Highmark BCBSD Inc.*, d/b/a
HIGHMARK BLUE CROSS BLUE SHIELD DELAWARE
and
HIGHMARK DELAWARE
(Called the Plan)

A Delaware non-profit corporation whose mailing address is
800 Delaware Avenue, Suite 900, Wilmington, DE 19801

MedigapBlue – Plan G
Medicare Supplement Subscription Agreement

NOTICE TO THE BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

GUARANTEED RENEWABLE/PREMIUM SUBJECT TO CHANGE

Subject to the right of the Plan to cancel, terminate, nonrenew or void coverage in accordance with Section I., this Subscription Agreement is guaranteed renewable and may be renewed by payment of the applicable subscription rate. Subject to the approval of the Delaware Department of Insurance, the Plan may adjust the subscription rates paid by all Subscribers covered under this Subscription Agreement. In addition, the required subscription rate due under this Agreement may also change based upon the current attained age of the Subscriber. For additional information, refer to Sections I and VI of this Agreement.

Subscriber's Right to Examine Agreement for Thirty (30) Days

Upon initial enrollment, the Subscriber covered under this Subscription Agreement has a right to return this Agreement within thirty (30) days of delivery for refund of subscription rates paid if after examination of this Agreement the Subscriber is not satisfied for any reason. (See Return of Agreement by Subscriber on page 5.) This Agreement may be returned to:

Highmark Blue Cross Blue Shield Delaware
800 Delaware Avenue, Suite 900, Wilmington, DE 19801

*An independent licensee of the Blue Cross and Blue Shield Association

Your Highmark Blue Cross Blue Shield Delaware
MedigapBlue - Plan G
Medicare Supplement Subscription Agreement

TABLE OF CONTENTS

MEDIGAPBLUE - PLAN G
MEDICARE SUPPLEMENT
Subscription Agreement

Supplement to Medicare Insurance (Part A and Part B)
(See Limitations in SECTION III. BENEFITS)

This is to certify that, in consideration for and upon payment of the appropriate subscription rate, the person covered under this Subscription Agreement ("this Agreement") is entitled to the benefits set forth herein in accordance with the terms and conditions specified.

Guaranteed Renewable/Premium Subject to Change

[Margaret Eitl]
[Regional Vice President]

Incorporated Under the Laws of the State of Delaware

This Agreement supersedes and replaces all Medicare Supplement Agreements previously entered into between the Plan and the Subscriber covered under this Agreement.

Return of Agreement by Subscriber

If the Subscriber covered under this Subscription Agreement elects to return this Agreement within thirty (30) days of its delivery, the Subscriber may be entitled to a refund. If benefits are paid for claims incurred by the Subscriber during this period, there shall be no right to a full refund of subscription rates paid by the Subscriber. Notwithstanding the foregoing, the Plan shall not be liable for payment of any benefits under this Agreement in such refund cases.

HIGHMARK BLUE CROSS BLUE SHIELD DELAWARE
MEDIGAPBLUE - PLAN G AGREEMENT

This Agreement describes a program of health care benefits provided by the Plan. These benefits supplement Medicare coverage, in part, by providing payment for the following:

- The Medicare Coinsurance amount of Part A Medicare Eligible Expenses for hospitalization from the sixty-first (61^{st}) through the ninetieth (90^{th}) day in a Medicare Benefit Period.
- The Medicare Coinsurance amount of Part A Medicare Eligible Expenses for hospitalization for each Medicare lifetime inpatient reserve day.
- An additional three hundred sixty-five (365) inpatient days of care in a Hospital after the Subscriber has used all of the allowed Medicare days.
- Coverage under Medicare Parts A and B for the first three (3) pints of whole blood during a calendar year.
- The Medicare Coinsurance or Medicare Copayment amount of Part B Medicare Eligible Expenses, subject to the Medicare Part B Deductible.
- The cost sharing amount of Part A Medicare Eligible Expenses for hospice and respite care.
- Skilled Nursing Facility Care Part A Coinsurance.
- The Medicare Deductible for Part A.
- Medicare Part B Excess Charges.
- Medically Necessary Emergency Care in a foreign country.

These benefits will be provided to the Subscriber in accordance with the terms and conditions of this Agreement when necessary for the treatment of a condition of illness or bodily injury.

SECTION I - GUARANTEED RENEWABLE

A. CONTINUATION OF THIS AGREEMENT

1. This Agreement is guaranteed renewable and may be renewed by payment of the appropriate renewal premium within the grace period.

2. Coverage continues for one (1) month from the Effective Date of this Agreement and from month to month thereafter until discontinued, terminated or voided as provided in this Section.

