

SPECIAL CARE



SM

GUARANTEED RENEWABLE HOSPITAL BENEFITS CONTRACT

For
Direct
Payment
Subscribers

21 Day Program

This Is A Limited Benefit Contract - Read It Carefully



**Independence
Blue Cross**

1901 Market Street • Philadelphia, PA 19103

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INDEPENDENCE BLUE CROSS
1901 MARKET STREET
PHILADELPHIA, PENNSYLVANIA 19103

**SPECIAL CARE HOSPITAL
EXPENSE COVERAGE**

NOTICE OF SUBSCRIBER'S RIGHT TO EXAMINE CONTRACT: You have a right to reject the Contract within 10 days of delivery for refund of the full premium paid if, after examination of the Contract, you are not satisfied for any reason. You may reject this Contract by providing signed written notification to us at the following address: Independence Blue Cross, 1901 Market Street, Philadelphia, PA 19103-1480. If the Contract is rejected it will be null and void from the beginning and no benefits will be payable under its terms.

REQUIRED OUTLINE OF COVERAGE

- (1) Read Your Contract Carefully – This Outline of Coverage provides a very brief description of the important features of your Contract. This outline is not the insurance contract and only the actual Contract provisions will control. The Contract itself sets forth in detail the rights and obligations of both you and Independence Blue Cross. It is, therefore, important that you **READ YOUR CONTRACT CAREFULLY!**
- (2) Limited Basic Hospital Expense Benefit Coverage – Contracts of this category are designed to provide, to persons covered, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for the daily hospital room and board, miscellaneous hospital services, and hospital outpatient services, subject to any limitations set forth in the Contract. Coverage is not provided for physicians' or surgeons' fees or unlimited hospital expenses.

Coverage under this Limited Basic Hospital Expense Benefit Coverage special program under the name of "Special Care" is made available on a periodic basis to Pennsylvania residents who reside within the geographical area served by the Plan, who are ineligible for any private or governmental group health care plan or program, or who would otherwise be uninsured, and who meet established income guidelines. Certification of eligibility is an enrollment requirement.

Benefits under the Contract are provided for Allowed Services exclusively at Special Care Participating Health Care Facilities in accordance with the terms of the Contract. Non-Participating Health Care Facilities may not be used except for Emergency Care. Benefits under the Contract for Emergency Services rendered at Non-Participating Health Care Facilities are provided as set forth in Article II, Section 8, of the Contract.

This is a Non-Participating contract.

A complete Managed Care Program requires review prior to use of specified services to determine the medical necessity and appropriateness of the proposed services. Failure to notify the Plans' precertification program administrator, Independence Healthcare Management, Inc., of an emergency admission to a Non Participating Health Care Facility as specified in the Managed Care section of the Contract will result in a penalty.

(3) A brief description of the benefits contained in the Contract is as follows:

- (a) Daily hospital room and board: up to twenty-one (21) total days per benefit period in semi-private or critical care accommodations.

THE TWENTY-ONE (21) DAYS OF INPATIENT CARE ARE AVAILABLE IN EACH BENEFIT PERIOD. A NEW BENEFIT PERIOD WILL OCCUR ONLY AFTER 90 CONSECUTIVE DAYS HAVE ELAPSED DURING WHICH THE SUBSCRIBER WAS NOT AN INPATIENT IN ANY HEALTH CARE FACILITY.

Benefit payment for Inpatient days stated above is provided in accordance with the category of the institution as follows:

1. In a Special Care Participating Health Care Facility, Allowed Services are covered in accordance with the terms of the Contract.
 2. In a Non-Participating Health Care Facility, benefits for an Emergency Admission only shall be provided. No benefits are provided for a Non-Emergency Admission. The amount to be paid by the Plan for each visit, stay or procedure shall be an amount determined from time to time by the Plan and approved by the Department of Insurance of the Commonwealth of Pennsylvania.
- (b) Miscellaneous Hospital Services: including meals, use of medical equipment and specialty rooms, transplant services, and other usual and customary Allowed Services not specifically excluded by the Contract.
- (c) Ambulatory Services: initial emergency services for accidental injury; medical emergencies; surgery of a non-oral nature; diagnostic services (limited to \$1,000 per Subscriber, per Calendar Year); specified oral surgery; chemotherapy; and radiation therapy.
- (d) Coverage for Newborn Care.
- (e) Preventive Services:
1. pediatric immunizations for Subscribers under age 21, and for Dependent Children of Subscribers;
 2. benefits are also available for one routine gynecological examination including a pelvic examination, clinical breast examination, and routine Papanicolaou Smear in accordance with the recommendations of the American College of Obstetricians and Gynecologists per calendar year for all female subscribers, and an annual Mammogram beginning at age 40, and for any physician recommended mammogram for women under age 40. Benefits for mammography screening are payable only if performed by a mammography service provider who is properly certified by the Department of Health in accordance with the Mammography Quality Assurance Act of 1992.
- (f) Coverage for Transplant Services.
- (g) Coverage for mastectomy and breast reconstruction following mastectomy.

- (h) Maternity Benefits – Hospital or Birthing Center: Coverage for prenatal, labor, delivery and postpartum care.
- (4) 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 newborn children, 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 advice or treatment was recommended by a physician or received from a physician within a one-year period preceding the effective date of the coverage of the Subscriber.
- (5) Benefits will be provided under the Contract only for services which are Medically Necessary and Appropriate. "Medically Necessary and Appropriate" (or Medical Appropriateness) means that the benefits under the Contract for Allowed services by an Approved Health Care Facility will be provided only when and as long as such services are determined by the Plan or its designated agent to be:
 - (a) appropriate for the symptoms and diagnosis or treatment of the Subscriber's condition, illness, disease or injury; and
 - (b) required for the diagnosis, or the direct care and treatment of the Subscriber's condition, illness, disease or injury; and
 - (c) in accordance with standards of good medical practice as generally recognized and accepted by the medical community; and
 - (d) not primarily for the convenience of the Subscriber, the Subscriber's family, or the Subscriber's physician and/or other provider; and
 - (e) the most appropriate supply or level of service that can safely be provided to the Subscriber. When applied to hospitalization, this further means that the Subscriber requires acute care as a bed patient due to the nature of the services rendered or the Subscriber's condition, and the Subscriber cannot receive safe or adequate care in some other setting without adversely affecting the Subscriber's condition or the quality of medical care.

Determination of whether the services or supplies provided were medically necessary and appropriate for the treatment of the Subscriber's condition and the level of care will be made by the Plan or its designated agent, or a utilization review committee of the Approved Health Care Facility acceptable to the Plan.

THE PLAN RESERVES THE RIGHT TO DETERMINE IN ITS SOLE JUDGMENT WHETHER THE SERVICES OR SUPPLIES ARE MEDICALLY NECESSARY AND APPROPRIATE.

NO BENEFITS HEREUNDER WILL BE PROVIDED UNLESS THE PLAN OR ITS DESIGNATED AGENT DETERMINES THAT THE SERVICES OR SUPPLIES ARE MEDICALLY NECESSARY AND APPROPRIATE.

- (6) Pregnancy Care:
- (a) Benefits for Allowed Services are provided for a Conversion Subscriber requiring pregnancy care who was enrolled under the Contract on the date the Contract became effective.
 - (b) Benefits for Allowed Services are provided for a Subscriber
 - (i) who requires pregnancy care; and
 - (ii) who becomes enrolled under the Contract subsequent to the date the Contract became effective for the Applicant.
 - (c) The Pre-Existing Condition Provision set forth in Article I. Section 15. and in Article III. G. will not apply:
 - (i) if it is medically established that the pregnancy commenced on or after the date such Subscriber became enrolled under the Contract, or under another contract issued by this Plan which this Contract replaces without lapse; and
 - (ii) the Subscriber remains continuously enrolled from such medically established date through the date on which the pregnancy care services are rendered.
 - (d) Benefits for Allowed Services are also provided If the Plan elects to terminate the Contract, under the termination provisions allowed under Article VI., Section 4. of the Contract, and Subscribers eligible for pregnancy care based on the date of conception are pregnant at the termination date, except that, if termination of the Contract is the result of non-payment of Subscription Rates, the liability of the Plan shall cease as of the date of such termination, and no benefits will be provided for pregnancy care incurred after that date.
 - (e) Complications of pregnancy will be treated as any other illness, as described in the Contract.
- (7) This is a limited benefit contract and, as such, is not subject to certain Pennsylvania mandates. The following is a brief description of policy exclusions:
- (a) In the case of Ambulatory Diagnostic Services, excluded from coverage are: board and general nursing care regularly provided for Inpatients; allergy testing; 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 Article II, Section 4 of the Contract; cardiac exercise visits; and any study determined to be experimental or investigational as defined in Article III, Paragraph K. of the Contract.
 - (b) An illness or injury covered by any Worker's Compensation Act or Occupational Disease Law or by the United States Longshoreman's Harbor Worker's Compensation Act.
 - (c) Charges for any care, treatment, services, facilities or supplies when the expenses are paid or the Subscriber is entitled to have them paid or obtained, in whole or in part, without cost in accordance with the law and regulations of CHAMPUS-CHAMPVA, the Department of Defense for Active Personnel, the Department of Veterans' Affairs, the National Health Service or the Bureau of Vocational Rehabilitation unless payment is required by law.
 - (d) An illness or injury to the extent that any covered person under the Contract is entitled to receive benefits under Medicare for the expenses incurred.
 - (e) Treatment or service for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law; including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.

