SIGNATURE 65

Over 65 Retirees

Group 64222-05

Effective January 1, 2021

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Disclosure

Your health benefits are entirely funded by your employer. Highmark Blue Shield provides administrative and claims payment services only and does not assume any financial risk or obligation with respect to claims.

Introduction to Your Signature 65℠ Program

This booklet provides you with the information you need to understand your Signature 65 program, a Medicare complement program offered by your group. 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 Signature 65 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 Signature 65 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 member of your Signature 65 program, you get important extras. Along with 24-hour assistance with any health care question or concern via Blues On Call℠, 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.

Prescription Drug Cost-Sharing Provisions

Cost-sharing is a requirement that you pay part of your covered expenses. The following provision(s) describe the methods of such payment.

Prescription drug benefits are not subject to the overall program deductible or coinsurance.

Coinsurance

The coinsurance is the specific percentage of the provider's allowable price for covered medications that is your responsibility. Refer to the Plan Payment Level in your 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.

Medicare Part A Covered Services			
Covered Services	**Medicare Pays**	**Plan Pays**	**Member Pays(1)**
Inpatient Hospital Days 1-60	All but Part A Deductible	Medicare Part A Deductible	$0
Inpatient Hospital Days 61-90	All but Part A Coinsurance	Medicare Part A Coinsurance	$0
Inpatient Hospital Days 91-150 (may be used once per lifetime)	All but Part A Coinsurance	Medicare Part A Coinsurance	$0
Additional Inpatient Hospital Days	$0	100% of Medicare-eligible expenses for 365 additional days per benefit period, after the sixty (60) Medicare inpatient hospital lifetime reserve days are exhausted.	$0 for the first 365 additional Inpatient Hospital days per benefit period, 100% thereafter.
Skilled Nursing Facility Days 1-20	100%	$0	$0
Skilled Nursing Facility Days 21-100	All but Part A Coinsurance	Medicare Part A Coinsurance	$0
Skilled Nursing Facility Days 101 and beyond	$0	$0	100%
Blood	$0 for the first 3 pints per calendar year, 100% thereafter.	100% for the first 3 pints per calendar year, $0 thereafter.	$0
Medicare Part B Covered Services			
Covered Services	**Medicare Pays**	**Plan Pays**	**Member Pays(1)**
Most Medicare Part B Covered Services	All but the Part B Deductible and Part B Coinsurance	Medicare Part B Coinsurance	Medicare Part B Deductible
Blood	$0 for the first 3 pints per calendar year, 80% after the Part B Deductible thereafter.	100% for the first 3 pints per calendar year, $0 thereafter.	$0 for the first 3 pints per calendar year, 20% thereafter (if the Part B Deductible has been satisfied).
Major Medical Benefits (for services not covered by Medicare)			
Benefit Period(2)		Calendar Year	
Deductible (per benefit period) (individual/family)		$100/$300	
Plan Pays - Payment based on the plan allowance		80% after deductible	
Out-of-Pocket Limit (Once met, plan pays100% for the rest of the benefit period)		$380 per individual	
Lifetime Maximum		$825,000/person	
Physician Office Visits		Not Covered	
Preventive Care Adult Routine physical exams		Not Covered	
Routine gynecological exams, including a PAP Test		80% (deductible does not apply/no lifetime maximum)	
Colorectal Cancer Screening, routine and medically necessary		80% after deductible	
Mammograms, as required		80% (deductible does not apply)	
Pediatric Routine physical exams		Not Covered	
Pediatric immunizations		80% (deductible does not apply/no lifetime maximum)	
Emergency Care		80% after deductible	
Spinal Manipulations		80% after deductible	
Physical Medicine		80% after deductible	

