the payment of benefits under this Contract, must be approved by the Plan before the Covered Service is received by the Subscriber.
B. Urgent Care Claim:

“Urgent Care Claim” means a Pre-service claim which, if decided within the time periods established by the Plan for making non-urgent care Pre-service Claim decisions, could seriously jeopardize the life or health of the Subscriber, the ability of the Subscriber to regain maximum function or, in the opinion of a physician with knowledge of the Subscriber’s medical condition, would subject the Subscriber to severe pain that cannot be adequately managed without the service requested.

C. Post-service Claim

“Post-service Claim” means a request for payment or reimbursement of the charges and costs associated with a Covered Service that has been received by a Subscriber.

For purposes of the Claim determination and approval procedure provisions of this Contract, whether a Claim or an appeal of a denied Claim involves a Pre-service, an Urgent Care Claim or a Post-service Claim will be determined at the time that the Claim or appeal is filed with the Plan in accordance with its procedures for filing Claims and appeals.”

B. By deleting Subsection 33. SUBSCRIBER, Paragraph D. CHILD, in its entirety, and replacing it with the following:

“CHILD – “Child” means a child, including a newborn, a stepchild, a child legally placed for adoption, and a legally adopted child, of the Applicant or the Applicant’s spouse, or any other whom the Applicant or the Applicant’s spouse is a legal guardian. The limiting age for coverage of a child shall be to the end of the month in which the child reaches the age of twenty-six (26). Eligibility will be continued past the limiting age for an unmarried child who is incapable of self-support because of mental retardation, physical handicap, mental illness, or developmental disability that occurs prior to age twenty-six (26) and is medically certified by a Physician. The Plan may require proof of such Subscriber’s disability from time to time.”

V. Section II. MEDICAL-SURGICAL BENEFITS, is hereby amended as follows:

A. By deleting Section II. MEDICAL-SURGICAL BENEFITS, Subsection 14. DIAGNOSTIC SERVICES, in its entirety, and replacing it with the following:

“DIAGNOSTIC SERVICES:

A. Benefits for Covered Services are provided when the Subscriber requires a Medically Necessary and Appropriate diagnostic procedure.
A diagnostic procedure is one to which the Subscriber is subjected, or which is performed on materials derived from the Subscriber, to obtain information to aid in the assessment of a medical condition or the identification of a disease.”

B. By adding the following new paragraph to Section II. MEDICAL-SURGICAL BENEFITS, Subsection 14:

“The following Diagnostic Services are excluded under this Contract:

- Board and general nursing care regularly provided for an Inpatient;
- Allergy testing, except as set forth in Section III – PREVENTIVE BENEFITS;
- Audiometric testing;
- Eye refractions;
- Examinations for the fitting of eyeglasses, contact lenses, or hearing aids;
- Psychiatric examinations;
- Psychological testing;
- Dental examinations;
- Premarital examinations;
- Research studies;
- Routine physical examinations or check-ups, except as set forth in Section III. PREVENTIVE BENEFITS;
- Cardiac exercise visits;
- Any study determined to be experimental or investigational as defined in Section I. DEFINITIONS and excluded by Section V. EXCLUSIONS.”

VI. Section III – PREVENTIVE BENEFITS, is hereby deleted, in its entirety, and replaced with the following:

“Subject to the Exclusions, conditions and limitations of this Contract, a Member is entitled to benefits for Covered Services when billed by a Professional Provider. Covered Services are payable when performed on an Outpatient basis, unless otherwise indicated in the description.”
All of the below outlined benefits are administered on a calendar year basis.

*This schedule is reviewed and updated periodically by the Plan based on the requirements of the Patient Protection and Affordable Care Act of 2010, as amended, and the advice of the American Academy of Pediatrics, U.S. Preventative Services Task Force, the Blue Cross and Blue Shield Association, and Medical Consultants. Accordingly, the frequency and eligibility of services is subject to change.

