PPO BLUE

PPO PROGRAM

Under 65 Retirees

Group 25079-66

Effective July 1, 2018

HIGHMARK | PPO Blue

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7BS12

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Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Insurance or benefit/claims administration may be provided by Highmark, Highmark Choice Company, Highmark Coverage Advantage, Highmark Health Insurance Company, First Priority Life Insurance Company, First Priority Health, Highmark Benefits Group, Highmark Select Resources, Highmark Senior Solutions Company or Highmark Senior Health Company, all of which are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان **فارسی** صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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Disclosure

Your health benefits are entirely funded by your employer (group). Highmark Blue Shield provides administrative and claims payment services only.

Non-Assignment

Highmark is authorized by the member to make payments directly to providers furnishing Covered Services provided under the program described in this benefit booklet; however, Highmark reserves the right to make these payments directly to the member. The right of a member to receive payment for a Covered Service described in this benefits booklet is not assignable, except to the extent required by law, nor may benefits described in this benefit booklet be transferred either before or after Covered Services are rendered. Any (direct or indirect) attempt to accomplish such

an assignment shall be null and void. Nothing contained in this benefit booklet shall be construed to make Highmark, the group health plan or the group health plan sponsor liable to any assignee to whom a member may be liable for medical care, treatment, or services.

Introduction to Your PPO Blue℠ Program

This booklet provides you with the information you need to understand your PPO Blue 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.

For a number of reasons, we think you'll be pleased with your health care program:

- ***Your PPO Blue program gives you freedom of choice.*** You are not required to select a primary care physician to receive covered care. You have access to a large provider network of physicians, hospitals, and other providers in Central Pennsylvania and the Lehigh Valley, as well as providers across the country who are part of the local Blue Cross and Blue Shield PPO network. For a higher level of coverage, you need to receive care from one of these network providers. However, you can go outside the network and still receive care at the lower level of coverage. To locate a network provider near you, or to learn whether your current physician is in the network, log onto your Highmark member website, www.highmarkblueshield.com.

- ***Your PPO Blue program gives you "stay healthy" care.*** You are covered for a range of preventive care, including physical examinations and selected diagnostic tests. Preventive care is a proactive approach to health management that can help you stay on top of your health status and prevent more serious, costly care down the road.

You can review your Preventive Care Guidelines online at your member website. And, as a member of your PPO Blue program, you get important extras. Along with 24-hour assistance with any health care question via Blues On Call, your member website connects you to a range of self-service tools that can help you manage your coverage. You can also access programs and services designed to help you make and maintain healthy improvements. And you can access a wide range of care cost and care provider quality tools to assure you spend your health care dollars wisely.

We understand that prescription drug coverage is of particular concern to our members. You'll find in-depth information on these benefits in this booklet.

If you have any questions on your PPO Blue program please call the Member Service toll-free telephone number on the back of your ID card. For TTY/TDD hearing impaired service, please dial 711 and the 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 coverage and how it works, here's an explanation of some benefit terms found in your Summary of Benefits.

Benefit Period

The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by your program. 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.

Medical Cost-Sharing Provisions

Cost-sharing is a requirement that you pay part of your expenses for covered services. The terms "copayment," "deductible" and "coinsurance" describe methods of such payment. You are required to pay your copayment at the time of service. You can be asked to pay any applicable coinsurance or deductible amounts at the time of service. Copayment, coinsurance and deductible amounts not paid at the time of your medical service must be paid within 60 days of the claim being finalized. If you fail to make payment within 60 days of the finalization date of your claim, you can be held responsible for fees in excess of your program's allowance.

Coinsurance

The coinsurance is the specific percentage of the plan allowance for covered services that is your responsibility. You can be asked to pay any applicable coinsurance at the time you receive care from a provider. Coinsurance amounts not paid at the time of your medical service must be paid within 60 days of the finalization date of your claim. Refer to the Plan Payment Level in your Summary of Benefits for the percentage amounts paid by the program.

Copayment

The copayment for certain covered services is the specific, upfront dollar amount which is deducted from the plan allowance and is your responsibility. See your Summary of Benefits for the copayment amounts.

The copayment does not apply toward your deductible or coinsurance, and does not accumulate toward the out-of-pocket limit. **You are expected to pay your copayment to the provider at the time of service.**

Deductible

The deductible is a specified dollar amount you must pay for covered services each benefit period before the program begins to provide payment for benefits. See the Summary of Benefits for the deductible amount. You can be asked to pay any applicable deductible at the time you receive care from a provider. Deductible amounts not paid at the time of your medical service must be paid within 60 days of the finalization date of your claim.

If your group changes group health care expense coverage during your benefit period, the amount you paid toward your deductible during the last partial benefit period for services covered under your prior coverage will be applied to the network and out-of-network deductible of the initial benefit period under this program.

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 two or more covered family members. However, the deductible contributed towards the total by any one covered family member will not 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 has not been met.

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 copayments, deductibles, prescription drug expenses and amounts in excess of the plan allowance.

Family Out-of-Pocket Limit

The family out-of-pocket limit refers to the amount of coinsurance incurred by you or your covered family members for covered services received in a benefit period.

Once all covered family members have incurred an amount equal to the family out-of-pocket limit, claims received for all covered family members during the remainder of the benefit period will be payable at 100% of the plan allowance.

Total Maximum Out-of-Pocket

The total maximum out-of-pocket, as mandated by the federal government, refers to the specified dollar amount of deductible, coinsurance, copayments incurred for network covered services and covered medications and any qualified medical expenses in a benefit period. When the specified individual dollar amount is attained by you, or the specified family dollar amount is attained by you or your covered family members, your program begins to pay 100% of all covered expenses and no additional coinsurance, copayments and deductible will be incurred for network covered services and covered medications in that benefit period. See your Summary of Benefits for the total maximum out-of-pocket. The total maximum out-of-pocket does not include out-of-network cost-sharing, amounts in excess of the plan allowance.

Out-of-Pocket Credit

If your group changes group health care expense coverage during your benefit period, the amount you paid toward your out-of-pocket limit during the last partial benefit period for services covered under your prior coverage will be applied to the network and out-of-network (combined) out-of-pocket limit of the initial benefit period under this program. This credit is similarly applied toward your total maximum out-of-pocket for network covered services.

Maximum

The greatest amount of benefits that the program will provide for covered services within a prescribed period of time. This could be expressed in dollars, number of days or number of services.

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.

Copayment

The copayment is the specific, upfront dollar amount you pay for covered medications which will be deducted from the provider's allowable price by Highmark. Your copayment obligation is the amount specified in the Summary of Benefits, or the cost of the covered medication, whichever is lower.

Summary of Benefits

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

Benefits	Network	Out-of-Network
General Provisions		
Benefit Period	Calendar Year	
Deductible (per benefit period) Individual Family	 $400 $800	 $800 $1,600
Plan Payment Level - Based on the plan allowance	100% after deductible	80% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limits Individual Family	 None None	 $3,200 $6,400
Lifetime Maximum (per member)	Unlimited	
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits (including virtual visits)	100% after $25 copayment; deductible does not apply	80% after deductible
Primary Care Physician Office Visits (including virtual visits)[1 2]	100% after $20 copayment; deductible does not apply	80% after deductible
Specialist Office Visits (including virtual visits)[1]	100% after $45 copayment; deductible does not apply	80% after deductible
Virtual Visit Originating Site Fee[1]	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $50 copayment; deductible does not apply	80% after deductible
Preventive Care Services[3]		
Adult		
Routine physical exams	100%; deductible does not apply	80% after deductible
Adult Immunizations	100%; deductible does not apply	80% after deductible
Routine screening tests and procedures	100%; deductible does not apply	80% after deductible
Routine gynecological exams, including a PAP Test	100%; deductible does not apply	80%; deductible does not apply
Mammograms, Annual routine Medically necessary	 100%; deductible does not apply 100% after deductible	80% after deductible
Colorectal cancer screening	100%; deductible does not apply	80% after deductible
Pediatric		
Routine physical exams	100%; deductible does not apply	80% after deductible
Pediatric immunizations	100%; deductible does not apply	80%; deductible does not apply
Routine screening tests and procedures	100%; deductible does not apply	80% after deductible