Speech Therapy	80% after deductible
Occupational Therapy	80% after deductible
Autism Spectrum Disorders including Applied Behavior Analysis(3)	80% after deductible
Ambulance	80% after deductible
Assisted Fertilization Procedures	Not Covered
Major Medical Benefits (for services not covered by Medicare)	
Diagnostic Services Advanced Imaging (including routine MRI, CAT Scan, PET scan, etc.)	80% after deductible
Basic Diagnostic Services (Standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible
Home Health Care	80% after deductible
Hospice	Not Covered
Hospital Services - Inpatient	80% after deductible
Hospital Services - Outpatient	80% after deductible
Infertility counseling, testing and treatment	80% after deductible
Maternity (facility and professional services)	80% after deductible
Medical/Surgical Expenses (except office visits)	80% after deductible
Mental Health – Inpatient	50% after deductible
Mental Health - Outpatient	50% after deductible;$50 maximum/visit
Prescription Drugs purchased at pharmacy**	80% after deductible
Private Duty Nursing	80% after deductible
Skilled Nursing Facility Care	80% after deductible
Substance Abuse - Inpatient Detoxification	Not Covered
Substance Abuse - Inpatient Rehabilitation	Not Covered
Substance Abuse - Outpatient	50% after deductible;$50 maximum/visit

(1) If the provider does not accept assignment from Medicare, any difference between the provider's change and the combined Medicare/Highmark Blue Shield payment shall be the personal responsibility of the member.
(2) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(3) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.

Custom S65MM

**Prescription Drug Discount Card is available for member's use.

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.

Inpatient Respite Care

Coverage is provided for Medicare eligible expenses in connection with care given to you when you are a hospice patient in a Medicare-approved facility so that the usual caregiver can rest (respite care). Coverage is provided for up to five days each time you receive respite care.

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.

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 starting at age 40 and over, and one baseline mammogram within age 35-39.

Gynecological Services

Benefits are provided 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.

Tobacco Use, Counseling and Interventions
Benefits are provided for screenings for tobacco use and, for those who use tobacco products, two tobacco cessation attempts per year. A tobacco cessation attempt includes four tobacco cessation counseling sessions and covered medications.

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 Foods

Coverage is provided for enteral foods when administered on an outpatient basis for:

- amino acid-based elemental medical formulae ordered by a physician for infants and children for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short bowel syndrome; and
- nutritional supplements administered under the direction of a physician for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.

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.

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.

Preventive Services

Coverage is provided for preventive care items and services set forth in a predefined schedule to the extent they are not covered under the Medicare Part B Preventive Services as provided herein.

The predefined preventive schedule is based on age, sex and certain risk factors. Highmark periodically reviews the schedule of covered services based on the requirements of the Patient Protection Affordable Care Act of 2010, and advice from organizations such as the American Academy of Pediatrics, the U.S. Preventive Services Task Force, the Blue Cross Blue Shield Association and medical consultants. Therefore, the frequency and eligibility of services is subject to change. Benefits include periodic physical examinations, well child visits, immunizations and selected diagnostic tests. For a current schedule of covered services, log onto the member Web site, www.highmarkblueshield.com or call Member Service at the toll-free telephone number listed on the back of your ID card.

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 initially rendered by a physician which are required as a result of accidental injury to the jaws, sound natural teeth, mouth or face. Follow-up services, if any, that are provided after the initial treatment are not covered. Injury as a result of 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 Foods

Coverage is provided for enteral foods when administered on an outpatient basis for:

- amino acid-based elemental medical formulae ordered by a physician for infants and children for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short bowel syndrome; and
- nutritional supplements administered under the direction of a physician for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.

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 plus $10 per day; 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.

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 Federal law, your self-insured group health program generally may not restrict 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, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 as applicable). In any case, under Federal law, your self-insured program 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

Preventive benefits are offered in accordance with a predefined schedule based on age, sex and certain risk factors. The schedule of covered services is periodically reviewed based on the requirements of the Patient Protection Affordable Care Act of 2010, and advice from organizations such as the American Academy of Pediatrics, the U.S. Preventive Services Task Force, the Blue Cross Blue Shield Association and medical consultants. Therefore, the frequency and eligibility of services is subject to change. Benefits include periodic physical examinations, well child visits, immunizations and selected diagnostic tests. For a current schedule of covered services, log onto the member Web site, www.highmarkblueshield.com, or call Member Service at the toll-free telephone number listed on the back of your ID card.

Adult Care

Benefits are provided for routine physical examinations, regardless of medical necessity and appropriateness, including a complete medical history, and other items and services.

Adult Immunizations

Benefits are provided for adult immunizations, including the immunizing agent, when required for the prevention of disease.