- (f) Ambulance service except for local surface ambulance services between Hospitals when provided by and billed by the Hospital.
- (g) Health care services furnished for a Pre-Existing Condition to a Subscriber during the twelve-month period following the date on which such Subscriber is most recently enrolled under the Contract except for newborn children, and 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.
- (h) Care, treatment or service which is determined by the Plan not to be Medically Necessary and Appropriate for the treatment of the Subscriber's condition.
- (i) Care, treatment or service for any loss sustained or contracted in consequence of the Subscriber being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.
- (j) Ambulatory services except as stated in the Contract.
- (k) Unless otherwise provided in the Contract, services and supplies which are "experimental or investigational" in nature. "Experimental or Investigative" means the use of any treatment, procedure, facility, equipment, drug, drug usage device or supply which the Plan does not accept as standard medical treatment of the condition being treated. In making this determination, the Plan shall rely on the advice of the general medical community which includes, but is not limited to, medical consultants, peer reviewed medical journals and/or governmental regulations. The Plan also will not accept as standard medical treatment of the condition being treated, the use of any items requiring federal or other governmental agency approval which approval was not granted at the time services were rendered.
- (l) Services and operations for cosmetic purposes done to improve the appearance of any portion of the body and from which no significant improvement in physiologic function can be expected, unless otherwise required by law. However, benefits are payable to correct a condition resulting from an accident which occurs while the Subscriber is covered by the Plan. The Subscriber must be enrolled without interruption from the date of the accident to the date of the operation in order to be eligible for such cosmetic surgery. This exclusion does not apply to services to restore bodily function or correct deformity resulting from covered disease, injury, trauma, congenital or developmental anomalies or previous therapeutic processes.
- (m) 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.
- (n) Care, treatment or service which has been disallowed under the provisions of the Managed Care Program.
- (o) Dental care except as allowed in Article II , Section 1.D.2. and Section 2.D. of the Contract.
- (p) Treatment in connection with sexual dysfunction not related to organic disease or injury.
- (q) Treatment leading to or in connection with transsexual surgery except for sickness or injury resulting from such surgery.

- (r) For any treatment leading to or in connection with Assisted Fertilization.
 - (s) Inpatient or outpatient private duty nursing.
 - (t) Convalescence, rest or custodial care.
 - (u) Blood and blood components.
 - (v) Personal comfort or convenience items.
 - (w) Physician's, surgeon's, or any other professional provider's fees.
 - (x) Care, treatment, or services for Alcohol or Drug Abuse, and/or Mental Illness.
 - (y) Cardiac Rehabilitation.
 - (z) Preventive pediatric care, except benefits for Pediatric Immunizations as set forth in Article II, Section 4.A. of the Contract.
 - (aa) Speech, occupational, physical, respiratory, or pulmonary therapy as an Outpatient.
 - (bb) Outpatient Drugs.
 - (cc) Durable Medical Equipment, Prosthetics (other than prosthetic devices inserted during reconstructive surgery incident to a mastectomy) and Orthotics.
 - (dd) For the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column (Spinal Manipulations).
 - (ee) Care, treatment or services provided by or in a Home Health Care Agency, Hospice or Skilled Nursing Facility, unless specifically covered under the Contract.
 - (ff) Treatment of temporomandibular joint syndrome (TMJ), also known as craniomandibular disorders (CMD), with intraoral devices or with any non-surgical method to alter vertical dimension.
 - (gg) Clinic visits.
 - (hh) Care, treatment, or services not specifically provided for in this Outline or the Contract except as required to be covered by law.
 - (ii) Care, treatment, or services for any loss to which a contributing cause was the Subscriber's commission of or attempt to commit a felony, or to which a contributing cause was the Subscriber's being engaged in an illegal occupation.
- (8) **GUARANTEED RENEWABLE/SUBSCRIPTION RATES SUBJECT TO CHANGE ON A CLASS BASIS** - This Contract can be renewed from month to month except for:
- (a) nonpayment of the required Subscription Rates; or
 - (b) fraud or intentional misrepresentation of a material fact; or

- (c) the Plan non-renews this Contract form for all enrolled persons. In such case, the Plan will provide notice to each Subscriber at least 90 days prior to the date of discontinuation of such coverage. Such notice will provide enrolled persons with the option to purchase any other individual health insurance coverage currently offered by the Plan; or
- (d) the Plan non-renews this Contract because it elects to discontinue offering all health insurance coverage in the individual market in the Commonwealth. In such case the Plan will provide notice to all enrolled persons and the Pennsylvania Insurance Department of such discontinuation at least 180 days prior to the date of the expiration of the coverage.

Nonrenewal shall not be based on any health status-related factors of a Subscriber.

The Applicant must make timely payment of all Subscription Rates due.

- (a) The Subscription Rates, at any given time, are those listed in the Schedule of Rates on file with the Department of Insurance of the Commonwealth of Pennsylvania.
- (b) The Plan reserves the right to change the Subscription Rates for the contract on a class basis.
- (c) Any change in the Subscription Rates shall become effective upon the expiration of the period covered by the Applicant's current Subscription Rates as applied by the Plan. The Applicant shall be given notice of such change, and payment of the new Subscription Rates shall be considered receipt of notice and acceptance of the change in Subscription Rates. In the event the Applicant fails to make payment of the new Subscription Rates within 30 days after the new Subscription Rates became due and payable, this Contract shall terminate at the end of that 30 day period. However, if the Subscription Rate is not paid by the end of the grace period, no payment will be made for any services provided during the grace period.

The Subscriber must continue to reside in the geographical area served by the Plan. Should the Subscriber change his or her residence to a geographic area outside the area served by the Plan and the Subscriber wishes to continue coverage, the Subscriber must transfer his or her coverage to the Blue Cross plan that serves the area of his or her new residence.

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INDEPENDENCE BLUE CROSS
whose home office is
1901 Market Street Philadelphia, Pennsylvania 19103

**SPECIAL CARE
CONTRACT**

FOR DIRECT PAYMENT SUBSCRIBERS
Description of Coverage

In consideration for and upon payment of the appropriate Subscription Rates, the persons covered under this Contract are entitled to the hospitalization and related health care benefits set forth herein in accordance with the terms and conditions of this Contract. All such services are required to be rendered by a Special Care Participating Health Care Facility. A Non-Participating Health Care Facility may be used only for Emergency Services, as set forth in Article II., Section 8. of this Contract.

NOTICE OF SUBSCRIBER'S RIGHT TO EXAMINE CONTRACT: The Subscriber has a right to reject this Contract within 10 days of delivery for refund of the full premium paid if, after examination of this Contract, the Subscriber is not satisfied for any reason. The Subscriber may reject this Contract by providing signed written notification to us at the following address: Independence Blue Cross, 1901 Market Street, Philadelphia, PA 19103-1480. If the Contract is rejected it will be null and void from the beginning and no benefits will be payable under its terms.

NOTE: READ THIS PROVISION CAREFULLY

GUARANTEED RENEWABLE/SUBSCRIPTION RATES SUBJECT TO CHANGE ON A CLASS BASIS:
This Contract can be renewed from month to month except for:

- (a) nonpayment of the required Subscription Rate; or
- (b) fraud or intentional misrepresentation of a material fact; or
- (c) the Plan non-renews this Contract form for all enrolled persons. In such case, the Plan will provide notice to each Subscriber at least 90 days prior to the date of discontinuation of such coverage. Such notice will provide enrolled persons with the option to purchase any other individual health insurance coverage currently offered by the Plan; or
- (d) the Plan non-renews this Contract because it elects to discontinue offering all health insurance coverage in the individual market in the Commonwealth. In such case the Plan will provide notice to all enrolled persons and the Pennsylvania Insurance Department of such discontinuation at least 180 days prior to the date of the expiration of the coverage.