Benefits	Network	Out-of-Network
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Services - Inpatient[5]	100% after deductible	80% after deductible
	Limit: 365 inpatient days per benefit period	
Hospital Services - Outpatient[4 5]	100% after deductible	80% after deductible
Maternity (non-preventive facility and professional services) Includes Dependent Daughters	100% after deductible	80% after deductible
Medical/Surgical Expenses (except office visits) Excludes Neonatal Circumcision	100% after deductible	80% after deductible
Emergency Services		
Emergency Room Services	100% after $200 copayment (waived if admitted as an inpatient); deductible does not apply	Same as network services
Emergency Ambulance Service	100%; deductible does not apply	100%; deductible does not apply
Non-Emergency Ambulance Service	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Infusion Therapy	100% after deductible	80% after deductible
Occupational Therapy	100% after $45 copayment; deductible does not apply	80% after deductible
	Limit: 30 visits per benefit period	
Physical Medicine	100% after $45 copayment; deductible does not apply	80% after deductible
Radiation Therapy	100% after deductible	80% after deductible
Respiratory Therapy	100% after deductible	80% after deductible
Speech Therapy	100% after $45 copayment; deductible does not apply	80% after deductible
	Limit: 30 visits per benefit period	
Spinal Manipulations	100% after $45 copayment; deductible does not apply	80% after deductible
	Limit: 30 visits per benefit period	
Other Therapy Services (Cardiac Rehabilitation, Chemotherapy, and Dialysis Treatment)	100% after deductible	80% after deductible
Mental Health/Substance Abuse Services		
Mental Health Care Services - Inpatient	100% after deductible	80% after deductible
Mental Health Care Services - Outpatient (including virtual visits)	100% after $45 copayment; deductible does not apply	80% after deductible
Substance Abuse Services - Inpatient Detoxification	100% after deductible	80% after deductible
Substance Abuse Services - Inpatient Residential Treatment and Rehabilitation Services	100% after deductible	80% after deductible
Substance Abuse Services - Outpatient	100% after $45 copayment; deductible does not apply	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Anesthesia for Non-Covered Dental Procedures (Limited)	100% after deductible	80% after deductible
Autism Spectrum Disorders including Applied Behavioral Analysis[6]	100% after deductible	80% after deductible
Assisted Fertilization Treatment	Not Covered	

Benefits	Network	Out-of-Network
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diabetes Treatment	100% after deductible	80% after deductible
Diagnostic Services *Advanced Imaging (*MRI, CAT Scan, PET scan, etc.)	100% after deductible	80% after deductible
Basic Diagnostic Services • standard imaging • diagnostic medical • lab/pathology • allergy testing	100% after deductible	80% after deductible
Durable Medical Equipment	100% after deductible	80% after deductible
Enteral Foods	100%; deductible does not apply	80%; deductible does not apply
Home Infusion and Suite Infusion Therapy Services	100% after deductible	80% after deductible
Home Health Care[7]	100% after deductible	80% after deductible
	Limit: 60 visits per benefit period	
Hospice	100% after deductible	80% after deductible
	Limit: 180 inpatient days per benefit period	
Infertility Counseling, Testing and Treatment[8]	100% after deductible	80% after deductible
Orthotics	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible	80% after deductible
	Limit: 240 hours per benefit period	
Prosthetics	100% after deductible	80% after deductible
Skilled Nursing Facility Care	100% after deductible	80% after deductible
	Limit: 100 days per benefit period	
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements	Yes[9]	
Condition Management	Case Management, Blues on Call, and Disease State Management	

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

1 You ***may*** be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a hospital, facility provider, ancillary provider, retail clinic or urgent care center. The specialist virtual visit is subject to availability within your service area.

2 A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics.

3 Services are limited to those on a predefined schedule. Gender, age and frequency limits may apply.

4 Other cost sharing provisions and/or limits may apply to specific benefits, i.e., physical medicine, therapies, diagnostic services, mental health/substance abuse visits.

5 For covered services rendered by a facility provider within the service area who has no contractual relationship with Highmark, the plan allowance will be 60% of the facility provider's billed charge for inpatient services and 40% of the facility provider's billed charge for outpatient services. See the plan allowance definition in this booklet for pricing for covered services rendered by an out-of-area provider. The plan allowance would then be subject to the coinsurance percentage after your deductible, if any, has been satisfied.

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

7 The maternity home health care visit for network care is not subject to the program copayment, coinsurance or deductible amounts, if applicable. See Maternity Home Health Care Visit in the Covered Services section.

8 If testing is required, cost sharing may apply as outlined under Diagnostic Services. Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

[9] Highmark must be contacted prior to a planned inpatient admission or within 48 hours of an emergency inpatient admission. Some facility providers will contact Highmark and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Highmark for precertification. If your provider does not, you are responsible for contacting Highmark. Also be sure to confirm Highmark's determination of medical necessity and appropriateness. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

Prescription Drug Benefits	Retail Pharmacy Up to 30-days [1] [2]	Mail Service Pharmacy Up to 90-days
Pharmacy Network	National	Express Scripts Pharmacy
Benefit Period	Calendar Year	
The following cost-sharing provisions do NOT apply to self-administered chemotherapy medications, including oral chemotherapy medications.		
Deductible (per benefit period)	None	None
Out of Pocket Limit	Not Applicable	
Generic Prescription Drug	$10 copayment	$20 copayment
Brand Formulary Prescription Drug	$30 copayment	$60 copayment
Brand Non-Formulary Prescription Drug	$50 copayment	$100 copayment
Formulary[3]	Incentive	
Generic Substitution *(Soft)*	When you purchase a brand drug that has a generic equivalent you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs, unless your physician requests that the brand name drug be dispensed.	
Claim Submission	Pharmacy Files at Point-of-Sale	
Non-Network Pharmacy	Covered	Not Covered
Preventive Medications		
Preventive Covered Drugs[4]	Deductibles, coinsurance and/or copayments do not apply	
Prescription Drug Categories		
Fertility Agents	Covered	
Fluoride Products	Covered	
Insulin and Diabetic Supplies	Covered	
Vitamins (prescription)	Covered	
Weight Loss Drugs	Covered	
Allergy Serum	Not Covered	
Durable Medical Equipment	Not Covered	
Prescription Hair Growth Products	Not Covered	
Care Management Programs		
Exclusive Pharmacy Provider	Applies – selected prescription drugs are eligible only when they are dispensed through an exclusive pharmacy provider.	
Quantity level Limits *on select prescription drugs*	Applies – the quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines.	
Managed R_x Coverage *on certain drug therapies*	Applies - certain drug therapies may be monitored for appropriate usage and subject to case evaluation if recommended guidelines are exceeded.	
Managed Prior Authorizations	Applies on select high cost drugs.	

[1] Certain retail participating pharmacy providers may have agreed to make covered medications available at the same cost-sharing and quantity limits as the mail order coverage. You may contact Highmark at the toll-free number or the Web site appearing on the back of your ID card for a listing of those pharmacies who have agreed to do so.

[2] The quantity level limit for your initial prescription order may be reduced, depending on the particular medication, to a quantity level necessary to establish that you can tolerate the medication. The cost-sharing provisions indicated above will be adjusted accordingly for the initial prescription order based upon the initial quantity dispensed. If you are able to tolerate the medication, the remainder of the available days supply for the initial prescription order will be filled and you will be responsible for the balance of the applicable cost-sharing amount indicated above.

[3] The Highmark formulary is an extensive list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above.

[4] This includes prescriptions and over-the-counter drugs that are set forth within the predefined schedule and that are prescribed for preventive purposes. Please refer to the Covered Services - Prescription Drug Program section for more information.

Covered Services - Medical Program

PPO Blue provides benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate. All benefit limits, deductibles and copayment amounts are described in the Summary of Benefits. Network care is covered at a higher level of benefits than out-of-network care.

Ambulance Service

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 you are covered for ambulance service to the closest facility outside your 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 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.

Anesthesia for Non-Covered Dental Procedures (Limited)

Benefits will be 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.

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 an attained skill or function.

Therapeutic care

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

Dental Services 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 shall not be considered an accidental injury.

Diabetes Treatment

Coverage is provided for the following when required in connection with the 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 aides, 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 the 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 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:

Advanced Imaging Services

Include, but are not limited to, computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET scan), positron emission tomography/computed tomography (PET/CT scan).