Diagnostic Services and Procedures

Benefits are provided for routine screening tests and procedures, regardless of medical necessity and appropriateness.

Pediatric Care

Benefits are provided for routine physical examinations, regardless of medical necessity and appropriateness, and other items and 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.

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. Benefits are exempt from all deductibles or maximums.

Mammographic Screening

Benefits will be provided for:

- an annual routine mammographic screening starting at 40 years of age or older;
- mammographic examination 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.

Colorectal cancer screening services which are otherwise not described herein and are prescribed by a physician for a symptomatic member are not considered preventive care services. The payment for these services will be consistent with similar medically necessary and appropriate covered services.

Tobacco Use, Counseling and Interventions

Benefits are provided for screenings for tobacco use and, for those who use tobacco products, two tobacco cessation attempts per year. A tobacco cessation attempt includes four tobacco cessation counseling sessions and covered medications.

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

Prescription drugs are covered when you purchase them through the pharmacy network applicable to your program . For convenience and choice, these pharmacies include both major chains and independent stores. *No benefits are available if drugs are purchased from a non-network pharmacy.*

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;
- preventive drugs that are offered in accordance with a predefined schedule and are prescribed for preventive purposes. Highmark periodically reviews the schedule based on legislative requirements and the advice of the American Academy of Pediatrics, the U.S. Preventive Services Task Force, the Blue Cross Blue Shield Association and medical consultants. Therefore, the frequency and eligibility of services is subject to change. For a current schedule of covered preventive drugs, log onto your Highmark member website, www.highmarkblueshield.com, or call Member Service at the toll-free telephone number listed on the back of your ID card;
- prescribed injectable insulin;
- diabetic supplies, including needles and syringes.

Exclusive Pharmacy Provider

Covered drugs also include selected prescription drugs within, but not limited to, the following drug classifications only when such drugs are covered medications and are dispensed through an exclusive pharmacy provider. These particular prescription drugs will be limited to your benefit program's retail cost-sharing provisions and retail days supply.

These selected prescription drugs may be ordered by a physician or other health care provider on your behalf or you may submit the prescription order directly to the exclusive pharmacy provider. In either situation, the exclusive pharmacy provider will deliver the prescription to you.

- Oncology-related therapies
- Interferons
- Agents for multiple sclerosis and neurological related therapies

- Antiarthritic therapies
- Anticoagulants
- Hematinic agents
- Immunomodulators
- Growth hormones
- Fertility drugs

For a complete listing of those prescription drugs that must be obtained through an exclusive pharmacy provider, contact Member Service at the toll-free telephone number on the back of your ID card.

Continuous Glucose Monitoring Devices

Coverage is provided for continuous glucose monitoring devices prescribed by your provider in connection with a covered service, when purchased at a participating pharmacy provider for outpatient use. Receiver kits are limited to one (1) per benefit period. Sensor kits are limited to one (1) refill every thirty (30) days. Transmitter kits are limited to one (1) refill every ninety (90) days.

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***:***

Key Word	**Exclusion**
Abortion	• for elective abortions, except those abortions necessary to avert your death or terminate pregnancies caused by rape or incest;
Allergy Testing	• for allergy testing;
Ambulance	• for ambulance services except to the extent covered by Medicare Part B or otherwise provided herein;
Assisted Fertilization	• 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	• 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	• 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	• 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	• for custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care;
Dental Care	• 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 (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 Foods	• For any food including, but not limited to, enteral foods, 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, except as provided herein.
Effective Date	• which are rendered prior to your effective date of coverage;
Experimental/ Investigative	• which are experimental/investigative in nature;
Eyeglasses/Contact Lenses	• 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	• 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	• 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	• for hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;
Home Health Care	• the following services you receive from a home health care agency or a hospital program for home health care: dietitian services; homemaker services; maintenance therapy; dialysis treatment; custodial care; and food or home-delivered meals;