B. GRACE PERIOD

A grace period of thirty-one (31) days from the due date will be granted for the payment of each subscription rate. During the grace period, the Agreement will stay in force; however, no benefits will be paid for services incurred subsequent to the Agreement's then current paid date. If appropriate payment is not received at the end of thirty-one (31) days, this Agreement automatically terminates as of the then current paid date without written notification to the Subscriber.

C. TERMINATION OF THIS AGREEMENT

1. The Plan will not cancel or nonrenew this Agreement solely on the ground of health status of the Subscriber.

2. The Plan shall terminate this Agreement if the subscription rate is not received by the Plan within the grace period. The effective date of termination shall be the last day of the period for which payment of the subscription rate has been received.

3. The Plan shall terminate this Agreement if the Subscriber obtained or attempted to obtain benefits or payment for benefits as a result of a material misrepresentation. If benefits were provided due to a material misrepresentation, the Subscriber agrees to reimburse the Plan for such benefits.

4. The Plan shall terminate this Agreement when the Plan cancels all Agreements of this type.

D. VOIDANCE

In the event a Subscriber makes a material misrepresentation or a false statement in obtaining Coverage under this Agreement, this Agreement is void. If benefits were provided under an Agreement issued under such circumstances, the Subscriber agrees to reimburse the Plan for the benefits which were provided.

E. REINSTATEMENT

If this Agreement is terminated due solely to nonpayment of the premium, coverage will be reinstated if the Subscriber, within sixty (60) days from the date of termination, tenders and the Plan receives payment of the premium required for reinstatement. The Subscriber and the Plan have the same rights under the reinstated Agreement as they had under the Agreement immediately before the due date of the defaulted premium. The right of the Subscriber to have this Agreement reinstated is limited to one (1) reinstatement during any twelve (12) month period and to two (2) reinstatements during the Subscriber's lifetime.

F. CONTINUATION OF BENEFITS AFTER TERMINATION

If a Subscriber is totally disabled on the date this Agreement is terminated for reasons other than material misrepresentation or at the request of the Subscriber, 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 Agreement.

Benefits will be provided, for charges incurred for the disabling cause, until the earlier of: (1) the end of the Medicare Benefit Period as defined in Section II of this Agreement; or (2) the exhaustion of benefits. Any such continuation of benefits after the date the Agreement 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. Receipt of Medicare Part D benefits will not be considered in determining continuous total disability.

In no event will payment be made for charges incurred on or after the date the Subscriber is covered for benefits which are similar under any other arrangement.

For the purposes of this provision, "total disability" shall mean a condition, commencing while this Agreement is in effect, resulting from illness or injury as a result of which, and as determined by the Plan, the Subscriber is unable to engage in the normal activities of an individual of the same age and sex.

G. NONDUPLICATION OF BENEFITS

This policy provides benefits for the services specified in this Agreement only to the extent that such benefits are not available under any other coverage the Subscriber may have. Benefits specified in this Agreement are also subject to **SECTION V. GENERAL PROVISIONS**, **Section B. COORDINATION OF BENEFITS**.

SECTION II - DEFINITIONS

A. AGREEMENT means this document, together with the Outline of Coverage, any endorsements thereto or required notice of change issued by the Plan, the application and any supplemental applications approved by the Plan, and the Subscriber's current Identification Card.

B. APPLICATION means the written request for Coverage under this Agreement on a form furnished by the Plan, together with any amendments or modifications thereof.

C. ASSIGNMENT means an agreement between the Provider and the Medicare beneficiary. When the Provider accepts Assignment, such Medicare Provider agrees to accept the Medicare Reasonable Charge set by Medicare as payment in full.

D. CONTINUOUS PERIOD OF CREDITABLE COVERAGE means the period during which the Subscriber was covered by Creditable Coverage, if, during the period of such Creditable Coverage, the Subscriber had no breaks in coverage greater than sixty-three (63) days.

E. COVERAGE means coverage under this Agreement except where the text requires otherwise.

F. COVERED SERVICE means a service or supply specified in this Agreement for which benefits will be provided when rendered by a Provider.

G. CREDITABLE COVERAGE means coverage of the Subscriber for which credit must be given under the Health Insurance Portability and Accountability Act of 1996, which includes coverage under any of the following: (1) A group health plan; (2) Health insurance coverage; (3) Part A or Part B of Title XVIII of the Social Security Act (Medicare); (4) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928; (5) Chapter 55 of Title 10, United States Code; (6) A medical care program of the Indian Health Service or a tribal organization; (7) A State health benefits risk plan; (8) A health plan offered under Chapter 89 of Title 5, United States Code; (9) A public health plan (as defined in federal regulations); (10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. §2504(e)); or (11) A State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. The term Creditable Coverage does not include coverage consisting solely of excepted benefits as defined in the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191, 110 Stat. 1936).

For purposes of this Agreement, the term Creditable Coverage does not mean creditable prescription drug coverage, as that term is defined under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Title XVIII, Section 1860D-13(b)(4) of the Social Security Act (Medicare).

