

SIGNATURE 65

State System of Higher Education
Group 64222-00, 01, 02, 03, 04, 05, 06, 07, 08, 09
Effective January 1, 2015
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Language Assistance Services Available for Multiple Languages

ENGLISH

We are committed to providing outstanding services for our applicants and members. If you require special assistance, including accommodations for disabilities or limited English proficiency, please call the number on your ID card to request these free services.

SPANISH

Estamos comprometidos a ofrecer servicios excepcionales a nuestros solicitantes y miembros. Si usted necesita ayuda especial, incluyendo acomodaciones para discapacidades o dominio limitado del inglés, por favor llámenos al número que aparece en su tarjeta de identificación para solicitar estos servicios gratuitos.

GERMAN

Wir haben uns verpflichtet, unseren Bewerbern und Mitgliedern außerordentliche Dienstleistungen anzubieten. Falls Sie beispielsweise Unterkünfte für Menschen mit Behinderungen oder aufgrund eingeschränkter Englischkenntnisse besondere Unterstützung benötigen, kontaktieren Sie uns unter der auf der Ausweiskarte angegebenen Rufnummer, um unsere kostenlosen Dienstleistungen in Anspruch zu nehmen.

ITALIAN

Ci impegniamo a fornire sempre servizi all'avanguardia per i nostri candidati e membri. In caso necessitate di assistenza speciale, compresi alloggi per disabili o supporto per la scarsa padronanza della lingua inglese, contattate il numero sulla vostra tessera ID per richiedere gratuitamente tali servizi.

CHINESE

我們致力於為我們的申請人和會員們提供卓越的服務。如果您需要特殊協助，包括殘障或英語能力有限，請致電您的證件上的電話號碼來要求這些免費服務。

FRENCH

Nous nous engageons à fournir des services exceptionnels pour nos candidats et membres. Si vous avez besoin d'une assistance particulière, y compris pour handicapés ou compétences limitées en anglais, s'il vous plaît appelez-nous au numéro de votre carte d'identité pour demander ces services gratuits.

RUSSIAN

Мы стремимся оказывать услуги самого высокого уровня нашим заявителям и участникам. Если вы нуждаетесь в специальной помощи, включая размещение для лиц с инвалидностью или ограниченным уровнем владения английским языком, пожалуйста позвоните по номеру, указанному на вашей идентификационной карте, чтобы запросить эти бесплатные услуги.

VIETNAMESE

Chúng tôi quyết tâm cung cấp dịch vụ xuất sắc cho các đương đơn và hội viên của mình. Nếu quý vị cần được trợ giúp đặc biệt, bao gồm các thích nghi cho người bị khuyết tật hoặc có khả năng Anh Ngữ hạn hẹp, xin gọi số điện thoại trên thẻ ID của quý vị để yêu cầu các dịch vụ miễn phí này.

POLISH

Zależy nam, aby usługi, które świadczymy dla naszych kandydatów i członków charakteryzowały się zawsze najwyższą jakością. Jeżeli potrzebna jest specjalna pomoc, np. w przypadku osób niepełnosprawnych lub osób z ograniczoną znajomością języka angielskiego, oferujemy bezpłatne usługi w tym zakresie – prosimy o telefon pod numer znajdujący się na Państwa karcie identyfikacyjnej.

KOREAN

저희들은 신청자들과 회원들에게 탁월한 서비스를 제공하고자 노력하고 있습니다. 신체장애인들이나 비영어권 참석자들을 위해 특별한 도움이 필요하시면 ID 카드에 적힌 전화번호로 알려주시기 바랍니다. 이러한 서비스는 무료입니다.

ARABIC

نلتزم بتوفير خدمة متميزة للمتقدمين والأعضاء. إذا كنت تتطلب مساعدة خاصة، شاملاً التجهيزات اللازمة للاحتياجات الخاصة أو إجابة محدودة للإنجليزية، برجاء الاتصال على الرقم الموجود على بطاقة هويتك لطلب هذه الخدمات المجانية.

HINDI

हम अपने आवेदकों और सदस्यों को उत्कृष्ट सेवाएं प्रदान करने के प्रति वचनबद्ध हैं। यदि आपको विशेष सहायता चाहिए हो, जिसमें अक्षमता अथवा सीमित अंग्रेजी निपुणता हेतु समायोजन भी शामिल हैं, तो कृपया इन निशुल्क सेवाओं हेतु अनुरोध के लिए अपने पहचान-पत्र पर दिए गए नंबर पर फोन करें।

GUJARATI

અમે અમારા અરજદારો અને સભ્યો માટે ઉમદા સેવાઓ પૂરી પાડવા કટિબદ્ધ છીએ ❁ જો તમને વિકલાંગતા કે અંગ્રેજીમાં મર્યાદિત નિપુણતા ધરાવનારાઓ માટે સગવડભરી ગોઠવણો સહિત ખાસ સહાયતા જોઈતી હોય ❁ તો આ મફત સેવાઓની વિનંતી કરવા કૃપા કરી તમારા આઈડી કાર્ડ પર આપેલા નંબર પર ફોન કરો ❁

TAGALOG

May pananagutan kaming magbigay ng bukod-tanging mga serbisyo para sa aming mga aplikante at mga miyembro. Kung kailangan mo ng espesyal na tulong, kabilang ang mga akomodasyon para sa mga kapansanan o limitadong kahusayan sa wikang Ingles, mangyaring tawagan ang numero sa iyong ID kard para hilingin ang mga libreng serbisyonang ito.

GREEK

Είμαστε δεσμευμένοι να παρέχουμε εξαιρετικές υπηρεσίες για τους αιτούντες και τα μέλη μας. Εάν χρειάζεστε ειδική βοήθεια, συμπεριλαμβανομένων διευκολύνσεων για ειδικές ανάγκες ή περιορισμένη ευχέρεια στα Αγγλικά, παρακαλούμε επικοινωνήστε μαζί μας στο τηλέφωνο που βρίσκεται στη κάρτα μέλους σας να ζητήσετε τις δωρεάν αυτές παροχές

JAPANESE

私たちは入会志願者とメンバーのために卓越したサービスを提供することに全力を注いでいます。あなたが、障害者のための便宜または制限英語能力を含む特別な支援が必要な場合は、これらの無料サービスを受けるために、あなたのIDカードの番号までお電話ください。

URDU

ہم اپنے درخواست دہندگان اور ممبران کے لیے عمدہ خدمات فراہم کرنے کے لیے عہد بستہ ہیں۔ اگر آپ کو خصوصی اعانت کی ضرورت ہے، جس میں معذوریوں یا انگریزی کی محدود لیاقت کے لیے سہولیات شامل ہیں، ان مفت خدمات کی درخواست کرنے کے لیے براہ کرم اپنے شناختی کارڈ پر موجود نمبر پر ہمیں کال کریں۔

PORTUGUESE

Estamos empenhados em fornecer serviços especiais para os nossos candidatos e membros. Caso necessite de assistência especial, incluindo alojamento por motivos de deficiência ou conhecimentos limitados de língua inglesa, ligue para o número indicado no seu cartão de identificação para solicitar estes serviços gratuitos.

YORUBA

An gbi iyanju lati ma pese ohun to dara fun awon omo egbe wa ati awon ti won ni fe si nkan ta npese. Ti e ba nfe iranlowo ti o peye tabi ti o joju pelu ile gbigbe fun awon alaabo ara tabi oore ofe lati le so ede geesi to se gbo seti. Ejowo, e pe number to wa lori cadi idayanmo fun eyikeyi ohun ti e ba nfe ki a se fun yin lofe.

SWAHILI

Sisi ni nia ya kutoa huduma bora kwa waombaji wetu na wanachama. Kama unahitaji msaada maalum, ikiwa ni pamoja na malazi kwa ulemavu au mdogo Kiingereza duni, tafadhali wito wetu katika idadi ya simu juu ya kitambulisho kadi yako kuomba huduma hizi bure.

Table of Contents

| | |
|--|-----------|
| Introduction to Your Signature 65 Program | 1 |
| Signature 65 Features..... | 1 |
| How Your Benefits Are Applied | 3 |
| Benefit Period..... | 3 |
| Major Medical Cost-Sharing Provisions..... | 3 |
| Prescription Drug Cost-Sharing Provisions..... | 4 |
| Summary of Benefits | 5 |
| Covered Services - Medical Program | 13 |
| MEDICARE PART A SERVICES | 13 |
| Hospital and Related Benefits..... | 13 |
| Skilled Nursing Facility Care..... | 13 |
| Blood..... | 13 |
| MEDICARE PART B SERVICES | 13 |
| Medical and Surgical Benefits | 13 |
| Therapy Services | 14 |
| Outpatient Hospital Services | 14 |
| Outpatient Psychiatric Treatment..... | 14 |
| Blood..... | 15 |
| Outpatient Prescription Drugs..... | 15 |
| Emergency Care | 15 |
| Preventive Services | 15 |
| Additional Medicare Part B Benefits..... | 17 |
| ADDITIONAL BENEFITS NOT COVERED BY MEDICARE | 17 |
| Emergency Care in a Foreign Country | 17 |
| Additional Inpatient Psychiatric Treatment | 17 |
| Chemotherapy..... | 17 |
| Enteral Formulae | 18 |
| Routine Gynecological Examination and Papanicolaou Smear | 18 |
| Maternity Home Health Care Visit..... | 18 |
| Colorectal Cancer Screenings | 18 |
| Autism Spectrum Disorders..... | 19 |
| Anesthesia for Non-Covered Dental Procedures | 20 |
| MAJOR MEDICAL SERVICES..... | 21 |
| Ambulance Services | 21 |
| Autism Spectrum Disorders..... | 21 |
| Dental Services (Limited)..... | 22 |
| Diabetes Treatment | 23 |
| Diagnostic Services | 23 |
| Durable Medical Equipment..... | 24 |
| Enteral Formulae | 24 |
| Home Health Care Services..... | 24 |
| Home Infusion Therapy Services | 24 |
| Hospital Services | 25 |

| | |
|---|-----------|
| Maternity Services..... | 25 |
| Medical Services..... | 26 |
| Orthotic Services..... | 26 |
| Prescription Drugs..... | 26 |
| Preventive Services..... | 27 |
| Private Duty Nursing Services..... | 28 |
| Prosthetic Appliances..... | 28 |
| Psychiatric Care Services/Substance Abuse Services..... | 28 |
| Skilled Nursing Facility Services..... | 29 |
| Spinal Manipulations..... | 29 |
| Surgical Services..... | 29 |
| Therapy and Rehabilitation Services..... | 30 |
| Transplant Services..... | 30 |
| Covered Services - Prescription Drug Program..... | 32 |
| Covered Drugs..... | 32 |
| What Is Not Covered..... | 33 |
| Eligible Providers..... | 40 |
| Providers Who Accept Assignment..... | 41 |
| Providers Who Do Not Accept Assignment..... | 41 |
| Network Pharmacies..... | 41 |
| General Information..... | 43 |
| Eligibility..... | 43 |
| Changes in Membership Status..... | 46 |
| Continuation of Coverage..... | 46 |
| Conversion..... | 47 |
| Certificates of Creditable Coverage..... | 47 |
| Termination of Your Coverage Under the Employer Contract..... | 47 |
| Benefits After Termination of Coverage..... | 48 |
| Other Types of Coverage..... | 48 |
| Subrogation..... | 49 |
| A Recognized Identification Card..... | 50 |
| How to File a Claim..... | 51 |
| Time Limit To File A Claim..... | 52 |
| Mailing Address For Claims..... | 52 |
| Your Explanation of Benefits Statement..... | 53 |
| Designation of an Authorized Representative..... | 53 |
| Additional Information on How to File a Prescription Drug Claim..... | 53 |
| Determinations on Prescription Drug Claims..... | 54 |
| Appeal Procedure..... | 54 |
| Autism Spectrum Disorders Expedited Review and Appeal Procedures..... | 58 |
| Member Service..... | 59 |
| Blues On Call..... | 59 |
| Highmark Website..... | 60 |
| Member Service..... | 61 |
| Member Rights and Responsibilities..... | 62 |
| How We Protect Your Right to Confidentiality..... | 62 |
| Terms You Should Know..... | 64 |

Notice of Privacy Practices71

This Booklet is not a Contract

This booklet does not constitute a contract of benefits and provisions. The complete set of terms of coverage are set forth in the Group Contract issued by Highmark Blue Shield, an Independent Licensee of the Blue Cross Blue Shield Association. This booklet is merely a description of the principal features of your Signature 65 program.

Introduction to Your Signature 65sm Program

This booklet provides you with the information you need to understand Signature 65, a Medicare complement program from Highmark. We encourage you to take the time to review this information so you understand how your health care program works.

Medicare does not pay for all of your hospital and doctor expenses if you become sick or injured. But Signature 65 complements your Medicare benefits by paying for some or all of the deductibles or coinsurance that are not covered by Medicare alone. Signature 65 also provides additional benefits, which are not covered by Medicare.

Signature 65 Features

Reliable Health Coverage

Highmark's financial stability has earned the company a "strong" rating and helps assure your coverage will be with you now and in the future.

Freedom of Choice

We know how important your relationship is with your doctor. Signature 65 lets you go directly to the doctors and hospitals of your choice for treatment. You aren't restricted to a limited network of hospitals and doctors.

Automatic Claim Filing

When you receive treatment from Medicare-participating physicians, hospitals and other providers, just present your Medicare ID card and your Signature 65 ID card. As a Highmark customer, you benefit because your claims for deductibles and coinsurance for covered expenses are automatically processed for you. You save time and trouble because, in most cases, we do all the paperwork for you.

Peace of Mind

Not all Medicare complement programs offer you full protection when you travel outside a specific geographic location. As a Highmark member, you will enjoy the security of knowing that your identification card is recognized and accepted by Medicare-participating hospitals and physicians throughout the United States.

A Wide Range of Member Support

As a Highmark member, you get important extras. Along with 24-hour assistance with any health care question or concern via Blues On CallSM, your member Web site connects you to a range of self-service tools that can help you manage your coverage. The Web site also offers programs and services designed to help you "Have A Greater Hand in Your Health[®]" to maintain or improve your health.