This is a Non-Participating contract.

Nonrenewal shall not be based on any health status-related factors of a Subscriber.

1. The Applicant must make timely payment of all Subscription Rates due.
 - (a) The Subscription Rates, at any given time, are those listed in the Schedule of Rates on file with the Department of Insurance of the Commonwealth of Pennsylvania.
 - (b) The Plan reserves the right to change the Subscription Rates for the contract on a class basis.
 - (c) Any change in the Subscription Rates shall become effective upon the expiration of the period covered by the Applicant's current Subscription Rates as applied by the Plan. The Applicant shall be given notice of such change, and payment of the new Subscription Rates shall be considered receipt of notice and acceptance of the change in Subscription Rates. In the event the Applicant fails to make payment of the new Subscription Rates within 30 days after the new Subscription Rates became due and payable, this Contract shall terminate at the end of that 30 day period. However, if the Subscription Rate is not paid by the end of the grace period, no payment will be made for any services provided during the grace period.
2. The Subscriber must continue to reside in the geographical area served by the Plan. Should the Subscriber change his or her residence to a geographic area outside the area served by the Plan and the Subscriber wishes to continue coverage, the Subscriber must transfer his or her coverage to the Blue Cross plan that serves the area of his or her new residence.

BY:



Linda Taylor
Sr. Vice President and Chief Marketing Executive

Attest:



John R. Janney
Sr. Vice President,
Marketing Services

Incorporated under the Laws of the Commonwealth of Pennsylvania

BLUE CROSS SPECIAL CARE CONTRACT

This Contract sets forth a program of limited hospitalization and related health care benefits of Independence Blue Cross (hereinafter called "the Plan").

The Subscriber will receive benefits in accordance with the terms of this Contract.

Benefits under this Contract are provided for Allowed Services at Special Care Participating Health Care Facilities in accordance with the terms of this Contract. Benefits under this Contract for services rendered at Non-Participating Health Care Facilities are provided as set forth in Article II, Section 8, of this Contract.

ENROLLMENT ELIGIBILITY PROVISIONS

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. Any individual eligible for or enrolled in any governmental program is ineligible for enrollment under Special Care. Any individual eligible for 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 Rates.

Determination by the Plan of enrollment eligibility and the applicable Subscription Rate is conclusive.

ARTICLE I. DEFINITIONS

Section 1. Accommodations:

A. Private Accommodation:

"Private Accommodation" means the bed, board and general nursing care regularly provided for patients by an Approved Health Care Facility in a one-bed room which is designated by the institution as private.

B. Semi-Private Accommodation:

"Semi-Private Accommodation" means the bed, board and general nursing care regularly provided for patients by an Approved Health Care Facility in a room with more than one bed which is designated by the institution as semi-private.

Section 2. Alcohol or Drug Abuse:

"Alcohol or Drug Abuse" means any use of alcohol or other drugs which produces a pattern of pathological use causing impairment in social or occupational functions or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Section 3. Allowed Services

"Allowed Services" means the usual and customary services furnished by a Special Care Participating Health Care Facility to the Subscriber for the diagnosis and treatment of a condition of illness or injury which is not specifically excluded by this Contract. In case of Emergency Accident Care, Medical Emergency, or an Emergency Admission "Allowed Services" means the usual and customary services furnished by an Approved Health Care Facility to the Subscriber for the diagnosis and treatment of a condition of illness or injury which is not specifically excluded by this Contract.

Section 4. Approved Health Care Facilities:

A. Approved Health Care Facility:

"Approved Health Care Facility" means an institution which has been approved by the Plan, such as a Hospital, Freestanding Ambulatory Surgery Facility or Birthing Center as defined herein, or any other health care institution which has been approved by the Plan.

In determining whether or not a particular facility is approved, the Facility must meet state licensing and Certificate of Need requirements, and where applicable be accredited or certified by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Health Care Financing Administration, and/or the Commission on Accreditation of Rehabilitation Facilities.

1. Hospital:

"Hospital" means an institution with an organized medical staff, with permanent facilities that include inpatient beds, and with medical services, including physicians' services, which provides diagnosis and treatment for patients who have a variety of medical conditions.

a. Inpatient:

"Inpatient" means a Subscriber who is registered as an overnight bed patient in a Hospital and for whom a room and board charge is made.

b. Outpatient:

"Outpatient" means a Subscriber who receives services or supplies while not an Inpatient.

2. Freestanding Ambulatory Surgery Facility:

"Freestanding Ambulatory Surgery Facility" means an institution which is equipped and operated exclusively for the purpose of performing surgical procedures for which patients are scheduled to arrive, receive surgery and be discharged the same day.

An Ambulatory Surgery Facility does not include individual or group practice offices of physicians or dentists, unless such offices have a distinct part used solely for outpatient surgical treatment on a regular and organized basis.

3. Birthing Center:

"Birthing Center" means a facility which is organized and staffed in accordance with applicable State laws and regulations to provide maternity care including prenatal, labor, delivery and postpartum care related to medically uncomplicated pregnancies not requiring hospitalization.

B. Special Care Participating Health Care Facility:

"Special Care Participating Health Care Facility" means an Approved Health Care Facility which has agreed to accept the Special Care payment by the Plan as payment-in-full for Allowed Services.

C. Non-Participating Health Care Facility:

"Non-Participating Health Care Facility" means an Approved Health Care Facility which is not a Special Care Participating Health Care Facility. Payment for Allowed Services provided in a Non-Participating Health Care Facility is subject to the benefit conditions stated in Article II, Section 8.B.

Section 5. Assisted Fertilization:

"Assisted Fertilization" means any method used to enhance the possibility of conception through retrieval or manipulation of the sperm or ovum. This includes, but is not limited to, artificial insemination, In Vitro fertilization, Gamete Intra-fallopian transfer (GIFT) and Zygote Intra-fallopian transfer (ZIFT).

Section 6. Benefit Period:

"Benefit Period" means a period of time starting with the date of the Subscriber's admission as an Inpatient to an Approved Health Care Facility, and ending after 90 consecutive days have elapsed during which the Subscriber was not an Inpatient in any Approved Health Care Facility.

Section 7. Conversion Subscriber:

"Conversion Subscriber" means (a) a Subscriber who is not employed in or affiliated with a Group where Independence Blue Cross coverage is in effect, and who is eligible for conversion privileges under an existing group contract, or (b) a Dependent whose eligibility under an existing contract has terminated and who elects coverage as an Applicant under a contract for which the Dependent is then eligible.

If another hospitalization program is available in the Group where the Subscriber is employed or with which the Subscriber is affiliated and the Subscriber is eligible for enrollment under such program, the Subscriber is not entitled to be a Conversion Subscriber, except in cases where an individual's income does not exceed guidelines for coverage under this Contract and such individual would otherwise be uninsured.

Section 8. Critical Care Unit:

"Critical Care Unit" means a designated unit of a Hospital which has concentrated all facilities, equipment and supportive services for the provision of an intensive level of care for critically ill patients.

Section 9. Emergency Care:

"Emergency Care" means the initial treatment of a sudden onset of a medical condition or injury that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent lay person who possesses any average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- A. placing the health of the Subscriber or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
- B. serious impairment of bodily functions; or
- C. serious dysfunction of any bodily organ or part.

Benefits are provided for the following Emergency Care:

- A. Emergency Accident Services - the initial treatment of bodily injuries resulting from an accident.
- B. Emergency Medical Services – the initial treatment after the sudden onset of a medical condition.

Treatment for an occupational injury for which benefits are provided under any Worker's Compensation Law or any similar Occupational Disease Law is not covered.

Section 10. Emergency Admission:

"Emergency Admission" means an admission to a Hospital for Emergency Care. The determination whether an admission is an emergency shall be made by the Plan in accordance with the definition of Emergency Care.

Section 11. Managed Care Program:

"Managed Care Program" consists of Preadmission Review and Admission Review as set forth in Article II, Section I, Paragraph C of this Contract.