H. EFFECTIVE DATE means the date the Subscriber's Coverage begins under this Agreement as shown on the records of the Plan and on the Identification Card issued to the Subscriber.

I. EMERGENCY CARE means Hospital, physician, and medical care needed immediately because of an injury or an illness of sudden and unexpected onset.

J. HOSPITAL means an institution which meets the Medicare requirements for a Hospital and participates in the Medicare program.

K. IDENTIFICATION CARD means the current effective card issued to the Subscriber by the Plan.

L. MEDICALLY NECESSARY AND APPROPRIATE means Covered Services or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. in accordance with generally accepted standards of medical practice;

2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

3. not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

The Plan reserves the right, utilizing the criteria set forth in this Definition, to render the final determination as to whether a Covered Service or supply is Medically Necessary and Appropriate. No benefits hereunder will be provided unless the Plan determines that the Covered Service or supply is Medically Necessary and Appropriate.

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

1. "Medicare Part A" means the Hospital Insurance Benefits provided by the United States Government under Public Law 89-97, Title XVIII of the Social Security Act as amended from time to time.

2. "Medicare Part B" means the Supplementary Medical Insurance Benefits provided by the United States Government under Public Law 89-97, Title XVIII of the Social Security Act as amended from time to time.

3. "Medicare Part D" means the Voluntary Prescription Drug Benefit Program provided by the United States Government under Public Law 108-173, Title XVIII of the Social Security Act as amended from time to time.

N. MEDICARE BENEFIT PERIOD means:

1. For purposes of Medicare Part A expenses, the period that begins on the first (1^{st}) day that the Subscriber receives services as an inpatient in a Hospital and ends after the Subscriber has been discharged from the Hospital and has not received skilled care in any other facility for a period of sixty (60) consecutive days.

2. For purposes of Medicare Part B expenses, the calendar year beginning January 1^{st} and ending on December 31^{st}.

O. MEDICARE COINSURANCE OR MEDICARE COPAYMENT means that portion of Medicare Eligible Expenses, or Medicare Reasonable Charges over and above the Medicare Deductible, which the Subscriber has the responsibility to pay under Medicare.

P. MEDICARE DEDUCTIBLE means that amount which is payable by the Subscriber during each Medicare Benefit Period before payment of benefits begin under Medicare Part A and/or Part B. (There is a separate Medicare Deductible for certain benefits under this Agreement, such as Hospital benefits, medical/surgical benefits and blood.)

Q. MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

R. MEDICARE NON-PARTICIPATING PROVIDER means a Provider eligible to provide services or supplies under Medicare Part B but who does not sign a participation agreement with Medicare, and may or may not elect to accept Assignment on each Medicare claim that is filed. A Medicare Non-Participating Provider who does not accept Assignment will not accept the Medicare Reasonable Charge for a certain service or supply as payment in full, and may charge his/her patient more than the Medicare Reasonable Charge, unless otherwise prohibited by law.

S. MEDICARE OPT-OUT PROVIDER means a Provider eligible to provide services or supplies under Medicare Part B but who has "opted out" of Medicare such that he/she foregoes any payments from Medicare, to his/her patients or themselves, and enters into private contracts with Medicare beneficiaries to provide eligible services, and bills Medicare beneficiaries directly for services provided.

T. MEDICARE PART B EXCESS CHARGES means those charges for Part B services that exceed the Medical Reasonable Charge.

U. MEDICARE REASONABLE CHARGE means the approved amount for services and supplies, as determined by Medicare.

V. PACE means the Program of All-Inclusive Care for the Elderly, the federal Medicare program permanently established by the United States Government under the Balanced Budget Act of 1997, Public Law 101-33 intended to provide comprehensive, community-based care and services to individuals otherwise in need of nursing home level of care. The term PACE does not include income-based prescription drug assistance programs offered and administered by states for the benefit of their qualified residents, age 65 or older, which are intended to provide individuals with greater access to prescription drug medications**.**

U. PLAN means Highmark BCBSD Inc., d/b/a Highmark Blue Cross Blue Shield Delaware, or its designated agent.

V. PROVIDER means anyone eligible to provide services or supplies under Medicare Part B such as a licensed doctor of medicine, doctor of osteopathy, doctor of dental surgery, doctor of pediatric medicine, doctor of optometry, doctor of chiropractic, psychologist, nurse midwife or certified registered nurse acting within the authority of his/her license.

W. SKILLED NURSING FACILITY means an institution which meets the Medicare requirements for a Skilled Nursing Facility and participates in the Medicare program.

X. SUBSCRIBER means a Medicare beneficiary, enrolled in Medicare Part A and Part B who has been enrolled by the Plan under this Agreement.

