

# SPECIAL CARE



**Guaranteed Renewable**

## Medical-Surgical Benefits Contract

### For Direct Payment Subscribers 21 Day Program

**Right to examine contract:** You have ten (10) days after receipt of the contract within which you may decide whether you desire to keep this contract. If for any reason you decide not to keep this contract, return it to the Blue Cross Plan in your area. Blue Cross is the billing and enrollment agent for Pennsylvania Blue Shield for this program and will refund your premium. Blue Shield shall not be liable for payment of any benefits under this contract in such refund cases.

*This Is A Limited Benefit Contract - Read It Carefully*



**Pennsylvania  
BlueShield**

An Independent Licensee of the Blue Cross  
and Blue Shield Association

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Special Care<sup>SM</sup> is not affiliated with SPECIAL CARE, Inc. a Home Care Company @ 1-888-777-7630.

# SPECIAL CARE

## Medical-Surgical Expense coverage

Coverage under this special program is made available 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.

When Covered Services are performed by a Pennsylvania Blue Shield Participating Professional Provider, payment for these Covered Services will be accepted by the Participating Professional Provider as payment-in-full (except where certain Maximums or Co-Payments are specified). When such Covered Services are performed by a Professional Provider who does not participate with Pennsylvania Blue Shield, payment will be made as provided in Section VI.1.F.

### ***Required Outline of Coverage***

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- (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 Pennsylvania Blue Shield. It is, therefore, important that you **READ YOUR CONTRACT CAREFULLY!**
- (2) **Special Care Medical-Surgical Expense Coverage** - Your Special Care Contract is designed to provide, to eligible persons, coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations set forth in the contract. Coverage is not provided for hospital expenses or unlimited medical-surgical expenses.
- (3) The benefits provided under this Contract are eligible when performed by a licensed audiologist, Certified Registered Nurse, chiropractor, Independent Clinical Laboratory, dentist, nurse midwife, optometrist, doctor of medicine, doctor of osteopathy, physical therapist, podiatrist, psychologist, speech-language pathologist and teacher of the hearing impaired acting within the authority of such licensure and include:
  - (a) Surgery;
  - (b) Transplant Services;
  - (c) Oral Surgery;
  - (d) Assistant Surgery;
  - (e) Second Surgical Opinion;

- (f) Anesthesia Services by other than the surgeon or his assistant and other than a local anesthetic;
  - (g) Maternity Services;
  - (h) Routine Newborn Care;
  - (i) Inpatient Medical Care;
    - (1) 21 Medical days;
    - (2) Concurrent Medical Care;
  - (j) Consultation Services limited to one per consultant;
  - (k) Emergency Accident Services;
  - (l) Emergency Medical Services;
  - (m) Outpatient Medical Visits;
  - (n) Inpatient Diagnostic Services; \$1,000 maximum per calendar year in an emergency outpatient setting;
  - (o) Radiation Therapy;
  - (p) Chemotherapy;
  - (q) Physical Therapy; and
  - (r) Preventive Services.
- (4) This is a limited benefits contract and as such is not subject to certain Pennsylvania mandated benefits.

The following is a brief description of contract exclusions:

- (a) Services provided in connection with Worker's Compensation;
- (b) Services that neither the subscriber nor any other covered person is legally obligated to pay;
- (c) Pre-operative care when not admitted and any post-operative care other than that normally provided following surgery;
- (d) Services which Blue Shield deems to be experimental or investigative;

- (e) Services which are not medically necessary;
- (f) Dental care except as allowed in Section II. 3;
- (g) Treatment of temporomandibular joint syndrome with intra-oral devices, or any method which alters vertical dimension;
- (h) Operations for cosmetic purposes;
- (i) Services related to radial keratotomy surgery;
- (j) Treatment of bunions, toe nails, corns, calluses, etc.;
- (k) Services by a professional provider compensated by a facility or enrolled in an education or training program;
- (l) Services billed by a facility or services which are payable by Blue Cross;
- (m) Charges for completion of insurance forms, or services for which the subscriber incurs no charge;
- (n) Services performed on certain high-cost technological equipment;
- (o) Pre-existing conditions where medical advice or treatment was recommended by a professional provider within 12 months of the effective date;
- (p) Clinical pathology services for which a facility bills;
- (q) Treatment in connection with sexual dysfunction not related to organic disease or injury;
- (r) Treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such surgery;
- (s) Any treatment leading to or in connection with Assisted Fertilization;
- (t) 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;
- (u) Benefits paid as a result of a motor vehicle accident;
- (v) Routine neonatal circumcision;
- (w) Allergy testing, including the allergy extract;
- (x) Care, treatment, or services for Alcohol or Drug Abuse, and/or Mental Illness;

- (y) Preventive pediatric care, except benefits for Pediatric immunizations as set forth in Section III of the Contract;
  - (z) Speech, occupational, physical, respiratory or pulmonary therapy as an outpatient;
  - (aa) Prescription Drugs;
  - (bb) Durable Medical Equipment, Orthotics and Prosthetics except for Prosthetic devices in connection with a mastectomy;
  - (cc) For 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);
  - (dd) Care, treatment, or services not specifically provided in this Outline or the Contract except as required to be covered by law;
  - (ee) Care, treatment, or services rendered prior to a subscriber's effective date of Coverage under this contract;
  - (ff) For any illness or injury suffered after the Subscriber's Effective Date during the Subscriber's commission of a felony;
  - (gg) Services rendered by a Provider who is a member of the Subscriber's Immediate Family.
- (5) Subject to any amendment permitted under applicable law, this Contract will remain in effect until terminated by the Subscriber or the Plan.
- (a) This Agreement is guaranteed renewable and cannot be terminated by the Plan except in the following instances:
    - 1) if payment of the appropriate subscriber rate is not made when due or within the grace period;
    - 2) if the Subscriber in obtaining coverage, or in connection with coverage hereunder, shall have performed an act or practice constituting fraud or intentional misrepresentation of a material fact (e.g., misuse of the Subscriber Identification Card). However, the Plan will not terminate this Contract because of a Subscriber's Medically Necessary and Appropriate utilization of services covered under this Contract;
    - 3) upon ninety (90) days notice to the Subscriber when the Plan discontinues this coverage, and offers to each individual the option to purchase any other individual health insurance coverage currently being offered by the Plan to individuals within the geographical area served by the Plan, or upon one



his payment to the Participating Professional Provider within sixty (60) days of the notification by Pennsylvania Blue Shield, or within sixty (60) days, makes arrangements with the Provider to pay any financial obligations owed by the Subscriber to the Provider.

