CLASSICBLUE

TRADITIONAL PROGRAM

Under 65 Retirees

Group 28572-00, 01, 02, 03

Effective July 1, 2018

HIGHMARK | Classic Blue

HIGHMARKBLUESHIELD.COM

14BS12

HIGHMARK
An Independent Licensee of the Blue Cross and Blue Shield Association

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.

U65_BS_G_M_1Col_12pt_blk_1c

Table of Contents

Introduction of Your Classic Blue Traditional Benefits Program **1**
How Your Benefits Are Applied **2**
Medical Cost-Sharing Provisions 2
Prescription Drug Cost-Sharing Provisions 3
Summary of Benefits **4**
Covered Services - Medical Program **9**
Ambulance Services 9
Anesthesia for Non-Covered Dental Procedures (Limited) 9
Autism Spectrum Disorders 10
Clinic Visits 11
Dental Services Related to Accidental Injury 11
Diabetes Treatment 11
Diagnostic Services 11
Durable Medical Equipment 12
Emergency Care 12
Enteral Foods 12
Home Health Care Services 13
Hospice Care Services 13
Hospital Services-Inpatient 14
Hospital Services-Outpatient 15
Maternity Services 15
Medical Services 16
Mental Health Services 18
Orthotic Devices 19
Prescription Drugs 19
Preventive Services 19
Private Duty Nursing Services 22
Prosthetic Appliances 22
Skilled Nursing Facility Services 22
Spinal Manipulations 22
Substance Abuse Services 22
Surgical Services 23
Therapy and Rehabilitation Services 25
Transplant Services 25
Covered Services - Prescription Drug Program **27**
Covered Drugs 27
What Is Not Covered **28**
Out-of-Area Care **37**
Inter-Plan Arrangements 37
Eligible Providers **41**
Participating Providers 42
Non-Participating Providers 42
Network Pharmacies 42
Health Care Management **44**

Medical Management....44
Precertification 44
Continued Stay Review 45
Discharge Planning 45
Case Management....45
General Information 47
Changes in Membership Status 50
Medicare 51
Continuation of Coverage....51
Conversion 51
Termination of Your Coverage Under the Employer Contract....52
Coordination of Benefits 52
Subrogation 53
A Recognized Identification Card 54
How to File a Claim....55
Your Explanation of Benefits Statement 56
Additional Information on How to File a Claim....56
Determinations on Benefit Claims 57
Appeal Procedure 58
Member Service 64
Blues On Call 64
myCare Navigator 65
Highmark Website 65
Baby Blueprints....66
Member Service....66
Member Rights and Responsibilities 68
How We Protect Your Right to Confidentiality 68
Terms You Should Know 70
Consent Decree Addendum 77
Notice of Privacy Practices 79

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 Classic Blue Traditional Benefits Program

This booklet provides you with information you need to understand your Classic Blue Traditional 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.

We think you will be very pleased with the freedom and flexibility, the provider choice and the coverage your program provides you.

You can review your Preventive Care Guidelines online at your member website. And, as a member of your Classic Blue Traditional 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 Classic Blue Traditional 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 and a description of how your benefits are applied. For specific amounts, refer to your Summary of Benefits.

Medical Cost-Sharing Provisions

Cost-sharing is a requirement that you pay part of your expenses for covered services. The terms "deductible" and "coinsurance" describe methods of such payment. You can be asked to pay any applicable coinsurance or deductible amounts at the time of service. Coinsurance and deductible amounts not paid at the time of 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 the difference between the provider's billed charge and your program's payment.

Major Medical Covered Services

Benefit Period

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

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 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.

Deductible

The deductible is a specified dollar amount you must pay for covered Major Medical 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 service must be paid within 60 days of the finalization date of your claim.

Family Deductible

For a family with several covered dependents, the deductible you pay for all covered family members, regardless of family size, is specified under family deductible. To reach this total, you can count the expenses incurred by three or more family members. However, the deductible contributed towards the total by any one covered family member cannot be more than the amount of the individual deductible. If one

family member meets the individual deductible and needs to use benefits, the program would begin to pay for that person's covered services even if the deductible for the entire family had not been met.