Basic Diagnostic Services

- **Standard Imaging Services** - procedures such as skeletal x-rays, ultrasound and fluoroscopy
- **Laboratory and Pathology Services** - procedures such as non-routine Papanicolaou (PAP) smears, blood tests, urinalysis, biopsies and cultures
- **Diagnostic Medical Services** - procedures such as electrocardiograms (ECG), electroencephalograms (EEG), echocardiograms, pulmonary studies, stress tests, audiology testing
- **Allergy Testing Services** - allergy testing procedures such as percutaneous, intracutaneous, and patch tests

Durable Medical Equipment

The rental or, at the option of Highmark, the purchase, adjustment, repair and replacement of durable medical equipment for therapeutic use when prescribed by a professional provider, within the scope of their license. Rental costs cannot exceed the total cost of purchase.

Enteral Foods

Enteral foods is a liquid source of nutrition equivalent to a prescription drug that is administered orally or enterally and which may contain some or all nutrients necessary to meet minimum daily nutritional requirements. Enteral foods are intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are identified through medical evaluation.

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

This program covers the following services you receive from a home health care agency or a hospital program for home health care:

- Skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN)*, excluding private duty nursing services
- Physical medicine, speech therapy and occupational 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 when you are also receiving covered nursing services or therapy and rehabilitation services

* The services of an LPN shall be made available only when the services of an RN are not available and only when medically necessary and appropriate. Services of an LPN are only reimbursable through a facility provider.

No home health care benefits will be provided for:

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

Home Infusion and Suite Infusion Therapy Services

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

Hospice Care Services

Hospice care services will be provided to members with a life expectancy of 180 days or less, as certified by a physician. This program covers the following services you receive from a home health care agency or a hospital program for hospice care:

- Skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN) *, excluding private duty nursing services
- Physical medicine, speech therapy and occupational therapy
- Medical and surgical supplies provided by the home health care agency or hospital program for hospice care
- Oxygen and its administration
- Medical social service consultations
- Health aide services when you are receiving covered nursing services or therapy and rehabilitation services
- Respite care
- Family counseling related to the member's terminal condition

* The services of an LPN shall be made available only when the services of an RN are not available and only when medically necessary and appropriate. Services of an LPN are only reimbursable through a facility provider.

No hospice care benefits will be provided for:

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

Hospital Services

This program covers the following services received in a facility provider. Benefits will be covered only when, and so long as, they are determined to be medically necessary and appropriate for the treatment of the patient's condition.

Inpatient Services

Bed and Board

Bed, board and general nursing services are covered when you occupy:

- a room with two or more beds;

- a private room; or
- a bed in a special care unit which is 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 you while you are an inpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives;

  Expenses incurred for the first 2 one-pint units of whole blood or blood components are your responsibility.
- anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;
- medical and surgical dressings, supplies, casts and splints;
- diagnostic services; or
- therapy and rehabilitation services.

Outpatient Services

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 you while you are an outpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives;
- anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;

- medical and surgical dressings, supplies, casts and splints.

Surgery

Hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, and anesthesia supplies and services rendered by an employee of the facility provider, other than the surgeon or assistant at surgery.

Pre-Admission Testing

Tests and studies, as indicated in the Basic Diagnostic Services subsection above, required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.

Emergency Care Services

As a PPO Blue member, you're covered at the higher, network level of benefits for emergency care received in *or outside* the provider network. This flexibility helps accommodate your needs when you need care *immediately*.

Your outpatient emergency room visits may be subject to a copayment, which is waived if you are admitted as an inpatient. (Refer to the Summary of Benefits for your program's specific amounts.)

In emergency situations where you must be treated immediately, go directly to your nearest hospital emergency provider; or call "911" or your area's emergency number.

Once the crisis has passed, call your physician to receive appropriate follow-up care. Emergency care services are services and supplies, including drugs and medicines, for the outpatient emergency treatment of bodily injuries resulting from an accident or a medical condition. Also included is a medical screening examination and ancillary services necessary to evaluate such injury or emergency medical condition and further medical examination and treatment as required to stabilize the patient.

Refer to the Terms You Should Know section for a definition of emergency care services. Treatment for any occupational injury for which benefits are provided under any worker's compensation law or any similar occupational disease law is not covered.

Maternity Services

If you think you are pregnant, you may contact your physician or go to a network obstetrician or nurse midwife. When your pregnancy is confirmed, you may continue

to receive follow-up care which includes prenatal visits, medically necessary and appropriate sonograms, delivery, postpartum and newborn care in the hospital.

This program provides services rendered by a facility provider or professional provider for:

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.

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

Nursery Care
Covered services provided to the newborn child from the moment of birth, including care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Routine nursery care includes inpatient medical visits by a professional provider. Benefits will continue for a maximum of 31 days. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within such period. Refer to the General Information section for further eligibility information.

Maternity Home Health Care Visit
You are covered for one maternity home health care visit 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 network 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 your network provider. The visit is subject to all the terms of this 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).

If you are pregnant, now is the time to enroll in the Baby BluePrints® Maternity Education and Support Program offered by Highmark. Please refer to the Member Services section of this booklet for more information.

Medical Services

Inpatient Medical Services

Medical care by a professional provider when you are an inpatient for a condition not related to surgery, pregnancy or mental illness, except as specifically provided herein:

Concurrent Care

Medical care rendered concurrently with surgery during one inpatient stay by a professional provider other than the operating surgeon for treatment of a medical condition separate from the condition for which surgery was performed. Medical care by two or more professional providers rendered concurrently during one inpatient stay when the nature or severity of your condition requires the skills of separate physicians.

Consultation

Consultation services rendered to an inpatient by another professional provider at the request of the attending professional provider. Consultation does not include staff consultations which are required by facility provider rules and regulations. Benefits are limited to one consultation per consultant per admission.

Inpatient Medical Care Visits

Intensive Medical Care

Medical care rendered to you when your condition requires a professional provider's constant attendance and treatment for a prolonged period of time.

Routine Newborn Care

Professional provider visits to examine the newborn infant while the mother is an inpatient.

Outpatient Medical Care Services (Office Visits)

Medical care rendered by a professional provider when you are an outpatient for a condition not related to surgery, pregnancy or mental illness, except as specifically

provided. Benefits include medical care visits and consultations for the examination, diagnosis and treatment of an injury or illness.

Please note that as a Highmark member, you enjoy many convenient options for where you can receive outpatient care. You can physically go to one of the following providers:

- Primary care physician's (PCP) or specialist's office
- Physician's office located in an outpatient hospital/hospital satellite setting
- Urgent Care Center
- Retail site, such as in a pharmacy or other retail store

Or you can interact with a professional provider as follows:

- A virtual visit between you and a PCP or retail clinic via an audio and video telecommunications system
- A virtual visit between you and a specialist via the internet or similar electronic communications for the treatment of skin conditions or diseases
- A specialist virtual visit between you and a specialist at a remote location via interactive audio and video telecommunications. Benefits are provided for a specialist virtual visit which is subsequent to your initial visit with your treating specialist for the same condition. The provider-based location from which you communicate with the specialist is referred to as the "originating site". Benefits will not be provided for a specialist virtual visit if the visit is related to the treatment of mental illness or substance abuse. (The specialist virtual visit is subject to availability within your service area.)

Different types of providers and their locations may require different payment amounts. The specific amounts you are responsible for paying depend on your particular Highmark benefits.

Allergy Extract/Injections
Benefits are provided for allergy extract and allergy injections.

Therapeutic Injections
Therapeutic injections required in the diagnosis, prevention and treatment of an injury or illness.

Mental Health Care Services

Your mental health is just as important as your physical health. That's why PPO Blue provides professional, confidential mental health care that addresses your individual needs. You have access to a wide range of mental health and substance abuse professional providers, so you can get the appropriate level of responsive, confidential care.

You are covered for a full range of counseling and treatment services. PPO Blue covers the following services you receive from a provider to treat mental illness:

Inpatient Facility Services

Inpatient hospital services provided by a facility provider or residential treatment facility provider that satisfies the criteria established by the plan for the treatment of mental illness.

Inpatient Medical Services

Covered inpatient medical services provided by a professional provider:

- Individual psychotherapy
- Group psychotherapy
- Psychological testing
- Counseling with family members to assist in your diagnosis and treatment
- Electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same professional provider.

Partial Hospitalization Mental Health Care Services

Benefits are only available for mental health care services provided on a partial hospitalization basis when received through a partial hospitalization program. A mental health care service provided on a partial hospitalization basis will be deemed to be an outpatient care visit and is subject to any outpatient care cost-sharing amounts.