Participating Professional Providers must be used to obtain maximum benefits and to minimize the Subscriber's financial liability. Charges in excess of the Special Care allowance made by Non-Participating Professional Providers shall remain the financial liability of the Subscriber.

# SPECIAL CARE

## Contract For Direct Pay Subscribers

Upon payment in advance of the applicable Subscriber rate, Pennsylvania Blue Shield agrees to make payment for those Covered Services performed as set forth in this Contract when performed by Professional Providers. Coverage is provided for Surgery, Anesthesia, Inpatient Medical Care, Emergency Accident and Medical Care, Diagnostic Services, Therapy Services, Maternity Services, and Preventive Services as described in this Contract. This Contract is non-participating in any divisible surplus of premium.

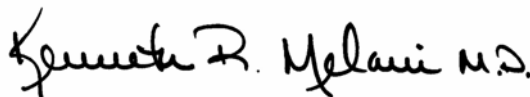
**PARTICIPATING PROFESSIONAL PROVIDERS must be used to obtain maximum benefits and to minimize Subscriber financial liability.** Participating Professional Providers accept the Special Care Allowance as payment in full. Charges in excess of the Special Care Allowance made by Non-Participating Professional Providers shall remain the liability of the Subscriber.

### ***Guaranteed Renewable/Subscriber Rate Subject to Change on a Class Basis***

This Contract is guaranteed renewable. Nonrenewal by the Plan shall not be based on the deterioration of mental or physical health of any individual covered under this Contract. This Contract may be terminated as set forth in Section VI, Section 2.G. Subject to the approval of the Pennsylvania Insurance Department, the Plan may adjust subscriber rates. Any change in the Subscriber rates shall become applicable for Subscribers upon expiration of the period covered by the Subscriber's current payment at the time of such change.



A not-for-profit corporation operating under the supervision of the Insurance Department and the Department of Health of the Commonwealth of Pennsylvania.



Kenneth R. Melani, M.D., President and Chief Executive Officer  
Highmark Inc. d/b/a Pennsylvania Blue Shield

This contract replaces all Special Care contracts previously entered into between Pennsylvania Blue Shield and the Subscribers covered under this Contract.

Pennsylvania Blue Shield • 1800 Center Street • Camp Hill, PA 17089

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## ***IMPORTANT***

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A Subscriber shall not be entitled to payment for Covered Services performed in connection with a Pre-existing Condition for the first 12 months that this or a prior Blue Shield Contract providing payment for such Covered Services has been in effect without interruption.

## **PRE-EXISTING CONDITION**

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A Pre-existing Condition is defined as any condition, illness or injury for which medical advice or treatment was recommended by a Professional Provider or received from a Professional Provider within a 12-month period preceding the Effective Date of this Contract.

## **PROOF OF LOSS**

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A claim for Covered Services must be submitted within one year after the Covered Services were received. A Participating Professional Provider is required to submit the claim within that time period. If Covered Services were performed by a Non-Participating Professional Provider, it is the Subscriber's responsibility to have a claim submitted within one year.

Failure to submit a claim within one year may result in a denial of payment, except if the Subscriber lacks legal capacity.

## ***When "PAID-IN-FULL BENEFITS" apply***

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When Covered Services are performed by a Pennsylvania Blue Shield Participating Professional Provider, payment for these Covered Services will be accepted by the Participating Professional Provider as payment-in-full (except where certain Maximums or Co-Payments are specified). When such Covered Services are performed by a Professional Provider who does not participate with Pennsylvania Blue Shield, payment will be made as provided in Section VI.1.F.

## ***ENROLLMENT ELIGIBILITY PROVISION***

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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, as 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 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 in order to determine their enrollment classification and to determine the appropriate subscriber rate. The Applicant further agrees to notify the Plan at the time of any such change in income that would change such eligibility status as the Plan may determine eligibility for the appropriate contract rate.

Determination of eligibility and the applicable Subscriber Rate classification by the Plan is conclusive.

## **Section I. DEFINITIONS**

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1. **ANESTHESIA** - the administration of regional or rectal anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation or loss of consciousness.
2. **ALCOHOL OR DRUG ABUSE** - any use of alcohol or other drugs which produce a pattern of pathological use causing impairment in social or occupational functions or which produces physiological dependency evidenced by physical tolerance or withdrawal.
3. **APPLICATION** - the written request for this Contract submitted on a Blue Shield form together with any amendments or modifications thereof. This request may be for a previous Blue Shield Contract which has been replaced by this Contract.
4. **ASSISTED FERTILIZATION** - 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).
5. **BENEFIT PERIOD** - the specified period of time during which charges for Covered Services must be Incurred in order to be eligible for payment by Pennsylvania Blue Shield. Benefits are stated in Section II - Medical-Surgical Benefits. All other benefits are administered on a calendar year basis. A charge shall be considered Incurred on the date the service or supply was provided to a Subscriber.
6. **BIRTHING CENTER** - a facility approved by Blue Cross which is primarily organized and staffed to provide maternity care by a licensed certified nurse midwife.
7. **BLUE CROSS** - Independence Blue Cross.
8. **BLUE SHIELD** - any of the Blue Shield Plans which are members of the Blue Cross and Blue Shield Association.
9. **CERTIFIED REGISTERED NURSE** - a certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or a certified clinical nurse specialist, certified by the State Board of Nursing, or a national nursing organization recognized by the

State Board of Nursing. This excludes any registered professional nurses employed by a health care facility, as defined in the Health Care Facilities Act, or by an anesthesiology group.

- 10. CO-PAYMENT** - a specified amount of expense applied to a specific Covered Service for which the Subscriber is responsible per Covered Service.
- 11. COVERED SERVICE** - a service or supply specified in this Contract for which benefits will be provided when rendered by a Professional Provider.
- 12. CUSTODIAL CARE** - care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury or condition. Custodial Care includes but is not limited to help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications not requiring constant attention of trained medical personnel.
- 13. DIAGNOSTIC SERVICES** - the following procedures ordered by a Professional Provider because of specific symptoms to determine a definite condition or disease. Diagnostic Services are covered to the extent specified in this Contract and include:
  - A** x-ray, radiology, ultrasound and nuclear medicine;
  - B.** diagnostic laboratory, consisting of pathology tests;
  - C.** diagnostic medical, consisting of ECG, EEG, and other diagnostic medical procedures approved by Blue Shield.
- 14. EFFECTIVE DATE** - the date on which coverage for a Subscriber begins under this Contract. The Effective Date is the first day of the premium period requested by the Subscriber on the application, upon receipt of the appropriate premium payment.
- 15. EXPERIMENTAL OR INVESTIGATIVE** - the use of any treatment, procedure, facility, equipment, drug and drug usage, device or supply which the Plan, relying on the advice of the general medical community which includes but is not limited to medical consultants, medical journals and/or governmental regulations, does not accept as standard medical treatment of the condition being treated by the general medical community or Blue Shield or any such items requiring federal or other governmental agency approval not granted at the time services were rendered.
- 16. FEE SCHEDULE** - the list of procedures and allowances as filed with and approved by the Pennsylvania Insurance Department. This Fee Schedule indicates the maximum Blue Shield Special Care payments for the respective Covered Services. This Fee Schedule may be modified from time to time during the term of this Contract with the approval of the Pennsylvania Insurance Department.