Y. UNITED STATES applies to all the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, Northern Mariana Islands and for purposes of Covered Services rendered on board ship, the territorial waters adjoining the land areas of the United States, subject to those limitations imposed by Medicare.

SECTION III - BENEFITS

Benefits under this Agreement are available for Medicare Eligible Expenses, except as otherwise excluded or limited in this Agreement. In addition, certain benefits which are not covered by Medicare are available under this Agreement only when and so long as they are determined to be Medically Necessary and Appropriate. The benefits for Medicare Deductible(s), Medicare Coinsurance and Medicare Copayment(s) under this Agreement will be changed automatically to coincide with changes under Medicare.

A. PRE-EXISTING CONDITION LIMITATION

The benefits stated in this Section will not be provided with respect to any pre-existing condition until after the expiration of at least six (6) consecutive months from the Effective Date of this Agreement. "Pre-existing condition" means a disease or physical condition for which the Subscriber has received medical advice or treatment within the six (6) consecutive month period immediately prior to the Subscriber's initial Effective Date under this Agreement.

Unless otherwise required or permitted by state or federal law, this pre-existing condition limitation may be reduced or waived in its entirety in the following instances:

1. **Waiver or reduction based on Creditable Coverage**:

   a) If the Subscriber submitted his/her Application for benefits under this Agreement prior to or during the six (6) month period beginning with the first (1^{st}) day of the first month in which the Subscriber was enrolled for benefits under Medicare Part B (regardless of age), and

   b) As of the date of the Application, the Subscriber had a Continuous Period Of Creditable Coverage of less than six (6) months, or if the Subscriber has replaced a prior Medicare Supplement policy with Coverage under this Agreement, the six (6) month pre-existing condition limitation will be reduced by the aggregate of the period of Creditable Coverage applicable to the Subscriber as of the date of enrollment. If, however, as of the date of the Application the Subscriber has a Continuous Period of Creditable Coverage of at least six (6) months, the pre-existing condition limitation will be waived in its entirety.

2. **Waiver based on "eligible person" status:**

   This pre-existing condition limitation does not apply to certain "eligible persons" as defined in the Balanced Budget Act of 1997 and other federal and state laws and regulations. For purposes of this provision, a general summary of an "eligible person" is an individual:

   a) Who was covered under an employer group health plan, and that plan was: (1)

supplemental to Medicare and terminated by the employer, or (2) primary to Medicare and terminated by the individual or the employer; or

b) Who was covered under a Medicare Advantage, Medicare SELECT, Medicare Demonstration, Medicare Cost or Risk plan, or who is sixty-five (65) years of age or older and was enrolled in a Program of All-Inclusive Care for the Elderly (PACE), which plan or program was terminated or otherwise discontinued by the organization that offered the plan or program or the organization has notified the individual of an impending termination; or

c) Who was covered under a Medicare Advantage, Medicare SELECT, Medicare Demonstration, Medicare Cost or Risk plan, or who is sixty-five (65) years of age or older and was enrolled in a PACE program, and moved out of the insurer/program/Blue Cross and/or Blue Shield plan's service area; or

d) Who was covered under a Medicare Advantage or Medicare SELECT or other Medicare supplemental coverage, or who is sixty-five (65) years of age or older and was enrolled in a PACE program, and left the plan or program because the insurer or organization offering the plan or program was bankrupt, the insurer or organization breached the policy or terms of the program or the policy or program was misrepresented upon purchase or enrollment; or

e) Who was first covered under Medicare Supplement coverage issued by this Plan, cancelled that coverage to join, for the first time, a Medicare Advantage, Medicare SELECT, Medicare Demonstration, Medicare Cost or Risk plan or a PACE program, and within twelve (12) months of the date their original Highmark Medicare Supplement coverage was terminated, elects to terminate enrollment in the Medicare Advantage, Medicare SELECT, Medicare Demonstration, Medicare Cost or Risk plan or PACE program, and return to the original or a lower cost Highmark Medicare Supplement plan; or

f) Who was first covered under a Medicare Supplement coverage, cancelled that coverage to join a Medicare Advantage or Medicare SELECT plan or a PACE program, and, within twelve (12) months of joining such plan, elects to terminate the Medicare Advantage, Medicare SELECT or PACE coverage and enroll in MedigapBlue because the initial Medicare supplemental plan is no longer available from that insurer; or

g) Who was covered under Medicare Advantage or Medicare SELECT plan or a PACE program when first notified of eligibility for Medicare, and, within twelve (12) months of joining such plan or program, elects to terminate that coverage; or

h) Who enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Medicare Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the Subscriber terminates enrollment in that Medicare supplement policy and submits evidence

of enrollment in Medicare Part D along with an Application for coverage under a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L.

B. BASIC BENEFIT PROVISIONS

This Agreement provides payment for the following:

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.

2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

3. Upon exhaustion of the Medicare Hospital inpatient coverage, including lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable Prospective Payment System (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the Plan's payment as payment in full and may not bill the Subscriber for any balance.

4. Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations.

5. Coverage for the Part B Medicare Coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the Medicare Copayment amount, of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B Deductible.

6. Coverage of cost sharing for all Part A Medicare Eligible Expenses for hospice and respite care.

C. ADDITIONAL BENEFITS

1. Skilled Nursing Facility Care Part A Coinsurance: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital Skilled Nursing Facility care eligible under Medicare Part A.

2. Medicare Part A Deductible: Coverage for 100% of the Medicare Part A inpatient Hospital deductible amount per Medicare Benefit Period.

3. Medicare Part B Excess Charges: Coverage for 100% of the difference between the Medicare Part B charges billed, not to exceed a charge limitation established by the Medicare program or state law (if any) and the Medicare-approved Part B charge.

4. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare Eligible Expenses for Medically Necessary emergency Hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States, and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000.

SECTION IV - EXCLUSIONS

Benefits will not be paid for services, supplies or charges under this Agreement as follows:

A. Benefits which are not specifically provided in Section III of this Agreement, including, but not limited to, the following: Medicare Part B Deductible.

B. Services, supplies or charges which are not covered by Medicare or for which benefits provided under Medicare have been exhausted, except as otherwise provided in Section III of this Agreement.

C. Services, supplies or charges covered under this Agreement which are not covered by Medicare and are not Medically Necessary and Appropriate as determined by the Plan.

D. Services, supplies or charges, not covered by Medicare, which are incurred due to confinement in a freestanding psychiatric facility.

E. Services, other than Emergency Care and urgent care services, covered by Medicare but rendered by a Medicare Opt-Out Provider to a Subscriber.

SECTION V - GENERAL PROVISIONS

A. PAYMENT OF BENEFITS

1. Identification Card

The Identification Card issued by the Plan must be presented by the Subscriber to anyone furnishing the Subscriber with services or supplies.

2. How to Obtain Benefits

In order to receive benefits under this Agreement, the Subscriber must furnish, or have furnished, an Explanation of Medicare Benefits if the services are covered by Medicare. Additionally, the Plan may require other necessary reports and records.

If services are performed outside of Delaware and the Provider accepts Assignment, the Medicare carrier for that state will automatically submit the Subscriber's claim to the Plan.

However, in order to collect benefits under this Medicare Supplement Subscription Agreement when services are performed outside of Delaware and the Provider does not accept Assignment, the Subscriber must notify the Plan.

For benefits which supplement Medicare Part A, and Hospital outpatient benefits that supplement Medicare Part B, the Subscriber must notify the Plan at:

[Highmark Blue Cross Blue Shield
Fifth Avenue Place
120 Fifth Avenue
Pittsburgh, PA 15222-3099]

For all other benefits that supplement Medicare Part B, the Subscriber must notify the Plan at:

[Highmark Inc.
P. O. Box 898845
Camp Hill, PA 17089-8845]

The Subscriber must mail a copy of the Explanation of Medicare Benefits with the Subscriber's identification number written in the right-hand corner. This identification number may be found on the Subscriber's Identification Card.

3. Notice of Claim and Proof of Loss

a. The Plan will not be liable for any claims under this Agreement unless proper notice is furnished to the Plan that services covered under this Agreement have

been rendered to a Subscriber. Written notice of a claim must be given to the Plan within twenty (20) days or as soon as reasonably possible after services have been rendered to the Subscriber. Notice given by or on behalf of the Subscriber to the Plan that includes information sufficient to identify the Subscriber who received the service shall constitute sufficient notice of a claim to the Plan. The Subscriber can give notice to the Plan by writing to the Member Service Department. The address of the Member Service Department can be found on the Subscriber's Identification Card. A charge shall be considered incurred on the date a Subscriber receives the service or supply for which the charge is made.

b. If the Subscriber (or if deceased, his/her personal representative) is required to submit a proof of loss for benefits under this Agreement, it must be submitted to the Plan on the appropriate claim form. The Plan, upon receipt of a notice of a claim will, within fifteen (15) days following the date a notice of a claim is received, furnish to the Subscriber claim forms for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of such notice, the Subscriber shall be deemed to have complied with the requirements of this Subsection as to filing a proof of loss upon submitting, within the time fixed in this Subsection for filing proofs of loss, itemized bills for Covered Services as described below.

c. For Subscriber submitted claims, the completed claim form, with all itemized bills attached, must be forwarded to the Plan at the address appearing on the claim form in order to satisfy the requirement of submitting a written proof of loss and to receive payment for benefits provided under this Agreement.

d. To avoid delay in handling Subscriber submitted claims, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing:

- Person or organization providing the service or supply
- Type of service or supply
- Date of service or supply
- Amount charged
- Name of patient

The Provider's bills must show specific treatment dates. The Subscriber's attending Provider must certify that he/she prescribed all services by signing his/her name on all bills, except doctor bills, or Hospital bills. (Some bills requiring a signature of the Provider include ambulance, prosthetic devices, rental of durable equipment, etc.). Itemized bills cannot be returned.