Immunizations	• for immunizations required for foreign travel or employment, except as otherwise set forth in the predefined schedule described herein;
Impotency	• for impotency treatment drugs;
Inpatient Admissions	• for inpatient admissions that are primarily for diagnostic studies;
	• for inpatient admissions that are primarily for physical therapy;
Learning Disabilities	• for any care that is related to conditions such as hyperkinetic syndromes, learning disabilities, behavioral problems, intellectual disability, 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 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	• 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;
Motor Vehicle Accident	• 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	• for nutritional counseling and services intended to produce weight loss except as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information;
Obesity	• for treatment of obesity, except for the medical and surgical treatment of morbid obesity or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information;
Oral Surgery	• 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	• 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	• for preventive care services, wellness services or programs, except as provided herein;
Provider of Service	• which are not prescribed or performed by or upon the 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	• for respite care, except as provided herein;
Screening Exams	• for screening examinations including x-ray examinations made without film;
Sexual Dysfunction	• for treatment of sexual dysfunction not related to organic disease or injury;
Skilled Nursing	• 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;
Sterilization	• for sterilization and reversal of sterilization, except as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information;;
Termination Date	• incurred after the date of termination of your coverage, except as provided herein;
Therapy	• 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;
TMJ	• 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;
Vision Correction Surgery	• for the correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;
War	• for an illness or injury suffered after your effective date as a result of any act of war;
Well-Baby Care	• for well-baby care visits, except as provided herein;
Workers' Compensation	• 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;

In addition, under your Prescription Drug benefits, 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:

Prescription Drugs (Drug Program)	• Services of your attending physician, surgeon or other medical attendant; • Prescription drugs dispensed for treatment of an illness or an injury for which the group is required by law to furnish hospital care in whole or in part - including, but not limited to, state or federal workers' compensation laws and occupational disease laws and other employer liability laws; • Any prescription drugs or supplies purchased at or dispensed by a non-participating pharmacy provider; • Any prescription drug purchased through mail order but not dispensed by a designated mail order pharmacy provider; • Any amounts you are required to pay directly to the pharmacy for each prescription order or refill; • For any prescription drug which has been disallowed under the prescription drug management section of this booklet;

- Prescription drugs to which you are entitled, with or without charge, under a plan or program of any government or governmental body;
- Charges for a prescription drug when such drug or medication is used for unlabeled or unapproved indications where such use has not been approved by the Food and Drug Administration (FDA);
- Any prescription for more than the retail days supply or mail service days supply as outlined in the Summary of Benefits;
- Any drug or medication except as provided for herein;
- Any drug or medication which does not meet the definition of covered maintenance prescription drug, except those set forth in the predefined preventive schedule. Please refer to the Covered Drugs section for more information;
- Any charges by any pharmacy provider or pharmacist except as provided herein;
- Allergy serums;
- Hair growth stimulants;
- Food supplements;
- Any drugs used to abort a pregnancy;
- Any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes;
- Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances);
- Any drugs and supplies that can be purchased without a prescription order including but not limited to blood glucose monitors and injection aids, unless otherwise specified herein;
- Charges for administration of prescription drugs and/or injectable insulin whether by a physician or other person;
- Any prescription drug which is experimental/investigative;
- Blood products;
- Antihemophilia drugs;
- Any drugs prescribed for cosmetic purposes only;
- Over-the-counter drugs, except those set forth in the predefined preventive schedule. Please refer to the Covered Drugs section for more information.
- Any selected diagnostic agents;
- Compounded medications;
- Prescription drugs and supplies that are not medically necessary and appropriate or otherwise excluded herein.

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 Signature 65 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 the Signature 65 program, 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/Signature 65 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. You will owe the pharmacy any copayment, coinsurance or deductible amounts that may apply. You should request and retain a paid receipt for any amounts that you paid to the pharmacy if you need it for income tax or any other purpose. 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 the "Prescriptions" tab. Scroll down the page to "Forms to Manage Your Plan" and click on "Mail order form and health questionnaire (PDF)".

  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.

Prescription Drug Management

Your prescription drug program provides the following provisions which will determine the medical necessity and appropriateness of covered medications and supplies.

Early Refill

Except for the purposes of Medication Synchronization, no coverage is provided for any refill of a covered medication that is dispensed before your predicted use of at least 90% of the days' supply of the previously dispensed covered medication, unless your physician obtains precertification from Highmark for an earlier refill.