- 17. HOSPITAL** - a short-term, acute care Hospital which has been approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by Blue Cross and which:
- A.** is a duly licensed institution;
  - B.** is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of physicians;
  - C.** provides 24-hour nursing service by or under the supervision of registered nurses; and
  - D.** is not other than incidentally a:
    - (1)** Skilled Nursing Facility,
    - (2)** nursing home,
    - (3)** Custodial Care home,
    - (4)** health resort,
    - (5)** spa or sanitarium,
    - (6)** place of rest,
    - (7)** place for the aged,
    - (8)** place for the treatment of Mental Illness,
    - (9)** place for the treatment of alcoholism or drug abuse,
    - (10)** place for the provision of hospice care, or
    - (11)** place for the treatment of pulmonary tuberculosis.
- 18. IDENTIFICATION CARD** - the currently effective card which shows that a Blue Shield Contract has been issued to the Applicant-Subscriber.
- 19. IMMEDIATE FAMILY** - the Subscriber's spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law or son-in-law.
- 20. INCURRED** - a charge shall be considered Incurred on the date a Subscriber receives the service or supply for which the charge is made.
- 21. INPATIENT** - a Subscriber who is registered as an overnight bed patient in a Hospital and for whom a room and board charge is made.
- 22. MAXIMUM** - the greatest amount payable by Blue Shield for Covered Services. This could be expressed in dollars, number of days, or number of services for a specified period of time.
- 23. MEDICAL CARE** - professional services rendered by a Professional Provider for the treatment of an illness or injury.
- 24. MEDICALLY NECESSARY (OR MEDICAL NECESSITY)** - services or supplies provided by a Professional Provider that Blue Shield determines are:

- A. appropriate for the symptoms and diagnosis or treatment of the Subscriber's condition, illness, disease or injury; and
  - B. provided for the diagnosis, or the direct care and treatment of the Subscriber's condition, illness, disease or injury; and
  - C. in accordance with current standards of good medical practice; and
  - D. not primarily for the convenience of the Subscriber, or the Subscriber's Professional 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.
25. **MENTAL ILLNESS** - a mental, nervous or emotional disorder, such as a neurosis, psychoneurosis, psychopathy or psychosis, without demonstrable organic origin.
26. **NON-PARTICIPATING PROFESSIONAL PROVIDER** - a Professional Provider who does not have a Participating Provider Agreement with the Plan pertaining to covered services rendered to a Subscriber.
27. **OUTPATIENT** - a Subscriber who receives services or supplies while not an Inpatient.
28. **PARTICIPATING PROFESSIONAL PROVIDER** - a Professional Provider with whom Blue Shield has a contract concerning payment for services covered by this Contract.
29. **PLAN** - Pennsylvania Blue Shield.
30. **PRE-EXISTING CONDITION** - a condition for which medical advice or treatment was recommended by a Professional Provider or received from a Professional Provider within a one-year period preceding the Effective Date of the coverage of the Subscriber.
31. **PRE-SURGICAL CERTIFICATION** – a process whereby the medical necessity and appropriate place of service is determined prior to the performance of such surgical procedures. The selected procedures are identified in Section IV. Pre-Surgical Certification.

**32. PROFESSIONAL PROVIDER** - a person or practitioner licensed where required performing services within the scope of such licensure. The Professional Providers are:

- audiologist
- physical therapist
- podiatrist
- nurse midwife
- doctor of medicine
- optometrist
- chiropractor
- psychologist
- dentist
- doctor of osteopathy
- Certified Registered Nurse
- speech language pathologist
- Independent Clinical Laboratory
- teacher of the hearing impaired

**33. SPECIAL CARE ALLOWANCE** - A feature whereby Participating Providers agree to accept the Special Care Fee Schedule or the UCR allowance as payment-in-full for covered services. This allowance is determined by the applicant's enrollment or recertification classification.

**34. SUBSCRIBER -**

- A. SUBSCRIBER** - "Subscriber" means any person who is covered by this Contract, and for whom the proper Subscriber Rate is currently being paid.
- B. APPLICANT** - "Applicant" means the Subscriber who signed the Application, and with whom the Corporation 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, 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.
- E. NEWBORN CHILD** - A Subscriber's newborn child will be considered a Dependent under this Contract for 31 days immediately following birth. If the Subscriber is not enrolled under a family contract and wishes to continue coverage for the newborn beyond this time, application must be made within the 31 day period and the appropriate rate must be paid when billed.

**35. SURGERY** - the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures. Treatment of fractures and dislocations is also considered Surgery.

- 36. THERAPY SERVICES** - services or supplies used for the treatment of an illness or injury to promote the recovery of the Subscriber. Therapy Services are covered to the extent specified in the Section II. Benefits.
- A. RADIATION THERAPY** - the treatment of disease by X-ray, radium, or radioactive isotopes.
  - B. CHEMOTHERAPY** - the treatment of malignant disease by chemical or biological antineoplastic agents.
  - C. DIALYSIS TREATMENT** - the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis.
  - D. PHYSICAL THERAPY** - the treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury or loss of body part.
- 37. USUAL, CUSTOMARY, AND REASONABLE (UCR) ALLOWANCE** - under the UCR methodology, Pennsylvania Blue Shield determines an allowed amount for Covered Services by applying one or more of the following criteria:
- A. USUAL** - the allowed amount determined by Blue Shield for a Professional Provider based upon that individual provider's charges for the procedure performed.
  - B. CUSTOMARY** - the allowed amount determined by Blue Shield by considering relevant professional, economic, and market factors, including but not limited to: the degree of professional involvement, charges of professional providers of the same or similar specialty for the procedure performed, the actual cost of equipment and facilities, or other factors which contribute to the cost of the procedure.
  - C. REASONABLE** - the allowed amount (which may differ from the Usual or Customary allowed amounts) determined by Blue Shield by considering unusual clinical circumstances.

Allowed amounts are updated periodically to respond to changing economic and market circumstances. The timing of updates and methodology employed are subject to approval by the Insurance Department of the Commonwealth of Pennsylvania.