Section 12. Medically Necessary and Appropriate:

"Medically Necessary and Appropriate" (or Medical Appropriateness) means that the benefits under this Contract for Allowed Services by an Approved Health Care Facility will be provided only when and so long as such services are determined by the Plan or its designated agent to be:

- A. appropriate for the symptoms and diagnosis or treatment of the Subscriber's condition, illness, disease or injury; and
- B. required for the diagnosis, or the direct care and treatment of the Subscriber's condition, illness, disease or injury; and
- C. in accordance with standards of good medical practice and as generally recognized and accepted by the medical community; and
- D. not primarily for the convenience of the Subscriber, the Subscriber's family, or the Subscriber's physician and/or other provider; and
- E. the most appropriate supply or level of service that can safely be provided to the Subscriber. When applied to hospitalization, this further means that the Subscriber requires acute care as a bed patient due to the nature of the services rendered or the Subscriber's condition, and the Subscriber cannot receive safe or adequate care as an Outpatient without adversely affecting the Subscriber's condition or the quality of medical care.

Determination of whether the services or supplies provided were Medically Necessary and Appropriate for the treatment of the Subscriber's condition and the level of care will be made by the Plan, or its designated agent.

THE PLAN RESERVES THE RIGHT TO DETERMINE IN ITS SOLE JUDGMENT WHETHER THE SERVICES OR SUPPLIES ARE MEDICALLY NECESSARY AND APPROPRIATE.

NO BENEFITS HEREUNDER WILL BE PROVIDED UNLESS THE PLAN OR ITS DESIGNATED AGENT DETERMINES THAT THE SERVICES OR SUPPLIES ARE MEDICALLY NECESSARY AND APPROPRIATE.

Section 13. Medicare:

"Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Section 14. Mental Illness:

"Mental Illness" or a mental, nervous or emotional disorder means a neurosis, psychoneurosis, psychopathy or psychosis.

Section 15. Pre-Existing Condition:

"Pre-Existing Condition" means a condition for which medical advice or treatment was recommended by a physician or received from a physician within a one-year period preceding the effective date of the coverage of the Subscriber.

Section 16. Subscriber:

A. Subscriber:

"Subscriber" means any person who is covered by this Contract, and for whom the proper Subscription Rate is currently being paid.

B. Applicant:

"Applicant" means the Subscriber who signed the Application, and with whom the Plan has entered into this Contract.

C. Dependent:

"Dependent" means a Subscriber who is the Applicant's spouse or a Child of the Applicant who is enrolled under this Contract.

D. Child:

"Child" means an unmarried child, including a newborn child, a stepchild, a child legally placed for adoption, and a legally adopted child of the Applicant or the Applicant's spouse, a child awarded coverage pursuant to an order of court or any other child for whom the Applicant or the Applicant's spouse is a legal guardian. The limiting age for coverage of unmarried children shall be to the end of the month in which they reach 19 years of age. 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 19 and is medically certified by a physician. The Plan may require proof of such Subscriber's disability from time to time.

ARTICLE II. BENEFITS

Benefits under this Contract are provided for Allowed Services at Special Care Participating Health Care Facilities in accordance with agreements between the Plan and such facilities. Benefits under this Contract for services rendered at Non-Participating Health Care Facilities are only provided as set forth in Section 8, of this Article.

Section 1. Inpatient Services:

Benefits for Medically Necessary and Appropriate Allowed Services will be provided for Inpatient treatment of Illness or bodily injury, subject to the following provisions:

A. Accommodations:

1. Semi-Private and Critical Care Accommodations:

A Subscriber is entitled to coverage for Semi-Private and Critical Care Accommodations under this Contract.

2. Private Accommodations:

If a Subscriber occupies a Private Accommodation, an allowance is made of the Facility's most frequent established charge (mode) for Semi-Private Accommodation. Such allowance is made upon payment by the Subscriber directly to the Facility of the difference between such allowance and the daily rate for the Private Accommodation occupied.

B. Inpatient Days:

For each Benefit Period, benefits for inpatient services, which are included within the definition of Allowed Services, shall be provided for a maximum of twenty-one (21) days, except as otherwise provided in Section 3. of this Article.

C. Managed Care Program:

1. Preadmission Review of Inpatient Admissions:

When a Subscriber requires care in a Hospital, benefits for Allowed Services will be provided subject to the following:

In the event of a proposed Inpatient stay for other than an Emergency Admission condition, it shall be the responsibility of the Hospital to contact the Plan's precertification program administrator, Independence Healthcare Management, Inc., prior to the proposed admission for pre-certification to determine if the proposed admission is Medically Necessary and Appropriate.

2. Admission Review of Inpatient Admissions to a Special Care Participating Health Care Facility:

In the event of an Emergency Admission to a Hospital that is a Special Care Participating Health Care Facility it shall be the responsibility of the Hospital to contact Independence Healthcare Management, Inc. prior to payment.

At or before the time of admission, the Hospital will verify the pre-certification with Independence Blue Cross. Independence Blue Cross will not authorize the Hospital admission if pre-certification is required and is not obtained in advance. Through its provider agreements or otherwise,

Independence Blue Cross will hold the Subscriber harmless and the Subscriber will not be financially responsible for admissions which fail to conform to the above precertification requirements unless the Hospital informs the Subscriber that the proposed admission does not meet the requirements of this Contract and will not be covered by Independence Blue Cross.

3. Emergency Admission to a Non-Participating Health Care Facility:

- a. Subscribers are responsible for notifying Independence Healthcare Management, Inc. of an emergency admission to any facility that is not a "Special Care Participating Health Care Facility" within 24 hours of such admission. If contact is not reasonably possible within 24 hours, a penalty will not be assessed as long as contact is made as soon as reasonably possible after 24 hours.
- b. Failure to initiate emergency admission review will result in a penalty in the amount equal to 75 percent of the Medicare Part A deductible.
- c. If the Subscriber elects to remain hospitalized after Independence Healthcare Management, Inc. or the designated agent has determined that a Hospital level of care is not medically appropriate, the Subscriber will be financially liable for non-covered Inpatient charges from the date of written notification.

To comply with the Hospital Admission Review Program your Hospital or your doctor should call Independence Healthcare Management, Inc. at 1-800-TO-ADMIT.

4. Presurgical Certificate:

The listed procedures, with the exception of emergency service, are subject to Presurgical Certification.

a. Presurgical Certification

Presurgical Certification assures that specific non-emergency surgical procedures are approved for coverage only when Medically Necessary and Appropriate. The Certification is required whether the procedure is performed as a Hospital Inpatient, in the Outpatient department of a Hospital or a freestanding surgical facility. The physician notifies Independence Healthcare Management, Inc. of the proposed surgery. Independence Healthcare Management, Inc. staff reviews the information provided by the Physician to determine if the surgery or admission is Medically Necessary and Appropriate. Independence Healthcare Management, Inc. notifies the Subscriber and the physician of approval or denial of the surgery.

The physician is responsible for obtaining Presurgical Certification. If the physician is properly advised of the need to obtain Presurgical Certification by the Subscriber presenting to the physician his or her identification card and the physician fails to obtain Presurgical Certification or fails to follow the Presurgical Certification process, the Plan will hold the Subscriber harmless.

No benefits will be provided for services which are determined to be not Medically Necessary and Appropriate through the Presurgical Certification Process.

Emergency Services do not require Presurgical Certification.

b. Presurgical Certification procedures

Presurgical Certification is required for the following surgical procedures:

Bunionectomy	Knee Surgery
Cataract Surgery	Ligation and Stripping of Varicose Veins
Cholecystectomy	Prostate Surgery
Coronary Artery Bypass	Spinal and Vertebral Surgery
Hemorrhoidectomy	Submucous Resection
Herniorrhaphy	Tonsillectomy/Adenoidectomy
Hysterectomy	

c. APPROVAL PROCESS

Requests for Presurgical Certification can be initiated by phone by calling 1-800-TO-ADMIT.

5. Appeal Procedure:

In the event that the Plan or its designated agent has determined through the Managed Care Program that a Subscriber is not eligible for benefits, the Subscriber may submit an appeal in writing to the Plan or its designated agent. Such appeal must be submitted not later than sixty (60) days from the date the Plan or its designated agent notified the Subscriber of its determination and should include specific information in support of the claim for benefits. The Plan or its designated agent will review the information and make a final decision concerning the Subscriber's eligibility for benefits and notify the Subscriber, in writing, not later than sixty (60) days following receipt of the appeal.

D. Special Cases:

In the following cases, a Subscriber is entitled to benefits for Allowed Services, subject to the following additional conditions and/or limitations:

Any Inpatient days used under this Subsection D. are part of the Inpatient Days set forth in Subsection B. of this Section 1.