Unexpected Event

If your prescription is lost or stolen due to an event such as a fire or theft, you may be able to get an early refill. Call Member Service at the number on your member ID card for help. You will need a copy of the report from the fire department, police department or other agency.

Please note: The early refill authorization does not apply to events that can be controlled, such as spilling or losing the medicine.

Traveling Abroad

If you will be out of the country when it is time to refill your prescription, call Member Service for help. Be sure to have your member ID card and your prescription information. Please allow at least five business days to complete the request.

Individual Case Management

Highmark, in its sole discretion, reserves the right to limit access to a benefit, regardless of the disease or condition, when Highmark identifies utilization patterns that could potentially result in harm to you or the public.

Exclusive Pharmacy Provider

The exclusive pharmacy provider has an agreement, either directly or indirectly, with Highmark pertaining to the payment and exclusive dispensing of selected prescription drugs provided to you. Please refer to the Covered Services - Prescription Drug Program section for a list of the selected prescription drug categories.

Preauthorization and Pre-Service Claims Review Processes

– **Authorized Representatives**
You have the right to designate an authorized representative to file or pursue a request for preauthorization or other pre-service claim on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Procedures adopted by Highmark will, in the case of an urgent care claim, permit a physician or other professional health care provider with knowledge of your medical condition to act as your authorized representative.

– **Decisions Involving Requests for Preauthorization and Other Non-Urgent Care Pre-Service Claims**
You will receive written notice of any decision on a request for preauthorization or other pre-service claim, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed 15 days from the date Highmark receives your claim. However, this 15 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 15 day pre-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 pre-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 pre-service claim.

– **Decisions Involving Urgent Care Claims**
If your request involves an urgent care claim, Highmark will make a decision on your request as soon as possible taking into account the medical exigencies involved. You will receive notice of the decision that has been made on your urgent care claim no later than 24 hours following receipt of your claim.

If Highmark determines in connection with an urgent care claim that you have not provided sufficient information to determine whether or to what extent benefits are provided under your coverage, you will be notified within 24 hours following Highmark's receipt of your claim of the specific information needed to complete your claim. You will then be given not less than 48 hours to provide the specific information to Highmark. Highmark will thereafter notify you of its determination on your claim as soon as possible but not later than 48 hours after the earlier of (i) its receipt of the additional specific information, or (ii) the date Highmark informed you that it must receive the additional specific information.

Similarly, when your urgent care claim seeks to extend a previously approved course of treatment and that request is made at least 24 hours prior to the expiration of the previously approved course of treatment, Highmark will notify you of its decision as soon as possible, but no later than 24 hours following receipt of the request.

– **Notices of Determination Involving Preauthorization Requests and Other Pre-Service Claims**
Any time your request for preauthorization or other pre-service claim is approved, you will be notified in writing that your claim has been approved. If your request for preauthorization or approval of any other pre-service claim has been denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse determination and a statement describing your right to file a an appeal.

For a description of your right to file an appeal concerning an adverse determination involving a request for preauthorization or any other pre-service claim, see the Appeal Procedure subsection in the How to File a Claim section of this benefit booklet.

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 the Group's 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 Annuitant's spouse under a legally valid existing 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 as determined by a court or other agency of competent jurisdiction;

v) A child age eighteen (18) being solely supported by the Annuitant if the Annuitant was the child's legal guardian as determined by a court or other agency of competent jurisdiction prior to the child's eighteenth (18th) birthday;

vi) A child of the Annuitant or a child with which the Annuitant has a recognized legal relationship that is 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, BENEFITS AFTER TERMINATION OF COVERAGE 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.

3. Special Enrollment Rights

An Eligible Person and Eligible Dependent also include the Annuitant and Dependent entitled to enroll for coverage under this benefit program pursuant to special enrollment rights granted under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") or any other applicable federal or state law.

Changes in Membership Status

In order for there to be 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.

Termination of Your Coverage Under the Employer Contract

Your coverage will be terminated when you cease to be eligible to participate under your group health plan in accordance with its terms and conditions for eligibility.

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. Your group health plan 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

As used in this booklet, "subrogation" refers to the Plan's right to seek payment and/or reimbursement from a person or organization responsible, or potentially responsible, for the Plan's payment of health care expenses you incurred in connection with an injury.