You can check eligibility information, order ID cards and claim forms, even review claims and Explanation of Benefits (EOB) information all online. You can also access

health information such as the comprehensive Healthwise Knowledgebase[®], full-color Health Encyclopedia, and the Health Crossroads[®] guide to treatment options. You can take an online Lifestyle Improvement course to manage stress, stop smoking or improve your nutrition. And the Web site connects you to a wide range of cost and quality tools to assure you spend your health care dollars wisely.

If you have any questions on your Signature 65 program, please call the Member Service toll-free telephone number on the back of your ID card.

Information for Non-English-Speaking Members

Non-English-speaking members have access to clear benefits information. They can call the toll-free Member Service telephone number on the back of their ID card to be connected to a language services interpreter line. Highmark Member Service representatives are trained to make the connection.

As always, we value you as a member, look forward to providing your coverage, and wish you good health.

How Your Benefits Are Applied

To help you understand your Major Medical coverage and how it works, here's an explanation of some benefits terms found in your Summary of Benefits and a description of how your benefits are applied. For specific amounts, refer to your Summary of Benefits.

Benefit Period

Your benefit period is the specified period of time during which charges for covered services must be incurred in order to be eligible for payment by Highmark. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Your benefit period is a calendar year starting on January 1.

Major Medical Cost-Sharing Provisions

Cost-sharing is a requirement that you pay part of your expenses for covered services. The terms "deductible" and "coinsurance" describe methods of such payment.

Coinsurance

The coinsurance is the specific percentage of the plan allowance for covered services that is your responsibility. You may be required to pay any applicable coinsurance at the time you receive care from a provider. Refer to the Plan Payment Level in your Summary of Benefits for the percentage amounts paid by the program.

Deductible

The deductible is a specified dollar amount you must pay for covered Major Medical services each benefit period before Highmark begins to provide payment for benefits. See your Summary of Benefits for the deductible amount.

Family Deductible

For a family with several covered dependents, the deductible you pay for all covered family members, regardless of family size, is specified under family deductible. To reach this total, you can count the expenses incurred by three or more family members. However, the deductible contributed towards the total by any one family member cannot be more than the amount of the individual deductible. If one family member meets the individual deductible and needs to use benefits, the program would begin to pay for that person's covered services even if the deductible for the entire family had not been met.

When two or more family members are injured in the same accident, only one deductible will be applied to the aggregate of such charges.

Expenses for covered services incurred during the last three months of a benefit period will be credited toward the deductible required in the following benefit period.

Out-of-Pocket Limit

The out-of-pocket limit refers to the specified dollar amount of coinsurance incurred for covered services in a benefit period. When the specified dollar amount is attained, your program begins to pay 100% of all covered expenses. See your Summary of Benefits for the out-of-pocket limit. The out-of-pocket limit does not include deductibles, outpatient mental health expenses, or amounts in excess of the plan allowance.

Lifetime Maximum

The maximum benefit that the program will provide for any covered individual during his or her lifetime is specified in your Summary of Benefits.

At the start of each benefit period, the amount paid for covered services in the preceding benefit period (up to \$1,000) will be restored to the lifetime maximum of each person who used the benefits.

Prescription Drug Cost-Sharing Provisions

Cost-sharing is a requirement that you pay part of your covered expenses. Refer to the Summary of Benefits for the percentage amounts paid by the program.

Summary of Benefits

This Summary of Benefits outlines your covered services. More details can be found in the Covered Services section.

| COVERED SERVICES | PLAN PAYS |
|--|---|
| Medicare Part A Covered Services | |
| Inpatient Hospital (Medicare inpatient mental health care coverage in a psychiatric facility is limited to 190 inpatient hospital days in a lifetime.) | |
| Days 1 – 60 Days 61 – 90 Days 91 – 150 For 60 Medicare lifetime reserve days that may be used only once Additional Inpatient Hospital Days | Medicare Part A deductible Medicare Part A coinsurance Medicare Part A coinsurance 100% of Medicare eligible expenses for 365 days per benefit period after the 60 Medicare inpatient lifetime reserve days are exhausted. |
| Skilled Nursing Facility Care | |
| Days 21 to 100 Day 101 and beyond | Medicare Part A coinsurance Not covered by this program |
| Blood | First three pints per calendar year |
| Medicare Part B Covered Services | |
| Deductible | Not covered by this program |
| Coinsurance | Medicare Part B coinsurance |

| COVERED SERVICES | PLAN PAYS |
|--|---|
| Therapy Services | |
| Outpatient Physical Therapy | Medicare Part B coinsurance |
| Outpatient Occupational Therapy | Medicare Part B coinsurance |
| Outpatient Speech Therapy | Medicare Part B coinsurance |
| Durable Medical Equipment | Medicare Part B coinsurance |
| Outpatient Hospital Services (except Outpatient Psychiatric Treatment) | Medicare Part B coinsurance |
| Outpatient Psychiatric Treatment | Medicare Part B coinsurance |
| Blood | First 3 pints per calendar year |
| Outpatient Prescription Drugs used in Immunosuppressive Therapy | Medicare Part B coinsurance |
| Emergency Care | |
| Emergency Accident Care | Medicare Part B coinsurance |
| Emergency Medical Care | Medicare Part B coinsurance |
| Preventive Services | |
| Mammogram Screening | Medicare Part B coinsurance (not subject to Medicare Part B deductible) |
| Gynecological Services | Medicare Part B coinsurance (not subject to Medicare Part B deductible) |
| Colorectal Cancer Screenings (For all members age 50 and over. No minimum age required for colonoscopy.) | Medicare Part B coinsurance |
| Diabetes Monitoring | Medicare Part B coinsurance |
| Bone Mass Measurements | Medicare Part B coinsurance |
| Prostate Cancer Screening | Medicare Part B coinsurance |
| Vaccinations | Medicare Part B coinsurance |
| Glaucoma Testing | Medicare Part B coinsurance |

| COVERED SERVICES | PLAN PAYS |
|--|--|
| Physical Examinations | Medicare Part B coinsurance |
| Additional Medicare Part B Benefits | Medicare Part B coinsurance |
| Additional Benefits Not Covered By Medicare | |
| Emergency Care in a Foreign Country | 100% of the plan allowance |
| Additional Inpatient Psychiatric Treatment | 100% of Medicare eligible expenses for 30 additional inpatient hospital days per lifetime. |
| Chemotherapy* | 100% of the plan allowance |
| Enteral Formulae* | 100% of the plan allowance |
| Routine Gynecological Exams and Papanicolaou Smear* | 100% of the plan allowance |
| Maternity Home Health Care Visit | 100% of the plan allowance |
| Colorectal Cancer Screenings | 100% of the plan allowance |
| Autism Spectrum Disorders including Applied Behavioral Analysis¹ | 100% of the plan allowance |
| Anesthesia for Non-Covered Dental Procedures (Limited)* | 100% of the plan allowance |

*State mandate applies

¹ Coverage for eligible members to age 21. Services will be paid according to the benefit category, i.e., speech therapy. Treatment for autism spectrum disorders does not reduce visit/day limits.

| BENEFIT PROVISIONS | COVERAGE |
|--|--|
| Major Medical Benefits | |
| Benefit Period | Calendar Year |
| Deductible (per benefit period) | See Exhibit A |
| Payment Level - Based on the plan allowance | 80% after deductible until out-of-pocket is met; then 100% |
| Out-of-Pocket Limit - Includes coinsurance. See the section "How Your Benefits Are Applied" for exclusions/details. | See Exhibit A |
| Lifetime Maximum (per member) | See Exhibit A |
| Ambulance | 80% after deductible |
| Anesthesia for Non-Covered Dental Procedures (Limited) | 80% after deductible |
| Autism Spectrum Disorders including Applied Behavioral Analysis¹ | 80% after deductible |
| Assisted Fertilization Treatment | Not Covered |
| Dental Services Related to an Accidental Injury | 80% after deductible |
| Diabetes Treatment | 80% after deductible |
| Diagnostic Services (Lab, x-ray and other tests) | 80% after deductible |
| Durable Medical Equipment, Orthotics and Prosthetics | 80% after deductible |
| Enteral Formulae | 80% no deductible |
| Home Health Care Excludes Respite Care | 80% after deductible |
| Hospice Includes Respite Care | Not Covered |
| Hospital Expenses Inpatient and Outpatient ² | 80% after deductible |

| BENEFIT PROVISIONS | COVERAGE |
|---|--|
| Infertility Counseling, Testing and Treatment³ | 80% after deductible |
| Maternity (facility and professional services) Excludes Dependent Daughters | 80% after deductible |
| Medical Care Includes Inpatient Visits and Consultations | 80% after deductible |
| Mental Health Care Services - Inpatient | 50% after deductible |
| Mental Health Care Services- Outpatient | 50% after deductible up to maximum payment of \$25 per visit |
| Office Visits⁴ | 80% after deductible |
| Oral Surgery | 80% after deductible |
| Physical Medicine Outpatient | 80% after deductible |
| Prescription Drugs⁵ | 80% after deductible |
| Preventive Care⁶ <i>Adult</i> Routine physical exam | Not Covered |
| Adult Immunizations | Not Covered |
| Colorectal Cancer Screenings | 80% after deductible |
| Routine gynecological exams, including a PAP Test | 80%; deductible does not apply; maximum does not apply |
| Mammogram, annual routine and medically necessary | 80%; deductible does not apply |
| Diagnostic Services and Procedures | Not Covered |
| <i>Pediatric</i> Routine physical exams | Not Covered |
| Pediatric Immunizations | 80%; deductible does not apply; maximum does not apply |
| Diagnostic Services and Procedures | Not Covered |
| Private Duty Nursing | 80% after deductible |

| BENEFIT PROVISIONS | COVERAGE |
|--|--|
| Skilled Nursing Facility Care | 80% after deductible |
| Speech and Occupational Therapy Outpatient | 80% after deductible |
| Spinal Manipulations | 80% after deductible |
| Substance Abuse Services - Detoxification | Not Covered |
| Substance Abuse Services - Inpatient Rehabilitation | Not Covered |
| Substance Abuse Services - Outpatient | 50% after deductible up to maximum payment of \$25 per visit |
| Surgical Services Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures | 80% after deductible |
| Therapy and Rehabilitation Services Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiratory Therapy | 80% after deductible |
| Transplant Services | 80% after deductible |
| Condition Management | Case Management, Blues On Call, and Disease State Management |

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during a benefit period will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

¹ Coverage for eligible members to age 21. Services will be paid according to the benefit category, i.e., speech therapy. Treatment for autism spectrum disorders does not reduce visit/day limits.

² For covered services rendered by a facility provider within the service area who has no contractual relationship with Highmark, the plan allowance will be based on the reimbursement methods for contracting facilities located in the same geographic region, e.g., metropolitan, providing similar levels of care. For covered services rendered by an out-of-area provider, such services will be priced by the local Blue Cross Blue Shield plan and submitted to Highmark via BlueCard. The plan allowance would then be subject to the coinsurance percentage after your deductible, if any, has been satisfied.

³ Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

⁴ You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

⁵ At a retail or mail order pharmacy, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated.

⁶ Services are limited to those on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.

Exhibit A

Groups: 064222-00, 01, 02, 03

Annuitants – Retired Before 7/01/1990

| Product Features | Benefit Level |
|------------------------------|------------------------------------|
| Deductible Individual/Family | \$100/\$300 per calendar year |
| Out-of-Pocket Limit | \$380 per person per calendar year |
| Lifetime Maximum | \$500,000 |

Group: 064222-04

Annuitants – Management and Coaches Retired 7/01/1990 – 6/30/1993; Faculty Retired 7/01/1990 – 6/30/1991; SCUPA Retired 7/01/1990 – 6/30/1994

| Product Features | Benefit Level |
|------------------------------|------------------------------------|
| Deductible Individual/Family | \$100/\$300 per calendar year |
| Out-of-Pocket Limit | \$380 per person per calendar year |
| Lifetime Maximum | \$575,000 |

Group: 064222-05

Annuitants – Faculty Retired 7/01/1991 – 6/30/1992

| Product Features | Benefit Level |
|------------------------------|------------------------------------|
| Deductible Individual/Family | \$100/\$300 per calendar year |
| Out-of-Pocket Limit | \$380 per person per calendar year |
| Lifetime Maximum | \$825,000 |

Group: 064222-06

Annuitants – Management and Coaches Retired 7/01/1993 – 1/01/1999; Faculty Retired 7/01/1992 – 1/01/1999; SCUPA Retired 7/01/1994 – 1/01/1999; Nurses Retired 1/03/1998 – 1/01/1999

| Product Features | Benefit Level |
|------------------------------|------------------------------------|
| Deductible Individual/Family | \$100/\$300 per calendar year |
| Out-of-Pocket Limit | \$380 per person per calendar year |
| Lifetime Maximum | \$1,075,000 |

Group: 064222-07

Annuitants – Faculty Retired 1/02/1999 – 6/30/2004; SCUPA Retired 1/02/1999 – 6/30/2004; Management and Coaches Retired 1/02/1999 – 6/30/2004; Nurses Retired 1/02/1999 – 6/30/2004

| Product Features | Benefit Level |
|------------------------------|------------------------------------|
| Deductible Individual/Family | \$250/\$750 per calendar year |
| Out-of-Pocket Limit | \$350 per person per calendar year |
| Lifetime Maximum | \$1,075,000 |

Groups: 064222-08, 09

Annuitants – Retired after 7/01/2004

| Product Features | Benefit Level |
|------------------------------|------------------------------------|
| Deductible Individual/Family | \$500/\$1,500 per calendar year |
| Out-of-Pocket Limit | \$350 per person per calendar year |
| Lifetime Maximum | \$1,075,000 |

Covered Services - Medical Program

MEDICARE PART A SERVICES

Hospital and Related Benefits

Benefits are provided for semi-private accommodations and all other services provided and billed for by the hospital. Coverage includes, but is not limited to, meals and special diets, general nursing care, drugs and medicines, use of operating, recovery and other specialty service rooms, anesthesia, laboratory tests, x-ray examinations, dressings, plaster casts and splints, oxygen, processing and administration of blood and blood plasma, physiotherapy and hydrotherapy, radiation therapy, EKG and EEG, basal metabolism testing, intravenous fluids and prosthetic devices surgically implanted.