A request for payment of a claim will not be reviewed and no payment will be made unless all of the information and evidence of payment required on the claim form has been submitted in the manner described above. The Plan reserves the right to require additional information and documents as needed to support a claim that Covered Services have been rendered.

e. Claims cannot be paid until a written proof of loss is submitted to the Plan. Written proof of loss must be provided to the Plan within ninety (90) days after the date of such loss. Proof of loss must include all data necessary for the Plan to determine benefits. Failure to submit a proof of loss to the Plan within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will the Plan be required to accept a proof of loss later than twelve (12) months from the time proof is otherwise required.

f. For claims submitted by a Provider, the Plan will not be liable under this Agreement unless proof of loss is furnished to the Plan that Covered Services have been rendered to a Subscriber. Written proof of loss must be provided within ninety (90) days following the date the services were rendered. The proof of loss must include data necessary for the Plan to determine benefits.

g. Claim payments for benefits payable under this Agreement will be processed promptly upon receipt of a proper proof of loss.

4. Method of Payment

a. Supplementing Medicare Part A

Payment for the benefits provided under this Agreement will ordinarily be made to the Hospital, but the Plan may make payment directly to the Subscriber. In no event, however, may such payment be assigned without the consent of the Plan, unless otherwise required by law.

The Plan reserves the right to make payment directly to the Subscriber.

b. Supplementing Medicare Part B

1) <u>Providers Who Accept Assignment</u>
Under the terms of Assignment, the Subscriber transfers to the Provider the right to both the Medicare Part B and the Plan's payment under this Agreement based on Covered Services specified on the claim. The Provider, in turn, agrees to accept the Medicare Reasonable Charge set by the Medicare Part B Carrier, as the total charge for Covered Services.

The sum of the Medicare Reasonable Charge payments, eighty percent (80%) by Medicare Part B and twenty percent (20%) by this Agreement (or in the case of Hospital outpatient charges under a prospective payment system, the applicable Medicare Copayment), constitute payment in full, except where maximums, deductibles or other Medicare reductions are specified.

The Plan reserves the right to make payment directly to the Provider.

2) Providers Who Do Not Accept Assignment
If the Provider does not accept Assignment, any difference between the Provider's charge and the combined Medicare Part B and the Plan's payment shall be the personal responsibility of the Subscriber except where prohibited by law.

3) Providers Who Opt-Out of Medicare
The Plan will make no payment to a Medicare Opt-out Provider, except in cases where the Medicare Opt-out Provider renders Emergency Care or urgent care services, to a Subscriber who has not executed a private contract with that Medicare Opt-Out Provider. In such situations, the Plan will reimburse the Medicare Opt-out Provider twenty percent (20%) of the Medicare Reasonable Charge.

The Plan reserves the right to make payment directly to the Subscriber.

5. Prohibition of Assignment of Benefits

The benefits provided under this Agreement are personal to the Subscriber and may not be transferred to anyone else.

6. Reports and Records

The Subscriber authorizes the Social Security Administration to furnish to the Plan medical or other information acquired by it under Title XVIII of the Social Security Act (Medicare) to the extent necessary to process any claim under this Agreement. The Subscriber authorizes any person or organization which furnishes services or supplies to the Subscriber to provide the Plan with information necessary to process claims under this Agreement.

B. COORDINATION OF BENEFITS

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

1. Definitions – In addition to the Definitions of this Agreement, the following

definitions apply only to this provision;

a. **"Other Plan"** means any arrangement providing health care benefits or Covered Services through:

   1) individual, group, blanket or franchise insurance coverage, except a hospital indemnity plan of one hundred dollars ($100) per day or less;

   2) Blue Cross Blue Shield, health maintenance organization and other prepayment coverage;

   3) coverage under labor-management trust plans, union welfare plans, employer organization plans, or employee benefit organization plans; and

   4) coverage under any tax supported or government program to the extent permitted by law, except a state plan under Medicaid, or a governmental plan which, by law provides benefits which are in excess to those of any private insurance plan or any non-governmental plan.

b. **"Allowable Benefits"** means the charge for Covered Services.

c. **"Benefits Payable"** means amounts actually paid or payable for Covered Services.