The Plan also has the right to seek payment and/or reimbursement from you if you receive a payment, settlement, judgment or award from a person, organization or insurance company in connection with an injury caused or alleged to be caused by the person or organization. The Plan has this right regardless of whether:

- liability is admitted by any potentially responsible person or organization;
- the payment, settlement, judgment or award you received identifies medical benefits provided by the Plan; or
- the payment, settlement, judgment or award is otherwise designated as "pain and suffering" or "non-economic damages" only.

The Plan shall have a first priority lien on the proceeds of any payment, settlement or award you receive in connection with an injury caused by a person or organization. The lien shall be in the amount of benefits paid on your behalf regardless of whether you are made-whole for your loss or because you have incurred attorney fees or costs.

The Plan will provide eligible benefits when needed, but you may be asked to show, execute and/or deliver documents, or take other necessary actions to support the Plan in any subrogation efforts. Neither you nor any of your dependents shall do anything to prejudice the right given to the Plan by this Subrogation section without the Plan's consent.

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 as soon as reasonably possible after you receive a covered service.
- Claims for services covered by Medicare should be submitted within one year from the date that the Medicare claim was finalized.
- Claims for services not covered by Medicare must be submitted no later than 12 months after the end of the benefit period following the benefit period for which benefits are payable.
- Drug claims, if applicable, must be submitted within 12 months following the date of purchase.
- Major Medical claims must be submitted no later than the end of the benefit period following the benefit period for which benefits are payable.

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 Benefit Determinations Involving Requests for Preauthorization and Other Pre-Service Claims***

  For a description of the time frames in which requests for preauthorization or other pre-service claims will be determined by Highmark and the notice you will receive concerning its decision, whether adverse or not, see the Preauthorization and Pre-Service Claims Review Processes subsection in the Drug Management section of this benefit booklet.

- ***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.

Medical Appeal Procedure

Highmark maintains an appeal process involving one level of review. You have the right to appeal any adverse benefit determination with which you disagree. Your appeal should be directed to the address below and be made in writing within the 180-day period following receipt of the notice of a claim denial or other issue that is the subject of the appeal. Mail the appeal to:

Highmark Blue Shield
P.O. Box 535095
Pittsburgh, PA 15253-5095
Attention: Review Committee

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.

Initial Review

If you receive notification that a claim has been denied by Highmark, in whole or in part, you may appeal the decision. Your appeal must be submitted not later than 180 days from the date you received notice from Highmark of the adverse benefit determination.

Upon request to Highmark, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit or present additional evidence or testimony, which includes any written or oral sstatements, comments and/or remarks, documents, records, information, data or other material in support of your appeal.

A representative from the Appeal Review Department will review the appeal. The representative will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on your appeal, the Appeal Review 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 Appeal Review Department will also afford no deference to any previous adverse benefit determination on the claim that is the subject of your appeal.

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal.

Your appeal will be promptly investigated and Highmark will provide you with written notification of its decision within a reasonable period of time not to exceed 60 days following receipt of the appeal.

In the event Highmark renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination and a statement regarding your right to request an external review or pursue a court action.

External Review

You have four months from the date you receive notice of a final Highmark adverse benefit determination to file a request for an external review with Highmark. To be eligible for external review, the decision of Highmark must have involved (i) a claim that was denied involving medical judgment, including, appllication of Highmark 's requirements as to medical necessity, appropriateness, health care sestting, level of care, effectiveness of a covered service or a determination that the treatment is experimental or investigational; or (ii) a determination made by your plan administrator to rescind your coverage.

In the case of a denied claim, the request for external review may be filed by either you or a health care provider with your written consent in the format required by or acceptable to Highmark. The request for external review should include any reasons, material justification and all reasonably necessary supporting information as part of the external review filing.

Preliminary Review

Highmark will conduct a preliminary review of your external review request within five business days following the date on which Highmark receives the request. Highmark 's preliminary review will determine whether:

- You were covered by your plan at all relevant times;
- The adverse benefit determination relates to your failure to meet your plan's eligibility requirements;
- You exhausted the above-described appeal process; and
- You submitted all required information or forms necessary for processing the external review.