Continued Stay Review

The medical progress of patients is reviewed to identify the continued medical necessity and appropriateness of the inpatient stay. If a member elects to continue to receive inpatient services after receipt of written notification by the plan that such level of care is no longer medically necessary and appropriate, the member will be financially responsible for the full amount of the professional providers' charges from the date appearing on the written notification.

Skilled Nursing Facility Care

Coverage is provided for a semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies when: the member needs daily skilled nursing or rehabilitation services; services as a practical matter can only be provided in an inpatient facility; and the care begins within 30 days of the member's discharge from a hospital stay of at least three days.

Blood

Coverage is provided for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) per calendar year, unless replaced in accordance with Federal regulations.

MEDICARE PART B SERVICES

Medical and Surgical Benefits

Coverage of Medicare Part B coinsurance is provided for physician services and inpatient and outpatient medical and surgical supplies.

Generally, Medicare Part B coverage includes, but is not limited to the following:

- X-ray, radium and radioactive isotope therapy, including material and services of technicians
- Diagnostic x-ray, diagnostic laboratory and other diagnostic tests performed or ordered by a professional provider
- Rental or purchase of durable medical equipment for use in your home, when prescribed by a provider
- Surgical dressings, splints and casts
- Ambulance services when an ambulance is needed to transport you to or from a hospital or skilled nursing facility because any other method of transportation would be dangerous to your health
- Surgical services performed by a professional provider, including services involving surgery of the jaw or related structures or setting of fractures of the jaw or facial bones
- Transplant services performed for a member including the services for the removal of an organ from a donor when the donor is not a member
- Medical services performed by a professional provider
- Services and supplies furnished as part of a professional provider's professional care and which are commonly included in the charge
- Obstetrical delivery including pre- and post-natal care for a female member
- Devices (other than dental) which replace all or part of an internal body organ, including replacement of the devices
- Leg, arm, back and neck braces and artificial legs, arms and eyes, including replacements, if required, because of a change in the member's physical condition

Therapy Services

Coverage is provided for the following services, when ordered by a physician:

- Outpatient physical therapy
- Outpatient occupational therapy
- Outpatient speech therapy

Outpatient Hospital Services

Coverage is provided for services for the diagnosis or treatment of an illness or injury.

Outpatient Psychiatric Treatment

Coverage is provided for the outpatient treatment of mental illness when services are rendered in a hospital or psychiatric facility.

Generally, coverage includes, but is not limited to, the following:

- Individual and group therapy with physicians, psychologists or other mental health professionals authorized by the state

- Services of social workers, trained psychiatric nurses and other staff trained to work with psychiatric patients
- Drugs and biologicals furnished to outpatients for therapeutic purposes, but only if they are of a type which cannot be self-administered
- Activity therapies, but only those that are individualized and essential for the treatment of your condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into your treatment
- Family counseling service. Counseling services with members of the household are covered only where the primary purpose of such counseling is the treatment of your condition
- Patient education programs, but only where the educational activities are closely related to your care and treatment
- Diagnostic services for the purpose of diagnosing you when extended or direct observation is necessary to determine functioning and interactions, to identify problem areas, and to formulate a treatment plan

Blood

Coverage is provided for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) per calendar year.

Outpatient Prescription Drugs

Coverage is provided only for prescription drugs used in immunosuppressive therapy.

Emergency Care

Coverage is provided for the following Medicare eligible expenses:

Emergency Accident

The initial treatment of bodily injuries resulting from an accident and any follow-up care.

Emergency Medical

The initial treatment after the sudden onset of a medical condition manifesting itself by acute symptoms that require immediate medical attention and any follow-up care.

Preventive Services

Coverage is provided for the following Medicare eligible expenses:

Mammogram Screening

Benefits are provided once every 12 months for all female members age 40 and over, and one baseline mammogram for female members age 35-39.

Gynecological Services

Benefits are provided to all female members for pelvic exams to check for cervical and vaginal cancer once every two years. If the member is of child bearing age and has had an abnormal Pap smear within three years, or has a high risk for cervical or vaginal cancer, coverage is provided for a pelvic exam every year. In addition to the pelvic exam, a clinical breast exam is also covered to check for breast cancer.

Colorectal Cancer Screenings

Benefits are provided for tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer to members age 50 and older (no minimum age required for colonoscopy) as follows:

- Fecal occult blood test once every 12 months
- Flexible sigmoidoscopy once every 48 months
- Colonoscopy once every 24 months if the member is at high risk for colon cancer, otherwise once every 10 years
- Barium enema (physician can substitute for flexible sigmoidoscopy or colonoscopy) once every 24 months if the member is at high risk for colon cancer, otherwise once every 48 months

Diabetes Monitoring

Benefits are provided to all members with diabetes (insulin users and non-users) for glucose monitors, test strips, lancets and self-management training.

Bone Mass Measurements

Benefits are provided to certain members at risk for losing bone mass once every 24 months.

Prostate Cancer Screening

Benefits are provided to all male members age 50 and older for a digital rectal examination once every 12 months and a Prostate Specific Antigen (PSA) test once every 12 months.

Vaccinations

Benefits are provided to all members on an outpatient basis for the following:

- Hepatitis B vaccine immunization for individuals at a high or intermediate risk for Hepatitis B
- Flu shots every 12 months
- Pneumococcal (pneumonia) shot upon the recommendation of a professional provider

Glaucoma Testing

Benefits are provided to all members at high risk for glaucoma once every 12 months.

Physical Exam

Benefits are provided for a one-time "Welcome to Medicare" exam and for annual "wellness" exams.

Additional Medicare Part B Benefits

Coverage is provided for the following Medicare eligible expenses:

- Limited chiropractic services
- One pair of eyeglasses after cataract surgery with an intraocular lens
- Kidney dialysis and kidney transplants
- Medical supplies for items such as ostomy bags and some diabetic supplies
- Prosthetic devices, including breast prosthesis after mastectomy and subsequent replacements of the removed breast or portions thereof, pursuant to an order of the member's physician
- Services of practitioners such as clinical psychologists, social workers and nurse practitioners
- Transplants, under certain conditions, for heart, lung and liver
- Nursery care for routine newborn care performed while the mother is confined in an accredited hospital

ADDITIONAL BENEFITS NOT COVERED BY MEDICARE

Emergency Care in a Foreign Country

Coverage is provided for medically necessary and appropriate emergency hospital, physician and medical care received in a foreign country, to the extent not covered by Medicare for the billed charges for Medicare eligible expenses, which would have been covered by Medicare if provided in the United States. Emergency care is care that is needed immediately because of an injury or illness of sudden and unexpected onset.

Additional Inpatient Psychiatric Treatment

Coverage of Medicare Part A eligible expenses for additional inpatient treatment of mental illness is provided when services are rendered in a hospital or psychiatric facility after the member has exhausted 190 Medicare inpatient hospital lifetime days in a psychiatric facility.

Chemotherapy

Benefits are available for the treatment of malignant diseases regardless of the type of facility in which treatment is rendered.

Enteral Formulae

Coverage is provided for enteral formulae when administered on an outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders. Benefits are exempt from all deductibles.

Routine Gynecological Examination and Papanicolaou Smear

Benefits are provided for one routine gynecological examination, including a pelvic examination and clinical breast examination and one routine Papanicolaou smear per calendar year for all female members.

Maternity Home Health Care Visit

Benefits for one maternity home health care visit will be provided at the member's home within 48 hours of discharge from a facility provider when the discharge occurs prior to: (a) 48 hours of inpatient care following a normal vaginal delivery; or (b) 96 hours of inpatient care following a Caesarean delivery. This visit shall be made by a participating provider whose scope of practice includes post partum care. The visit includes parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments. The visit may, at the mother's sole discretion, occur at the facility of the participating provider. Maternity home health care visit is subject to all terms of this program.

Colorectal Cancer Screenings

Benefits are provided for diagnostic pathology and laboratory screening services such as a fecal occult blood or fecal immunochemical test; diagnostic x-ray screening services such as a barium enema; surgical screening services such as flexible sigmoidoscopy and colonoscopy; and such other diagnostic pathology and laboratory, diagnostic x-ray and surgical screening tests and diagnostic medical screening services consistent with approved medical standards and practices for the detection of colon cancer.

Benefits are provided for members 50 years of age or older, or more frequently and regardless of age when prescribed by a physician, as follows:

- An annual fecal-occult blood test or fecal immunochemical test
- A sigmoidoscopy every five years
- A screening barium enema or test consistent with approved medical standards and practices to detect colon cancer every five years
- A colonoscopy every 10 years

If you are determined to be at high or increased risk, regardless of age, benefits are provided for a colonoscopy or any other combination of covered services related to colorectal cancer screening when prescribed by a physician and in accordance with the American Cancer Society guidelines on screening for colorectal cancer as of January 1, 2008.

Autism Spectrum Disorders

Benefits are provided to members under 21 years of age for the following:

Diagnostic Assessment of Autism Spectrum Disorders

Medically necessary and appropriate assessments, evaluations or tests performed by a physician, licensed physician assistant, psychologist or certified registered nurse practitioner to diagnose whether an individual has an autism spectrum disorder.

Treatment of Autism Spectrum Disorders

Services must be specified in a treatment plan developed by a physician or psychologist following a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. Highmark may review a treatment plan for autism spectrum disorders once every six months, or as agreed upon between Highmark and the physician or psychologist developing the treatment plan.

Treatment may include the following medically necessary and appropriate services:

Pharmacy care

Any assessment, evaluation or test prescribed or ordered by a physician, licensed physician assistant or certified registered nurse practitioner to determine the need or effectiveness of a prescription drug approved by the Food and Drug Administration (FDA) and designated by Highmark for the treatment of autism spectrum disorders.

Psychiatric and psychological care

Direct or consultative services provided by a psychologist or by a physician who specializes in psychiatry.

Rehabilitative care

Professional services and treatment programs, including Applied Behavioral Analysis, provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.

Therapeutic care

Services that are provided by a speech language pathologist, occupational therapist or physical therapist.

Anesthesia for Non-Covered Dental Procedures

Benefits are provided for general anesthesia and associated hospital and medical services normally related to the administration of general anesthesia which are rendered in connection with non-covered dental procedures or non-covered oral surgery. Benefits are provided for members age seven or under and for developmentally disabled members when determined by Highmark to be medically necessary and appropriate and when a successful result cannot be expected for treatment under local anesthesia, or when a superior result can be expected from treatment under general anesthesia.

MAJOR MEDICAL SERVICES

Major Medical coverage is designed to supplement your hospital, medical surgical and Medicare Complementary benefits by providing additional protection against the expenses incurred due to non-occupational illness or accidents only when such services are determined to be medically necessary and appropriate for the proper treatment of the patient's condition. Please refer to the section headed "Terms You Should Know" for specific details. Any benefit limits, deductibles and coinsurance amounts are described in the Summary of Benefits. Major Medical will reimburse you for certain covered medical expenses not covered by the hospital and medical surgical plan.

Ambulance Services

Ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

- from your home, the scene of an accident or medical emergency to a hospital, or skilled nursing facility; or
- between hospitals; or
- between a hospital and a skilled nursing facility;

when such facility is the closest institution that can provide covered services appropriate for your condition. If there is no facility in the local area that can provide covered services appropriate for your condition, then ambulance service means transportation to the closest facility outside the local area that can provide the necessary service.

Transportation and related emergency services provided by an ambulance service will be considered emergency ambulance service if the injury or condition is considered emergency care. Use of an ambulance as transportation to an emergency room of a facility provider for an injury or condition that is not considered emergency care will not be covered as emergency ambulance services. Refer to the Terms You Should Know section for a definition of emergency care services.

Autism Spectrum Disorders

Benefits are provided to members under 21 years of age for the following:

Diagnostic Assessment of Autism Spectrum Disorders

Medically necessary and appropriate assessments, evaluations or tests performed by a physician, licensed physician assistant, psychologist or certified registered nurse practitioner to diagnose whether an individual has an autism spectrum disorder.

Treatment of Autism Spectrum Disorders

Services must be specified in a treatment plan developed by a physician or psychologist following a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. Highmark may review a treatment plan for autism spectrum disorders once every six months, or as agreed upon between Highmark and the physician or psychologist developing the treatment plan.

Treatment may include the following medically necessary and appropriate services:

Pharmacy care

Pharmacy care for autism spectrum disorders includes any assessment, evaluation or test prescribed or ordered by a physician, licensed physician assistant or certified registered nurse practitioner to determine the need or effectiveness of a prescription drug approved by the Food and Drug Administration (FDA) and designated by Highmark for the treatment of autism spectrum disorders.

Psychiatric and psychological care

Direct or consultative services provided by a psychologist or by a physician who specializes in psychiatry.

Rehabilitative care

Professional services and treatment programs, including Applied Behavioral Analysis, provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.

Therapeutic care

Services that are provided by a speech language pathologist, occupational therapist or physical therapist.

Dental Services (Limited)

Related to Accidental Injury

Dental services rendered by a physician immediately following an accidental injury to the jaws, mouth or face. Follow-up services, if any, that are provided after the initial treatment to jaws, mouth or face are not covered. Injury caused by chewing or biting will not be considered accidental injury.

Anesthesia for Non-Covered Dental Procedures

General anesthesia and associated hospital and medical services normally related to the administration of general anesthesia which are rendered in connection with non-covered dental procedures or non-covered oral surgery. Benefits are provided for members age seven or under and for developmentally disabled members when

determined by Highmark to be medically necessary and appropriate and when a successful result cannot be expected for treatment under local anesthesia, or when a superior result can be expected from treatment under general anesthesia.

Diabetes Treatment

Coverage is provided for the following equipment and supplies when required in connection with treatment of diabetes, and when prescribed by a physician legally authorized to prescribe such items under the law:

- Equipment and Supplies: Blood glucose monitors, monitor supplies, injection aids, syringes and insulin infusion devices.
- Diabetes Education Program*: When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through a diabetes education program:
 - Visits medically necessary and appropriate upon the diagnosis of diabetes
 - Subsequent visits under circumstances whereby your physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in self-management, or b) identifies as medically necessary and appropriate, a new medication or therapeutic process relating to your treatment and/or management of diabetes.

***Diabetes Education Program** - an outpatient program of self-management, training and education, including medical nutrition therapy, for the treatment of diabetes. Such outpatient program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education services will be covered subject to Highmark's criteria. These criteria are based on the certification programs for outpatient diabetes education developed by the American Diabetes Association (ADA) and the Pennsylvania Department of Health.