1. Pregnancy Care:

- a. Benefits for Allowed Services are provided for a Conversion Subscriber requiring pregnancy care who was enrolled under this Contract on the date this Contract became effective.
- b. Benefits for Allowed Services are provided for a Subscriber:
 - i. who requires pregnancy care; and
 - ii. who becomes enrolled under this Contract subsequent to the date this Contract became effective for the Applicant.
- c. The Pre-Existing Condition Provision set forth in Article I. Section 15. and Article III. G. will not apply:
 - i. if it is medically established that the pregnancy commenced on or after the date such Subscriber became enrolled under this Contract, or under another contract issued by this Plan which this Contract replaces without lapse; and
 - ii. the Subscriber remains continuously enrolled from such medically established date through the date on which the pregnancy care services are rendered.

- d. Benefits for Allowed Services are also provided If the Plan elects to terminate this Contract, under the termination provisions allowed under Article VI., Section 4., and Subscribers eligible for pregnancy care based on the date of conception are pregnant at the termination date, except that, if termination of this Contract is the result of non-payment of Subscription Rates, the liability of the Plan shall cease as of the date of such termination, and no benefits will be provided for pregnancy care incurred after that date.
- e. Complications of pregnancy will be treated as any other illness. Complications of pregnancy means physical conditions arising during pregnancy which diagnosis is distinct from the pregnancy but which are adversely affected by the pregnancy or are caused by the pregnancy. Complications of pregnancy shall not include physical conditions such as false labor, physician prescribed rest, morning sickness or any condition associated with a normal pregnancy.

2. Oral Surgery:

Benefits for Allowed Services are provided if the Subscriber is admitted for treatment of a fracture, dislocation or disease of the jaw.

Section 2. Ambulatory Services:

Benefits are payable for the following Outpatient care:

A. Emergency Accident Care:

Benefits for Allowed Services for initial treatment are provided if a Subscriber requires Emergency Accident care as an ambulatory patient. Emergency Accident Care must commence within 24 hours of the accident.

B. Medical Emergency Cases:

Benefits for Allowed Services are provided for a Medical Emergency only for the initial visit.

The Plan reserves the right to determine, on the basis of the severity of symptoms, final diagnosis and supporting medical data, whether the services received by the Subscriber are eligible for benefits under this Subsection B.

C. Surgery Cases (Non-Oral):

Benefits for Allowed Services are provided if a condition of illness or of bodily injury requires the Subscriber to undergo treatment as an ambulatory patient for other than oral surgery.

D. Oral Surgery:

- 1. Benefits for Allowed Services are provided if the Subscriber requires and receives treatment only for a fracture or a dislocation of the jaw.
- 2. Benefits for Allowed Services are provided for the extraction of teeth, only when such services are required due to an accidental injury to the jaw, sound and natural teeth, or the mouth or face.

E. Diagnostic Services

1. Benefits for Allowed Services are provided when the Subscriber requires a Medically Necessary and Appropriate diagnostic procedure.

These benefits for Allowed Services are limited to \$1,000, per Subscriber, per calendar year. The benefit dollar limitation does not apply to diagnostic procedures in connection with approved Pre-Admission Testing as approved by the Plan for inpatient care or pregnancy care or in connection with a visit for ambulatory surgery, oral surgery, Emergency Accident Services, or Emergency Medical Services when diagnostic procedures are performed during such visit.

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.

2. The following are excluded from benefits as Diagnostic Services under this Section 2.E:
 - a. Board and general nursing care regularly provided for Inpatients;
 - b. Allergy testing;
 - c. Audiometric testing;
 - d. Eye refractions;
 - e. Examinations for the fitting of eyeglasses, contact lenses, or hearing aids;
 - f. Psychiatric examinations;
 - g. Psychological testing;
 - h. Dental examinations;
 - i. Premarital examinations;
 - j. Research studies;
 - k. Routine physical examinations or check-ups;
 - l. Cardiac exercise visits;
 - m. Any study determined to be experimental or investigational as defined in Article III, Paragraph K.

F. Chemotherapy:

If a Subscriber requires chemotherapy which can be administered intravenously or orally in accordance with accepted medical practice, benefits for such Inpatient or Outpatient care by an Approved Health Care Facility will be provided for the treatment of malignant diseases.

G. Radiation Therapy:

If a Subscriber requires radiation therapy in accordance with accepted medical practice, benefits for such care provided by an Approved Health Care Facility will be provided for the treatment of neoplastic or malignant diseases.

Section 3. Newborn Care:

Benefits for Medically Necessary and Appropriate Allowed Services will be provided to the newborn child of a Subscriber from the moment of birth. Such benefits shall continue for a maximum of 31 days from birth, and shall include, but not be limited to, care which is necessary for treatment of medically diagnosed congenital defects, birth abnormalities, prematurity, and routine nursery care.

In the event that a newborn child is not otherwise eligible for continuing benefits beyond the first 31 days as a dependent under this or any other current contract, benefits may be continued for such child if, within said 31-day period, the Subscriber applies for and is issued a contract for said newborn either individually or as a dependent.

Section 4. Preventive Services:

A. Pediatric Immunizations:

With respect to Subscribers under age 21, and their Dependent Children, coverage will be provided for those pediatric immunizations, including the immunizing agents, which, as determined by the Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services. Benefits are exempt from deductibles or maximums.

B. Women's Preventive:

1. Benefits for Allowed Services will be provided for one (1) routine gynecological examination including a pelvic examination, clinical breast examination, and routine papanicolaou smear in accordance with the recommendations of the American College of Obstetricians and Gynecologists per calendar year for female Subscribers. Benefits are exempt from deductibles or maximums.
2. Benefits for Allowed Services will be provided for one mammogram per Subscriber per calendar year, beginning at age 40, and for any physician recommended mammogram for women under age 40. Benefits for mammography screening are payable only if performed by a mammography service provider who is properly certified by the Department of Health in accordance with the Mammography Quality Assurance Act of 1992. Benefits are exempt from deductibles or maximums.

Section 5. Transplant Services:

When the Subscriber is the recipient of transplanted organs, bones or tissue, benefits under this Contract are provided for Medically Necessary and Appropriate Allowed Services which are directly and specifically related to transplantation.

Benefits are provided for the Medically Necessary and Appropriate hospitalization of donors and for those hospital services directly and specifically related to the transplantation, to the extent that the Subscriber (Recipient) would be entitled to such benefits, and the donor is not otherwise entitled to benefits under a policy of insurance or other health plan providing benefits for services related to transplantation.

Section 6. Mastectomy and Breast Reconstruction following Mastectomy:

Benefits are provided following a mastectomy and performed on an inpatient or outpatient basis for the following:

- A. Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy;
- B. Initial and subsequent prosthetic devices to replace the removed breast or portions thereof; and
- C. Physical complications of all stages of mastectomy, including lymphedemas.

Benefits are also provided for one home health care visit, as determined by the Subscriber's physician, received within forty-eight (48) hours after discharge, if such discharge occurs within forty-eight (48) hours after an admission for a mastectomy.

Section 7. Maternity Benefits:

Benefits are provided for facility services provided by a Hospital or Birthing Center rendered in the care and management of a pregnancy for a Subscriber. Maternity care Inpatient Benefits will be provided for a minimum of 48 hours following a normal vaginal delivery and 96 hours following a cesarean delivery.

Benefits are also provided for one home health care visit within 48 hours after early post-partum discharge. Early post-partum discharge is a discharge that occurs prior to the times set forth in the paragraph above. Such home health care visit shall be made by a licensed health care provider whose scope of practice includes post-partum care. The home health care visit shall include parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments. At the mother's sole discretion, the visit may occur at the facility of the provider. No copayment, coinsurance or deductible amount applies to the post-partum home health care visit.

Section 8. Benefit Conditions:

The Benefits in this Article II are subject to the following additional conditions:

- A. In a Special Care Participating Health Care Facility, Allowed Services are covered in accordance with the terms of this Contract.
- B. In a Non-Participating Health Care Facility, the amount for each emergency visit, stay or procedure to be paid by the Plan for the Allowed Services shall be the provider's charges, or if less, the amount mutually agreed to by the Plan and the health care facility. The Plan may, in its discretion, make payment to either the Subscriber or the provider of services. The Subscriber's right to receive payment under this Subsection may not be assigned, unless otherwise required by law.

Under this Contract benefits for a non-Emergency Admission are available only when the Subscriber is admitted to a Special Care Participating Health Care Facility.