A. ADULT CARE

Benefits are provided for routine physical examinations regardless of Medical Necessity and Appropriateness, including a complete medical history, and other items and services in accordance with a predefined schedule* based on age and sex.

Routine adult physical examination benefits are exempt from all Deductibles.

B. ADULT IMMUNIZATIONS

Benefits are provided for adult immunizations when required for the prevention of disease.

Adult immunization benefits are exempt from all Deductibles.

C. MAMMOGRAPHIC SCREENING

One (1) annual routine mammographic screening for all female Members forty (40) years of age or older.

Mammographic examination for all female Members regardless of age when such Services are prescribed by a Physician.

Mammographic screening benefits are exempt from all Deductibles. Benefits for Mammographic Screening are payable only if performed by a Mammography Service provider who is properly certified by the Pennsylvania Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

D. PEDIATRIC CARE

Benefits are provided for routine physical examinations regardless of Medical Necessity and Appropriateness, and other items and services, in accordance with a predefined schedule* based on age and sex.

Routine pediatric physical examination benefits are exempt from all Deductibles.
E. PEDIATRIC IMMUNIZATIONS

Coverage will be provided to Subscribers under twenty-one (21) years of age for those pediatric immunizations, including immunizing agents, which, as determined by the Pennsylvania Department of Health, conform with the standards of the Advisory Committee on Immunizations Practices of the Center for Disease Control, and the U.S. Department of Health and Human Services in accordance with a predefined schedule*.

Pediatric immunization benefits are exempt from all Deductibles and Maximums.

F. ROUTINE GYNECOLOGICAL AND PAPANICOLAOU SMEAR

Benefits are provided for one (1) routine gynecological examination, including a pelvic examination and clinical breast examination and one (1) routine Papanicolaou Smear per calendar year for all female Members.

Routine gynecological benefits are exempt from all Deductibles and Maximums.”

VII. Section IV. PRE-SURGICAL CERTIFICATION, Subsection 4, APPEALS PROCEDURES, is hereby amended by adding the following:

“AUTHORIZED REPRESENTATIVE

Nothing in this Subsection shall preclude a duly authorized representative of the Subscriber from filing or otherwise pursuing a pre-certification request or other Pre-service Claim on behalf of a Subscriber. The Plan reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Subscriber. Such procedures as adopted by the Plan shall, in the case of an Urgent Care Claim, permit a physician or other professional provider with knowledge of the Subscriber’s medical condition to act as the Subscriber’s authorized representative.

NOTIFICATION OF PRE-CERTIFICATION AND OTHER PRE-SERVICE CLAIM DETERMINATIONS

Pre-certification of Covered Services, when required under this Contract, and all other Pre-service Claims including requests to extend a previously approved course of treatment will be processed and notice of the Plan’s determination, whether adverse or not, will be given to the Subscriber within the following time frames unless otherwise extended by the Plan for reasons beyond its control:

1. In the case of an Urgent Care Claim, as soon as possible, taking into account the medical exigencies involved, but not later than twenty-four (24) hours following the Plan’s receipt of the Urgent Care Claim. Similarly, when the Urgent Care Claim seeks to extend a previously approved course of treatment and the request is made at least twenty-four (24) hours prior to the expiration of such previously approved course of treatment, notice of the Plan’s determination will be given to
the Subscriber as soon as possible, taking into account the medical exigencies involved, but no later than twenty-four (24) hours following receipt of the request; and

2. In the case of a non-urgent care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days following the Plan’s receipt of the non-urgent care Pre-service Claim.

Notice of the Plan’s approval of a Pre-service Claim will include information sufficient to apprise the Subscriber that the request has been approved. In the event that the Plan renders an adverse determination on a Pre-service Claim, the notification shall include, among other items, the specific reason or reasons for the adverse determination and a statement describing the right of the Subscriber to file an appeal.”