Diagnostic Services

Benefits will be provided for the following covered services when ordered by a professional provider:

- Diagnostic X-ray consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine
- Diagnostic pathology, consisting of laboratory and pathology tests
- Diagnostic medical procedures consisting of ECG, EEG, and other electronic diagnostic medical procedures and physiological medical testing approved by Highmark
- Allergy testing, consisting of percutaneous, intracutaneous, and patch tests

Durable Medical Equipment

The rental (but not to exceed the total cost of purchase) or, at the option of Highmark, the purchase, adjustment, repairs and replacement of durable medical equipment when prescribed by a professional provider within the scope of their license and required for therapeutic use.

Enteral Formulae

Coverage is provided for enteral formulae when administered on an outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

Home Health Care Services

Services rendered by a home health care agency or a hospital program for home health care for which benefits are available as follows:

- Skilled nursing services of an RN or LPN, excluding private duty nursing services
- Physical medicine, occupational therapy and speech therapy
- Medical and surgical supplies provided by the home health care agency or hospital program for home health care
- Oxygen and its administration
- Medical social service consultations
- Health aide services to an individual who is receiving covered nursing or therapy and rehabilitation services

You must be essentially confined at home and home health care services must be rendered for treatment of the same illness or injury for which the individual was in the facility provider.

No home health care benefits will be provided for:

- dietitian services;
- homemaker services;
- maintenance therapy;
- dialysis treatment;
- custodial care;
- food or home-delivered meals;

Home Infusion Therapy Services

Benefits will be provided when performed by a home infusion therapy provider in a home setting. This benefit includes pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with home infusion therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with home infusion therapy.

Hospital Services

Bed and Board

Bed, board and general nursing services in a facility provider when you occupy:

- a room with two or more beds; or
- a private room (private room allowance is the average semi-private room charge; or
- a bed in a special care unit --a designated unit which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients.

Ancillary Services

Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms and equipment;
- drugs and medicines provided to a member who is an inpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives.
- medical and surgical dressings, supplies, casts, and splints

Maternity Services

Hospital, surgical/medical services rendered by a provider for:

Normal Pregnancy

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

Benefits are not provided for normal pregnancy services for Dependent daughters.

Complications of Pregnancy

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

Nursery Care

Ordinary nursery care of the newborn infant, including inpatient medical visits by a professional provider.

Maternity Home Health Care Visit

Benefits for one maternity home health care visit will be provided at your home within 48 hours of discharge when the discharge from a facility provider occurs prior to: (a) 48 hours of inpatient care following a normal vaginal delivery; or (b) 96 hours of inpatient care following a cesarean delivery. This visit shall be made by a provider whose scope of practice includes postpartum care. The visit includes parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests, and the performance of any necessary maternal and neonatal physical assessments. The visit may, at your sole discretion, occur at the office of the provider. The visit is subject to all the terms of the program.

Under state law, entities like Highmark, which issue health insurance to your employer or union, are generally prohibited from restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, state law does not prohibit the mother's or newborn's attending provider from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable) if the mother and newborn meet the medical criteria for a safe discharge contained in guidelines which recognize treatment standards used to determine the appropriate length of stay; including those of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. In any case, health insurance issuers like Highmark can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

Medical Services

Inpatient Medical Services

Medical care and consultations by a professional provider for the diagnosis and treatment of an injury or illness to a member who is an inpatient.

Outpatient Medical Care Services

Medical care and consultations rendered by a professional provider for the diagnosis and treatment of an injury or illness to you when you are an outpatient for a condition not related to surgery.

Orthotic Devices

Purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.

Prescription Drugs

Benefits will be provided for drugs and medicines requiring a professional provider's prescription and dispensed by a licensed pharmacist.

Preventive Services

Pediatric Immunizations

Benefits are provided to members under 21 years of age for those pediatric immunizations, including the immunizing agents, which, as determined by the Pennsylvania Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, and the U.S. Department of Health and Human Services. The Immunization Schedule is reviewed and updated periodically by Highmark based on the advice of the American Academy of Pediatrics, U.S. Preventive Service Task Force, the Blue Cross Blue Shield Association, and the medical consultants. Accordingly, the frequency and eligibility of services is subject to change.

Routine Gynecological Examination and Papanicolaou Smear

Benefits are provided for one routine gynecological examination, including a pelvic examination and clinical breast examination and one routine Papanicolaou smear per calendar year for all female members. Benefits are exempt from all deductibles or maximums.

Mammographic Screening

Benefits will be provided for:

- an annual routine mammographic screening for all female members 40 years of age or older;
- mammographic examination for all female members regardless of age when prescribed by a physician.

Benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified by the Pennsylvania Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

Colorectal Cancer Screenings

Benefits are provided for the following tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer:

- Diagnostic pathology and laboratory screening services such as a fecal-occult blood or fecal immunochemical test
- Diagnostic x-ray screening services such as barium enema
- Surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services

- Such other diagnostic pathology and laboratory, diagnostic x-ray and surgical screening tests and diagnostic medical screening services consistent with approved medical standards and practices for the detection of colon cancer

Benefits are provided for members 50 years of age or older as follows, or more frequently and regardless of age when prescribed by a physician:

- An annual fecal-occult blood test or fecal immunochemical test
- A sigmoidoscopy every five years
- A screening barium enema or test consistent with approved medical standards and practices to detect colon cancer every five years
- A colonoscopy every 10 years

If you are determined to be at high or increased risk, regardless of age, benefits are provided for a colonoscopy or any other combination of covered services related to colorectal cancer screening when prescribed by a physician and in accordance with the American Cancer Society guidelines on screening for colorectal cancer as of January 1, 2008.

Private Duty Nursing Services

Private duty nursing services of an actively practicing RN or an LPN when ordered by a physician, providing such nurse does not ordinarily reside in the your home or is not a member of your immediate family.

- If you are an inpatient in a facility provider, only when Highmark determines that the nursing services required are of a nature or degree of complexity or quantity that could not be provided by the regular nursing staff.
- If you are at home, only when Highmark determines that the nursing services require the skills of a Registered Nurse or of a Licensed Practical Nurse.

Prosthetic Appliances

Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses).

Psychiatric Care Services/Substance Abuse Services

The following services are provided for the inpatient and outpatient treatment of mental illness and the treatment of substance abuse by a facility or professional provider:

- Inpatient and outpatient medical care visits
- Individual psychotherapy
- Group psychotherapy
- Psychological testing
- Counseling with family members to assist in the patient's diagnosis and treatment

For purposes of this benefit, an alcohol and drug abuse service provided on a partial hospitalization basis for rehabilitation therapy shall be deemed to be an outpatient care visit and is subject to any outpatient care cost-sharing amounts.

Serious Mental Illness Care Services

Serious mental illnesses include schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, anorexia nervosa, bulimia nervosa and delusional disorder.

Coverage is provided for inpatient care and outpatient care for the treatment of serious mental illness. A serious mental illness service provided on a partial hospitalization basis will be deemed to be an outpatient care visit subject to any outpatient cost-sharing amounts.

Skilled Nursing Facility Services

Services rendered in a skilled nursing facility to the same extent benefits are available to an inpatient of a hospital. No benefits are payable:

- after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care;
- when confinement in a skilled nursing facility is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience;
- for the treatment of alcohol abuse, drug abuse or mental illness.

Spinal Manipulations

Benefits will be provided for spinal manipulations 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.

Surgical Services

Surgery

Surgery performed by a professional provider. Separate payment will not be made for pre- and post-operative services.

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

Assistant At Surgery

Services of a physician who actively assists the operating surgeon in performing a covered surgery if a house staff member, intern or resident is not available.

Anesthesia

Administration of anesthesia, anesthesia supplies and services ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery.

Therapy and Rehabilitation Services

Benefits will be provided for the following covered services only when such services are ordered by a professional provider:

- Radiation therapy
- Chemotherapy
- Dialysis treatment
- Respiratory therapy
- Physical medicine
- Occupational therapy
- Speech therapy
- Infusion therapy when performed by a facility provider and for self-administration if the components are furnished by and billed by a facility provider
- Cardiac rehabilitation

Transplant Services

Subject to the provisions of this program, benefits will be provided for covered services furnished by a hospital which are directly and specifically related to transplantation of organs, bones or tissue.

If a human organ, bone or tissue transplant is provided from a living donor to a human transplant recipient:

- when both the recipient and the donor are members, each is entitled to the benefits of the program;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of the program subject to the following additional limitations:

- the donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, other Blue Shield coverage, or any government program; and
- benefits provided to the donor will be charged against the recipient's coverage under this program;
- when only the donor is a member, the donor is entitled to the benefits of the program, subject to the following additional limitations:
 - the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of the program, and
 - no benefits will be provided to the non-member transplant recipient;
- if any organ or tissue is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the member recipient's program limit.

Covered Services - Prescription Drug Program

Covered Drugs

Covered drugs include:

- those which, under Federal law, are required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription;"
- legend drugs under applicable state law and dispensed by a licensed pharmacist;
- compounded medications, consisting of the mixture of at least two ingredients other than water, one of which must be a legend drug (drug that requires a pharmacist dispenses it);
- prescribed injectable insulin;
- diabetic supplies, including needles and syringes.

What Is Not Covered

Except as specifically provided in this program or as Highmark is mandated or required to provide based on state or federal law, no benefits will be provided for services, supplies, prescription drugs or charges:

| <u>Key Word</u> | <u>Exclusion</u> |
|---------------------------|--|
| Abortion | <ul style="list-style-type: none"> for elective abortions, except those abortions necessary to avert your death or terminate pregnancies caused by rape or incest; |
| Allergy Testing | <ul style="list-style-type: none"> for allergy testing; |
| Ambulance | <ul style="list-style-type: none"> for ambulance services except to the extent covered by Medicare Part B or otherwise provided herein; |
| Assisted Fertilization | <ul style="list-style-type: none"> related to treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization; |
| Comfort/Convenience Items | <ul style="list-style-type: none"> for personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider; |
| Cosmetic Surgery | <ul style="list-style-type: none"> for operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise required by law. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; and b) surgery to correct functional impairment which results from a covered disease, injury or congenital birth defect; |
| Court Ordered Services | <ul style="list-style-type: none"> for otherwise covered services ordered by a court or other tribunal unless medically necessary and appropriate or if the reimbursement of such services is required by law; |
| Custodial Care | <ul style="list-style-type: none"> for custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care; |
| Dental Care | <ul style="list-style-type: none"> directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy |

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| | (dental root resection) root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for anesthesia for non-covered dental procedures and orthodontic treatment for congenital cleft palates as provided herein; |
| Enteral Formulae | <ul style="list-style-type: none"> • for any food, including but not limited to, enteral formulae, normal food products used in the dietary management of rare hereditary genetic metabolic disorders, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis. This does not include enteral formulae prescribed solely for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria; |
| Effective Date | <ul style="list-style-type: none"> • which are rendered prior to your effective date of coverage; |
| Experimental/ Investigative | <ul style="list-style-type: none"> • which are experimental/investigative in nature; |
| Eyeglasses/Contact Lenses | <ul style="list-style-type: none"> • for eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury); |
| Felonies | <ul style="list-style-type: none"> • for any illness or injury you suffer during your commission of a felony, as long as such illness or injuries are not the result of a medical condition or an act of domestic violence; |
| Foot Care | <ul style="list-style-type: none"> • for palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet except when such devices or services are related to the treatment of diabetes; |
| Hearing Care Services | <ul style="list-style-type: none"> • for hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids; |
| Home Health Care | <ul style="list-style-type: none"> • the following services you receive from a home health care agency or a hospital program for home health care: dietitian |

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| | services; homemaker services; maintenance therapy; dialysis treatment; custodial care; and food or home-delivered meals; |
| Immunizations | <ul style="list-style-type: none"> • for immunizations required for foreign travel or employment; |
| Impotency | <ul style="list-style-type: none"> • for impotency treatment drugs; |
| Inpatient Admissions | <ul style="list-style-type: none"> • for inpatient admissions that are primarily for diagnostic studies; • for inpatient admissions that are primarily for physical therapy; |
| Learning Disabilities | <ul style="list-style-type: none"> • for any care that is related to conditions such as hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, but not including care related to autism spectrum disorders, which extends beyond traditional medical management, or for inpatient confinement for environmental change. Care which extends beyond traditional medical management or for inpatient confinement for environmental change includes the following: a) services that are primarily educational in nature; such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services provided for purposes of behavioral modification and/or training; d) services related to the treatment of learning disorders or learning disabilities; e) services provided primarily for social or environmental change or for respite care; f) developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which you have not yet attained; and g) services provided for which, based on medical standards, there is no established expectation of achieving measurable, sustainable improvement in a reasonable and predictable period of time; |

- for any care that is related to autism spectrum disorders which extends beyond traditional medical management, except as otherwise provided herein. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing); except for specific evaluation purposes directly related to medical treatment; and c) services provided primarily for respite care.
- Legal Obligation
- for which you would have no legal obligation to pay;
- Medicare
- for the Medicare Part B deductible;
- Medicare
- for any illness or injury to the extent that payment has been made by Medicare or any Medicare supplemental insurance program, when Medicare is primary;
- Medicare
- which are not covered by Medicare and not specifically referenced in this booklet;
 - which are not covered by Medicare but covered under this program, and not medically necessary and appropriate as determined by the plan;
 - not covered by Medicare and incurred due to confinement in a freestanding psychiatric facility;
 - charges for services, other than emergency and urgent care services when a private contract has not been executed by the Medicare beneficiary, which are payable under Medicare rendered by a Medicare opt-out provider when Medicare is primary;
 - charges for any services payable under Medicare and rendered by a Medicare non-participating provider in excess of the Medicare reasonable charge, when Medicare is primary;
 - for any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage;
- Military Service
- to the extent benefits are provided to members of the