ARTICLE III. EXCLUSIONS

This is a limited benefit contract and, as such, is not subject to certain Pennsylvania mandated benefits. No benefits are available nor will they be provided under this Contract for:

- A. In the case of Ambulatory Diagnostic Services, excluded from coverage are: board and general nursing care regularly provided for Inpatients; allergy testing; 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 Article II, Section 4 of this Contract; cardiac exercise visits; and any study determined to be experimental or investigational as defined in Article III, Paragraph K. of this Contract.
- B. An illness or injury covered by any Worker's Compensation Act or Occupational Disease Law or by the United States Longshoreman's Harbor Worker's Compensation Act.
- C. Charges for any care, treatment, services facilities or supplies when the expenses are paid or the Subscriber is entitled to have them paid or obtained, in whole or in part, without cost in accordance with the law and regulations of CHAMPUS-CHAMPVA, the Department of Defense for Active Personnel, the Department of Veterans' Affairs, the National Health Service or the Bureau of Vocational Rehabilitation unless payment is required by law.
- D. An illness or injury to the extent that any covered person under this Contract is entitled to receive benefits under Medicare for the expenses incurred.
- E. Treatment or service for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law; including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.
- F. Ambulance service except for local surface ambulance services between Hospitals when provided by and billed by the Hospital.
- G. Health care services furnished for a Pre-Existing Condition to a Subscriber during the twelve-month period following the date on which such Subscriber is most recently enrolled under this Contract, except for newborn children, and for Conversion Subscribers who have been continuously enrolled under this Contract from the date this Contract was effective for the Applicant. However, if such Subscriber was covered under another contract issued by the Plan which this 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.
- H. Care, treatment or service which is determined by the Plan not to be Medically Necessary and Appropriate for the treatment of the Subscriber's condition.
- I. Care, treatment or service for any loss sustained or contracted in consequence of the Subscriber being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.
- J. Ambulatory service except as allowed in Article II, Section 2.

- K. Unless otherwise provided in this Contract, services and supplies which are "experimental or investigational" in nature. "Experimental or Investigative" means the use of any treatment, procedure, facility, equipment, drug, drug usage device or supply which the Plan does not accept as standard medical treatment of the condition being treated. In making this determination, the Plan shall rely on the advice of the general medical community which includes, but is not limited to, medical consultants, peer reviewed medical journals and/or governmental regulations. The Plan also will not accept as standard medical treatment of the condition being treated, the use of any items requiring federal or other governmental agency approval which approval was not granted at the time services were rendered.
- L. Services and operations for cosmetic purposes done to improve the appearance of any portion of the body and from which no significant improvement in physiologic function can be expected, unless otherwise required by law. However, benefits are payable to correct a condition resulting from an accident which occurs while the Subscriber is covered by the Plan. The Subscriber must be enrolled without interruption from the date of the accident to the date of the operation in order to be eligible for such cosmetic surgery. This exclusion does not apply to services to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or pervious therapeutic processes.
- M. 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.
- N. Care, treatment, or service which has been disallowed under the provisions of the Managed Care Program.
- O. Dental care, except as allowed in Article II, Section 1.D.2. and Section 2.D.
- P. Treatment in connection with sexual dysfunction not related to organic disease or injury.
- Q. Treatment leading to or in connection with transsexual surgery except for sickness or injury resulting from such surgery.
- R. For any treatment leading to or in connection with Assisted Fertilization.
- S. Inpatient or outpatient private duty nursing.
- T. Convalescence, rest or custodial care.
- U. Blood and blood components.
- V. Personal comfort or convenience items.
- W. Physician's, surgeon's, or any other professional provider's fees.
- X. Care, treatment, or services for Alcohol or Drug Abuse, and/or Mental Illness.
- Y. Cardiac Rehabilitation.
- Z. Preventive pediatric care, except benefits for Pediatric Immunizations set forth in Article II, Section-4. A.

- AA. Speech, occupational, physical, respiratory, or pulmonary therapy as an Outpatient.
- BB. Outpatient Drugs.
- CC. Durable Medical Equipment, Prosthetics (other than prosthetic devices inserted during reconstructive surgery incident to a mastectomy) and Orthotics.
- DD. For the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column (Spinal Manipulations).
- EE. Care, treatment or services provided by or in a Home Health Care Agency, Hospice or Skilled Nursing Facility, unless specifically covered under the Contract.
- FF. Treatment of temporomandibular joint syndrome (TMJ), also known as craniomandibular disorders (CMD), with intra-oral devices or with non-surgical method to alter vertical dimension.
- GG. Clinic visits.
- HH. Care, treatment, or services not specifically provided for in this Contract except as required to be covered by law.
- II. Care, treatment or services for any loss to which a contributing cause was the Subscriber's commission of or attempt to commit a felony, or to which a contributing cause was the Subscriber's being engaged in an illegal occupation.

ARTICLE IV. CONTRACT AND SUBSCRIPTION RATE

Section 1. Contract

:

A. Entire Contract

This Contract consists of this document together with any endorsements thereto issued by the Plan, the Subscription Application, and any supplemental applications submitted by the Applicant and approved by the Plan as amended from time to time. No change in this Contract shall be valid until approved by an executive officer of the Plan and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Contract or to waive any of its provisions.

B. Time Limit on Certain Defenses

After three (3) years from the date of issue of this Contract, no misstatements, except fraudulent 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.

Section 2. Subscription Rates:

- A. Each Contract is maintained at a Subscription Rate for which the Subscriber is eligible. The rate at which this Contract is maintained reflects the correct rate applicable to those Subscribers who applied for coverage under this Contract and who were approved for coverage by the Plan.
- B. The amount of the Subscription Rate for the Subscriber, and the Subscriber's Dependents, if applicable, at any time is the rate set forth in the Schedule of Rates on file with the Department of Insurance of the Commonwealth of Pennsylvania.
- C. The Subscription Rate is payable in advance directly to the Plan.

Section 3. Revision of Terms or Rates:

The Plan, subject to the approval of the Department of Insurance of the Commonwealth of Pennsylvania, may alter or revise the terms of this Contract. The Subscription Rates at any time are those set forth in the Schedule of Rates on file with the Department of Insurance of the Commonwealth of Pennsylvania. Any such alteration or revision of the terms of this Contract shall become applicable for all Subscribers on the effective date of the alteration or revision, whether or not Subscribers have paid Subscription Rates in advance.

Should the Plan determine that the Applicant, based on an increase in income, is no longer eligible for the current Subscription Rates, the Plan will apply an increase to the existing Subscription Rate and the Plan will bill the Applicant the new Subscription Rate. Any change in the Subscription Rates shall become applicable for Subscribers upon the expiration of the period covered by the Applicant's current payment at the time of such change. In the event of such alteration or revision, the Subscriber shall be notified in advance of the new Subscription Rate and the effective date.

Any notice shall be considered to have been given when mailed to the Applicant at the address on the records of the Plan.

Section 4. Grace Period:

This Contract has a grace period of 30 days. This means that if a payment is not made on or before the date it is due, it may be paid during the grace period. During the grace period the Contract will stay in force. But no benefits will be paid for services incurred subsequent to the Contract's then current paid date. If the Subscriber does not make payment during the grace period, the Contract will be cancelled and the Plan will have no liability for services which are incurred after the Contract's then current paid date.

ARTICLE V. EFFECTIVE DATE

- A. An Applicant's enrollment under this Contract begins on the effective date shown on the records of the Plan. The Plan will provide written confirmation of the Applicant's effective date in a letter and endorsement to this Contract, which will be sent to the Applicant following receipt of the application and appropriate Subscription Rate.

For a Dependent, the effective date is the day as of which the Subscription Rate is maintained at a Rate which entitles the Dependent to enroll, provided, however, that such Dependent must be eligible and accepted by the Plan before enrollment is allowed.

The date of eligibility for an eligible Dependent required to be covered under a medical release or Court Order will be no longer than thirty (30) days of receipt by the Plan of the Court Order, as required by law.

- B. If this Contract is being maintained at a Rate which does not provide enrollment of a newly acquired Dependent, change to the Rate which provides enrollment for such Dependent may be made as follows:
1. If an application for change to the Rate which provides enrollment for such Dependent is received by the Plan within 60 days after the Applicant acquires the Dependent, change to the requested Rate may be made the first day of the month after such application is received, provided said Dependent has been accepted for enrollment by the Plan.
 2. If an application for such a change is received later than 60 days after a Dependent is acquired, the requested change in Rate may be made only at such time and under such conditions as are accepted by the Plan.
- C. The newborn child of a Subscriber shall be eligible for benefits from the moment of birth according to the following provisions:
1. A newborn child of a Subscriber is entitled to benefits for 31 days from date of birth.
 2. If the mother is not eligible for maternity care under this Contract, the newborn child is entitled to benefits as a Subscriber from moment of birth to a maximum of 31 days.
 3. A newborn child is entitled to continue coverage either as a dependent under this Contract, if eligible, or as an individual Subscriber in accordance with the provisions of Article II, Section 3.