VIII. Section V. EXCLUSIONS, is hereby amended as follows:

A. By adding the following new language to Subsection 19:

“The Pre-existing Condition Exclusion Period will not be imposed on any Subscriber or Dependent under the age of nineteen (19).”

B. By deleting Subsection 25, in its entirety, and replacing it with the following:

“Treatment of obesity, except for surgical treatment of morbid obesity when weight is at least twice the ideal weight specified for frame, age, height and sex or as otherwise provided in the predefined schedule described in Section III, PREVENTIVE BENEFITS.”

IX. Section VI. GENERAL PROVISIONS, is hereby amended as follows:

A. By deleting, in its entirety, Section 2. SUBSCRIBER CONTRACT, Subsection B. TIME LIMIT ON CERTAIN DEFENSES, and replacing it with the following:

“After three (3) years from the date of issue of this Contract, no misstatements, except intentional material misstatements, made by the Applicant in the application for such Contract shall be used to void the Contract or to deny a claim for loss incurred or disability (as defined in the Contract) commencing after the expiration of such three (3) year period.”

B. By deleting Section 2. SUBSCRIBER CONTRACT, Subsection H. VOIDING OF COVERAGE DUE TO MATERIAL MISREPRESENTATIONS, in its entirety, and replacing it with the following:

“Subsection H. VOIDANCE DUE TO INTENTIONAL MISREPRESENTATION:
This Contract shall be rendered null and void, at the Plan’s option, by the occurrence of either of the following events:

(1) If it is proven that the Subscriber committed fraud in the application for coverage under this Contract and such fraud is discovered by the Plan within three (3) years of the Effective Date of the coverage; or

(2) If the Subscriber makes a material intentional misrepresentation in the application for coverage under this Contract and such material intentional misrepresentation is discovered by the Plan within three (3) years of the Effective Date of coverage.

No claim for loss Incurred after one (1) year from the date of issue of this Contract shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of coverage of this Contract.

In the event the Plan elects to void the Contract, the Subscriber will be given at least thirty (30) days advanced written notice and will forfeit any charges paid to the extent of any liability incurred by the Plan.

The Plan shall refund to the Subscriber the amount of the subscription rate paid by the Subscriber after deducting the amount of any benefits paid by the Plan under this Contract.”

C. By adding the following new paragraph to Section 2. SUBSCRIBER CONTRACT, Subsection K. RIGHT OF APPEAL:

“APPEALS PROCEDURE

a. Internal Appeal Process

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

(2) At any time during the appeal process, a Member may choose to designate an authorized representative to participate in the appeal process on his/her behalf. The Member or Member’s authorized representative shall notify the Plan, in writing, of the designation. For purposes of the appeal process, Member included 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. Such procedures as adopted by the Plan shall, in the case of an Urgent Care Claim, permit a Professional Provider with knowledge of the Member’s medical condition to act as the Member’s authorized representative.

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

(3) 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 Contract, 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.

(4) 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.

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 appeal.
(5) Each appeal will be promptly investigated and the Plan will provide written notification of its decision within the following time frames:

i When the appeal involves a non-urgent care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances involved not to exceed thirty (30) days following the receipt of the appeal;

ii When the appeal involves an Urgent Care Claim, as soon as possible taking into account the medical exigencies involved but not later than seventy-two (72) hours following receipt of the appeal; or

iii When the appeal involves a Post-service Claim or decision by the Plan to rescind coverage or deny an enrollment request because the individual is not eligible for coverage, within a reasonable period of time not to exceed thirty (30) days following the receipt of the appeal.

(6) 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 request an external review and/or pursue any applicable legal action.

(7) In the event that the Plan renders an adverse decision on the 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 request an external review and/or pursue any applicable legal action.

b. **External Review Process**

A member will have fifteen (15) days from the receipt of the notice of the Plan’s decision to appeal the denial resulting from the Internal Appeal Process by requesting an external review of the decision. Depending on the nature of the Claim that has been denied or the matter involved, the external review shall follow one of the processes set forth below.