Outpatient Mental Health Care Services

Inpatient facility service and inpatient medical benefits (except room and board) provided by a facility provider or professional provider as previously described are also available when you are an outpatient, including a virtual visit between you and a specialist via an audio and video telecommunications system.

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 care cost-sharing amounts.

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.

Preventive Care 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 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.

Adult and Pediatric Care

Routine physical examinations, regardless of medical necessity and appropriateness, including a complete medical history for adults, and other items and services.

Well-woman benefits are provided for items and services including, but not limited to, an initial physical examination to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods and counseling for all members capable of pregnancy and breastfeeding support and counseling.

Adult Immunizations

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

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

Routine Gynecological Examination and Pap Test
Benefits are provided for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine Papanicolaou smear (pap test) per calendar year.

Mammographic Screening
Benefits are provided for the following:

- An annual routine mammographic screening starting at 40 years of age or older pursuant to the 2002 recommendations by the United States Preventive Services Task Force.
- Mammographic screenings for all members regardless of age when such services are 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:

- Basic diagnostic laboratory and pathology screening services such as a fecal-occult blood or fecal immunochemical test
- Basic diagnostic standard imaging 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 basic diagnostic laboratory and pathology, basic diagnostic standard imaging, surgical screening tests, basic diagnostic medical and advanced imaging 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.

Diabetes Prevention Program

Benefits are provided if you meet certain medical criteria of having a high risk of developing type 2 diabetes and when you are enrolled in a diabetes prevention program that is delivered by a diabetes prevention provider. Coverage is limited to one enrollment in a diabetes prevention program per year, regardless of whether you complete the diabetes prevention program.

Pediatric Immunizations

Benefits are provided to members under 21 years of age and dependent children for those pediatric immunizations, including the immunizing agents, which conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services. Benefits are not subject to the program deductibles or dollar limits.

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

Services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) when ordered by a physician, providing such nurse does not ordinarily reside in 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 an RN or of a LPN.

Prosthetic Appliances

Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues; 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). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof, are also covered.

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 is intended solely to assist you, with the activities of daily living or to provide an institutional environment for your convenience; or
- for treatment of substance abuse or mental illness.

Spinal Manipulations

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.

Substance Abuse Services

Benefits are provided for individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance abuse and include the following:

- Inpatient hospital or substance abuse treatment facility services for detoxification
- Substance abuse treatment facility services for non-hospital inpatient residential treatment and rehabilitation services
- Outpatient hospital or substance abuse treatment facility or outpatient substance abuse treatment facility services for rehabilitation therapy.

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

Surgical Services

This program covers the following services you receive from a professional provider. If you use an out-of-network professional provider and an inpatient hospital admission is required, you must contact HMS prior to your admission.

Anesthesia

Administration of anesthesia for covered surgery when ordered by the attending professional provider and rendered by a professional provider other than the surgeon or the assistant at surgery. Benefits will also be provided for the administration of anesthesia for covered oral surgical procedures in an outpatient setting when ordered and administered by the attending professional provider.

Assistant at Surgery

Services of a physician who actively assists the operating surgeon in the performance of covered surgery.

Your condition or the type of surgery must require the active assistance of an assistant surgeon. Surgical assistance is not covered when performed by a professional provider who performs and bills for another surgical procedure during the same operative session.

Second Surgical Opinion

A consulting physician's opinion and directly related diagnostic services to confirm the need for recommended elective surgery.

Keep in mind that:

- the second opinion consultant must not be the physician who first recommended elective surgery;
- elective surgery is a covered surgery that may be deferred and is not an emergency;
- use of a second surgical opinion is your option;
- if the first opinion for elective surgery and the second opinion conflict, then a third opinion and directly related diagnostic services are covered services; and

- if the consulting opinion is against elective surgery and you decide to have the elective surgery, the surgery is a covered service. In such instance, you will be eligible for a maximum of two such consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

Special Surgery

- Sterilization

  Sterilization and its reversal regardless of medical necessity and appropriateness.

- Oral surgery

  Benefits are provided for the following limited oral surgical procedures determined to be medically necessary and appropriate:

  – Extraction of impacted third molars when partially or totally covered by bone

  – Extraction of teeth in preparation for radiation therapy

  – Mandibular staple implant, provided the procedure is not done in preparation of the mouth for dentures

  – Lingual frenectomy, frenotomy or frenoplasty (to correct tongue-tie)

  – Facility provider and anesthesia services rendered in a facility setting in conjunction with non-covered dental procedures when determined by Highmark to be medically necessary and appropriate due to your age and/or medical condition

  – Accidental injury to the jaw or structures contiguous to the jaw except teeth

  – The correction of a non-dental physiological condition which has resulted in a severe functional impairment

  – Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth

  – Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus

- Mastectomy and Breast Cancer Reconstruction

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

  – All stages of reconstruction of the breast on which the mastectomy has been performed

- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses; and
- Treatment of physical complications of mastectomy, including lymphedema

Benefits are also provided for one home health care visit, as determined by your physician, within 48 hours after discharge, if such discharge occurred within 48 hours after an admission for a mastectomy.

Surgery

- Surgery performed by a professional provider. Separate payment will not be made for pre- and post-operative services.
- If more than one surgical procedure is performed by the same professional provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure and no allowance shall be made for additional procedures except where Highmark deems that an additional allowance is warranted.

Therapy and Rehabilitation Services

Benefits will be provided for the following services when such services are ordered by a physician:

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

Transplant Services

Benefits will be provided for covered services furnished by a hospital which are directly and specifically related to the transplantation of organs, bones, tissue or blood stem cells.

If a human organ, bone, tissue or blood stem cell 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 their program;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this program subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Shield coverage or any government program; and 2) benefits provided to the donor will be charged against the recipient's coverage under this program to the extent that benefits remain and are available under this program after benefits for the recipient's own expenses have been paid;
- when only the donor is a member, the donor is entitled to the benefits of this program, subject to the following additional limitations: 1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this program; and 2) no benefits will be provided to the non-member transplant recipient; and
- if any organ, tissue or blood stem cell is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; 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 or from a non-participating pharmacy. For convenience and choice, these pharmacies include both major chains and independent stores.

To help contain costs, if a generic drug is available, you will be given the generic. As you probably know, generic drugs have the same chemical composition and therapeutic effects as brand names and must meet the same FDA requirements.

Should you purchase a brand name drug when a generic is available, unless authorized by your doctor, you must pay the price difference between the brand and generic prices in addition to the applicable copayment or coinsurance amount.

Covered Drugs – Incentive Formulary

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;
- prescription drugs listed in your program's prescription drug formulary;
- 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; and
- certain drugs that may require prior authorization from Highmark.

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.

Your prescription drug program follows a select drug list which is referred to as a "formulary." The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. Your program includes coverage for both formulary and non-formulary drugs.

To receive a copy of the formulary, call your toll-free Member Service number. You can also look up the formulary via your Highmark member website, www.highmarkblueshield.com.

These listings are subject to periodic review and modification by Highmark or a designated committee of physicians and pharmacists.

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 the death of the mother or to terminate pregnancies caused by rape or incest;
Acupuncture	• For acupuncture services;
Allergy Testing	• For allergy testing, except as provided herein;
Ambulance	• For ambulance services, except as 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 a cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except: a) as otherwise provided herein, b) when required to correct a condition directly resulting from an accident; c) when necessary to correct a functional impairment which directly results from a covered disease or injury, or d) to correct a 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;
Effective Date	• Rendered prior to your effective date of coverage;
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.
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 aphakic patients and soft 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 (except surgery for ingrown 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;
Health Care Management program	• For any care, treatment, prescription drug, or service which has been disallowed under the provisions of the Health Care Management program;
Hearing Care Services	• For hearing aids, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;
Home Health Care	• For the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: dietitian services, homemaker services, maintenance therapy, dialysis treatment, custodial care, food or home-delivered meals;
Immunizations	• For immunizations required for foreign travel or employment;
Inpatient Admissions	• For inpatient admissions which are primarily for diagnostic studies; • For inpatient admissions which are primarily for physical medicine services;