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| | armed forces and the National Health Service or to patients in Veteran’s Administration facilities for service-connected illness or injury unless you have a legal obligation to pay; |
| Miscellaneous | <ul style="list-style-type: none"> • for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form; • for any other medical or dental service or treatment, except as provided herein; • For any charges for benefits provided through the Commonwealth or the State System of Higher Education as an employer or a Health and Welfare Fund Benefit Program to which the Commonwealth or the State System of Higher Education contributes as a result of collective bargaining; |
| Motor Vehicle Accident | <ul style="list-style-type: none"> • for treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a program or policy of motor vehicle insurance, including a certified or qualified program of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act; |
| Nutritional Counseling | <ul style="list-style-type: none"> • for nutritional counseling and services intended to produce weight loss; |
| Obesity | <ul style="list-style-type: none"> • for treatment of obesity, except for the medical and surgical treatment of morbid obesity when weight is at least twice the ideal weight specified for frame, age, height and sex; |
| Oral Surgery | <ul style="list-style-type: none"> • for oral surgery procedures unless specifically provided, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, unless specifically provided for herein; |
| Physical Examinations | <ul style="list-style-type: none"> • for routine or periodic physical examinations, the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein; |
| Preventive Care | <ul style="list-style-type: none"> • for preventive care services, wellness services or programs, except as provided herein; |
| Provider of Service | <ul style="list-style-type: none"> • which are not prescribed or performed by or upon the |

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| | <ul style="list-style-type: none"> direction of a professional provider; • which are rendered by other than hospitals, facility providers or professional providers; • received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group; • 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; • rendered by a professional provider who is a member of your immediate family; • performed by a professional provider enrolled in an education or training program when such services are related to the education or training program; |
| Respite Care | <ul style="list-style-type: none"> • for respite care, except as provided herein; |
| Screening Exams | <ul style="list-style-type: none"> • for screening examinations including x-ray examinations made without film; |
| Sexual Dysfunction | <ul style="list-style-type: none"> • for treatment of sexual dysfunction not related to organic disease or injury; |
| Skilled Nursing | <ul style="list-style-type: none"> • for skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness; |
| Spinal Manipulations | <ul style="list-style-type: none"> • For spinal manipulations for which there is no expectation of restoring the patient's level of function which has been lost or reduced by injury or illness, or which is performed repetitively to maintain a level of function, or prevent regression of that function, unless medically necessary or appropriate; |
| Termination Date | <ul style="list-style-type: none"> • incurred after the date of termination of your coverage, except as provided herein; |
| Therapy | <ul style="list-style-type: none"> • for therapy services for which there is no expectation of restoring or improving a level of function or when no |

additional functional progress is expected to occur, and which are determined not to be medically necessary and appropriate;

- for drug and alcohol abuse rehabilitation;
 - for treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma;
- TMJ
- for any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery;
- Transsexual Surgery
- for the correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;
- Vision Correction Surgery
- for an illness or injury suffered after your effective date as a result of any act of war;
- War
- for well-baby care visits, except as provided herein;
- Well-Baby Care
- for any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease, or similar type legislation. This exclusion applies whether or not you file a claim for said benefits or compensation;
- Workers' Compensation

Eligible Providers

Facility Providers

- Ambulatory surgical facility
- Birthing facility
- Day/night psychiatric facility
- Freestanding dialysis facility
- Freestanding nuclear magnetic resonance facility/MRI facility
- Home health care agency
- Hospice facility
- Hospital
- Outpatient physical rehabilitation facility
- Outpatient psychiatric facility
- Psychiatric hospital
- Rehabilitation hospital
- Skilled nursing facility
- Substance abuse treatment facility

Professional Providers

- Audiologist
- Behavior specialist
- Certified Clinical Nurse Specialist*
- Certified Community Health Nurse*
- Certified Enterostomal Therapy Nurse*
- Certified Psychiatric Mental Health Nurse*
- Certified Registered Nurse Anesthetist*
- Certified Registered Nurse Practitioner*
- Chiropractor
- Clinical social worker
- Dentist
- Dietician-nutritionist
- Marriage and family therapist
- Nurse-midwife
- Occupational therapist
- Optometrist

- Osteopath
- Physical therapist
- Physician
- Podiatrist
- Professional counselor
- Psychologist
- Registered nurse
- Speech-language pathologist

Ancillary Providers

- Ambulance service
- Clinical laboratory
- Home infusion therapy provider
- Suppliers (durable medical equipment suppliers, hearing aid device vendors, vendors/fitters, orthotic and prosthetic suppliers, pharmacy/durable medical equipment suppliers)

**Excluded from eligibility are registered nurses employed by a health care facility or by an anesthesiology group.*

Providers Who Accept Assignment

Under the terms of assignment, you transfer to the provider the right to both the Medicare and Highmark payment based on Medicare eligible expenses specified on the claim. The provider, in turn, agrees to accept the Medicare reasonable charge set by the Medicare carrier as his total charge for the covered service.

The sum of the reasonable charge payments, 80% by Medicare Part B and 20% by Highmark, constitute payment in full, except where maximums or deductibles are specified. Highmark reserves the right to make payment directly to the provider.

Providers Who Do Not Accept Assignment

You are responsible to pay any difference between the provider's charge and the combined Medicare/Highmark payment if the provider does not accept assignment.

Highmark reserves the right to make payment directly to you.

Network Pharmacies

Network Pharmacies

You must purchase drugs from a network pharmacy to be eligible for benefits under this program. *No benefits are available if drugs are purchased from a non-network pharmacy.*

- **Network Pharmacy:** Network pharmacies have an arrangement with Highmark to provide prescription drugs to you at an agreed upon price. When you purchase covered drugs from a pharmacy in the network applicable to your program, present your prescription and ID card to the pharmacist. (Prescriptions which the pharmacy receives by phone from your physician or dentist may also be covered.) Upon presenting your ID card, you will be required to pay the agreed upon price to the network pharmacy. If you fail to show your ID card to the pharmacy, you will be responsible for paying the full charge for your prescriptions. For a description on how to obtain reimbursement, see the How to File a Claim section of this benefit booklet.

If you travel within the United States and need to refill a prescription, call Member Service for help. They can help you find a network pharmacy near the area you are visiting. You also can use the member website to find a pharmacy. Once you have the name and address of the network pharmacy, take the prescription bottle to that pharmacy. The pharmacist will contact your home pharmacy to start the refill process. **Note: Save the new medicine container. This will make it easier to transfer the prescription back to your pharmacy at home.**

- **Mail Order Pharmacy:** Express Scripts® is your program's mail order pharmacy. This option offers savings and convenience for prescriptions you may take on an ongoing basis. To start using mail order:
 1. Ask your doctor to write a prescription for up to a 90-day supply, plus refills for up to one year, if appropriate.
 2. Complete the Pharmacy Mail Order Form and Health, Allergy & Medication Questionnaire. You can get these forms by calling Member Service or from your member website. After logging in, click on "Fill Rx" at the top of the home page. Then click on "Health & Benefits Information" and select the "Print Forms" link.
 3. Send the completed forms and your payment to the address listed on the mail order form. It usually takes about five days to get your prescription after it has been processed.

Your mail order will include directions for ordering refills.

General Information

Eligible Person and Eligible Dependent

From time to time eligible new Annuitants or Dependents may be added to the group originally covered in accordance with the terms of the Contract, or as required by applicable law. The Group is responsible for determining if a person is eligible for coverage and for reporting such eligibility to the Plan. The Plan reserves the right to request, at any time, documentation relative to eligibility for coverage of any individual enrolled for coverage provided under the terms of this Contract.

1. **Eligible Person** is defined as:

a. Annuitant

State System Annuitant and eligible Dependents may enroll in the State System of Higher Education Annuitant Health Care Program ("SSHEAHCP") if they were eligible for coverage in the State System of Higher Education Group Health Program ("SSHEGHP") on the last day actively at work. Employees must retire and begin drawing an annuity from one of the State System's retirement plans in order to receive SSHEAHCP benefits. Annuitants who continue coverage under the State System's active or Annuitant health care programs as a Dependent under a spouse's contract will be permitted to delay enrollment in the SSHEAHCP until coverage under the spouse's contract ceases. The retiree must attest they are covered under another health plan in order to be eligible to enroll in the SSHEAHCP at a later date by completing an Annuitant Health Care Program Waiver Form. To exercise their right of a one-time enrollment at a later date, enrollment in the SSHEAHCP must be elected within sixty (60) days of loss of other coverage or at Open Enrollment.

b. The Group may not discriminate in enrollment or contribution based on the health status, as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or genetic information, as defined by the Genetic Information Nondiscrimination Act of 2008 ("GINA"), of an Eligible Person. If the Group does discriminate in enrollment or contribution based on health status, the Group shall be solely liable for any claims or expenses, including medical claims or expenses, incurred by the Eligible Person who has been discriminated against.

2. **Eligible Dependent** is defined as:

The following Dependents are eligible to be enrolled:

- a. The Employee's spouse under a legally valid existing marriage between persons of the opposite sex or between persons of the same sex when entered into within a state that sanctions such marriages by law and that is valid pursuant to such law at the time of the marriage. Such spouse must also meet the eligibility requirements provided in the Group's collective bargaining agreements and/or as required by action of the Group's board of governors.
- b. Unmarried Dependent child under nineteen (19) years of age who meets one of the following requirements:
 - i) A blood descendent of the first degree;
 - ii) A legally adopted child (including a child living with the Annuitant during the probation period);
 - iii) A stepchild;
 - iv) A child being solely supported by the Annuitant and for whom the Annuitant is the legal guardian;
 - v) A child age eighteen (18) being solely supported by the Annuitant if the Annuitant was the child's legal guardian or foster parent prior to the child's eighteenth (18th) birthday;
 - vi) A child awarded coverage pursuant to an order of court; or
 - vii) A newborn child of an Annuitant or Eligible Dependent from the moment of birth to a maximum of thirty-one (31) days from the date of birth. To be covered as a Dependent beyond thirty-one (31) days from the date of birth, the newborn child must be added as a Dependent through the System university office. Subject to the termination provision set forth in **SECTION GP - GENERAL PROVISIONS, CONTINUATION OF BENEFITS AFTER TERMINATION** Subsection, in the event that a newborn child is not eligible for continuing coverage as a Dependent under this Contract, the parent may convert such child's coverage to individual coverage provided an application for conversion is made within thirty-one (31) days of the child's birth and the appropriate premium is received within such period.
- c. Unmarried Dependent child nineteen (19) to twenty-five (25) years of age who

meets all of the following requirements:

- i) Enrolled in and attending as a full-time student a recognized course of study or training;
- ii) Not employed on a regular full-time basis; and
- iii) Not covered under any group insurance plan or prepayment plan through the student's employer.

To be covered under this provision, the child must have been the Annuitant's Dependent before the age of nineteen (19).

Coverage for full-time students continues during a regularly scheduled vacation period or between-term period as established by the institution. Work limited to that period is not considered employment "on a regularly scheduled basis.

A Dependent child who takes a medically necessary leave of absence from school, or who changes his or her enrollment status (such as changing from full-time to part-time) due to a serious illness or injury may continue coverage for one (1) year from the first day of the medically necessary leave of absence or other change in enrollment or, if earlier, until the date coverage would otherwise terminate under the terms of this Contract. The Plan may require a certification from the Dependent child's treating Physician in order to continue such coverage.

Note: To the extent mandated by the requirements of Pennsylvania Act 83 of 2005, eligibility will be continued past the limiting age for children who are enrolled as Dependents under their parent's coverage at the time they are called or ordered into active military duty. The Dependent must be a member of the Pennsylvania National Guard or any reserve component of the armed forces of the United States, who is called or ordered to active duty, other than active duty for training, for a period of thirty (30) or more consecutive days, or be a member of the Pennsylvania National Guard ordered to active state duty for a period of thirty (30) or more consecutive days. If the Dependent becomes a full-time student no later than the first term or semester starting sixty (60) or more days after his or her release from active duty, the Dependent shall be eligible for coverage as a Dependent past the limiting age for a period equal to the duration of the Dependent's service on active duty or active state duty.

For the purposes of this Note, full-time student shall mean a Dependent who is enrolled in and regularly attending, an accredited school, college or university, or a licensed technical or specialized school for fifteen (15) or more credit hours per semester, or, if less than fifteen (15) credit hours per semester, the number of credit hours deemed by the school to constitute full-time student status.

- d. Unmarried Dependent child nineteen (19) years of age or older who is incapable of self-support because of a physical or mental disability that commenced before the age of nineteen (19).
- e. Unless otherwise set forth in this Section, an Eligible Dependent child's coverage automatically terminates and all benefits hereunder cease, whether or not notice to terminate is received by the Plan on the day following the date in which such Eligible Dependent ceases to be eligible.
- f. A Domestic Partner and if applicable, the child of a Domestic Partner shall be considered for eligibility as provided in the Group's collective bargaining agreements and as required by action of the Group's board of governors.

Changes in Membership Status

For Highmark to administer consistent coverage for you, you must keep your Employee Benefit Department informed about any address changes or changes that may affect your coverage.

Continuation of Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that covers group health plans sponsored by an employer (private sector or state/local government) that employed at least 20 employees on more than 50 percent of its typical business days in the previous calendar year. Employers that are subject to COBRA must temporarily extend their health care coverage to certain categories of employees when, due to certain "qualifying events," they are no longer eligible for group coverage.

Contact your employer for more information about COBRA and the events that may allow you to temporarily extend health care coverage.

Conversion

If your employer does not offer continuation of coverage, or if you do not wish to continue coverage through your employer's program, you may be able to enroll in an individual conversion program. Also, conversion is available to anyone who has elected continued coverage through your employer's program and the term of that coverage has expired.

If your coverage through your employer is discontinued for any reason, except as specified below, you may be able to convert to a direct payment program.

The conversion opportunity is not available if either of the following applies:

- You are eligible for another group health care benefits program through your place of employment.
- When your employer's program is terminated and replaced by another health care benefits program.

Certificates of Creditable Coverage

A "certificate of creditable coverage" provides evidence of an individual's length of coverage in a group health plan or other health insurance program defined under the Health Insurance Portability and Accountability Act of 1996.

Upon termination from a group health program or health insurance policy, such as this program, you will automatically receive a certificate of creditable coverage from the group health plan administrator or insurance company. The certificate of creditable coverage may be used to reduce the applicable pre-existing condition exclusion that a successor plan or program may impose. In addition, you have the right to request a certificate of creditable coverage from the plan administrator or insurance company (such as Highmark) for up to 24 months after coverage under this program or policy has terminated.