(1) Where the Claim that has been denied or the matter involved relates to the determinations made by the Plan to rescind a Member’s coverage or to deny the enrollment request of an individual due to ineligibility for coverage under this Contract, then the Member shall submit a written
request, unless the Member is required to file the request in an alternative format, for an external review of the decision at the following address:

Pennsylvania Insurance Department  
Bureau of Consumer Services  
1321 Strawberry Square  
Harrisburg, Pennsylvania 17120

All records from the initial review shall be forwarded to the Pennsylvania Insurance Department. Additional material related to the issue which is the subject of the external review may be submitted by the Member, the health care Provider or the Plan. Each shall provide the other, copies of additional documentation provided. The Member may be represented by an attorney or other individual before the Pennsylvania Insurance Department.

(2) Where the Claim that has been denied is based on the Plan’s requirements as to medical necessity, appropriateness, health care setting, level of care or effectiveness of the service, a Member or a health care Provider, with the written consent of the Member, may appeal the denial of the decision by filing a request for an external review with the Plan. The Member should include any material justification and all reasonably necessary supporting information as part of the external review filing.

Within five (5) business days of the filing of the request for an external review, the Plan will notify the Department of Health, the Member or the health care Provider, as appropriate, that an external review request has been filed. The Plan’s notification to the Department of Health shall include a request for an assignment of a Certified Utilization Review Entity (CRE). The Plan shall forward copies of all written documentation regarding the denial, including the decision, all reasonably necessary supporting information, a summary of applicable issues and the basis and clinical rational for the decision to the CRE conducting the external review within fifteen (15) days of the receipt of notice that the external review request was filed. Within the same period, the Plan shall provide the Member or the health care Provider with a list of documents forwarded to the CRE for external review. The Member or the health care Provider may supply additional written information, with copies to the Plan, to the CRE for consideration on the external review within fifteen (15) days of receipt of the notice that the external review request was filed.
The external review will be conducted by a CRE selected by the Department of Health. The Department of Health will notify the Member or the health care Provider, and the Plan of the name, address and telephone number of the CRE assigned within two (2) business days following receipt of the request for assignment. If the Department of Health fails to select a CRE within two (2) business days of receiving the request, the Plan has the right to designate and notify a CRE to conduct the external review.

The CRE conducting the review shall review all the information considered in reaching any prior decisions to deny payment for the health care service and any other written submission by the Member or the health care Provider.

Within sixty (60) days of the filing of the external review, the CRE conducting the external review shall issue a written notification of the decision to the Plan, the Member or the health care Provider, including the basis and clinical rationale for the decision.

The external review decision may be appealed to a court of competent jurisdiction within sixty (60) days of receipt of the notification of the external review decision.

The Plan shall authorize any health care service or pay a Claim determined to be Medically Necessary and Appropriate based on the decision of the CRE regardless of whether an appeal to the court of competent jurisdiction has been filed.

(3) Member Assistance Services

Members may obtain assistance with the Plan’s internal appeal and external review procedures set forth in this Subsection by contacting the Pennsylvania Insurance Department Office of Consumer Services or such other applicable office of health insurance consumer assistance or ombudsman.”

D. By deleting, in its entirety, Section 2. SUBSCRIBER CONTRACT, Subsection L. CLAIM FORM – PROOF OF LOSS, and replacing it with the following:

“CLAIM FORMS (Applies to Post-service Claims Only)
Proof of loss for benefits under this Contract must be submitted to the Plan on the appropriate claim form. The Plan, upon receipt of notice of a claim will, within fifteen (15) days following the date a notice of claim is received, furnish to the Subscriber claim forms for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of such notice, the Subscriber shall be deemed to have complied with the requirements of this Article as to filing a proof of loss upon submitting, within the time fixed in this Article 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 Subscriber’s identification card.

The completed claim form, with all itemized bills attached, must be forwarded to the Plan at the address appearing on the Subscriber’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 Contract.