Learning Disabilities	• For any care that is related to conditions such as hyperkinetic syndromes, learning disabilities, behavioral problems or 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 the member has 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;
Medically Necessary and Appropriate	• Which are not medically necessary and appropriate as determined by Highmark;
Medicare	• To the extent payment has been made under Medicare

	when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program;
Medicare	• For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage;
Methadone Hydrochloride	• For methadone hydrochloride treatment for which no additional functional progress is expected to occur.
Military Service	• To the extent benefits are provided to members of the armed forces while on active duty 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 or prescription drug except as provided herein. • For any charges for benefits provided through the Commonwealth or the State System of Higher Education as an employer or a Health and Welfare Fund Benefit Program to which the Commonwealth or the State System of Higher Education contributes as a result of collective bargaining;
Motor Vehicle Accident	• 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 plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act;
Neonatal Circumcision	• For routine neonatal circumcision;
Nutritional Counseling	• For nutritional counseling, except as provided herein;
Obesity	• For treatment of obesity, except for 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, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, except as provided herein;
Physical Examinations	• For routine or periodic physical examinations, the completion of forms, and the 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;
Prescription Drugs (Medical Program)	• For prescription drugs which were paid or are payable under a freestanding prescription drug program;
Preventive Care Services	• For preventive care services, wellness services or programs, except as provided herein;
Provider of Service	• Which are not prescribed by or performed by or upon the direction of a professional provider; • Rendered by other than ancillary providers, facility providers and 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 member; • Rendered by a 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;
Sexual Dysfunction	• For the treatment of sexual dysfunction that is 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;
Spinal Manipulations	• For spinal manipulations for which there is no expectation of restoring the patient's level of function which has been lost or reduced by injury or illness, or which is performed repetitively to maintain a level of function, or prevent regression of that function, unless medically necessary or appropriate;
Termination Date	• Incurred after the date of termination of your coverage except as provided herein;
Therapy	• For outpatient habilitative and rehabilitative 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;

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, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services;
War	• For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared;
Weight Reduction	• For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate;
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 claim the 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 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;
- Immunizations and biologicals;
- 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.

How PPO Blue Works

Your PPO program lets you get the care you want from the provider you select. When you or a covered family member needs medical care, you can choose between two levels of health care services: **network** or **out-of-network.**

Network Care

For further information, please refer to the Consent Decree Addendum provided at the end of this benefit booklet.

Network care is care you receive from providers in the PPO program's network.

When you receive health care within the PPO network, you enjoy maximum coverage and maximum convenience. You present your ID card to the provider who submits your claim.

Out-of-Network Care

For further information, please refer to the Consent Decree Addendum provided at the end of this benefit booklet.

Out-of-network care is care you receive from providers who are not in the PPO network.

Even when you go outside the network, you will still be covered for eligible services. However, your benefits generally will be paid at the lower, out-of-network level. Additionally, precertification may be required from Highmark before services are received. For specific details, see your Summary of Benefits.

You may be responsible for paying any difference between the provider's actual charge and the PPO Blue program's payment.

When you receive care from an out-of-network provider, coverage is almost always paid at the lower level - *unless it is an emergency or you are referred by Highmark to an out-of-network provider because the non-emergency service is not available from a network provider*. **That's why it is critical - in all cases - that you check to see that your provider is in the network before you receive care.**

Out-of-Area Care

Your program also provides coverage for you and your eligible dependents who are temporarily away from home, or those dependents who permanently reside away from home.

Services received from providers across the country who are part of the local Blue Shield PPO network will be covered at the higher level of benefits. If you receive covered services from a provider who is not part of the local Blue Shield PPO network, these services will be covered at the out-of-network level of benefits.

If you are traveling and an urgent injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic:

- If the illness or injury is an emergency, it will be covered at the higher benefit level, regardless of whether the provider is in the local Blue Shield PPO network. If the treatment results in an admission, the local Blue Shield PPO network provider must obtain precertification from Highmark. However, it is important that you confirm Highmark's determination of medical necessity and appropriateness. If precertification is not obtained and the admission is not considered to be medically necessary and appropriate, you will be responsible for all costs associated with the stay. For specific details, see the Healthcare Management section of this booklet.
- If the illness or injury is not an emergency, you are required to use providers in the local Blue Shield PPO network in order to be covered at the higher benefit level. If you receive care from an out-of-network provider, benefits for eligible services will be provided at the out-of-network level of benefits.

Inter-Plan Arrangements

Out-of-Area Services

Highmark has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "inter-plan arrangements." These inter-plan arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association. Whenever members access health care services outside the geographic area Highmark serves, the claim for those services may be processed through one of these inter-plan arrangements, as described generally below.

Typically, when accessing care outside the geographic area Highmark serves, members obtain care from health care providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, members may obtain care from

health care providers in the Host Blue geographic area that do not have a contractual agreement ("non-participating providers") with the Host Blue. Highmark remains responsible for fulfilling our contractual obligations to you. Highmark's payment practices in both instances are described below.

BlueCard® Program

The BlueCard® Program is an inter-plan arrangement. Under this arrangement, when members access covered services outside the geographic area Highmark serves, the Host Blue will be responsible for contracting and handling all interactions with its participating health care providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method per Claim

Unless subject to a fixed dollar copayment, the calculation of the member liability on claims for covered services will be based on the lower of the participating provider's billed charges for covered services or the negotiated price made available to Highmark by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's health care provider contracts. The negotiated price made available to Highmark by the Host Blue may be represented by one of the following:

- an actual price - An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases, or
- an estimated price - An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives, or
- an average price - An average price is a percentage of billed charges for covered services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices, (ie, prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds

received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Highmark in determining your premiums.

Special Cases: Value-Based Programs

If members receive covered services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Highmark through average pricing or fee schedule adjustments.

Return of Overpayments

Recoveries of overpayments from a Host Blue or its participating and non-participating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/health care provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to Highmark, they will be credited to your account. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to you as a percentage of the recovery.

Non-Participating Providers Outside of the Plan Service Area

Member Liability Calculation

When covered services are provided outside of the plan service area by non-participating providers, the amount(s) a member pays for such services will generally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable law. In these situations, the member may be responsible for the difference between the amount that the non-participating provider bills and the payment Highmark will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services are governed by applicable federal and state law.

Exceptions

In some exception cases, Highmark may pay claims from non-participating health care providers outside of the plan service area based on the provider's billed charge. This may occur in situations where a member did not have reasonable access to the participating provider, as determined by Highmark in Highmark's sole and absolute discretion or by applicable law. In other exception cases, Highmark may pay such

claims based on the payment Highmark would make if Highmark were paying a non-participating provider inside the plan service area. This may occur where the Host Blue's corresponding payment would be more than the plan in-service area non-participating provider payment. Highmark may choose to negotiate a payment with such provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the member may be responsible for the difference between the amount that the non-participating health care provider bills and payment Highmark will make for the covered services as set forth in this paragraph.

Blue Cross Blue Shield Global Core Program

If members are outside the United States (hereinafter "BlueCard service area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing covered services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when members receive care from providers outside the BlueCard service area, they will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if members contact the service center for assistance, hospitals will not require members to pay for inpatient covered services, except for their cost-sharing amounts. In such cases, the hospital will submit member claims to the service center to initiate claims processing. However, if the member paid in full at the time of service, the member must submit a claim to obtain reimbursement for covered services. **Members must contact Highmark to obtain precertification for non-emergency inpatient services**.

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for covered services.

Submitting a Blue Cross Blue Shield Global Core Claim

When members pay for covered services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, members should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center

address on the form to initiate claims processing. The claim form is available from Highmark, the service center or online at www.bcbsglobalcore.com. If members need assistance with their claim submissions, they should call the service center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

Your Provider Network

Your PPO provider network is your key to receiving the higher level of benefits. The network includes: primary care physicians; a wide range of specialists; mental health and substance abuse providers; community and specialty hospitals; and laboratories in the plan service area.

To determine if your physician is in the network, call the Member Service toll-free telephone number on the back of your ID card or log onto www.highmarkblueshield.com.

Getting your care "through the network" also assures you get quality care. All physicians are carefully evaluated before they are accepted into the network. We consider educational background, office procedures and performance history to determine eligibility. Then we monitor care on an ongoing basis through office record reviews and patient satisfaction surveys.

Please note that while you or a family member can use the services, including behavioral health and well-woman care, of any network physician or specialist without a referral and receive the maximum coverage under your benefit program, you are encouraged to select a personal or primary care physician. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal physician can help you select an appropriate specialist and work closely with that specialist when the need arises. In addition, primary care providers or their covering physicians are on call 24/7.