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## **Section II. MEDICAL-SURGICAL BENEFITS**

Subject to exclusions, conditions and limitations of this Contract, the Subscriber is entitled to benefits for Covered Services as described in this section. The following services are eligible when performed in any place of treatment except where otherwise indicated and when deemed Medically Necessary by Blue Shield, and performed and billed for by a Professional Provider.

1. **SURGERY** - Surgery for the treatment of disease or injury. Separate payment will not be made for Inpatient pre-operative care or post-operative care normally provided by the surgeon as part of the surgical procedure.

Surgery includes coverage for the following when performed in connection with a mastectomy; surgery to re-establish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and maxtopexy. Coverage is also provided for the initial and subsequent prosthetic devices to replace the removed breast or portions thereof.

Also covered is the orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft Surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

2. **TRANSPLANT SERVICES** - Services performed for a Subscriber, including the Covered Services for the removal of an organ from a donor when the donor is not a Subscriber and not covered under another health care plan.
3. **ORAL SURGERY** - The following oral surgical services are eligible only as the result of an accidental injury: surgical extractions, root recovery, surgical exposure, and alveolectomy.
4. **ASSISTANT SURGERY** - Services by an assistant surgeon who actively assists the operating surgeon in the performance of covered Surgery. The condition of the Subscriber or the type of Surgery must require the active assistance of an assistant surgeon. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.
5. **SECOND SURGICAL OPINION** - Consultations to determine the Medical Necessity of an elective surgical procedure.

Elective Surgery is that Surgery which is not of an emergency or life-threatening nature. Such Covered Services must be performed and billed by a Professional Provider other than the Provider who initially recommended performing the Surgery.

One additional consultation, as a third opinion, is eligible in cases where the second opinion disagrees with the first recommendation. In such instances, the Subscriber will be eligible for the Maximum of two such consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

6. **ANESTHESIA** - Administration of Anesthesia in connection with the performance of Covered Services when rendered by a Professional Provider other than the surgeon, assistant surgeon, or attending Professional Provider.

## **7. MATERNITY SERVICES**

### **A. Normal Pregnancy**

Normal pregnancy includes any condition usually associated with the management of a pregnancy but not considered a complication of pregnancy.

A Subscriber must be enrolled without interruption from the date of conception to the birth of the child under a Pennsylvania Blue Shield Medical-Surgical Agreement order to be eligible for this benefit.

### **B. Complications of Pregnancy**

Physical effects directly caused by pregnancy, but which are not considered from a medical viewpoint to be part of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.

### **C. Interruptions of Pregnancy**

- (1) Treatment of miscarriage;
- (2) Non-elective induced abortion;

Non-elective induced abortions are defined as abortions:

- (a) necessary to avert the death of the mother;
  - (b) performed in a case of pregnancy which is the result of rape reported within 72 hours to a law enforcement agent; and
  - (c) performed in a case of pregnancy which is the result of incest which is reported within 72 hours from the date the female first learns she is pregnant.
- (3) Elective induced abortion;
  - (4) Septic abortion.

### **D. Routine Newborn Care**

Professional visits to examine the newborn while an Inpatient during the mother's confinement in a Hospital or Birthing Center.

- 8. MEDICAL CARE** - Medical Care rendered by the Professional Provider in charge of the case to a Subscriber who is an Inpatient in a Hospital for a condition not related to Surgery, Maternity Services, Radiation Therapy or Mental Illness, except as specifically provided in the benefit description.

The Subscriber is eligible for 21 days of care for each Benefit Period. The Benefit Period is renewed when 90 days have elapsed between the discharge from and subsequent admission to a Hospital. Such care includes Inpatient Intensive Medical Care rendered to a Subscriber whose condition requires a Professional Provider's constant attendance and treatment for a prolonged period of time.

- 9. CONCURRENT CARE** - Medical Care rendered to an Inpatient by a Professional Provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Subscriber, stand-by services, routine pre-operative physical examinations or Medical Care routinely performed in the pre- or post-operative or pre- or post-natal periods.
- 10. CONSULTATIONS** - Consultation services rendered to an Inpatient at the request of the attending Professional Provider. Consultations do not include staff consultations which are required by Hospital rules and regulations. Consultation services are limited to one consultation per consultant during any one Inpatient stay.
- 11. EMERGENCY ACCIDENT CARE** - Medical Care for the initial treatment of traumatic bodily injuries resulting from an accident. However, if the accident services are classified as Surgery (e.g., suturing, fracture care, etc.) payment will be made as a surgical benefit.
- 12. EMERGENCY MEDICAL CARE** - Medical Care for the initial treatment of a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:
- A.** permanently placing the Subscriber's health in jeopardy;
  - B.** causing other serious medical consequences;
  - C.** causing serious impairment to bodily functions; or
  - D.** causing serious and permanent dysfunction of any bodily organ or part.
- 13. OUTPATIENT MEDICAL VISITS** - Medical Care visits by a Professional Provider for the examination, diagnosis, and treatment of an injury or illness.

Benefits will be provided for up to 4 visits per subscriber per calendar year. Each visit is subject to a \$10 copayment.

**14. DIAGNOSTIC SERVICES** - Diagnostic Services rendered to an inpatient or performed in an outpatient setting by a Professional Provider. Services performed in an outpatient setting are subject to a \$1,000 maximum per subscriber per calendar year.

- A. X-ray, radiology, ultrasound and nuclear medicine. All physician-recommended mammographies for females under age 40 are covered. 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.
- B. Laboratory and pathology tests performed, billed for, or ordered by a Professional Provider.
- C. ECG, EEG, radioisotopic studies and other diagnostic medical procedures approved by Blue Shield.

**15. THERAPY SERVICES**

- A. Radiation Therapy.
- B. Chemotherapy, by intravenous or intra-arterial injection, infusion or perfusion, subcutaneous and intramuscular routes, intracavitary and oral administration. The cost of drugs approved by the Food and Drug Administration (FDA) as antineoplastic agents is covered, provided they are administered as described in this paragraph.
- C. Dialysis Treatment.
- D. Physical Therapy for an Inpatient.

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***Section III. PREVENTIVE BENEFITS***

Subject to the Exclusions, conditions and limitations of this Contract, a subscriber 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.

- A. **PEDIATRIC PREVENTIVE CARE** includes routine physical examinations, immunizations, and routine diagnostic services, regardless of medical necessity. Benefits are provided for the following pediatric preventive services when the service is received during the ages listed. When a range is given (i.e., 2- 3 months) the dash indicates that coverage is available for one service from 2 months through 3 months of age.

This schedule of Pediatric Preventive benefits may be updated periodically in response to guidelines issued by the medical community.