Termination of Your Coverage Under the Employer Contract

Your coverage can be terminated in the following instances:

- When you cease to be an employee, the group shall promptly notify Highmark that you are no longer eligible for coverage and that your coverage should be terminated as follows:
 - When prompt notification is received, coverage will be terminated no earlier than the date on which you cease to be eligible.

- When a group requests a retroactive termination of coverage, coverage will be terminated no earlier than the first day of the month preceding the month in which Highmark received notice from the group.
- When you fail to pay the required contribution, your coverage will terminate at the end of the last month for which payment was made.
- Termination of the employer contract automatically terminates the coverage of all the members. It is the responsibility of the employer to notify you of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given to you by the employer.
- If it is proven that you obtained or attempted to obtain benefits or payment for benefits through fraud or intentional misrepresentation of a material fact, Highmark may, upon notice to you, terminate your coverage under the program.

Benefits After Termination of Coverage

- If you are totally disabled at the time your coverage terminates, benefits will be continued for covered services directly related to the condition causing such total disability, and for no condition, illness, disease or injury, as follows:
 - Up to a maximum period of 12 consecutive months
 - Until the maximum amount of benefits has been paid
 - Until the total disability ends
 - Until you become covered without limitation as to the disabling condition under other group coverage, whichever occurs first
- Your benefits will not be continued if your coverage is terminated because you failed to pay any required premium.

Other Types of Coverage

If you are also covered by another group benefit program or under any governmental program for which any periodic payment is made by or for you, it must be determined which coverage has primary liability – that is, which coverage will pay first for eligible medical services – and which coverage has secondary liability or pays second. Highmark makes this determination to prevent members from receiving more in benefits than the actual cost of care and to ultimately conserve funds allocated for health care.

If the other plan does not have a policy to determine primary or secondary liability, then it has primary liability; if it does have a policy, then it has primary liability if you are the

contract holder for both plans. If primary liability cannot be determined by looking at the contract holder for both plans, then the plan that has covered the patient the longest has primary liability. Except when prohibited by law, or when you have elected Medicare secondary, services provided under any governmental program for which any periodic payment is made by or for you, will always have primary liability.

Subrogation

If you need medical care as a result of an injury caused by someone else, Highmark has the right to seek repayment from the responsible party or his or her insurance company through a process called "subrogation". Highmark will provide benefits at the time of need, but you may be asked to execute and deliver documents or take other action as necessary to assure the rights of Highmark. Subrogation helps to conserve funds allocated for health care.

A Recognized Identification Card

Your card is your “passport” to quality care. The Blue Shield symbol on your card is recognized throughout the country and around the world. Carry your identification card with you at all times and show this card along with your Medicare card to the hospital, doctor, or other health care professional whenever you need medical care.

Protect your card: If your card is lost or stolen, please contact Member Service immediately. It is illegal to loan your card to persons who are not eligible to use your Signature 65 benefits.

To request additional ID cards, contact Member Service or request cards online by logging onto www.highmarkblueshield.com.

How to File a Claim

In most instances, health care providers will submit a claim on your behalf directly to Medicare and/or Highmark. **Most of the time, you will not have to take any action.**

If your claim is not submitted directly by your provider, you may need to file the claim yourself. The procedure is simple. Just take the following steps.

- **Know your benefits.** Review this information to see if the services you received are eligible under your medical program.
- **For benefits covered by Medicare** (see the 'Medicare Covered Services' section of your Summary of Benefits):
 - You must submit a copy of the Explanation of Medicare Benefits (EOMB) that states the Medicare portion of the claim has been paid.
 - If you receive a Medicare EOMB and no Explanation of Benefits (EOB) from Highmark within 30 days, submit the Medicare EOMB.
 - Write your ID number on the top right corner of the EOMB. Your ID number can be found on your ID card.
- **For benefits that are not covered by Medicare** (see the 'Additional Benefits Not Covered By Medicare' section of your Summary of Benefits): Mail the itemized bill to Highmark. Itemized bills must include:
 - The name and address of the service provider;
 - The patient's full name;
 - The date of service or supply;
 - A description of the service/supply;
 - The amount charged;
 - The diagnosis or nature of illness.
 - Write your ID number on the top right corner of the bill.
- **For Major Medical benefits** (see the Major Medical section of your Summary of Benefits): Itemized bills must include:
 - The name and address of the service or pharmacy provider;
 - The patient's full name;
 - The date of service or supply or purchase;
 - A description of the service or medication/supply;
 - The amount charged;
 - For a medical service, the diagnosis or nature of illness;
 - For durable medical equipment, the doctor's certification;

- For private duty nursing, the nurse’s license number, charge per day and shift worked, and signature of provider prescribing the service;
 - For ambulance services, the total mileage.
 - Drug and medicine bills must show the prescription name and number and the prescribing provider's name.
- **Complete a Major Medical claim form.** Make sure all information is completed properly, and then sign and date the form. *Claim forms are available from your employee benefits department, or call the Member Service telephone number on the back of your ID card.*
 - **Attach itemized bills, your EOMB and/or EOB, if applicable, to the Major Medical claim form and mail everything to the address on the form.**

Note: If you have already made payment for the services you received, you must also submit proof of payment (receipt from the provider) with your claim. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

- **Keep a copy for your records.** You must submit originals, so you may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.

Time Limit To File A Claim

- Claims should be submitted within 90 days of the date of service.
- Claims must be submitted no later than 36 months from the date of service.
- Drug claims, if applicable, must be submitted no later than 15 months from the date of purchase.
- Major Medical claims must be submitted within 12 months following the end of the Benefit Period in which the Covered Service was rendered.

Mailing Address For Claims

Mail claims for benefits which complement Medicare Part A or Medicare part B to:

Highmark Blue Shield
P.O. Box 898845
1800 Center Street
Camp Hill, PA 17089

Mail Major Medical claims to the address on your Major Medical claim form.

Your Explanation of Benefits Statement

Once your claim is processed, an Explanation of Benefits (EOB) statement will be issued within 30 days of receipt of the claim, unless extended for reasons outside our control. Highmark reserves the right to require additional information and documents as needed to support a claim.

Designation of an Authorized Representative

You may authorize someone else to file and pursue a claim on your behalf. If you do so, you must notify Highmark in writing of your choice of an authorized representative by completing a "Designation of an Authorized Representative" form. This form may be requested from a member service representative and must also be included in the letter you receive from Highmark that acknowledges receipt of your appeal.

Additional Information on How to File a Prescription Drug Claim

Member Inquiries

General inquiries regarding your eligibility for coverage and benefits do not involve the filing of a claim, and should be made by directly contacting the Member Service Department using the telephone number on your ID card.

Filing Benefit Claims

– *Authorized Representatives*

You have the right to designate an authorized representative to file or pursue a request for reimbursement or other post-service claim on your behalf. Highmark Blue Shield reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

– *Requests for Preauthorization and Other Pre-Service Claims*

For additional information on filing a request for preauthorization or other pre-service claim, see the Preauthorization and Pre-Service Claims Review Processes subsection in the Drug Management section of this benefit booklet.

– *Requests for Reimbursement and Other Post-Service Claims*

When a participating hospital, physician or other provider submits its own reimbursement claim, the amount paid to that participating provider will be determined in accordance with the provider's agreement with Highmark or the local licensee of the Blue Cross Blue Shield Association serving your area. Highmark will notify you of the amount that was paid to the provider. Any remaining amounts

that you are required to pay in the form of a copayment, coinsurance or program deductible will also be identified in that EOB or notice. If you believe that the copayment, coinsurance or deductible amount identified in that EOB or notice is not correct or that any portion of those amounts are covered under your benefit program, you may file a claim with Highmark. For instructions on how to file such claims, you should contact the Member Service Department using the telephone number on your ID card.

Determinations on Prescription Drug Claims

– *Notice of Adverse Benefit Determinations Involving Requests for Reimbursement and Other Post-Service Claims*

Highmark will notify you in writing of its determination on your request for reimbursement or other post-service claim within a reasonable period of time following receipt of your claim. That period of time will not exceed 30 days from the date your claim was received. However, this 30-day period of time may be extended one time by Highmark for an additional 15 days, provided that Highmark determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day post-service claim determination period. If an extension of time is necessary because you failed to submit information necessary for Highmark to make a decision on your post-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your post-service claim.

If your request for reimbursement or other post-service claim is denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

For a description of your right to file an appeal concerning an adverse benefit determination of a request for reimbursement or any other post-service claim, see the Appeal Procedure subsection below.

Appeal Procedure

Internal Appeal Process

Highmark maintains an internal appeal process involving one level of review. At any time during the appeal process, you may choose to designate a representative to participate in the appeal process on your behalf. You or your representative shall notify Highmark in writing of the designation. For purposes of the appeal process, "you"

includes designees, and legal representatives and, in the case of a minor, parents entitled or authorized to act on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures, as adopted by Highmark shall, in the case of an urgent care claim, permit a professional provider with knowledge of your medical condition to act as your authorized representative.

At any time during the appeal process, you may contact the Member Service Department at the toll-free telephone number listed on your ID card to inquire about the filing or status of your appeal.

If you receive notification your coverage has been rescinded or that a claim has been denied by Highmark, in whole or in part, you may appeal the decision. Your appeal must be submitted within 180 days from the date of your receipt of notification of the adverse decision. You may mail your appeal to:

Highmark Blue Shield
P.O. Box 890178
Camp Hill, PA 17089-0178
ATTN: Review Committee

Upon request to Highmark, you may review all documents, records and other information relevant to your appeal and shall have the right to submit or present additional evidence or testimony which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of your appeal. Your appeal will be reviewed by a representative from the Member Grievance and Appeals Department. The representative shall not have been involved in any previous decision to deny the claim or matter which is the subject of your appeal or the subordinate of any individual that was involved in that decision. In rendering a decision on your appeal, the Member Grievance and Appeals Department will take into account all evidence, comments, testimony, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Highmark. The Member Grievance and Appeals Department will also afford no deference to any prior adverse decision on the claim which is the subject of your appeal.

Each appeal will be promptly investigated and Highmark will provide written notification of its decision within a reasonable period of time appropriate to the medical circumstances involved not to exceed 30 days following receipt of your appeal.

If Highmark fails to provide notice of its decision within the above-stated time frames or otherwise fails to strictly adhere to these appeal procedures, you shall be permitted to request an external review and/or pursue any applicable legal action.

In the event Highmark renders an adverse decision on your internal appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding your right to request an external review and/or pursue any applicable legal action

External Review Process

You will have 15 days from the receipt of the notice of Highmark's decision to appeal the denial resulting from the internal appeal process by requesting an external review of the decision. Depending on the nature of the claim that has been denied or the matter involved, the external review shall follow one of the following processes.

Where the claim that has been denied or the matter involved relates to determinations made by Highmark to rescind your coverage, you shall submit a written request, unless you are required to file the request in an alternative format, for an external review of the decision at the following address:

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

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

Where the claim that has been denied is based on Highmark's requirements as to medical necessity, appropriateness, health care setting, level of care or effectiveness of the service, you or a health care provider, with your written consent, may appeal the denial of the decision by filing a request for an external review with Highmark. You should include any material justification and all reasonably necessary supporting information as part of the external review filing.

Within five business days of the filing of the request for an external review, Highmark will notify the Department of Health, you or the health care provider as appropriate, that an external review request has been filed. Highmark's notification to the Department of Health shall include a request for assignment of a Certified Utilization

Review Entity (CRE). Highmark shall forward copies of all written documentation, regarding the denial, including the decision, all reasonably necessary supporting information, a summary of applicable issues and the basis and clinical rationale for the decision to the CRE conducting the external review within 15 days of the receipt of notice that the external review request was filed. Within this same period, Highmark shall provide you or the health care provider with a list of documents forwarded to the CRE for the external review. You or the health care provider may supply additional written information, with copies to Highmark, to the CRE for consideration on the external review within 15 days of receipt of notice that the external review request was filed.

The external review will be conducted by a CRE selected by the Department of Health. The Department of Health will notify you or the health care provider, and Highmark of the name, address and telephone number of the CRE assigned within two business days following receipt of the request for assignment. If the Department of Health fails to select a CRE within two business days of receiving the request, Highmark has the right to designate and notify a CRE to conduct the external review.

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

Within 60 days of the filing of the external review, the CRE conducting the external review shall issue a written notification of the decision to Highmark, you or the health care provider, including the basis and clinical rationale for the decision.

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

Highmark shall authorize any health care service or pay a claim determined to be medically necessary and appropriate based on the decision of the CRE regardless of whether an appeal to a court of competent jurisdiction has been filed.

Member Assistance Services

You may obtain assistance with Highmark's internal appeal and external review procedures as described herein by contacting the Pennsylvania Insurance Department Office of Consumer Services or such other applicable office of health insurance consumer assistance or ombudsman.

Autism Spectrum Disorders Expedited Review and Appeal Procedures

Upon denial, in whole or in part, of claim for diagnostic assessment or treatment of autism spectrum disorders, there is an appeal procedure for expedited internal review which you may choose as an alternative to those procedures set forth above. In order to obtain an expedited review, you or your authorized representative shall identify the particular claim as one related to the diagnostic assessment or treatment of an autism spectrum disorder to the Member Service Department and request an expedited review which will be provided by Highmark. If, based on the information provided at the time the request is made, the claim cannot be determined as one based on services for the diagnostic assessment or treatment of autism spectrum disorders, Highmark may request from you or the health care provider additional clinical information including the treatment plan described in the Covered Services section of the booklet.

An appeal of a denial of a claim for services for the diagnostic assessment or treatment of an autism spectrum disorder is subject to review by a Review Committee. The request to have the decision reviewed by the Review Committee may be communicated orally or be submitted in writing within 180 days from the date the denial of the claim is received, and may include any written information from you or the health care provider. The Review Committee shall be comprised of three employees of Highmark who were not involved or the subordinate of any individual that was previously involved in any decision to deny coverage or payment for the health care service. The Review Committee will hold an informal hearing to consider the appeal. When arranging the hearing, Highmark will notify you or the health care provider of the hearing procedures and rights at such hearing, including your or the health care provider's right to be present at the review and to present a case. If you or the health care provider cannot appear in person at the review, Highmark shall provide you or the health care provider the opportunity to communicate with the Review Committee by telephone or other appropriate means.