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

The deductible does not include any charges for which benefits are excluded in whole or in part under the provisions in the Health Care Management section.

Out-of-Pocket Limit

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

The out-of-pocket does not include any charges for which benefits are excluded in whole or in part under the provisions in the Health Care Management section.

Prescription Drug Cost-Sharing Provisions

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

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

Coinsurance

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

Summary of Benefits

Under the Traditional benefits program, benefits include coverage for both facility and professional services. Below are specific benefit levels.

Benefits	Hospital	Medical/Surgical	Major Medical
General Provisions			
Benefit Period	Calendar Year		
Deductible (per benefit period)	None	None	$100 Individual $300 Family
			Aggregate
Plan Payment Level -- Based on the plan allowance	100%	100%	80% after deductible until out-of-pocket is met; then 100%
Out-of-Pocket Limit	None	None	$380 Individual
Lifetime Maximum (per member)	None	None	$500,000/per individual
Office/Clinic/Urgent Care Visits			
Hospital Clinic Visits[1]	100%	Not Covered	Not Covered
Outpatient Medical Visits Physician Office Visits[1] (including virtual visits)	Not Covered	Not Covered	80% after deductible
Virtual Visit Originating Site Fee[1]	Not Covered	Not Covered	80% after deductible
Retail Clinic Visits (including virtual visits)	Not Covered	Not Covered	80% after deductible
Urgent Care Center Visits	Not Covered	Not Covered	80% after deductible
Preventive Care Services[2]			
Adult Routine physical exams	Not Covered	Not Covered	Not Covered
Immunizations	Not Covered	Not Covered	Not Covered
Diagnostic Services and Procedures	Not Covered	Not Covered	Not Covered
Colorectal Cancer Screenings	Not Covered	Not Covered	Not Covered
Routine gynecological exams, including a PAP Test	100%	100%	80%; deductible does not apply
Mammograms, annual routine and medically necessary	100%	100%	80%; deductible does not apply
Pediatric Routine physical exams	Not Covered	Not Covered	Not Covered
Immunizations	100%	100%	80%; deductible does not apply
Diagnostic Services and Procedures	Not Covered	Not Covered	Not Covered

Benefits	Hospital	Medical/Surgical	Major Medical
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Services - Inpatient[3]	100% Limited to 365 days of inpatient care. You become eligible for a new benefit period (an additional 365 days) whenever you do not use any inpatient care for at least 90 consecutive days.	100%	80% after deductible
Hospital Services - Outpatient[3]	100%	Not Covered	80% after deductible
Inpatient Medical Care (professional)	Not Covered	100%	80% after deductible
Concurrent Care	Not Covered	100%	80% after deductible
Consultations	Not Covered	100% Limited to 1 consultation per consultant per inpatient stay	80% after deductible
Maternity (non-preventive facility and professional services) Includes Dependent Daughters	100%	100%	80% after deductible
Medical/Surgical (except office visits)	100%	100%	80% after deductible
Assistant At Surgery	Not Covered	100%	80% after deductible
Second Surgical Opinion	Not Covered	100%	80% after deductible
Emergency Services			
Emergency Room Care	100%	100%	80% after deductible
Ambulance	100% Facility-billed only	Not Covered	80% after deductible
Therapy and Rehabilitation Services			
Occupational Therapy	100%	Not Covered	80% after deductible
Physical Medicine	100%	100%	80% after deductible
Chemotherapy, Radiation Therapy, Respiratory Therapy, and Dialysis	100%	100%	80% after deductible
Speech Therapy	100%	Not Covered	80% after deductible
Spinal Manipulations	Not Covered	Not Covered	80% after deductible
Infusion Therapy	100%	Not Covered	80% after deductible
Cardiac Rehabilitation Therapy	Not Covered	Not Covered	80% after deductible