To avoid delay in handling Subscriber-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 supply
- Type of service or supply
- Date of service or supply
- Amount charged
- Name of patient

In addition to the above, provider bills must show specific treatment dates. The Subscriber’s attending Professional Provider must certify that he/she prescribed all services by signing his/her name on all bills, except doctor bills or Hospital bills. (Some bills requiring signature of the Professional Provider include ambulance, prosthesis devices, etc.) 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 Subscriber.

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 Subscriber to file an appeal.”
E. By adding the following new Subsection to Section 2. SUBSCRIBER CONTRACT:

“NOTICE OF CLAIM (Applies to Post-service Claims Only)

Special Care Professional Providers have entered into an agreement with the Plan pertaining to the payment for Covered Services rendered to the Subscriber. When a Subscriber received Covered Services from a Special Care Professional Provider, it is the responsibility of the Special Care Professional Provider to submit its claim to the Plan in accordance with the terms of its participation agreement. Should the Special Care Professional Provider fail to submit its claim in a timely manner or otherwise satisfy the Plan’s requirements as they relate to the filing of a claims, the Subscriber will not be liable and the Special Care Professional Provider shall hold the Subscriber harmless relative to payment of the Covered Services received by the Subscriber.

When Covered Services are received from other than a Special Care Professional Provider, the Subscriber is responsible for submitting the claim to the Plan. In such instances, the Subscriber must submit the claim in accordance with the procedures set forth in this Section and the Sections pertaining to CLAIM FORMS, PROOF OF LOSS, and TIME OF PAYMENT OF CLAIMS.

The Plan will not be liable for any claims under this Contract unless proper notice is furnished to the Plan that Covered Services in this Contract have been rendered to a Subscriber. 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 Subscriber. Notice given by or on behalf of the Subscriber to the Plan that includes information sufficient to identify the Subscriber that received the Covered Services shall constitute sufficient notice to the Plan. The Subscriber 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 Subscriber’s identification card. A charge shall be considered incurred on the date the Subscriber receives the service or supply for which the charge is made.”

F. By deleting Section 2. SUBSCRIBER CONTRACT, Subsection M. TIME OF PAYMENT, in its entirety, and replacing it with the following:

“TIME OF PAYMENT OF CLAIMS (Applies to Post-service Claims Only)

Claim payments for benefits payable under this Contract will be processed immediately upon receipt of the proper proof of loss.”

G. By adding the following new Subsection to Section 2. SUBSCRIBER CONTRACT:

“PROOF OF LOSS (Applies to Post-service Claims Only)
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 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.”

X. Last Page of Policy, “REMEMBER THAT...”, is hereby deleted, in its entirety, and replaced with the following:

“...coverage for children under the Highmark Blue Shield family Contract ends when they reach age twenty-six (26). If Member rate for coverage extended beyond this date has been paid, coverage for the Child will continue during the period for which the Member rate was paid. In order to continue Highmark Blue Shield coverage without interruption in benefits, application may be made to Highmark Blue Shield no later than thirty-one (31) days following the twenty-sixth birthday.

...if you become divorced, your spouse must be removed from your Contract at the end of the month in which the divorce is final or the end of the period for which Member rate for coverage extending beyond that date was paid. In order to maintain continuous coverage, your former spouse must make application to Highmark Blue Shield no later than thirty-one (31) days after the divorce becomes final.

...if you move out of Pennsylvania, you cannot continue to be covered by Highmark Blue Shield. If you wish, your coverage may be transferred to the local Blue Shield Plan which services the location of your new home.

PRESENT YOUR HIGHMARK BLUE SHIELD IDENTIFICATION CARD TO YOUR PROVIDER WHEN YOU REQUIRE SERVICES AS COVERED HEREIN.

Except as stated in this Endorsement, the Contract remains unchanged.

This Endorsement is effective on October 1, 2010 or the date of issue of your Contract, whichever is later.