Highmark will notify you of the results of its preliminary review within one business day following its completion of the review. This will include our reasons regarding the ineligibility of your request. If your request is not complete, Highmark's notification will describe the information or materials needed to make the request complete. You will then have the balance of the four month filing period or, if later, 48 hours from receipt of the notice, to perfect your request for external review; whichever is later.

In the event that the external review request is complete but not eligible for external review, notification by Highmark will include the reasons why the request is ineligible for external review and contact information that you may use to receive additional information and assistance.

Referral to an Independent Review Organization (IRO)

Highmark will, randomly or by rotation, select an IRO to perform an external review of your claim if your request found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Within five business days thereafter, Highmark will provide the IRO with documents and information we considered when making our final adverse benefit determination. The IRO may reverse Highmark's final adverse benefit determination if the documents and information are not provided to the IRO within the five-day time frame.

The IRO will timely notify you in writing of your eligibility for the external review and will provide you with at least 10 business days following receipt of the notice to provide additional information.

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim *de novo*. In other words, the IRO will not be bound by any decisions or conclusions reached during the above-described appeal process.

The assigned IRO must provide written notice of its final external review decision within 45 days after the IRO received the request for the external review. The IRO will deliver its notice of final external review decision to you and Highmark. The IRO's notice will inform you of:

- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Coverage or payment for the requested benefits will be paid immediately upon Highmark's receipt of the IRO's notice of a final external review decision from the IRO that reverses Highmark's prior final internal adverse benefit determination.

Prescription Drug Appeal Procedure

Your benefit program maintains an 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, legal representatives and, in the case of a minor, parent(s) 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 your physician or other provider of health care with knowledge of your medical condition to act as your 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 that a claim has been denied by Highmark, in whole or in part, you may appeal the decision. Your appeal must be submitted not later than 180

days from the date you received notice from Highmark of the adverse benefit determination.

Upon request to Highmark, you may review all documents, records and other information relevant to the claim which is the subject of 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.

A representative from the Appeal Review Department will review the appeal. The representative will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on your appeal, the Appeal Review 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 Appeal Review Department will also afford no deference to any previous adverse benefit determination on the claim that is the subject of your appeal.

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including determinations of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal.

Your appeal will be promptly investigated and Highmark will provide you with written notification of its decision within the following time frames:

- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of the appeal;

- When the appeal involves an urgent care claim, as soon as possible taking into account the medical exigencies involved but not later than 72 hours following receipt of the appeal; or

- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 60 days following receipt of the appeal.

In the event Highmark renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination and a statement regarding your right to request an external review or pursue a court action.

External Review

You have four months from the date you receive notice of a final Highmark adverse benefit determination to file a request for an external review with Highmark. To be eligible for external review, the decision of Highmark must have involved (i) a claim that was denied involving medical judgment, including, application of Highmark's requirements as to medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered service or a determination that the treatment is experimental or investigational; or (ii) a determination made by your plan administrator to rescind your coverage.

In the case of a denied claim, the request for external review may be filed by either you or a health care provider with your written consent in the format required by or acceptable to Highmark. The request for external review should include any reasons, material justification and all reasonably necessary supporting information as part of the external review filing.

Preliminary Review

Highmark will conduct a preliminary review of your external review request within five business days following the date on which Highmark receives the request. Highmark's preliminary review will determine whether:

- You were covered by your plan at all relevant times;
- The adverse benefit determination relates to your failure to meet your plan's eligibility requirements;
- You exhausted the above-described appeal process; and
- You submitted all required information or forms necessary for processing the external review.

Highmark will notify you of the results of its preliminary review within one business day following its completion of the review. This will include our reasons regarding the ineligibility of your request. If your request is not complete, Highmark's notification will describe the information or materials needed to make the request complete. You will then have the balance of the four month filing period or, if later, 48 hours from receipt of the notice, to perfect your request for external review; whichever is later.

In the event that the external review request is complete but not eligible for external review, notification by Highmark will include the reasons why the request is ineligible for external review and contact information that you may use to receive additional information and assistance.