<b>1. Routine Pediatric History and Examination</b>	<b>One routine examination is covered during each of the following age ranges.</b>	
	<i>0-1 months</i>	<i>2 years</i>
	<i>2-3 months</i>	<i>3-4 years</i>
	<i>4-5 months</i>	<i>5-6 years</i>
	<i>6-8 months</i>	<i>7-8 years</i>
	<i>9-11 months</i>	<i>9-11 years</i>
	<i>12-14 months</i>	<i>12-14 years</i>
	<i>15-17 months</i>	<i>15-17 years</i>
<i>18-24 months</i>		
<b>2. Routine Urinalysis</b>	One routine urinalysis is covered from 15 months through 4 years.	
<b>3. Hemoglobin or Hematocrit</b>	One routine hemoglobin or hematocrit is covered during each of the following age ranges:	
	<i>2-11 months</i>	<i>15-17 years</i>
<b>4. Rubella Titer Test</b>	One rubella titer test covered from 11 through 17 years of age.	
<b>5. Tine Test</b>	One tine test is covered from 9 through 17 months.	
<b>6. Pediatric Immunizations</b>	With respect to Subscribers under Age 21 and their Dependent Children, coverage will be provided for those pediatric immunizations for childhood diseases, 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. ADULT PREVENTIVE CARE** includes:

1. Benefits are provided for one (1) routine gynecological examination, including a pelvic examination, clinical breast examination, and one (1) routine pap smear per calendar year for all female Subscribers. Benefits are exempt from all deductibles or maximums;
2. Benefits are provided for one screening mammography per calendar year for females 40 years of age and older. 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.

## **Section IV. PRE-SURGICAL CERTIFICATION**

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The listed procedures, with the exception of emergency services, are subject to Pre-surgical Certification.

### **1. PRE-SURGICAL CERTIFICATION**

Pre-surgical 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, the physician's office, or a freestanding surgical facility. The physician notifies Quality Care Admission Review of the proposed surgery. Quality Care Admission Review staff reviews the information provided by the physician to determine if the surgery or admission is Medically Necessary and Appropriate, and then notifies the Subscriber and the physician of approval or denial of the surgery.

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

No benefits will be provided (by either Blue Cross or Blue Shield) for services which are determined to be not Medically Necessary and Appropriate through the Pre-surgical Certification Process.

Emergency Services do not require Pre-surgical Certification.

### **2. PRE-SURGICAL CERTIFICATION PROCEDURES**

Pre-surgical Certification is required for the following surgical procedures:

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

### **3. APPROVAL PROCESS**

Precertification must be requested before the specified procedure is performed. Services performed as a result of an emergency do not require Precertification.

The Professional Provider should initiate the precertification process by calling the managed care center telephone number:

1-800-862-3648

#### **4. APPEAL PROCEDURE**

In the event the Subscriber disagrees with the Pre-surgical Certification determination, the Subscriber may submit an appeal in writing. Such appeal must be submitted no later than sixty (60) days from the date the Subscriber is notified. The appeal should include all information in support of the Subscriber's claim. The Precertification Center will review the appeal, make a final decision, and notify the Subscriber of the final decision within sixty (60) days of the receipt of the Subscriber's appeal. All appeals should be sent to:

Quality Care Admission Review  
1901 Market Street  
Philadelphia, PA 19103

#### ***Section V. EXCLUSIONS***

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**This is a limited benefits contract and as such is not subject to certain Pennsylvania mandated benefits.**

Except as specified in this Contract, no benefits will be provided for services, supplies or charges:

1. 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;
2. To the extent benefits are provided by the Veteran's Administration or by the Department of Defense for active military personnel;
3. For any loss sustained or expenses incurred during military service while on active duty; or as a result of an act of war, whether declared or undeclared;
4. That neither the subscriber or any other covered person is legally obligated to pay;
5. For pre-operative care when the Subscriber is not an Inpatient and any post-operative care other than that normally provided following operative or cutting procedures;
6. Which are Experimental or Investigative in nature;
7. Which Blue Shield has determined to be not Medically Necessary; or for screening examinations and routine or periodic physical examinations except those specifically provided for in Section III;

- 8.** Dental care except as allowed in Section II. 3;
- 9.** For treatment of temporomandibular joint syndrome with intra-oral devices or any other method to alter vertical dimension;
- 10.** 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. 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 previous therapeutic processes;
- 11.** For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
- 12.** Performed in a facility by a Professional Provider who in any case is compensated by the facility for similar services performed for patients;
- 13.** Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
- 14.** For which the fees or charges are billed by Hospitals or other facilities;
- 15.** Performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program;
- 16.** For completion of any insurance forms, or services for which the Subscriber incurs no charge;
- 17.** For local infiltration anesthetic;
- 18.** For equipment costs related to services performed on high cost technological equipment as defined by Blue Shield, such as, but not limited to, computer tomography (CT) scanners, Magnetic Resonance Imagers (MRI) and extra-corporeal shock wave lithotripters, unless the acquisition of such equipment of a Professional Provider was approved through the Certificate of Need (CON) process and/or by Blue Shield;
- 19.** Performed for a Subscriber in connection with any condition, illness or injury for which medical advice or treatment was recommended by a Professional Provider or received from a Professional Provider within a one-year period preceding the Effective Date of this Contract. This exclusion applies only to the first 12 months that this or a prior Blue Shield contract providing payment for such services has been in effect without interruption;

20. For clinical pathology services for which a Hospital or other facility bills;
21. Treatment in connection with sexual dysfunction not related to organic disease, or injury;
22. Treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such surgery;
23. Any treatment leading to or in connection with Assisted Fertilization;
24. For correction of myopia or hyperopia by means of corneal microsurgery such as keratomileusis, keratophakia, and radial keratotomy, and all related services;
25. 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;
26. For payment made by Medicare when Medicare is primary;
27. Which are paid, or payable, in whole or in part, by a Blue Cross Plan;
28. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;
29. Which are submitted by a Certified Registered Nurse and another Professional Provider for the same services performed on the same date for the same patient;
30. For routine neonatal circumcision;
31. Which were or are Incurred after the date of termination of the Subscriber's coverage, except as provided in Section VI of this Contract;
32. Care, treatment, or services for Alcohol or Drug Abuse, and/or Mental Illness;
33. Prescription Drugs;
34. Durable Medical Equipment, Orthotics and Prosthetics except for Prosthetic devices in connection with a mastectomy;
35. Speech, occupational, physical, respiratory or pulmonary therapy as an Outpatient;
36. For preventive pediatric care, except benefits for Pediatric Immunizations as set forth in Section III of the contract;

37. 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);
38. For allergy testing, including the allergy extract;
39. For any illness or injury suffered after the Subscriber's Effective Date during the Subscriber's commission of a felony;
40. Rendered by a Provider who is a member of the Subscriber's Immediate Family;
41. For any other medical or dental service or treatment except as provided in Section II of this Contract;
42. For care, treatment, or services rendered prior to a Subscriber's effective date of coverage under this contract.