Benefits	Hospital	Medical/Surgical	Major Medical
Mental Health/Substance Abuse Services			
Mental Health - Inpatient[4]	100% Limited to 60 days per calendar year (applies toward your inpatient hospital facility day limit)	100% Limited to 60 days per calendar year	50% after deductible
Mental Health - Outpatient (including virtual visits)	Not Covered	Not Covered	50% after deductible
Substance Abuse - Inpatient Detoxification	100% 7 days/admission; 4 admissions/lifetime	100%	Not Covered
Substance Abuse - Inpatient Residential Treatment and Rehabilitation Services	100% 30 days/calendar year; 90 days/lifetime	100% Limited to 60 days per calendar year	Not Covered
Substance Abuse - Outpatient[5]	100% 60 visits/calendar year; 120 visits/lifetime	Not Covered	50% after deductible
Other Services			
Anesthesia	Not Covered	100%	80% after deductible
Anesthesia for Non-Covered Dental Procedures (Limited)	Not Covered	100%	80% after deductible
Autism Spectrum Disorders including Applied Behavioral Analysis[6]	100%	100%	80% after deductible
Assisted Fertilization Treatment	Not Covered	Not Covered	Not Covered
Dental Services Related to Accidental Injury	Not Covered	100%	80% after deductible
Diabetes Treatment	100%	100%	80% after deductible
Diagnostic Services	100%	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	Not Covered	Not Covered	80% after deductible
Enteral Foods	Not Covered	100%	80%; deductible does not apply
Hearing Care Services	Not Covered	Not Covered	Not Covered
Home Health Care	100% Limit: 60 visits within a 90 day period	Not Covered	80% after deductible
Hospice	100%	Not Covered	Not Covered
Infertility Counseling, Testing and Treatment[7]	100%	100%	80% after deductible
Private Duty Nursing **Skilled Nursing Facility Services**	Not Covered 100%	Not Covered 100%	80% after deductible Not Covered
Transplant Services	100%	100%	80% after deductible
Precertification Requirements	Yes[8]		
Condition Management	Case Management, Blues On Call, and Disease State Management		

[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, retail clinic or urgent care center. The specialist virtual visit is subject to availability within your service area.

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

[3] 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. For covered services rendered by an out-of-area provider, such services will be priced by the local Blue Cross Blue Shield plan and submitted to Highmark via BlueCard. The plan allowance would then be subject to the coinsurance percentage after your deductible, if any, has been satisfied.

[4] State mandated benefits (30 inpatient days and 60 outpatient visits annually, with the right to exchange inpatient days for outpatient visits on a one-for-two basis) apply to a diagnosis of serious mental illness. Serious mental illnesses include: schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa and delusional disorder.

[5] Of the 60 outpatient visits or equivalent partial visits or partial hospitalization services per benefit period, a maximum of 30 of these visits may be exchanged on a two-for-one basis to secure up to 15 additional days per benefit period beyond the 30-day limit for inpatient non-hospital rehabilitation services.

[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] 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.

[8] 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 sureto 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[1]	Mail Service Pharmacy Up to 90-days
Pharmacy Network	National Plus	Express Scripts Pharmacy
Benefit Period	Calendar Year	
Deductible (per benefit period)	None	None
Out of Pocket Limit	Not Applicable	
Preventive Covered Drugs	Deductibles, coinsurance and/or copayments do not apply	Deductibles, coinsurance and/or copayments do not apply
Generic Prescription Drug	None	None
Brand Prescription Drug	None	None
Formulary	Open	
Generic Substitution	Not Applicable	
Claim Submission	Member Files	
Non-Network Pharmacy	Not Covered	Not Covered
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	Does Not Apply	
Quantity level Limits *on select prescription drugs*	Does Not Apply	
Managed R_x Coverage *on certain drug therapies*	Does Not Apply	
Managed Prior Authorizations	Does Not Apply	

[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] 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

The program provides benefits for the following hospital, medical-surgical and major medical services you receive from an eligible provider.