Highmark shall conduct the expedited internal review and notify you or your authorized representative of its decision as soon as possible but not later than 48 hours following the receipt of your request for an expedited review. The notification to you and the health care provider shall include, among other items, the specific reason or reasons for the adverse decision including any clinical rationale, the procedure for obtaining an expedited external review and a statement regarding your right to pursue legal action.

Following the receipt of the expedited internal review decision, you may contact Highmark to request an expedited external review pursuant to the expedited external review procedure for autism spectrum disorders established by the Pennsylvania Insurance Department.

Member Service

As a Highmark member, you have access to a wide range of readily available health education tools and support services, all geared to help you "Have A Greater Hand in Your Health®."

Blues On Callsm - 24/7 Health Decision Support

Just call **1-888-BLUE-428 (1-888-258-3428)** to be connected to a specially-trained wellness professional. You can talk to a Health Coach whenever you like, any time of the day, any day of the week.

Health Coaches are specially-trained registered nurses, dietitians and respiratory therapists who can help you make more informed health care and self-care (when appropriate) decisions. They can assist with a health symptom assessment, provide health-related information, and discuss your treatment options. Please be assured that your discussions with your Health Coach are kept strictly confidential.

Help with common illnesses, injuries and questions

Health Coaches can address any health topic that concerns you:

- Everyday conditions, such as a rash, an earache or a sprain
- A recent diagnosis you've received
- A scheduled medical test
- Planned surgery or other medical procedure
- Questions to ask your doctor at your next appointment
- How to care for a child or elder

You don't have to be ill to talk to a Health Coach. Call to learn about programs and other resources available to help you manage:

- Stress
- Personal nutrition
- Weight management
- Physical activities
- Insomnia
- Depression

Help with chronic conditions

If you have diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease or coronary artery disease, you need to manage your condition every day in order to stay healthy and avoid hospital stays. That means keeping track of

medications, tests, doctor appointments and your diet. Your Blues On Call Health Coach can help you work more closely with your doctor and get more involved in taking good care of yourself.

You can even establish a relationship with a specific Health Coach and schedule time to talk about your concerns and conditions.

Highmark Website

As a Highmark member, you have a wealth of health information at your fingertips. It's easy to access all your online offerings. Whether you are looking for a health care provider or managing your claims...want to make informed health care decisions on treatment options...or lead a healthier lifestyle, Highmark can help with online tools and resources.

Go to www.highmarkblueshield.com. Then click on the "Members" tab and log in to your homepage to take advantage of all kinds of programs and resources to help you understand your health status, through the online Wellness Profile, then take steps toward real health improvement.

You have access to a wide selection of Lifestyle Improvement and Condition Management Programs. Here are examples of the types of free programs available to you as a Highmark member:

Eat Healthy - You know that a healthy diet is key to a healthy body. You have a range of programs to help you learn more about food and nutrition, change your eating habits, and enjoy it all in the process!

Get Active - Exercise enhances both the body and the mind. It's a critical component of a healthy lifestyle for everyone, but not everyone needs the same kind of workout. That's why you've got a variety of "get fit" programs to help you feel better and get in shape.

Manage Your Stress - Stress has more impact on your health than you might think. It can damage your immune system and make you more susceptible to illnesses. It can also have a detrimental impact on your job and personal life. You can learn proven techniques to better cope and reduce stress.

Manage Your Weight - You *can* get control over your weight! Health eating habits and a healthy attitude toward food can help. You have a choice of programs to take the approach best suited for you.

Quit Smoking - There's no doubt about the dangers of smoking. And there's no time like the present to quit. As a Highmark member, you can choose the program that suits your style and quit for good!

Member Service

Whether it's for help with a claim or a question about your benefits, you can call your Member Service toll-free telephone number on the back of your ID card or log onto your Highmark member website at www.highmarkblueshield.com. A Highmark Member Service representative can also help you with any coverage inquiry. Representatives are trained to answer your questions quickly, politely and accurately.

Highmark realizes the importance of a healthy lifestyle. Our goal is to help you reach your healthiest potential. That's why, in addition to your online wellness tools, we keep you informed via your quarterly member newsletter, *Looking Healthward*. This newsletter contains new product updates, as well as a wide variety of health and preventive care articles and "stay healthy" tips. Watch for your copy in the mail!

Member Rights and Responsibilities

Your participation in the Signature 65 program is vital to maintaining quality in your program and services. Your importance to this process is reflected in the following statement of principles.

You have the right to:

1. Receive information about Highmark, its products and its services, its practitioners and providers, and your rights and responsibilities.
2. Be treated with respect and recognition of your dignity and right to privacy.
3. Participate with practitioners in decision-making regarding your health care. This includes the right to be informed of your diagnosis and treatment plan in terms that you understand and participate in decisions about your care.
4. Have a candid discussion of appropriate and/or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Highmark does not restrict the information shared between practitioners and patients and has policies in place, directing practitioners to openly communicate information with their patients regarding all treatment options regardless of benefit coverage.
5. Voice a complaint or file an appeal about Highmark or the care provided and receive a reply within a reasonable period of time.
6. Make recommendations regarding the Highmark Members' Rights and Responsibilities policies.

You have a responsibility to:

1. Supply to the extent possible, information that the organization needs in order to make care available to you, and that its practitioners and providers need in order to care for you.
2. Follow the plans and instructions for care that you have agreed on with your practitioners.
3. Communicate openly with the physician you choose. Ask questions and make sure you understand the explanations and instructions you are given, and participate in developing mutually agreed upon treatment goals. Develop a relationship with your doctor based on trust and cooperation.

How We Protect Your Right to Confidentiality

We have established policies and procedures to protect the privacy of our members' protected health information ("PHI") in all forms, including PHI given verbally, from unauthorized or improper use. Some of the ways we protect your privacy include not discussing PHI outside of our offices, e.g., in hallways, elevators, as well as verifying your identity before we discuss PHI with you over the phone. As permitted by law, we may use or disclose protected health information for treatment, payment and health

care operations, such as: claims management, routine audits, coordination of care, quality assessment and measurement, case management, utilization review, performance measurement, customer service, credentialing, medical review and underwriting. With the use of measurement data, we are able to manage members' health care needs, even targeting certain individuals for quality improvement programs, such as health, wellness and disease management programs.

If we ever use your protected health information for non-routine uses, we will ask you to give us your permission by signing a special authorization form, except with regard to court orders and subpoenas.

You have the right to access the information your doctor has been keeping in your medical records, and any such request should be directed first to your network physician.

You benefit from the many safeguards we have in place to protect the use of data we maintain. This includes requiring our employees to sign statements in which they agree to protect your confidentiality, using computer passwords to limit access to your protected health information, and including confidentiality language in our contracts with physicians, hospitals, vendors and other health care providers.

Our Privacy Department review and approves policies regarding the handling of confidential information.

Recognizing that you have a right to privacy in all settings, we even inspect the privacy of examination rooms when we conduct on-site visits to physicians' offices. It's all part of safeguarding the confidentiality of your protected health information.

Terms You Should Know

Annuitant – an individual who meets the eligibility requirements specified in SECTION SE – SCHEDULE OF ELIGIBILITY.

Applied Behavioral Analysis - The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Assignment - An agreement between the professional provider and the Medicare beneficiary. It is a process through which a professional provider or supplier agrees to accept the amount Medicare approves as payment in full. You pay any coinsurance amount.

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 (IVF), Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), Tubal Embryo Transfer (TET), Peritoneal Ovum Sperm Transfer, Zona Drilling, and sperm microinjection.

Autism Spectrum Disorders - Any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

Benefit Period - That period which begins on the first day (which is not part of a prior benefit period) in which you are an inpatient in a hospital or skilled nursing facility. The benefit period ends when you have not been an inpatient of a hospital or skilled nursing facility for 60 consecutive days. Most Medicare Part A and Part B benefits are renewed when a new benefit period begins. There is no limit to the number of benefit periods you may have. See the section How Your Benefits Are Applied for the benefit period applicable to your Major Medical program.

Brand Drug - A recognized trade name prescription drug product, usually either the innovator product for new drugs still under patent protection or a more expensive product marketed under a brand name for multi-source drugs and noted as such in the pharmacy database used by Highmark.

Claim – A request for preauthorization or prior approval of a covered service or for the payment or reimbursement of the charges or costs associated with a covered service. Claims include:

- **Pre-Service Claim** – A request for preauthorization or prior approval of a covered service which under the terms of your coverage must be approved before you receive the covered service.
- **Urgent Care Claim** – A pre-service claim which, if decided within the time periods established for making non-urgent care pre-service claim decisions, could seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service.
- **Post-Service Claim** – A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

Coinsurance - The percentage of Medicare eligible expenses or Medicare reasonable charges over and above the Medicare deductible, which you have the responsibility to pay under Medicare.

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.

Deductible - The amount you pay each year for Medicare eligible expenses or Medicare reasonable charges before payment of benefits begins under Medicare. There are separate Medicare Part A and Medicare Part B deductibles which may apply to services covered under your program.

Dependent – a Member other than the Annuitant as specified in **SECTION SE – SCHEDULE OF ELIGIBILITY**.

Designated Agent - An entity that has contracted with Highmark, either directly or indirectly, to perform a function and/or service in the administration of this program. Such function and/or service may include, but is not limited to, medical management and provider referral.

Domestic Partner – a member of a Domestic Partnership as provided in the Group's collective bargaining agreements and as required by action of the Group's board of governors.

Emergency Care Services - The treatment of bodily injuries resulting from an accident, or following the sudden onset of a medical condition, or following, in the case of a chronic condition, a sudden and unexpected medical event that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- placing your health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
- causing serious impairment to bodily functions; and/or
- causing serious dysfunction of any bodily organ or part

and for which care is sought as soon as possible after the medical condition becomes evident to you.

Experimental/Investigative - The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by Highmark Inc. to be medically effective for the condition being treated. Highmark will consider an intervention to be experimental/investigative if: the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or, available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or, the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or, the intervention does not improve health outcomes; or, the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date.

Medical Researchers constantly experiment with new medical equipment, drugs and other technologies. In turn, health care plans must evaluate these technologies.

Highmark believes that decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. That is why a panel of more than 400 medical professionals works with our nationally recognized Medical Affairs Committee to review new technologies and new applications for existing technologies for medical and behavioral health procedures and devices. To stay current and patient-responsive, these reviews are ongoing and all-encompassing, considering factors such as product efficiency, safety and effectiveness. If the technology passes the test, the Medical Affairs Committee recommends it be considered as acceptable medical practice and a covered benefit. Technology that does

not merit this status is usually considered "experimental/investigative" and is not generally covered. However, it may be re-evaluated in the future.

A similar process is followed for evaluating new pharmaceuticals. The Pharmacy and Therapeutics (P & T) Committee assesses new pharmaceuticals based on national and international data, research that is currently underway and expert opinion from leading clinicians. The P & T Committee consists of at least one Highmark-employed pharmacist and/or medical director, five board-certified, actively practicing network physicians and two Doctors of Pharmacy currently providing clinical pharmacy services within the Highmark service area. At the committee's discretion, advice, support and consultation may also be sought from physician subcommittees in the following specialties: cardiology, dermatology, endocrinology, hematology/oncology, obstetrics/gynecology, ophthalmology, psychiatry, infectious disease, neurology, gastroenterology and urology. Issues that are addressed during the review process include clinical efficacy, unique value, safety, patient compliance, local physician and specialist input and pharmacoeconomic impact. After the review is complete, the P & T Committee makes recommendations.

Highmark recognizes that situations may occur when you elect to pursue experimental/investigative treatment. If you have a concern that a service you will receive may be experimental/investigational, you or the hospital and/or professional provider may contact Highmark's Member Service to determine coverage.

Explanation of Benefits (EOB) - This is the statement you'll receive from Highmark after your claim is processed. It lists: the provider's charge, allowable amount, copayment, deductible and coinsurance amounts, if any, you're required to pay; total benefits payable; and total amount you owe.

Explanation of Medicare Benefits (EOMB) - This is the statement you'll receive after your Medicare claim is processed. It explains how much Medicare paid and how much you are responsible for. In most cases, amounts Medicare didn't pay will be filed automatically with Highmark for consideration under your Signature 65 coverage.

Family Coverage – coverage for the Annuitant and one (1) or more of the Annuitant's Dependents.

Generic Drug - A drug that is available from more than one manufacturing source and accepted by the FDA as a substitute for those products having the same active ingredients as a brand drug and listed in the FDA "Approved Drug Products with Therapeutic Equivalence Evaluations," otherwise known as the orangebook, and noted as such in the pharmacy database used by Highmark.

Immediate Family - Your 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.

Inpatient - A member who is a registered bed patient in a hospital or skilled nursing facility and for whom a room and board charge is made.

Maximum - The greatest amount payable by the program for covered services. This could be expressed in dollars, number of days, or number of services for a specified period of time.

Medically Necessary and Appropriate (Medical Necessity and Appropriateness) - Services, supplies or covered medications 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: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (iii) 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. Highmark reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply or covered medication is medically necessary and appropriate. No benefits will be provided unless Highmark determines that the service, supply or covered medication is medically necessary and appropriate.

Medicare Eligible Expenses - Expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary and appropriate by Medicare. If this program provides for benefits not covered by Medicare, Highmark reserves the right to determine whether such benefits are medically necessary and appropriate.

Medicare Non-Participating Provider - A professional 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 does not accept the Medicare reasonable charge for certain service or supply as payment in full and may charge the patient more than the Medicare reasonable charge, unless otherwise prohibited by law.

Medicare Opt-Out Provider - A professional provider eligible to provide services or supplies under Medicare Part B but who has "opted out" of Medicare such that he or she forgoes any payments from Medicare to his or her patients or themselves, and

enters into private contracts with Medicare beneficiaries to provide eligible services, and bills Medicare beneficiaries directly for services provided.

Medicare Reasonable Charge - The approved amount for services and supplies, as determined by Medicare.

Member - A contract holder or dependent enrolled for health care coverage.

Outpatient - A member who receives services or supplies while not a registered bed patient in a hospital or skilled nursing facility.

Partial Hospitalization - The provision of medical, nursing, counseling or therapeutic mental health care services or substance abuse services on a planned and regularly scheduled basis in a facility provider designed for a patient or client who would benefit from more intensive services than are generally offered through outpatient treatment but who does not require inpatient care.