Referral to an Independent Review Organization (IRO)

Highmark will, randomly or by rotation, select an IRO to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Within five business days thereafter, Highmark will provide the IRO with documents and information we considered when making our final adverse benefit determination. The IRO may reverse Highmark's final adverse benefit determination if the documents and information are not provided to the IRO within the five-day time frame.

The IRO will timely notify you in writing of your eligibility for the external review and will provide you with at least 10 business days following receipt of the notice to provide additional information.

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim *de novo*. In other words, the IRO will not be bound by any decisions or conclusions reached during the above-described appeal process.

The assigned IRO must provide written notice of its final external review decision within 45 days after the IRO received the request for the external review. The IRO will deliver its notice of final external review decision to you and Highmark. The IRO's notice will inform you of:

- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Coverage or payment for the requested benefits will be paid immediately upon Highmark's receipt of the IRO's notice of a final external review decision from the IRO that reverses Highmark's prior final internal adverse benefit determination.

Expedited External Review (Applies to Urgent Care Claims Only)
You are entitled to the same procedural rights to an external review as described above on an expedited basis:

- If the final adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or your health or would jeopardize your ability to regain maximum function and you filed a request for an expedited internal appeal; or
- Following a final internal adverse benefit determination, if you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from the facility rendering the emergency services.

In the above circumstances, Highmark will immediately conduct a preliminary review and will immediately notify you of our reasons regarding the ineligibility of your request. If your request is not complete, Highmark's notification will describe the

information or materials needed to make the request complete. You will then have 48 hours from receipt of the notice, to perfect your request for external review.

Referral to an Independent Review Organization (IRO)

Highmark will, randomly or by rotation, select an IRO to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Thereafter, Highmark will immediately provide the IRO with documents and information we considered when making our final adverse benefit determination via the most expeditious method (e.g., electronic, facsimile, etc.).

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim *de novo*. In other words, the IRO will not be bound by any decisions or conclusions reached during the above-described appeal process.

The assigned IRO must provide notice of its final external review decision as expeditiously as possible, but in no event more than 72 hours from the time the IRO received the request for the external review. The IRO must provide written notice of its final external review decision to you and to Highmark, if not originally in writing, within 48 hours of its original decision. The IRO's written notice will inform you of:

- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Coverage or payment for the requested benefits will be paid immediately upon Highmark's receipt of the IRO's notice of a final external review decision from the IRO that reverses Highmark's prior final internal adverse benefit determination.

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 Call℠ - 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.

Member Service

When you have questions about a claim, benefits or coverage, our Member Service Representatives are here to help you. Just call Member Service at the toll-free telephone number on your member ID card or log in to your Highmark member website at www.highmarkblueshield.com. For TTY/TDD hearing impaired service, please dial 711 and the number on the back of your ID card.

Member Rights and Responsibilities

Your participation in 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 your group health plan, 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. Your group health plan 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 your group health plan or the care provided and receive a reply within a reasonable period of time.
6. Make recommendations regarding the 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 reviews 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

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.

Covered Maintenance Prescription Drug – A maintenance prescription drug, which your program is contractually obligated to pay or provide as a benefit to you under this program when dispensed by a participating maintenance pharmacy. Any prescription order for not more than a 90-day supply of a legend drug shall be considered a covered maintenance prescription drug, unless otherwise expressly excluded.

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.

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.

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 to be medically effective for the condition being treated. An intervention is considered 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.

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 a 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.

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.

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.

Maintenance Prescription Drug - A prescription drug prescribed for the control of a chronic disease or illness, or to alleviate the pain and discomfort associated with a chronic disease or illness.

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 the health plan to provide covered medications to you under this program.

Plan Allowance - The amount used to determine payment by your program 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 your program'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.

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 INC.
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 Inc. ("Highmark"), we are committed to protecting the privacy of your "Protected Health Information" (PHI). 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 a Highmark 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:

A. 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.

B. 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.

C. 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.

D. 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.

E. 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.

F. 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.

G. 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.

H. 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.

I. 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.

J. 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.

K. 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.

L. 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.

M. 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.

N. 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.

O. 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.

P. 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 a Highmark member and will annually reaffirm our privacy policy for as long as the group remains a Highmark 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 a Highmark 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 Highmark, 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