## ***Section VI. GENERAL PROVISIONS***

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### **1. PAYMENT OF BENEFITS**

**A. IDENTIFICATION CARD** - The Subscriber Identification Card must be presented to the Professional Provider when a service is requested.

**B. NOTICE OF CLAIM** -

(1) Blue Shield will not be liable under this Contract unless proper notice is furnished to Blue Shield that Covered Services have been rendered to a Subscriber. Written notice must be given within ninety (90) days after completion of the Covered Services. The notice must include the data necessary for Blue Shield to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered. Notice given by or on behalf of the Subscriber to Pennsylvania Blue Shield at its main office in Camp Hill, with information sufficient to identify the Subscriber, shall be deemed notice to the Plan.

(2) Failure to give notice to Blue Shield within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will Blue Shield be required to accept notice more than twelve months after Covered Services are rendered except if the Subscriber lacks legal capacity.

**C. RELEASE OF INFORMATION** - Each Subscriber agrees that any person or entity having information relating to an illness or injury for which benefits are claims under this Contract may furnish to Pennsylvania Blue Shield, upon its request, any information (including copies of records) relating to the illness or injury. In addition, Pennsylvania Blue Shield may furnish similar information to other entities providing similar benefits at their request.

In addition, Pennsylvania Blue Shield conducts quality of care initiatives. These may include reviews of medical records in the Professional Provider’s office or at a Facility Provider and notification to a Subscriber or the Subscriber’s Professional Provider of potentially beneficial treatment options. Each Subscriber agrees to permit Pennsylvania Blue Shield to review and share such information with such individuals, each of whom must sign agreements to keep this information confidential.

Pennsylvania Blue Shield 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.

**D. PAYMENT ALLOWANCES** - Blue Shield shall pay the Special Care Allowance or the amount charged (whichever is less) for services covered by this Contract except:

- (1) where certain Maximums are specified;
- (2) (a) for the medical direction of anesthesia services administered by a nurse anesthetist not employed by a Professional Provider, payment is made at 50% of the Special Care allowance;
- (b) for anesthesia services administered by an independently practicing Certified Registered Nurse Anesthetist (CRNA) under the medical direction (supervision) of a Professional Provider other than the surgeon, assistant surgeon, or attending Professional Provider, payment is made at 50% of the Special Care allowance;
- or
- (3) for assistant surgeon services which are payable as follows:

<b><i>Blue Shield Payment for Surgical Procedures</i></b>	<b><i>Blue Shield Maximum Payment for Assisted Surgeon</i></b>
<i>\$250.00 and under</i>	<i>\$50.00</i>
<i>Over \$250.00</i>	<i>20% of surgical payment</i>

- (4) when two or more surgical services are performed by the same Professional Provider at the same operative session and through the same incision, Blue Shield will pay the Special Care allowance for the highest paying procedure and no allowance for additional procedures. When two or more surgical services are performed by the same Professional Provider at the same operative session, but not through the same incision, Blue Shield will pay the Special Care allowance for the highest paying procedure and 50 percent of the Special Care allowance for each other procedure.

- E. SERVICES OF PARTICIPATING PROFESSIONAL PROVIDERS** - If Covered Services are performed by a Participating Professional Provider, Blue Shield will make payment directly to the Professional Provider. Participating Professional Providers have agreed to accept Blue Shield's payment for Covered Services performed as payment-in-full, except when certain Maximums or Co-Payments are specified in this Contract.
- F. SERVICES OF PROFESSIONAL PROVIDERS WHO ARE NOT PARTICIPATING PROFESSIONAL PROVIDERS** - If Covered Services are performed by a Professional Provider who is not a Participating Professional Provider, Blue Shield reserves the right to make payment to the Subscriber. Any difference between the Professional Provider's charge and the Blue Shield payment shall be the personal responsibility of the Subscriber.
- G. MEDICAL NECESSITY** - Blue Shield's decision as to Medical Necessity for Covered Services performed shall be final.
- H. ASSIGNMENT** - Any rights of a Subscriber to receive payment for Covered Services under this Contract are personal to the Subscriber and may not be assigned unless otherwise required by law.
- I. PHYSICAL EXAMINATION** - The Plan at its own expense, shall have the right and opportunity to examine the person of the insured when as often as it may be reasonably required during the pendency of a claim hereunder.
- J. BENEFITS TO WHICH SUBSCRIBERS ARE ENTITLED** -
- (1) The liability of Blue Shield is limited to the benefits specified in this Contract.
  - (2) A Subscriber shall be entitled to only those benefits specified in this Contract.
  - (3) The right to benefits and coverage is not transferable.
  - (4) Benefits for Covered Services specified in this Contract will be provided only for services that are rendered by a Professional Provider listed in the Definitions section of this Contract and regularly included in such Professional Provider's charges.
- K. APPLICABLE LAW** - This Contract is entered into and is subject to the laws of the Commonwealth of Pennsylvania.
- L. NOTICE** - Any notice required under this Contract must be in writing. Notice given to Blue Shield will be sent to Blue Shield. Notice given to a Subscriber will be sent to the Subscriber's address as it appears on the records of Blue Shield. Blue Shield or a Subscriber may, by written notice, indicate a new address for giving notice.

**M. COORDINATION OF BENEFITS** - All benefits provided under this Contract are subject to this provision, and will not be increased by virtue of this provision.

**(1) Definitions**

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

- (a)** “Plan” means any individual coverage or group arrangement providing health care benefits or Covered Services through:
  - 1)** individual, group, blanket (except student accident) or franchise insurance coverage;
  - 2)** Blue Cross, Blue Shield, health maintenance organization, group practice, and other prepayment coverage;
  - 3)** coverage under labor management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans;
  - 4)** coverage under any tax-supported or government program to the extent permitted by law; and
  - 5)** coverage under a hospital indemnity plan of more than \$100 per 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.

- (b)** “Dependent” means, for any Plan, any person who qualifies as a Dependent under that Plan.
- (c)** “Allowable Benefits” means the charge for Covered Services.
- (d)** “Benefits Paid or Payable” means the amounts actually paid for Covered Services.

**(2) Effect on Benefits**

- (a)** 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.
- (b)** 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 other Plans does not exceed the total of Allowable Benefits.