Remember:
If you want to enjoy the higher level of coverage, it is *your* responsibility to ensure that you receive network care. You may want to double-check any provider recommendations to make sure the doctor or facility is in the network.

How to Obtain Information Regarding Your Physician

To view information regarding your PCP or network specialist, visit your member website at www.highmarkblueshield.com and click on "Find a Doctor or Rx" and "Find a doctor, hospital or other medical provider." Search for the physician, then click on the provider's name to view the following information:

- Name, address, telephone numbers
- Professional qualifications
- Specialty
- Medical school attended
- Residency completion
- Board certification status
- Hospital affiliations

In addition to this information, to obtain more information on network providers, you may call Member Service at the toll-free telephone number on the back of your ID card.

Eligible Providers

Eligible network providers include facilities, general practitioners, internists, obstetricians/gynecologists and a wide range of specialists.

Facility Providers

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

Professional Providers

- Audiologist
- Behavior specialist
- Certified registered nurse*
- Chiropractor
- Clinical social worker
- Dentist
- Dietician-nutritionist
- Licensed practical nurse
- Marriage and family therapist
- Nurse-midwife
- Occupational therapist
- Optometrist
- Physical therapist
- Physician
- Podiatrist
- Professional counselor
- Psychologist
- Registered nurse
- Respiratory therapist
- Speech-language pathologist
- Teacher of hearing impaired

Ancillary Providers:

- Ambulance service
- Clinical laboratory
- Diabetes prevention provider
- Home infusion therapy provider
- Independent diagnostic testing facility (IDTF)
- Suite infusion therapy provider
- Suppliers

Contracting Suppliers (for the sale or lease of):

- Durable medical equipment
- Supplies
- Orthotics
- Prosthetics

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

Network/Non-Network Pharmacies

Network/Non-Network Pharmacies

You may purchase prescription drugs from either a network or non-network retail 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.

- **Non-Network Pharmacy:** When covered drugs are purchased from a non-network pharmacy, you will be required to pay the full charge made by the pharmacy for the prescription. You must submit a completed prescription drug claim form for reimbursement. you will be reimbursed at reduced benefits. See the How To File a Claim section of this booklet.

Health Care Management

Medical Management

For your benefits to be paid under your program, at either the network or out-of-network level, services and supplies must be considered medically necessary and appropriate. However, not all medically necessary and appropriate services are covered under your program.

Highmark, or its designated agent, is responsible for determining whether care is medically necessary and provided in the appropriate setting.

A Highmark nurse will review your request for an inpatient admission to ensure it is appropriate for the treatment of your condition, illness, disease or injury, in accordance with standards of good medical practice, and the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered for your condition and you cannot receive safe or adequate care as an outpatient.

Network Care

When you use a network provider for inpatient care, the provider will contact Highmark for you to receive authorization for your care.

If the network provider is located outside the plan service area, you are responsible for contacting Highmark at the toll-free number listed on the back of your ID card to confirm Highmark's determination of medical necessity and appropriateness.

Out-of-area network providers are not obligated to abide by any determination of medical necessity and appropriateness rendered by Highmark. You may, therefore, receive services which are not medically necessary and appropriate for which you will be solely responsible.

Out-of-Network Care

When you are admitted to an out-of-network facility provider, ***you are responsible*** for notifying Highmark of your admission. However, some facility providers will contact Highmark and obtain preauthorization of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Highmark for preauthorization. If not, you are responsible for contacting Highmark.

You should call 7 to 10 days prior to your planned admission. For emergency admissions, call Highmark within 48 hours of the admission, or as soon as reasonably

possible. You can contact Highmark via the toll-free Member Service telephone number located on the back of your ID card.

If you do not notify Highmark of your admission to an out-of-network facility provider, Highmark may review your care after services are received to determine if it was medically necessary and appropriate. **If your admission is determined not to be medically necessary and appropriate, you will be responsible for all costs not covered by your program.**

Remember:
Out-of-network providers are not obligated to contact Highmark or to abide by any determination of medical necessity or appropriateness rendered by Highmark. You may, therefore, receive services which are not medically necessary and appropriate for which you will be solely responsible.

Care Utilization Review Process

In order to assess whether care is provided in the appropriate setting, Highmark administers a care utilization review program comprised of prospective, concurrent and/or retrospective reviews. In addition, Highmark assists hospitals with discharge planning. These activities are conducted by a Highmark nurse working with a medical director. Here is a brief description of these review procedures:

Prospective Review

Prospective review, also known as precertification or pre-service review, begins upon receipt of treatment information.

After receiving the request for care, Highmark:

- verifies your eligibility for coverage and availability of benefits;
- reviews diagnosis and plan of treatment;
- assesses whether care is medically necessary and appropriate;
- authorizes care and assigns an appropriate length of stay for inpatient admissions

Concurrent Review

Concurrent review may occur during the course of ongoing treatment and is used to assess the medical necessity and appropriateness of the length of stay and level of care.

Discharge Planning

Discharge planning is a process that begins prior to your scheduled hospital admission. Working with you, your family, your attending physician(s) and hospital staff, Highmark will help plan for and coordinate your discharge to assure that you receive safe and uninterrupted care when needed at the time of discharge.

Procedure or Covered Service Precertification

Precertification may be required to determine the medical necessity and appropriateness of certain procedures or covered services as determined by Highmark. Network providers in the plan service area and the Highmark managed care network service area are responsible for the precertification of such procedures or covered services and you will be held harmless whenever certification for such procedures or covered services is not obtained. If the procedure or covered service is deemed not to be medically necessary and appropriate, you will be held harmless, except when Highmark provides prior written notice to you that charges for the procedure or covered service will not be covered. In such case, you will be financially responsible for such procedure or covered service.

Retrospective Review

Retrospective review may occur when a service or procedure has been rendered without the required precertification.

Case Management Services

Case Management is a voluntary program in which a case manager, with input from you and your health care providers, assists when you are facing and/or recovering from a hospital admission, dealing with multiple medical problems or facing catastrophic needs. Highmark case managers can provide educational support, assist in coordinating needed health care services, put you in touch with community resources, assist in addressing obstacles to your recovery such as benefit and caregiver issues and answer your questions.

Highmark case managers are a free resource to all Highmark members. If you have an inpatient hospital admission, you may be contacted as part of our Outreach program. If your claims history indicates that your needs appear to be more complex, you may

be contacted by a case manager from our Complex program. In either case, you are always free to call and request case management services if you feel you need it by contacting Member Services at the telephone number listed on the back of your ID card.

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 Authorization

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.

Quantity Level Limits

Quantity level limits may be imposed on certain prescription drugs by Highmark. Such limits are based on the manufacturer's recommended daily dosage or as determined by Highmark. Quantity level limits control the quantity covered each time a new prescription order or refill is dispensed for selected prescription drugs. Each time a

prescription order or refill is dispensed, the pharmacy provider may limit the amount dispensed.

Quantity Level Limits for Initial Prescription Orders

Additional quantity level limits may be imposed for your initial prescription order for certain covered medications. In such instances, the quantity dispensed will be reduced to the level necessary to establish that you can tolerate the covered medication. Consequently, the applicable cost-sharing amount will be adjusted according to the quantity level dispensed for the initial prescription order.

Managed Prescription Drug Coverage

A prescription order or refill which may exceed the manufacturer's recommended dosage over a specified period of time may be denied by Highmark when presented to the pharmacy provider. Highmark may contact the prescribing physician to determine if the covered medication is medically necessary and appropriate. The covered medication will be dispensed if it is determined by Highmark to be medically necessary and appropriate.

Preauthorization

The prescribing physician must obtain authorization from Highmark prior to prescribing certain prescription drugs. The specific drugs or drug classifications which require preauthorization may be obtained by calling the toll-free Member Service telephone number appearing on your ID card.

Precertification, Preauthorization and Pre-Service Claims Review Processes

The precertification, preauthorization and pre-service claims review processes information described below applies to both medical and prescription drug management.

Authorized Representatives

You have a right to designate an authorized representative to file or pursue a request for precertification 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 Precertification and Other Non-Urgent Care Pre-Service Claims

You will receive written notice of any decision on a request for precertification 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 the 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 72 hours following receipt of the 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, your physician will be notified within 24 hours following Highmark's receipt of the claim of the specific information needed to complete your claim. Your physician 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 your physician 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 Precertification Requests and Other Pre-Service Claims

Any time your request for precertification or other pre-service claim is approved, you will be notified in writing that the request has been approved. If your request for precertification 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 benefit determination and a statement describing your right to file an internal appeal or request an external review.