The benefits in this section will be covered only when and so long as they are determined to be medically necessary and appropriate for the proper treatment of the patient's condition. Please refer to the section headed "Terms You Should Know" and also the section headed "Health Care Management" for specific details. Any benefit limits, deductibles and coinsurance amounts are described in the Summary of Benefits.

Ambulance Services

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

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

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

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

Anesthesia for Non-Covered Dental Procedures (Limited)

Benefits will be provided for general anesthesia and associated hospital 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

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

Psychiatric and psychological care

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

Rehabilitative care

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

Therapeutic care

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

Clinic Visits

Benefits will be provided for routine outpatient medical treatment or care at a facility provider. Such care must be received in the outpatient clinic portion of the hospital rather than the emergency room. The charge must be billed by the facility provider.

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 caused by chewing or biting will not be considered 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 aids, syringes and insulin infusion devices.

*Outpatient Diabetes Education**

When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through an outpatient diabetes education program:

- Visits medically necessary and appropriate upon the diagnosis of diabetes
- Subsequent visits under circumstances whereby your physician:
  - identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in your self-management; or
  - identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to your treatment and/or management of diabetes

Diagnostic Services

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

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

- Allergy testing, consisting of percutaneous, intracutaneous and patch tests

Durable Medical Equipment

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

Emergency Care

Medical care, services and supplies for the outpatient emergency treatment of bodily injuries resulting from an accident or 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.

Benefits are also provided for all follow-up care within 60 days.

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.

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.

Coverage for enteral foods <u>excludes</u> the following:

- Blenderized food, baby food, or regular shelf food
- Milk or soy-based infant formulae with intact proteins
- Any formulae, when used for the convenience of you or your family members

- Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance
- Semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally

This coverage does not include normal food products used in the dietary management of the disorders included above.

Home Health Care Services

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

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

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

No home health care benefits will be provided for:

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

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

- Skilled nursing services of an RN or LPN, excluding private duty nursing services
- Physical medicine, occupational therapy and speech therapy
- Medical and surgical supplies provided by the home health care agency or hospital program for hospice care

- Oxygen and its administration
- Medical social service consultations
- Health aide services to a member who is receiving covered nursing or therapy and rehabilitation services
- Respite care
- Family counseling related to the member's terminal condition
- Dietitian services
- Inpatient room, board and general nursing service

No hospice care benefits will be provided for:

- dialysis treatment;
- custodial care;
- medical care rendered by the patient's private physician;
- volunteer services;
- pastoral services;
- homemaker services;
- food or home delivered meals; and
- private duty nursing services.

Hospital Services-Inpatient

Bed and Board

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

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

Ancillary Services

Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms and equipment;
- drugs and medicines provided to you when you are an inpatient 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, and the 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.

Hospital Services-Outpatient

Emergency Care

Services and supplies for the outpatient emergency treatment of bodily injuries resulting from an accident or 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. Emergency care includes benefits for unlimited visits of follow-up care.

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.

Pre-Admission Testing

Tests and studies 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.

Surgery

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

Maternity Services

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

Normal Pregnancy

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

Complications of Pregnancy

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

Nursery Care

Care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. 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

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

Concurrent Care

Services rendered to an inpatient at the request of the attending professional provider by another professional provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance, stand-by services, routine pre-operative physical examinations or medical care routinely performed in the pre- or post-operative or pre-or post-natal periods or medical care required by hospital rules and regulations.

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 hospital rules and regulations.

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.

Inpatient medical care is renewed when 90 days have elapsed between discharge from and subsequent admission to a hospital or skilled nursing facility.

Outpatient Medical Care Services (Office Visits)
Medical care visits and consultations rendered by a professional provider for the examination, diagnosis and treatment of an injury or illness to you when you are an outpatient for a condition not related to surgery, pregnancy or mental illness, except as specifically provided.

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:

- Physician's office, including those 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 physician 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.

Mental Health Services

Inpatient Facility Services

Hospital services are provided for the inpatient treatment of mental illness by a facility provider.