ARTICLE VI. CONTINUATION OF BLUE CROSS COVERAGE

Section 1. Term of Contract:

Benefits continue for one month from the effective date of this Contract and from month-to-month thereafter until discontinued, terminated or voided as provided in this Article.

A Subscriber who is receiving benefits hereunder in an Approved Health Care Facility on the date this Contract is terminated as provided in Section 4. of this Article, will be entitled to benefits until the date of discharge, or expiration of eligible benefit days, whichever is earlier.

Section 2. Continuation of Pregnancy Benefits:

If the Plan elects to terminate this Contract and Subscribers eligible for pregnancy care based on the date of conception are pregnant at the termination date, benefits for Allowed Services for pregnancy care will be provided; however, if termination of this Contract is the result of non-payment of Subscription Rates, the liability of the Plan shall cease as of the date of such termination, and no benefits will be provided for pregnancy care incurred after that date.

Section 3. Coverage Discontinued Because of Ineligibility:

The Dependents specified below become ineligible for coverage under this Contract as of the end of the month in which either of the following events occur:

1. A child ceases to meet any of the requirements of the definition of Child set forth in Article I, Section 16.D.; or
2. A spouse becomes divorced from the Applicant.

However, if Blue Cross accepts payment of the Subscription Rate for coverage extending beyond the date determined in this Section 3, then coverage as to such person shall continue during the period for which an identifiable premium was accepted, except where such acceptance was predicated on a misstatement of age.

Section 4. Termination:

The Applicant may renew this Contract of Insurance from month to month except the Plan can make a determination not to renew the Contract for nonpayment of the required Subscription Rate, fraud or intentional misrepresentation of a material fact. The Plan can determine not to renew the Contract if the Applicant does not reside in the geographical area served by the Plan. Should the Applicant reside in a geographic area outside the area served by the Plan and he wishes to continue coverage, the Subscriber must transfer his coverage to the Blue Cross plan that serves the area.

Nonrenewal shall not be based on any health status-related factors of a Subscriber. With respect to relocation outside the area served by the Plan, the Subscriber will be given 30 days advance notice of any decision not to renew.

The Plan can also nonrenew this Contract form for all enrolled persons. In such case, the Plan will provide notice to each Subscriber at least 90 days prior to the date of discontinuation of such coverage. Such notice will provide enrolled persons with the option to purchase any other individual health insurance coverage currently offered by the Plan.

The Plan can non-renew this Contract because it elects to discontinue offering all health insurance coverage in the individual market in the Commonwealth. In such case the Plan will provide notice to all enrolled persons and the Pennsylvania Insurance Department of such discontinuation at least 180 days prior to the date of the expiration of the coverage.

Section 5. Voiding of Coverage due to Material Misrepresentations:

As a material inducement for the issuance of this Contract, it is represented by the Applicant that all statements made and information shown in the Application are true and complete and are correctly recorded and noted in the Application. Misrepresentations material to the risk will, at the option of the Plan, render this Contract void from inception, provided such material misrepresentation is discovered by the Plan within three (3) years of the Effective Date of Coverage. In the event the Plan elects to void this Contract, the Applicant will forfeit any charges paid to the extent of any liability incurred by the Plan.

After three years from the date of issue of this Contract, no misstatements, except fraudulent misstatements made by the Applicant in the Application for such Contract, shall be used to void said Contract or to deny benefits for a claim incurred commencing after the expiration of such three year period.

Section 6. Conversion Privileges:

A. Conversion after Ineligibility:

The Subscriber who becomes ineligible for coverage under this Contract in accordance with Section 3. of this Article may apply within 30 days thereafter to continue coverage under a contract of the type for which the Subscriber is then eligible.

B. Conversion upon Death of Applicant:

In the event of the death of the Applicant, that coverage for Applicant shall terminate at the end of the last period for which premium was accepted by Blue Cross. The spouse of the deceased Applicant, if covered under the Contract, shall become the "Applicant" under the Contract and eligible Dependents will continue as the Applicant's Dependents under the Contract.

Section 7. Reinstatement:

In the event that this Contract lapses due solely to nonpayment of premium, the Plan may, at its option, accept payment of the premium due and upon acceptance shall reinstate this Contract. If the Contract is reinstated, no claims shall be paid for any accidental injury or sickness which occurred while this Contract had lapsed. Once the Contract is reinstated, losses resulting from accidental injury shall be covered while loss due to sickness will be covered after ten (10) days from that reinstatement date. In addition, the Subscriber and Plan shall have the same rights as they had under the Contract before the due date of the defaulted premium.

ARTICLE VII. MULTIPLE COVERAGE

Section 1. Coordination Of Benefits with Other Health Care Plans:

All benefits provided under this Contract are subject to this provision, and will not be increased by virtue of this provision.

A. Definitions:

In addition to the Definitions of this Contract, the following definitions apply only to this provision:

- (1) "Plan" means any individual coverage or group arrangement providing health care benefits or Covered Services through:
 - (a) individual, group, blanket (except student accident) or franchise insurance coverage;
 - (b) Blue Cross, Blue Shield, group or individual practice, health maintenance organization and other prepayment coverage;
 - (c) coverage under labor-management trust plans, union welfare plans, employer organization plans, or employee benefit organization plans;
 - (d) coverage under any tax supported or government program to the extent permitted by law;
 - (e) coverage under a hospital indemnity coverage of more than \$100 a day.

"Plan" shall be applied separately with respect to each arrangement for benefits or services and separately with respect to that portion of any arrangement which reserves the right to take benefits or services of Plans into consideration in determining its benefits and that portion which does not.
- (2) "Dependent" means, for any Plan, any person who qualifies as a Dependent under that Plan.
- (3) "Allowable Benefits" means the charge for Covered Services.
- (4) "Benefits Paid or Payable" means amounts actually paid for Covered Services.

B. Effect on Benefits:

- (1) This provision shall apply in determining the benefits of this Contract if, for Covered Services received, the sum of the Benefits Payable under this Contract and the Benefits Payable under other Plans would exceed the Allowable Benefits.
- (2) Except as provided in item (3) of this Section, the Benefits Payable under this Contract for Covered Services will be reduced so that the sum of the reduced benefits and the Benefits Payable for Covered Services under Plans does not exceed the total of Allowable Benefits.
- (3) If,
 - a) the other Plan contains a provision coordinating its benefits with those of this Contract and its rules require the benefit of this Contract to be determined first, and
 - b) the rules set forth in item (5) of this Section require the benefits of this Contract to be determined first, then the benefits of the Plan will be ignored in determining the benefits under this Contract.

(4) If the Plan does not include a Coordination of Benefits provision, such Plan will be the primary Plan.

(5) If the Plan does include a Coordination of Benefits provision:

a) The Plan covering the patient other than as a Dependent will be the primary Plan.

b) Where both Plans cover the patient as a Dependent child, the Plan covering the patient as a dependent child of a parent whose date of birth, excluding year of birth, occurs earlier in the calendar year shall be the primary Plan. But, if both parents have the same birthday, the Plan which covered the parents longer will be the primary Plan. If the parents are separated or divorced the following will apply:

(i) The Plan which covers the child as a Dependent of the parent with custody will be the primary Plan.

(ii) If the parent with custody has remarried, the Plan which covers the child as a Dependent of the stepparent with custody will determine its benefits before the Plan covering the child as dependent of the parent without custody.

(iii) Where there is a court decree which establishes financial responsibility for the health care expenses of the dependent child, the Plan which covers the child as a Dependent of the parent with such financial responsibility will be the primary Plan as long as the Plan of that parent has actual knowledge of the court decree.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in the first paragraph of B. (5) b).

In the event this Plan is coordinating with a Plan that uses the male/female rule regarding dependent children, the first paragraph of B. (5) b defaults to the following:

Where both Plans cover the patient as a dependent child, the Plan covering the patient as a dependent child of a male will be the primary Plan, except that if the parents are separated or divorced, the following will apply:

c) Where the determination cannot be made in accordance with B. (5) a) or b) above, the Plan which has covered the patient for the longer period of time will be the primary Plan, provided that:

(i) the benefits of a Plan covering the person as an Applicant - Subscriber other than a laid-off or retired Applicant - Subscriber, or as the Dependent of such person shall be determined before the benefits of a Plan covering the person as a laid-off or retired Applicant - Subscriber or as a dependent of such person; and

(ii) if either Plan does not have a provision regarding laid-off or retired Applicant - Subscribers, and, as a result, the benefits of each Plan are determined after the other, then the provisions of c) (i) above shall not apply.