- (c) If,
- 1) the other Plan contains a provision coordinating its benefits with those of this Contract and its rules require the benefits of this Contract to be determined first, and
  - 2) 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 other Plan will be ignored in determining the benefits under this Contract.
- (d) If the other Plan does not include a Coordination of Benefits provision, such Plan will be primary.
- (e) If the other Plan does not include a Coordination of Benefits provision:
- 1) The Plan covering the patient other than as a Dependent will be the primary Plan.
  - 2) 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 a calendar year shall be the primary Plan. But, if both parents have the same birthday, the Plan which covered the parent longer will be the primary Plan. If the parents are separated or divorced, the following will apply:
    - a) The Plan which covers the child as a Dependent of the parent with custody will be the primary Plan.
    - b) 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 a Dependent of the parent without custody.
    - c) 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.
    - d) 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 GENERAL PROVISIONS, COORDINATION OF BENEFITS, Effect of Benefits, 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:

- 3)** Where the determination cannot be made in accordance with (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:
  - a)** The benefits of a Plan covering the person as an employee other than a laid-off or retired employee 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 employee or as a Dependent of such person; and
  - b)** If either Plan does not have a provision regarding laid-off or retired employees, and, as a result, the benefits of each Plan are determined after the other, then the provisions of (3) (a) above shall not apply.

**(3) Facility of Payment**

Whenever payments should have been made under this Contract in accordance with this provision, but the payments have been made under this Contract in accordance with this 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.

**(4) Right of Recovery**

- (a)** 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 company or any other organization.
- (b)** 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 necessary to secure the Plan's rights to recover the excess payments.

- (c) 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 Pennsylvania Blue Shield is furnished with information relative to such other Plans by the employer or employee or any other insurance company or organization or person.

When the benefits are reduced under the primary Plan because a Subscriber does not comply with the Plan provisions, the amount of such reduction will not be considered an allowable benefit.

**N. SUBROGATION -**

- (1) To the extent that benefits for Covered Services are provided or paid under this Contract, Blue Shield shall be subrogated and succeed to any rights of recovery of a Subscriber for expenses incurred against any person or organization except insurers on policies of health insurance issued to and in the name of the Subscriber or where specifically prohibited by law.
- (2) The Subscriber shall pay Blue Shield all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided or paid under this Contract, unless prohibited by law or regulation.
- (3) The Subscriber shall take such action, furnish such information and assistance, and execute such papers as Blue Shield may require to facilitate enforcement of its rights and shall take no action prejudicing the rights and interests of Blue Shield under this Contract.

**O. STATUTORY LIMITATIONS OF BLUE SHIELD LIABILITY -** Blue Shield shall not be liable for injuries or damage resulting from acts or omissions of any Blue Shield officer or employee or of any Professional Provider or other person furnishing services or supplies to the Subscriber.

**P. LEGAL ACTION -** No legal action may be commenced against Blue Shield with respect to this Contract until sixty (60) days after Blue Shield has received a properly completed claim. Nor may such action be taken at all later than three (3) years after the time written proof of loss is required to be furnished.

**Q. ENROLLMENT IN MEDICARE -** If the Subscriber is also entitled to receive benefits paid under Medicare Part B for services covered under this Contract, payments shall be made after the Medicare Part B payment in order to avoid duplication of benefits. The Subscriber shall have the right at that time to convert to such programs as Pennsylvania Blue Shield may then have available.

## 2. SUBSCRIBER CONTRACT

- A. ENTIRE CONTRACT** - The entire contract between Blue Shield and the Subscriber consists of the Application, the Identification Card, this Contract and any amendments to it, the Special Care Fee Schedule, and the applicable Subscriber rate. The Special Care Fee Schedule and the Subscriber rates will be periodically reviewed by Blue Shield and, subject to the approval of the Pennsylvania Insurance Department, may be adjusted. No change in this Contract shall be valid until approved by an executive officer of Pennsylvania Blue Shield 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 Subscriber in application for such Contract shall be used to void Contract or to deny a claim for loss incurred or disability commencing after the expiration of such three (3) year period. No claim for loss incurred commencing after one (1) year from the date of issue of this Contract shall be reduced or denied on the grounds 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.
- C. SUBSCRIBER RATE** - The Applicant-Subscriber agrees to pay to Blue Shield in advance, as billed, the applicable Subscriber rate as filed with and approved by the Pennsylvania Insurance Department. Blue Shield, subject to the approval of the Pennsylvania Insurance Department, may change the Subscriber rates. In the event of such change, the Applicant-Subscriber shall be notified in advance of the effective date. Any notice will be considered given when mailed to the Subscriber at the address on the records of Blue Shield. Payment of the new rate shall be considered receipt of notice and acceptance of the change in rate.

When a Subscriber ceases to be an Eligible Person or Eligible Dependent, or the required contribution is not paid, the Subscriber's coverage will terminate at the end of the last month for which payment was made.

Should the Plan determine that the Applicant, based on an increase in income, is no longer eligible for the current Subscriber Rates, the Plan will apply an increase to the existing Subscriber Rate and the Plan will bill the Applicant the new Subscriber Rate. Any change in the Subscriber 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 Subscriber Rate and the effective date.

- D. GRACE PERIOD** - A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium during which grace period the policy shall continue in force, subject to the right of Pennsylvania Blue Shield to terminate in accordance with the Guaranteed Renewable/Subscriber Rate Subject to

Change provision hereof. However, if the premium is still unpaid after the thirty-one (31) day grace period, coverage is cancelled retroactively to the date the premium was originally due.

- E. 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 Subscriber 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 Subscriber 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 Subscriber Rate, and will apply the Subscriber Rate applicable to over-income Subscribers.

- F. REINSTATEMENT** - If this Contract is terminated due solely to nonpayment of the Subscriber rate, coverage will be reinstated if the Subscriber, within thirty-six (36) days from the date of termination, tenders and the Plan receives payment of the Subscriber rate required for reinstatement. The Subscriber and the Plan shall have the same rights under the reinstated Contract as they had under the Contract immediately before the due date of the defaulted subscriber rate. The right of the Subscriber to have this Contract reinstated is limited to one reinstatement during any twelve-month period and to two (2) reinstatements during the Subscriber's lifetime.

- G. RENEWAL AND TERMINATION** - Subject to any amendment permitted under applicable law, this Contract will remain in effect until terminated by the Subscriber or the Plan.