Plan - Refers to Highmark, which is an independent licensee of the Blue Cross Blue Shield Association. Any reference to the plan may also include its designated agent as defined herein and with whom the plan has contracted, either directly or indirectly, to perform a function or service in the administration of this program.

Provider's Allowable Price - The amount at which a participating pharmacy provider has agreed with Highmark to provide covered medications to you under this program.

Plan Allowance - The amount used to determine payment by Highmark for non-Medicare covered services provided to you and to determine your liability. Plan allowance is based on the type of provider who renders such services or as required by law. The plan allowance for a non-participating facility or professional provider is based on an adjusted contractual allowance for like services rendered by a participating facility or professional provider in the same geographic region. You will be responsible for any difference between the provider's billed charges and Highmark's payment.

Service Area - The geographic area consisting of the following counties in Pennsylvania:

| | | | |
|---------------|-----------|----------------|------------|
| Adams | Franklin | Lehigh | Perry |
| Berks | Fulton | Mifflin | Schuylkill |
| Centre (part) | Juniata | Montour | Snyder |
| Columbia | Lancaster | Northampton | Union |
| Cumberland | Lebanon | Northumberland | York |

Dauphin

Totally Disabled (or Total Disability) - A condition resulting from illness or injury as a result of which, and as certified by a physician, for an initial period of 24 months, you are continuously unable to perform all of the substantial and material duties of your regular occupation. However: (i) after 24 months of continuous disability, "totally disabled" (or total disability) means your inability to perform all of the substantial and material duties of any occupation for which you are reasonably suited by education, training or experience; (ii) during the entire period of total disability, you may not be engaged in any activity whatsoever for wage or profit and must be under the regular care and attendance of a physician, other than your immediate family. If you do not usually engage in any occupation for wages or profits, "totally disabled" (or total disability) means you are substantially unable to engage in the normal activities of an individual of the same age and sex.

You or Your - Refers to individuals who are covered under the program.

Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association.

Highmark is a registered mark of Highmark Inc.

Signature 65 is a service mark of Highmark Inc.

Blues On Call is a service mark of the Blue Cross and Blue Shield Association.

Blue Shield and the Shield symbol are registered service marks of the Blue Cross and Blue Shield Association.

The Blue Cross Blue Shield Association is an independent company that does not provide Highmark Blue Shield products and services. It is solely responsible for the services described in this booklet.

Express Scripts is a registered trademark of Express Scripts Holding Company.

You are hereby notified, your health care benefit program is between the Group, on behalf of itself and its employees and Highmark Blue Shield. Highmark Blue Shield is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield companies throughout the United States. Although all of these independent Blue Cross and Blue Shield companies operate from a license with the Association, each of them is a separate and distinct operation. The Association allows Highmark Blue Shield to use the familiar Blue Shield words and symbol. Highmark Blue Shield shall be liable to the Group, on behalf of itself and its employees, for any Highmark Blue Shield obligations under your health care benefit program.

Sí necesita ayuda para traducir esta información, por favor comuníquese con el departamento de Servicios a miembros de Highmark al número al réves de su tarjeta de identificación de Highmark. Estos servicios están disponibles de lunes a viernes, de 8:00 a 19:00, y los sábados de 8:00 a 17:00.

HIGHMARK NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE ALSO DESCRIBES HOW WE COLLECT, USE AND DISCLOSE NON-PUBLIC PERSONAL FINANCIAL INFORMATION.

Our Legal Duties

At Highmark, we are committed to protecting the privacy of your protected health information. “Protected health information” (PHI) is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members’ protected health information. We are required by applicable federal and state laws to maintain the privacy of your protected health information. We also are required by the HIPAA Privacy Rule (45 C.F.R. parts 160 and 164, as amended) to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We are also required to notify affected individuals following a breach of unsecured health information.

We will inform you of these practices the first time you become an HMHS customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice became effective September 23, 2013, and will remain in effect unless we replace it.

On an ongoing basis, we will review and monitor our privacy practices to ensure the privacy of our members’ protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this Notice. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will become effective for all protected health information that we maintain,

including protected health information we created or received before we made the changes. Before we make a material change in our privacy practices, we will change this Notice and notify all affected members in writing in advance of the change. Any change to this notice will be posted on our website and we will further notify you of any changes in our annual mailing.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. Uses and Disclosures of Protected Health Information

In order to administer our health benefit programs effectively, we will collect, use and disclose protected health information for certain of our activities, including payment and health care operations.

A. Uses and Disclosures of Protected Health Information for Payment and Health Care Operations

The following is a description of how we may use and/or disclose protected health information about you for payment and health care operations:

Payment

We may use and disclose your protected health information for all activities that are included within the definition of "payment" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "payment," so please refer to 45 C.F.R. § 164.501 for a complete list.

For example:

We may use and disclose your protected health information to pay claims from doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and/or to issue explanations of benefits to the person who subscribes to the health plan in which you participate.

Health Care Operations

We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "health care operations," so please refer to 45 C.F.R. § 164.501 for a complete list.

For example:

We may use and disclose your protected health information to rate our risk and determine the premium for your health plan, to conduct quality assessment and improvement activities, to credential health care providers, to engage in care coordination or case management, and/or to manage our business.

B. Uses and Disclosures of Protected Health Information to Other Entities

We also may use and disclose protected health information to other covered entities, business associates, or other individuals (as permitted by the HIPAA Privacy Rule) who assist us in administering our programs and delivering health services to our members.

(i) Business Associates.

In connection with our payment and health care operations activities, we contract with individuals and entities (called “business associates”) to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation, or pharmacy benefit management). To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

(ii) Other Covered Entities.

In addition, we may use or disclose your protected health information to assist health care providers in connection with *their* treatment or payment activities, or to assist other covered entities in connection with certain of *their* health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

II. Other Possible Uses and Disclosures of Protected Health Information

In addition to uses and disclosures for payment, and health care operations, we may use and/or disclose your protected health information for the following purposes:

1. To Plan Sponsors

We may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us regarding a member’s question, concern, issue regarding claim, benefits, service, coverage, etc. We may also disclose summary health information (this type of information is

defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

2. Required by Law

We may use or disclose your protected health information to the extent that federal or state law requires the use or disclosure. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.

3. Public Health Activities

We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability.

4. Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

5. Abuse or Neglect

We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence.

6. Legal Proceedings

We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information.

7. Law Enforcement

Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for

such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; or (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person.

8. Coroners, Medical Examiners, Funeral Directors, and Organ Donation

We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

9. Research

We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

10. To Prevent a Serious Threat to Health or Safety

Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

11. Military Activity and National Security, Protective Services

Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

12. Inmates

If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

13. Workers' Compensation

We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

14. Others Involved in Your Health Care

Unless you object, we may disclose your protected health information to a friend or family member that you have identified as being involved in your health care. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

15. Underwriting

We may disclose your protected health information for underwriting purposes; however, we are prohibited from using or disclosing your genetic information for these purposes.

16. Health Information Exchange

We all participate in a Health Information Exchange (HIE). An HIE is primarily a secure electronic data sharing network. In accordance with federal and state privacy regulations, regional health care providers participate in the HIE to exchange patient information in order to facilitate health care, avoid duplication of services, such as tests, and to reduce the likelihood that medical errors will occur.

The HIE allows your health information to be shared among authorized participating healthcare providers, such as health systems, hospitals and physicians, for the purposes of Treatment, Payment or Healthcare Operations purposes. Examples of this health information may include:

- General laboratory, pathology, transcribed radiology reports and EKG Images
- Results of outpatient diagnostic testing (GI testing, cardiac testing, neurological testing, etc.)
- Health Maintenance documentation/Medication
- Allergy documentation/Immunization profiles
- Progress notes, Urgent Care visit progress notes
- Consultation notes
- Inpatient operative reports
- Discharge summary/Emergency room visit discharge summary notes

All participating providers who provide services to you will have the ability to access your information. Providers that do not provide services to you will not

have access to your information. Information may be provided to others as necessary for referral, consultation, treatment or the provision of other healthcare services, such as pharmacy or laboratory services. All participating providers have agreed to a set of standards relating to their use and disclosure of the information available through the HIE. Your health information shall be available to all participating providers through the HIE.

You cannot choose to have only certain providers access your information. Patients who do not want their health information to be accessible through the HIE may choose not to participate or may "opt-out."

In order to opt-out, you must complete an opt-out Form, which is available at highmark.com or by calling the customer service number located on the back of your membership card. You should be aware, if you choose to opt-out, your health care providers will not be able to access your health information through the HIE. Even if you chose to opt-out, your information will be sent to the HIE, but provider will not be able to access this information. Additionally, your opt-out does not affect the ability of participating providers to access health information entered into the HIE prior to your opt-out submission.

III. Required Disclosures of Your Protected Health Information

The following is a description of disclosures that we are required by law to make:

A. Disclosures to the Secretary of the U.S. Department of Health and Human Services

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

B. Disclosures to You

We are required to disclose to you most of your protected health information that is in a "designated record set" (defined below) when you request access to this information. We also are required to provide, upon your request, an accounting of many disclosures of your protected health information that are for reasons other than payment and health care operations.

IV. Other Uses and Disclosures of Your Protected Health Information

Sometimes we are required to obtain your written authorization for use or disclosure of your health information. The uses and disclosures that require an authorization under 45 C.F.R. § 164.508(a) are:

1. For marketing purposes
2. If we intend to see your PHI

3. For use of Psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. An Authorization for use of psychotherapy notes is required unless:
 - a. Used by the person who created the psychotherapy note for treatment purposes, or
 - b. Used or disclosed for the following purposes:
 - (i) the provider's own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;
 - (ii) for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;
 - (iii) if required for enforcement purposes;
 - (iv) if mandated by law;
 - (v) if permitted for oversight of the provider that created the note;
 - (vi) to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or
 - (vii) if needed to avert a serious and imminent threat to health or safety.

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

V. Your Individual Rights

The following is a description of your rights with respect to your protected health information:

A. Right to Access

You have the right to look at or get copies of your protected health information in a designated record set. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so, if you request the information in an electronic format that is not readily producible, we will provide the information in a readable electronic format as mutually agreed upon. You must make a request in writing to obtain access to your protected health information.

To inspect and/or copy your protected health information, you may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. The first request within a 12-month period will be free. If you request access to your designated record set more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. If you request an alternative format, we will charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

B. Right to an Accounting

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment or health care operations. You should know that most disclosures of protected health information will be for purposes of payment or health care operations.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or submitting your request in writing to the Highmark Privacy Department, 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

The first list you request within a 12-month period will be free. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

C. Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing. We have a right to terminate this restriction, however if we do so, we must inform you of this restriction.

You may request a restriction by contacting us at the Customer Service phone number on the back of your identification card, or writing to the Highmark Privacy Department, 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222. In your request tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

D. Right to Request Confidential Communications

If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. For example, you may ask that we contact you only at your work address or via your work e-mail.

You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence by the alternative means or to the alternative location you want. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the subscriber of the health plan in which you participate.

In the event that a Confidential Communication is placed against you, then you will no longer have the ability to access any of your health and/or policy information online.

E. Right to Request Amendment

If you believe that your protected health information is incorrect or incomplete, you have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended.

We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

F. Right to a Paper Copy of this Notice

If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. Please contact us using the information listed at the end of this Notice to obtain this Notice in written form.

VI. Questions and Complaints

If you want more information about our privacy policies or practices or have questions or concerns, please contact us using the information listed below.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made to amend or restrict the use or disclosure of your protected health information or to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed below.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Highmark Privacy Department
Telephone: 1-866-228-9424 (toll free)
Fax: 1-412-544-4320
Address: 120 Fifth Avenue Place 1814
Pittsburgh, PA 15222

PART II – NOTICE OF PRIVACY PRACTICES (GRAMM-LEACH-BLILEY)

Highmark is committed to protecting its members' privacy. This notice describes our policies and practices for collecting, handling and protecting personal information about our members. We will inform each group of these policies the first time the group becomes an HMHS member and will annually reaffirm our privacy policy for as long as the group remains an HMHS customer. We will continually review our privacy policy and monitor our business practices to help ensure the security of our members' personal information. Due to changing circumstances, it may become necessary to revise our privacy policy in the future. Should such a change be required, we will notify all affected customers in writing in advance of the change.

In order to administer our health benefit programs effectively, we must collect, use and disclose non-public personal financial information. Non-public personal financial information is information that identifies an individual member of an HMHS health plan. It may include the member's name, address, telephone number and Social Security number or it may relate to the member's participation in the plan, the provision of health care services or the payment for health care services. Non-public personal financial information does not include publicly available information or statistical information that does not identify individual persons.

Information we collect and maintain: We collect non-public personal financial information about our members from the following sources:

- We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.
- We collect and create information about our members' transactions with HMHS, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits/payments (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

Information we may disclose and the purpose: We do not sell any personal information about our members or former members for marketing purposes. We use and disclose the personal information we collect (as described above) only as necessary

to deliver health care products and services to our members or to comply with legal requirements. Some examples are:

- We use personal information internally to manage enrollment, process claims, monitor the quality of the health services provided to our members, prevent fraud, audit our own performance or to respond to members' requests for information, products or services.
- We share personal information with our affiliated companies, health care providers, agents, other insurers, peer review organizations, auditors, attorneys or consultants who assist us in administering our programs and delivering health services to our members. Our contracts with all such service providers require them to protect the confidentiality of our members' personal information.
- We may share personal information with other insurers that cooperate with us to jointly market or administer health insurance products or services. All contracts with other insurers for this purpose require them to protect the confidentiality of our members' personal information.
- We may disclose information under order of a court of law in connection with a legal proceeding.
- We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.
- We may disclose information under a subpoena or summons to government agencies that investigate fraud or other violations of law.

How we protect information: We restrict access to our members' non-public personal information to those employees, agents, consultants and health care providers who need to know that information to provide health products or services. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to guard non-public personal financial information from unauthorized access, use and disclosure.

For questions about this Privacy Notice, please contact:

Contact Office: Highmark Privacy Department
Telephone: 1-866-228-9424 (toll free)
Fax: 1-412-544-4320
Address: 120 Fifth Avenue Place 1814
Pittsburgh, PA 15222