C. Facility of Payment:

When payments should have been made under this Contract in accordance with the provision, but the payments have been made under any other Plan, this Plan has the right to pay to any organization that has made such payment any amount it determines to be warranted to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this Contract and to the extent of the payments for covered services, the Plan shall be fully discharged from liability under this Contract.

D. Right of Recovery

- (1) Whenever payments have been made by this Plan for covered services in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, this Plan shall have the right to recover the excess from among the following, as the Plan shall determine: any person to or for whom such payments were made, any insurance companies, or any other organizations.
- (2) The Subscriber, personally and on behalf of family members shall, upon request, execute and deliver such documents as may be required and do whatever else is reasonably necessary to secure the Plan's rights to recover the excess payments.

- E. The Plan shall not be required to determine the existence of any Plan or amount of Benefits Payable under any Plan except this Contract, and the payment of benefits under this Contract shall be affected by the Benefits payable under any and all other Plans only to the extent that this Plan is furnished with information relative to such other Plans by the employer or employee or any other insurance company or organization in person.

When the benefits are reduced under the primary Plan because the member does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Benefit. Examples of such provisions are those related to second surgical opinions and pre-certification of admissions and services.

Section 2. Coordination with Medicare:

If a Subscriber is also entitled to receive benefits under Medicare (Part A and/or Part B) for services covered by this Contract, payment may be coordinated between the Plan and Medicare in order to avoid duplication of benefits.

Section 3. Subrogation:

In the event any benefit is provided under this Contract, the Plan shall be subrogated and succeed to the Subscriber's right of recovery therefore against any person, firm, or organization except against insurers on policies issued to and in the name of the Subscriber, and except where prohibited by law. The Subscriber shall execute and deliver such instruments and take such other reasonable action as the Plan may require to secure such rights. The Subscriber shall do nothing to prejudice the rights given the Plan by this paragraph without its consent.

ARTICLE VIII. REPORTS AND RECORDS

Section 1. Release of Information:

Each Subscriber agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under this Contract may furnish to the Plan, upon its request, any information (including copies of records relating to the illness or injury).

In addition, the Plan may furnish similar information to other entities providing similar benefits at their request.

The Plan may also furnish other Plans or Plan sponsored entities with membership and/or coverage information for the purpose of claims processing or facilitating patient care.

Section 2. Recertification:

In order to verify a Subscriber's income, the Subscriber is obligated to provide to the Plan, or its designated agent on a periodic basis as requested by the Plan, a completed recertification of eligibility form and any supporting documentation to allow the Plan to determine continued eligibility under the appropriate Subscription Rate. The Subscriber hereby grants permission to the Plan or its designated agent to verify any such information with employers, insurance companies, or other organizations or individuals.

The Subscriber is responsible for maintaining and supplying any records which may be requested by the Plan to determine continued eligibility for the appropriate Subscription Rate applicable to this Contract. If the Subscriber fails to provide records or disclose such information at the Plan's request, the Plan will determine that the Subscriber is no longer eligible for the current Subscription Rate, and will apply the Subscription Rate applicable to over-income Subscribers according to the terms detailed under "Section 3. Revision of Terms or Rates" of Article IV. Contract and Subscription Rates.

ARTICLE IX. GENERAL PROVISIONS

Section 1. Medically Necessary and Appropriate:

Benefits for Allowed Services set forth in this Contract are provided only when and as long as they are Medically Necessary and Appropriate for the proper treatment of the Subscriber's condition, in compliance with the Managed Care Program.

Section 2. Assignment:

The benefits of this Contract are personal and may not be assigned. The right to receive payment for benefits under this Contract may not be assigned unless otherwise required by law. Any attempted assignment shall be void.

Section 3. Plan Liability:

The Plan shall not be required to furnish equipment or facilities or personnel to provide the services covered by this Contract nor is it liable for the acts or omissions of any Approved Health Care Facility or any person who undertakes to render such services.

Section 4. Special Care Participating Facility Provider:

- A. The agreement between the Plan and a Special Care Participating Health Care Facility may be terminated by either party upon the giving of 90 days prior written notice to the other party. However, during any Subscriber's Admission which began prior to the date of termination of the agreement between the Plan and a Special Care Participating Health Care Facility, the facility shall continue to receive payment for services under the terms of this Contract.
- B. In computing the number of Inpatient Days a Subscriber has used, either the day of admission or the day of discharge shall be counted, but not both. Except, however if the Subscriber is admitted and discharged on the same day, it shall be counted as one day. The Plan, however, may not be held responsible for any charges made by the Approved Health Care Facility for the Subscriber's failure to vacate a room prior to the Facility's established discharge hour for all patients.
- C. If war, public disaster, public emergency, general epidemic, or other similar conditions prevent any Approved Health Care Facility from providing care to Subscribers, the only obligation of the Plan shall be to refund the amount of unearned prepaid Subscription Rates held by the Plan on the date such event occurs.

Section 5. Notice of Claim:

Written notice of illness or injury must be given to the Plan within 20 days after the date such illness or injury occurred. Failure to furnish such notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. The notice that is given by the Subscriber shall be sent to the Plan's home address; or, it can be given to any authorized agent of the Plan, with information sufficient to identify the Subscriber. This shall be deemed notice to the company.

Section 6. Claim Forms:

Special Care Participating Health Care Facilities are required to submit claims on behalf of the Subscriber. Non-Participating Health Care Facilities are not required to submit claims on behalf of the Subscriber. In the event that a Subscriber is required to submit a claim form, the Plan, upon receipt of a notice of claim, will furnish to the Subscriber such forms that are usually furnished by it for filing proof of loss. If such forms are not furnished within fifteen days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Contract as to proof of loss upon submitting, within the time fixed in the Contract for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Section 7. Proof of Loss:

Written proof of loss must be furnished to the Plan at its said office in case of claim for loss for which this Contract provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the Plan is liable. In the case of claim for any other loss, written proof of such loss must be furnished to the Plan within 90 days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible and in no event, except the absence of legal capacity, later than one year from the time proof is otherwise required.

Section 8. Time of Payment of Claims:

Benefits payable under this Contract for any claim other than a claim for which this Contract provides any periodic payment, will be processed immediately upon receipt of proper proof of loss. Subject to receipt of proper written proof of loss, all benefits for loss for which this Contract provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof of loss.

Section 9. Payment of Benefits:

Payments for Allowed Services provided by Special Care Participating Health Care Facilities will normally be made to the provider of such services. However, the Plan reserves the right to make payments to Subscribers toward expenses for Allowed Services in accordance with the intent and the provisions of this Contract and only in amounts as would be payable by the Plan to such Special Care Participating Health Care Facilities.

Section 10. Subscriber's Classification:

The Subscriber's classification is determined by the classification of the Applicant as set forth in Article I, Section 16. Upon a change in the classification of the Applicant, all Subscribers covered by this Contract will be classified according to the Applicant's classification and will be entitled to the benefits provided for that classification.

Section 11. Error in Payment:

In the event payment has been made to the Subscriber for any excluded services or supplies, or for any services or supplies through inadvertence or error the Subscriber shall reimburse Independence Blue Cross for such payment.

Section 12. Legal Action:

No legal action may be taken to recover benefits within 60 days after notice of claim has been given as specified above, and no such action may be taken later than three years after the time written proof of loss is required to be furnished to the Plan.

Section 13. Conformity with State Statutes:

Any provision of this Contract which, on its effective date, is in conflict with the statutes of the state in which the Subscriber resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Section 14. Misstatement of Age:

If the age of the Subscriber has been misstated, all amounts payable under this Contract shall be such as the subscriber rate paid would have purchased at the correct age.

Section 15. Relationship to Blue Cross and Blue Shield Plans:

This Contract is between the Subscriber and Independence Blue Cross only. Independence Blue Cross is an independent corporation operating under a license from the Blue Cross and 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 Independence Blue Cross to use the familiar Blue Cross and Blue Shield words and symbols. Independence Blue Cross, which is entering into this Contract, is not contracting as an agent of the national Association. Only Independence Blue Cross shall be liable to the Subscriber for any of the Plan's obligations under this Contract. This paragraph does not add any obligations to this Contract.



Special Care
Hospital Expense Coverage

This Is A Limited Benefit Contract - Read It Carefully



Independence
Blue Cross

1901 Market Street • Philadelphia, PA 19103