- (1) This Agreement is guaranteed renewable and cannot be terminated by the Plan except in the following instances:
- (a) if payment of the appropriate subscriber rate is not made when due or within the grace period;
  - (b) if the Subscriber in obtaining coverage, or in connection with coverage hereunder, shall have performed an act or practice constituting fraud or intentional misrepresentation of a material fact (e.g., misuse of the Subscriber Identification Card). However, the Plan will not terminate this Contract because of a Subscriber's Medically Necessary and Appropriate utilization of services covered under this Contract;

- (c) upon ninety (90) days' notice to the Subscriber when the Plan discontinues this coverage, and offers to each individual the option to purchase any other individual health insurance coverage currently being offered by the Plan to individuals within the geographical area served by the Plan, or upon one hundred eighty (180) days' notice to the Subscriber when the Plan discontinues all individual coverage within the geographical area served by the Plan; or
  - (d) in the event the Subscriber no longer lives or resides within the geographical area served by the Plan.
- (2) This Contract may be terminated at the end of any calendar month at the option of the Subscriber by the giving of thirty (30) days' prior written notice.
  - (3) If this Contract is terminated at the option of either party, the Plan shall refund to the Subscriber the amount of any unearned prepaid Subscriber rates held by the Plan.

**H. VOIDING OF COVERAGE DUE TO MATERIAL MISREPRESENTATIONS -**

This Contract shall be rendered null and void 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; or
- (2) if the Subscriber makes a material misrepresentation in the application for coverage under this Contract and such material misrepresentation is discovered by the Plan within three (3) years of the Effective Date of coverage.

In either event, this Contract shall, upon notice to the Subscriber, be rendered null and void. The Plan shall refund to the Subscriber the amount of the Subscriber Rate paid by the Subscriber after deducting the amount of any benefits paid by the Plan under this Contract.

**I. 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 the Plan. 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.

**J. BENEFITS AFTER TERMINATION OF COVERAGE -** Except when termination results from fraud or intentional misrepresentation of a material fact, benefits shall continue after termination as stated in Section V.

- (1) In the event the Subscriber is an Inpatient at the time of termination, the Inpatient stay shall continue to be covered until benefits are exhausted or the Subscriber is discharged, whichever occurs first.

- (2) If the Plan elects to terminate this Contract and a Subscriber eligible for maternity care based on the date of conception is pregnant at the termination date, benefits for Covered Services for maternity care are set forth in Section II – Medical-Surgical Benefits of this Contract, will be provided; however, if termination of the Contract is the result of, fraud or intentional misrepresentations of a material fact, the liability of the Plan shall cease as of the date of such termination, and no benefits will be provided for maternity care incurred after that date.
- (3) If a Subscriber is totally disabled on the date this Contract is terminated, for reasons other than fraud, or intentional misrepresentation of a material fact, and the Subscriber incurs charges for the disabling cause while the Subscriber remains so disabled, the Subscriber shall be entitled to benefits under the terms of this Contract.

Benefits will be provided, for charges incurred for the disabling cause, until the earlier of: (1) the end of the Benefit Period; or (2) the exhaustion of benefits. Any such continuation of benefits after the date this Contract is terminated is conditioned upon the continuous total disability of the Subscriber and the providing of documentation as required by the Plan which evidences continued total disability.

- K. RIGHT OF APPEAL** - Whenever a Subscriber disagrees with the Plan's denial of all or part of a claim under this Contract, the Subscriber may seek review of that denial by submitting a written appeal. The appeal shall set forth the reasons on which the Subscriber is relying in support of his request for payment of claim. The appeal must be received by the Plan within sixty (60) days after the Subscriber received notice that the claim was denied.

The appeal should be sent to:

Pennsylvania Blue Shield  
P.O. Box 898847  
Camp Hill, Pennsylvania 17089-8847

- L. CLAIM FORM - PROOF OF LOSS** - Pennsylvania Blue Shield will not be liable under this Contract unless a claim form is furnished to Pennsylvania Blue Shield indicating that Covered Services have been rendered to a Subscriber. A claim form may be submitted in paper format or through electronic format. A claim form may be submitted within ninety (90) days after completion of the Covered Services. The claim form must include the data necessary for Pennsylvania Blue Shield to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

Failure to submit a claim form to Pennsylvania Blue Shield within the time specified will not reduce any benefit if it is shown that the claim form was submitted as soon as reasonably possible, but in no event will Pennsylvania Blue Shield be required to accept

the claim form more than twelve (12) months after Covered Services are rendered, except if the person lacks legal capacity.

A Participating Professional Provider is required to submit a claim form within ninety (90) days after completion of Covered Services on behalf of Subscribers. If Covered Services were performed by a Non-Participating Professional Provider, it is the Subscriber's responsibility to assure the claim form is submitted within one (1) year, except if the person lacks legal capacity.

Participating Professional Providers are required to submit claims on behalf of the Subscriber. Non-Participating Professional Providers 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 which are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) 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.

**M. TIME OF PAYMENT** - Claim payment for benefits payable under this Contract will be processed immediately upon receipt of proper proof of loss.

### **3. RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD PLANS**

This contract is between the Subscriber and Pennsylvania Blue Shield only. Pennsylvania Blue Shield 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 Pennsylvania Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Pennsylvania Blue Shield, which is entering into this Contract, is not contracting as an agent of the national Association. Only Pennsylvania Blue Shield 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.

## **REMEMBER THAT...**

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...coverage for unmarried children under Pennsylvania Blue Shield family Agreement ends when they reach age nineteen (19), unless they are full-time students. If Subscriber rate for coverage extending beyond this date has been paid, coverage for the Child will continue during the period for which the Subscriber rate is paid. In order to maintain Pennsylvania Blue Shield coverage without interruption in benefits, application must be made to Pennsylvania Blue Shield no later than thirty-one (31) days following the nineteenth birthday.

...children who marry before age nineteen (19) are no longer covered under their parent's Pennsylvania Blue Shield family Agreement. If Subscriber rate for coverage extending beyond this date has been paid, coverage for the Child will continue during the period for which the Subscriber rate was paid. In order to maintain continuous coverage, these children must make application to Pennsylvania Blue Shield no later than thirty-one (31) days following date of marriage.

...if you become divorced, your spouse must be removed from your Agreement at the end of the month in which the divorce is final or the end of the period for which Subscriber rate for coverage extending beyond that date was paid. In order to maintain continuous coverage, your former spouse must make application to Pennsylvania 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 Pennsylvania 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 Blue Shield Identification card to your provider when you require services as by this contract.***

***This Is A Limited Benefit Contract - Read It Carefully***



**Pennsylvania  
BlueShield**

® Registered mark of the Blue Cross and Blue Shield Association.

SM Service Mark of the Blue Cross Plans of Pennsylvania and Pennsylvania Blue Shield.

Special Care<sup>SM</sup> is not affiliated with SPECIAL CARE, Inc. a Home Care Company @ 1-888-777-7630.