For a description of your right to file an appeal concerning an adverse benefit determination involving a request for precertification 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.

- 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;

  – 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;

  – 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

  v) 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.

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 and your dependents, you must keep your Employee Benefit Department informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage.

Your newborn child may be covered under your program for a maximum of 31 days from the moment of birth. To be covered as a dependent beyond the 31-day period,

the newborn child must be enrolled as a dependent under this program within such period.

Medicare

Retirees or Dependents

If you or a dependent are entitled to Medicare benefits (either due to age or disability) your program will not duplicate payments or benefits provided under Medicare. However, your program may supplement the Medicare benefits, including the deductible and coinsurance not covered by Medicare, provided the services are eligible under your group's program. Contact your Personnel Department for specific details.

The deductible and coinsurance will not be covered if the services are not covered under your Highmark program, even if they are covered under Medicare.

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 and their covered dependents 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 or your dependents 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 available from Highmark. 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.

Coordination of Benefits

Most health care programs, including your PPO Blue program, contain a coordination of benefits provision. This provision is used when you, your spouse or your covered dependents are eligible for payment under more than one health care plan. The object of coordination of benefits is to ensure that your covered expenses will be paid, while preventing duplicate benefit payments.

Here is how the coordination of benefits provision works:

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your plan.
- When the person who received care is covered as an employee under one contract, and as a dependent under another, then the employee coverage pays first.
- When a dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the calendar year pays first. But, if both parents have the same birthday, the plan which covered the parent longer will be the primary plan. If the dependent child's parents are separated or divorced, the following applies:
  - The parent with custody of the child pays first.
  - The coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody.
  - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.
- When none of the above circumstances applies, the coverage you have had for the longest time pays first, provided that:

- the benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person and if
- the other plan does not have this provision regarding laid-off or retired employees, and, as a result, plans do not agree on the order of benefits, then this rule is disregarded.

If you receive more than you should have when your benefits are coordinated, you will be expected to repay any overpayment.

Prescription drug benefits are not coordinated against any other health care or drug benefit coverage.

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

The Blue Shield symbol on your identification (ID) card is recognized throughout the country and around the world. Carry your ID card with you at all times, destroy any previously issued cards, and show this card to the hospital, doctor, pharmacy, or other health care professional whenever you need medical care.

If your card is lost or stolen, please contact Highmark Member Service immediately. You can also request additional or replacement cards online by logging onto www.highmarkblueshield.com.

Below is a sample of the type of information that will be displayed on your ID card:

- Your name and your dependent's name, if applicable
- Identification number
- Group number
- Copayment for physician office visits and emergency room visits
- Member Service toll-free number (on back of card)
- Toll-free telephone number for out-of-network facility admissions (on back of card)
- "PPO in Suitcase" symbol

There is a logo of a suitcase with "PPO" inside it on your ID card. This PPO suitcase logo lets hospitals and doctors know that you are a member of a Blue Shield PPO, and that you have access to PPO providers nationwide.

How to File a Claim

If you receive services from a network provider, you will not have to file a claim. If you receive services from an out-of-network provider, you may be required to file the claim yourself.

If you receive medications from a network pharmacy and present your ID card, you will not have to file a claim. You will owe the pharmacy any copayment, coinsurance or deductible amounts that may apply.

If you forget your ID card when you go to a network pharmacy, the pharmacy may ask you to pay in full for the prescription. If you use a non-network pharmacy, you will need to submit a claim form 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.
- ***Get an Itemized Bill.*** 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;
  - 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, 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.

  Please note: If you've already made payment for the services you received, you must also submit proof of payment (receipt from the provider) with your claim

form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

- ***Copy Itemized Bills*.** You must submit originals, so you may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.
- ***Complete a Claim Form.*** Make sure all information is completed properly, and then sign and date the form. *Claim forms can be downloaded from blog.highmarkhealth.org by entering "forms" in the search box. Claim forms are also available from your employee benefits department, or call the Member Service telephone number on the back of your ID card.*
- ***Attach Itemized Bills to the Claim Form and Mail*.** After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the back of your ID card.

Remember: Multiple services or medications for the same family member can be filed with one claim form. However, a separate claim form must be completed for each member.

If you file the claim yourself, your medical claims must be submitted no later than the end of the benefit period following the benefit period for which benefits are payable.

Your prescription claims must be submitted no later than 12 months from the date that the prescription drug was dispensed.

Your Explanation of Benefits Statement

Once your claim is processed, you will receive an Explanation of Benefits (EOB) statement. This statement lists: the provider's or pharmacy charge; allowable amount; copayment; deductible and coinsurance amounts, if any, you are required to pay; total benefits payable; and the total amount you owe.

How to Voice a Complaint

In the event that you are dissatisfied with any aspect of your health care benefits or you have an objection regarding participating health care providers, coverage, operations or management policies, please contact Highmark via the toll-free Member Service telephone number located on the back of your ID card or by mail at the

address listed below. Please include your identification and group numbers as displayed on your ID card.

Highmark Blue Shield
P.O. Box 226
Pittsburgh, PA 15222

A representative will review, research and respond to your inquiry as quickly as possible.

If the informal dissatisfaction process is not successful and does not meet your needs, you have the right to have your objection reviewed by our Member Grievance and Appeals Department. For details about how this process works, please refer to the Appeal Procedure section of this booklet or call Member Service at the number on your member ID card.

Fraud or Provider Abuse
If you think that a provider is committing fraud, please let us know. Examples of fraud include: Submitting claims for services that you did not get; Adding extra charges for services that you did not get; Giving you treatment for services you did not need. Please call the local state toll-free Fraud Hotline.

Additional Information on How to File a 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 reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

- ***Requests for Precertification and Other Pre-Service Claims***

  For a description of how to file a request for precertification or other pre-service claim, see the Precertification, Preauthorization and Pre-Service Claims Review Processes subsection in the Health Care Management section of this benefit booklet.

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

When a hospital, physician or other provider submits its own reimbursement claim, the amount paid to that 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 Benefit Claims

– ***Notice of Benefit Determinations Involving Requests for Precertification and Other Pre-Service Claims***

For a description of the time frames in which requests for precertification 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 Precertification, Preauthorization and Pre-Service Claims Review Processes subsection in the Health Care 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.

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 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.

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.

myCare Navigator[sm] - 24/7 Health Advocate Support

Getting the right care and finding the right doctor and wellness services for you and your family is now as quick and easy as calling myCare Navigator at **1-888-BLUE-428**.

Your dedicated health advocate can help you and your family members:

- locate a primary care physician or get an appointment with a hard-to-reach specialist;
- get your medical records transferred;
- get a second opinion;
- understand your health care options;
- locate wellness resources, such as services for your special needs child or quality elder care for a parent; or
- handle billing questions and make the most of your care dollars.

Get the help you need to navigate the health care system easily and effectively. The same number that connects you to Blues On Call now connects you to your health advocate, myCare Navigator. So call **1-888-BLUE-428** for *total* care support!

Highmark Website

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

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

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

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

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

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

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

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

Baby Blueprints®

If You are Pregnant, Now is the Time to Enroll in Baby Blueprints

If you are expecting a baby, this is an exciting time for you. It's also a time when you have many questions and concerns about you and your developing baby's health.

To help you understand and manage every stage of pregnancy and childbirth, Highmark offers the Baby Blueprints Maternity Education and Support Program.

By enrolling in this free program you will have access to online information on all aspects of pregnancy and childbirth. Baby Blueprints will also provide you with personal support from a nurse Health Coach available to you throughout your pregnancy.

Easy Enrollment

Just call toll-free at 1-866-918-5267. You can enroll at any time during your pregnancy.

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 PPO Blue 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

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

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

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.

Blues On Call - A 24-hour health decision support program that gives you ready access to a specially-trained health coach.

Board-Certified - A designation given to those physicians who, after meeting strict standards of knowledge and practices, are certified by the professional board representing their specialty.

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 precertification 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 precertification 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. Whether a request involves an urgent care claim will be determined by your attending physician or provider.

- **Post-Service Claim** – A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

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 the 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.

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

Designated Agent - An entity that has contracted, either directly or indirectly with the health plan 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.