2. Effects on Benefits

a. This provision shall apply in determining the benefits of this Agreement if, for Covered Services received, the sum of the Benefits Payable under this Agreement and the Benefits Payable under Other Plans would exceed the Allowable Benefits.

b. Except as provided in item c. of this Section, the Benefits Payable under this Agreement 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 Allowable Benefits.

c. If,
   1) the Other Plan contains a provision coordinating its benefits with those of this Agreement and its rules require the benefits of this Agreement to be determined first, and

   2) the rules set forth in item e. of this Section require the benefits of this Agreement to be determined first, then the benefits of the Other Plan will be ignored in determining the benefits under this Agreement.

d. If the Other Plan does not include a Coordination of Benefits provision, such

plan will be the primary plan.

e. If the Other Plan does include a Coordination of Benefits provision the plan covering the patient other than as a dependent will be the primary plan.

f. Where the determination cannot be made in accordance with d and e above, the plan which has covered the patient for the longer period of time will be the primary plan, provided that:

1) the benefits of a plan covering a person as an Subscriber other than a laid-off or retired 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 Subscriber or as a dependent of such person; and

2) if either plan does not have a provision regarding laid-off or retired Subscribers, and, as a result, the benefits of each plan are determined after the other, then the provision of f.1) above shall not apply.

g. Services provided under any governmental program for which any periodic payment of rate is made by the Subscriber shall always be the primary plan, except when prohibited by law, or when the Subscriber has elected Medicare secondary payer.

3. Facility of Payment

When payments should have been made under this Agreement in accordance with the provision, but the payments have been made under any Other Plan, the Plan has the right to pay 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 Agreement and to the extent of the payments for Covered Services, the Plan shall be fully discharged from liability under this Agreement.

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, the 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.

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 reasonably necessary to secure the Plan's rights to recover the excess payments.

The Plan shall not be required to determine the existence of any plan or amount of Benefits Payable under any plan except this Agreement, and the payment of benefits under this Agreement shall be affected by the Benefits Payable under any and 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 or person.

When the benefits are reduced under the primary plan because a Subscriber does not comply with the plan provisions, or does not maximize benefits available under the primary plan, the amount of such reduction will not be considered an Allowable Benefit. Examples of such provisions are those related to second surgical opinions, precertification of admissions and services, and preferred provider arrangements.

C. DUPLICATE MEDICARE SUPPLEMENT COVERAGE

If any benefits to which a Subscriber is entitled under this Agreement are also provided in full or in part by another Medicare supplement agreement, the Plan may treat this Agreement void and without effect.

D. SUBROGATION

Subrogation means that if the Subscriber is injured because of the negligence or wrongdoing of another party, the Plan has the right to seek recovery of benefits paid for related expenses. The Subscriber is expected to take any reasonable action necessary to protect and to assure the subrogation rights of the Plan. This provision does not apply to an individual insurance policy covering the Subscriber.

If benefits are provided or payments made under this Agreement, the Plan will be subrogated and succeed to the Subscriber's right of recovery therefore against any person or organization except against insurers on policies of insurance issued to and in the name of the Subscriber. When it shall appear to the Plan that such rights of recovery may exist, the Subscriber will not be entitled to any benefits under this Agreement until the Subscriber has (1) completely answered all questions submitted by the Plan concerning the accident or cause of the condition of illness or injury, and (2) if requested by the Plan, executed an assignment of the right of recovery evidencing the subrogation rights of the Plan to the extent of benefits to be furnished or payment to be made under this Agreement.

The Subscriber may also be required to execute and deliver other instruments, furnish information and assistance, and take other reasonable action as the Plan may require either prior to or after the approval of benefits or payments under this Agreement in order to facilitate enforcement of their respective rights. The Subscriber will do nothing to prejudice these rights without the consent of the Plan.

The Subscriber shall pay the Plan 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 Agreement, unless prohibited by law.

The rights of subrogation of the Plan shall be waived when subrogation is prohibited by law.

E. LIMITATIONS OF PLAN LIABILITY

The Plan shall not be liable for injuries or damage resulting from any acts or omissions of any Highmark Blue Cross Blue Shield Delaware officer or employee or any Provider or other person furnishing services or supplies to the Subscriber.

F. LIMITATIONS ON LEGAL ACTION

No action at law or in equity shall be brought to recover on this Agreement prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Agreement. No such action shall be brought after the expiration of two (2) years after the time written proof of loss is required to be furnished.

G. COMPUTATION OF BENEFIT DAYS

In computing the number of inpatient benefit days a Subscriber has used, either the day of admission or the day of discharge shall be counted, but not both. The Subscriber agrees that the Plan may not be held responsible for any charges made by a Hospital if the Subscriber fails to vacate the room prior to the established discharge hour for all patients after being discharged by the attending physician.

H. TIME LIMIT ON CERTAIN DEFENSES

After three (3) years from the date of issue of this Agreement, no misstatements, except fraudulent misstatements, made by the Subscriber in the Application for such Agreement shall be used to void the Agreement 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 after one hundred-eighty (180) days from the date of issue of this Agreement 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 Agreement.