Diabetes Prevention Program - A 12-month program using curriculum approved by the Centers for Disease Control to deliver a prevention lifestyle intervention for those at high risk of developing type 2 diabetes. The program includes behavioral and motivational content focusing on moderate changes in both diet and physical activity.

Diabetes Prevention Provider - An entity that offers a diabetes prevention program based on an in-person/onsite or digital model and that has an agreement with Highmark. If the program is based on an in-person/onsite model, the program must offer services through a participating member association which has a contract with the YMCA.

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

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

- placing your health or, with respect to a pregnant member, the health of the member or the 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 with 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.

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

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

Highmark Managed Care Network Service Area - The geographic area consisting of the following counties in western Pennsylvania:

Allegheny	Centre (part)	Forest	Mercer
Armstrong	Clarion	Greene	Potter
Beaver	Clearfield	Huntingdon	Somerset
Bedford	Crawford	Indiana	Venango
Blair	Elk	Jefferson	Warren
Butler	Erie	Lawrence	Washington
Cambria	Fayette	McKean	Westmoreland
Cameron			

Immediate Family - Your spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law, grandchild, grandparent, stepparent, stepbrother or stepsister.

Infertility - The medically documented inability to conceive with unprotected sexual intercourse between partners of the opposite biological sex for a period of at least 12 months. The inability to conceive may be due to either partner.

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.

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.

Network - Depending on where you receive services, the network is designated as one of the following:

- When you receive services within the plan service area, the designated network for professional providers is the PremierBlue Shield network and the designated network for facility providers is the Highmark Blue Shield participating facility provider network.
- When you receive services within the Highmark service area, the designated network for professional providers and facility providers is the Highmark managed care network.
- When you receive services out of area but within Pennsylvania, the designated network for professional providers is the PremierBlue Shield network and the designated network for facility providers is the local PPO network.
- When you receive services out of area and outside Pennsylvania, the designated network for professional providers and facility providers is the local PPO network.

Network Provider - An ancillary provider, professional provider or facility provider who has entered into an agreement, either directly or indirectly, with Highmark or with any licensee of the Blue Cross and Blue Shield Association located out-of-area, pertaining to payment as a participant in a PPO network for covered services rendered to a member.

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 Allowance - The amount used to determine payment by your program for 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 an in-area out-of-network provider is based on an adjusted contractual allowance for like services rendered by a network provider in the same geographic region. You will be responsible for any difference between the provider's billed charges and your program's payment. The plan allowance for an out-of-area provider is determined based on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your program's participation in the BlueCard program described in the How Your Program Works section of this booklet.

The plan allowance for an out-of-network state-owned psychiatric hospital is what is required by law.

In some cases, an allowance may be negotiated with an out-of-area non-participating provider. The negotiated reimbursement amount will be based on prevailing market reimbursement amounts. In the event the negotiations with a non-participating out-of-area provider are unsuccessful, the plan allowance will be based on pricing determined by a national database. For facility claims, the pricing will be determined on the basis of detailed data reflecting actual reported billings and payments over the preceding 24 months and includes an inflation factor. For professional claims, pricing will be determined on median-based cost of care that is adjusted for geography.

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

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

Precertification (Preauthorization) - The process through which medical necessity and appropriateness of inpatient admissions, services or place of services is determined by Highmark prior to or after an admission or the performance of a procedures or service.

Preferred Provider Organization (PPO) Program - A program that does not require the selection of a primary care physician, but is based on a provider network made up of physicians, hospitals and other health care facilities. Using this provider network helps assure that you receive maximum coverage for eligible services.

Primary Care Physician (PCP) - A physician who limits his or her practice to family practice, general practice, internal medicine or pediatrics and who may supervise, coordinate and provide specific basic medical services and maintain continuity of patient care.

Provider's Allowable Price - The amount at which a participating pharmacy provider has agreed, either directly or indirectly, with the health plan to provide covered medications to you under this program.

Specialist - A physician, other than a primary care provider, who limits his or her practice to a particular branch of medicine or surgery.

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

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

Highmark is a registered mark of Highmark Inc.

PPO Blue, Blues On Call and myCare Navigator are service marks of the Blue Cross and Blue Shield Association.

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

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

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

You are hereby notified that Highmark Blue Shield provides administrative services only on behalf of your self-funded group health plan. Highmark Blue Shield is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield companies throughout the United States. Although all of these independent Blue Cross and Blue Shield companies operate from a license with the Association, each of them is a separate and distinct operation. The Association allows Highmark Blue Shield to use the familiar Blue Shield words and symbol. Highmark Blue Shield is neither the insurer nor the guarantor of benefits under your group health plan. Your Group remains fully responsible for the payment of group health plan benefits.

Consent Decree Addendum to Your Benefit Booklet

On June 27, 2014, Highmark and UPMC entered into a Consent Decree that was designed to protect your access to UPMC providers.

Please be aware that certain UPMC providers may still continue to participate in the network for your plan. You can always receive benefits at the network level from these UPMC network providers. Be sure to check the provider directory for the most up-to-date listing of network providers.

Under the Consent Decree, covered services may be available at the network level of benefits from out-of-network UPMC providers under your plan but only in the circumstances described below:

Continued Care

If you are in the midst of a course of treatment from an out-of-network UPMC provider, you may choose to request to continue treatment with that UPMC provider. Covered services will be available at the network level of benefits.

The need for a continuing course of treatment with a UPMC provider shall be determined, in the first instance, by your treating physician acting in consultation with you and in accordance with your wishes or your authorized representative. If you are pregnant, and your pregnancy was confirmed before December 31, 2015, or if you started a continuing course of treatment for a chronic or persistent medical condition with a UPMC provider in calendar years 2013, 2014 or 2015 (or on or before June 30, 2016 for UPMC Mercy), you may continue treatment with that UPMC provider through the period of delivery and post-partum care for that pregnancy or completed treatment of the chronic or persistent medical condition. Notwithstanding the above, if you were treated at UPMC Mercy and by a UPMC Mercy physician for a confirmed pregnancy on or before June 30, 2016, you may continue to receive treatment at UPMC Mercy through the period of delivery and post-partum care for that pregnancy or completed treatment of the chronic or persistent medical condition.

Services such as routine wellness care and routine preventive care are not considered to be continued care for purposes of this addendum. Furthermore, benefits will not be provided for purposes of this addendum when the course of treatment for a chronic or persistent medical condition started before January 1, 2013, but for which no treatment was subsequently received from a UPMC provider, unless the UPMC provider can demonstrate that the member was receiving ongoing care in accordance with recognized medical protocols and/or standards.

While undergoing a continuing course of treatment with such UPMC provider, benefits will include all covered services reasonably related to the treatment including, but not limited to, testing and follow-up care. In the event that Highmark disputes the opinion of the treating physician that a continuation of care is medically necessary and appropriate, or disputes the scope of that care, the Pennsylvania Department of Health or its designated representative will review that matter and make a final non-appealable determination.

Oncology Services (Cancer Care)

If you have been diagnosed with cancer and your treating physician determines that you should be treated by an out-of-network UPMC provider that renders oncology services, you may choose to request treatment from that UPMC provider. Covered services will be available at the network level of benefits. Treatment includes care for illnesses resulting from the cancer treatment such as, but not limited to, mental health, endocrinology, orthopedics and cardiology. The need for a treatment of a resulting illness shall be determined, in the first instance, by your treating physician acting in consultation with and in accordance with your wishes or your authorized representative.

Local Community Needs

If your treating physician believes that you require certain medical services and the Pennsylvania Department of Health has determined that such services are not available from another source locally other than from an out-of-network UPMC provider, you may receive covered services from that UPMC provider. Covered services will be available at the network level of benefits.

Emergency Care Services

When emergency care services are received from an out-of-network UPMC provider, hospital and medical benefits are provided as described in the Covered Services section. This also includes other services and supplies necessary to continue your treatment, including any resulting inpatient admission through the period of discharge. Covered services will be available at the network level of benefits.

Other Out-of-Network Services

In other situations not specifically described above, if you receive covered services from an out-of-network UPMC provider, these services will be covered at the lower, out-of-network level of benefits. However, out-of-network UPMC providers, if paid promptly, cannot require you to pay any amount greater than the difference between Highmark's payment and 60 percent of the UPMC provider's billed charge. The UPMC provider must advise you of these charges before rendering any services. If you receive services that are not covered under this program, you will be responsible for all charges associated with those services.

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

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