I. PHYSICAL EXAMINATIONS

The Plan, at its own expense, shall have the right and opportunity to examine the person of the Subscriber when and as often as it may reasonably require during the

pendency of a claim hereunder.

J. MISSTATEMENT OF AGE

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

K. RELEASE OF INFORMATION

Certain personally identifiable information about individual Subscribers (collectively, "Personal Information") is subject to various statutory privacy standards, including, but not limited to, state insurance regulations implementing Title V of the Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and regulations adopted thereunder by the Department of Health and Human Services (45 CFR Parts 160, 162, 164). In accordance with those standards, the Plan may use and disclose Personal Information as permitted or required by law, and to facilitate payment, treatment and health care operations as described in the Plan's Notice of Privacy Practices ("NPP"). Copies of the Plan's current NPP are available on the Plan's Internet site, or from the Plan's Privacy Department.

SECTION VI - SUBSCRIPTION AGREEMENT

A. ENTIRE CONTRACT; CHANGES

The entire contract between the Plan and the Subscriber consists of the Application and this Agreement, including amendments to its terms reflected in any endorsement or required notice of change issued by the Plan, the Subscriber's current Identification Card, and the applicable Subscription rate. No agent other than a Plan officer, may otherwise change this Agreement or waive its provisions.

B. SUBSCRIPTION RATES

The subscription rates that apply to this Agreement at any given time are those on file with and approved by the Delaware Department of Insurance. The Subscriber agrees to pay to the Plan in advance, as billed, the applicable subscription rate.

This Agreement is attained age rated. This means that the subscription rate charged will increase as the age of the Subscriber changes. The initial subscription rate charged to the Subscriber is based upon his/her attained age at the time the application for coverage is approved. When coverage is renewed, the subscription rate charged will be adjusted and based upon the age which the Subscriber has then attained.

The Plan also reserves the right to adjust applicable subscription rates based upon changes in Medicare, health care costs and factors other than the Subscriber's attained age.

C. CHANGE OF RESIDENCE

If the Subscriber establishes a residence outside the United States, benefits provided outside the United States as defined in this Agreement shall not be available.

D. REVISION OF AGREEMENT OR RATES

The Plan, subject to the approval of the Delaware Department of Insurance, may:

1. alter or revise the terms of this Subscription Agreement by endorsement or required notice of change issued by the Plan; and/or

2. modify applicable subscription rates.

Any such alteration or revision of the terms of the Subscription Agreement 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.

In the event of a modification of the subscription rates, 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 Subscriber at the address on the records of the Plan.

E. NOTICE TO THE SUBSCRIBER

Any notice mailed by the Plan to the last address of the Subscriber as shown on the records of the Plan will be considered notice to the Subscriber.

F. SUSPENSION AND REINSTITUTION OF COVERAGE

1. **Suspension of Coverage** – A Subscriber may request that benefits and premiums under this Agreement be suspended under the following conditions:

   a. Subscribers entitled to medical assistance:

      1) The Subscriber has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act (Medicaid); and

      2) The Subscriber notifies the Plan within ninety (90) days after the Subscriber becomes entitled to Medicaid.

      The Agreement will be suspended for up to a total of twenty-four (24) months.

   b. Disabled Subscribers:

      A Subscriber who is entitled to Medicare by reason of disability becomes covered under an employer group health plan.

2. **Reinstitution of Coverage –** A Subscriber whose Coverage is suspended and who loses Medicaid coverage or coverage under an employer group health plan may have Coverage reinstituted under the following conditions:

   a. Coverage will be automatically reinstituted effective as of the date of termination of either Medicaid coverage or coverage under an employer group health plan, provided the Subscriber notified the Plan of the Subscriber's loss of entitlement to Medicaid or group coverage within ninety (90) days after the date of such loss and pays the premium attributable to the period effective as of the date of termination of the Subscriber's entitlement to Medicaid coverage or coverage under an employer group health plan.

   b. Upon reinstitution of Coverage the Subscriber will not be required to satisfy any waiting period for pre-existing conditions.

c. Coverage provided shall be substantially equivalent to Coverage in effect before the date of suspension.

d. Classification of premiums upon reinstitution shall be on terms at least as favorable as the premium classification terms that would have applied to the Subscriber had the Coverage not been suspended.

G. RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD PLANS

The Subscriber is hereby notified:

This Agreement is between the Subscriber and Highmark Blue Cross Blue Shield Delaware only. Highmark Blue Cross Blue Shield Delaware 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 Highmark Blue Cross Blue Shield Delaware to use the familiar Blue Cross and Blue Shield words and symbols. Highmark Blue Cross Blue Shield Delaware, upon entering into this Agreement, is not contracting as an agent of the national Association. Only Highmark Blue Cross Blue Shield Delaware shall be liable to the Subscriber for any of the plan's obligations under this Agreement. This paragraph does not add any obligations to this Agreement.