Inpatient Medical Services

The following services are provided for the inpatient treatment of mental illness by a professional provider:

- Individual psychotherapy
- Group psychotherapy
- Psychological testing
- Family counseling
  Counseling with family members to assist in the patient's diagnosis and treatment
- Convulsive therapy treatment
  Electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same professional provider

Partial Hospitalization Mental Health 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 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 cost-sharing amounts.

Each day of inpatient care for the treatment of serious mental illness or any other mental illness reduces the total number of inpatient care days available under the mental health care services benefit by one day. Each outpatient care visit utilized for the treatment of serious mental illness or any other mental illness reduces the total number of outpatient care visits available under the mental health care services benefit by one visit. Once you have exhausted your benefit period outpatient care visits, additional outpatient care visits may be obtained in exchange for each unused inpatient care day on a two-for-one basis.

In any event, no matter how many inpatient care days or outpatient care visits for the treatment of mental illness are utilized, coverage for at least 30 inpatient care days and at least 60 outpatient care visits for the treatment of serious mental illness as required under Act 150 of 1998 are always available per benefit period.

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.

However, replacements are covered only in the case of dependent children and only when Highmark determines that such replacement is medically necessary and appropriate.

Prescription Drugs

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

Preventive Services

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

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

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

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

Pediatric Immunizations
Benefits are provided to members under 21 years of age for those pediatric immunizations, including the immunizing agents, which, as determined by the Pennsylvania Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, and the U.S. Department of Health and Human Services.

Routine Gynecological Examination and Papanicolaou Smear
Benefits are provided for one routine gynecological examination, including a pelvic examination and clinical breast examination and one routine Papanicolaou smear per calendar year.

Mammographic Screening
Benefits will be provided for:

- 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; and
- mammographic screenings for all members regardless of age when prescribed by a physician.

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

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

- Diagnostic pathology and laboratory screening services such as a fecal-occult blood or fecal immunochemical test
- Diagnostic x-ray screening services such as barium enema
- Surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services
- Such other diagnostic pathology and laboratory, diagnostic x-ray and surgical screening tests and diagnostic medical screening services consistent with approved medical standards and practices for the detection of colon cancer

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

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

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

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.

Tobacco Use, Counseling and Interventions

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

Private Duty Nursing Services

Private duty nursing services of an actively practicing RN or a 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 a Registered Nurse or of a Licensed Practical Nurse.

Prosthetic Appliances

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

Skilled Nursing Facility Services

Services rendered in a skilled nursing facility to the same extent benefits are available to an inpatient of a hospital. Two days of skilled nursing facility care are available for each unused day of the hospital benefit period. No benefits are payable:

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

Spinal Manipulations

Benefits will be provided for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

Substance Abuse Services

Services include individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of alcohol abuse and drug abuse.

- Inpatient hospital or alcohol or drug abuse treatment facility services for detoxification.
- Substance abuse treatment facility services for inpatient non-hospital residential 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.

Once you have exhausted your benefit period inpatient residential treatment and rehabilitation days, any unused full session, equivalent partial-session or partial hospitalization outpatient care visits may be exchanged on a two-for-one basis to secure additional residential treatment and rehabilitation service days beyond the residential treatment and rehabilitation service day maximum per benefit period as set forth herein.

Surgical Services

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.

Special Surgery

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

  - Extraction of partial or full bony impactions
  - Extraction of teeth other than impacted teeth or other oral surgical procedures provided inpatient hospitalization or outpatient care is medically necessary and appropriate to safeguard the health of the patient
  - Frenectomy, frenulectomy, frenotomy
  - Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth

- **Sterilization**
  Sterilization and procedures to reverse sterilization regardless of their medical necessity and appropriateness.

- **Cleft Palate Surgery**
  Benefits are provided for orthodontic treatment of a congenital cleft palate 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.

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 himself performs and bills for another surgical procedure during the same operative session.

Anesthesia

Administration of anesthesia in connection with the performance of covered services and rendered by a professional provider other than the surgeon, assistant surgeon or attending professional provider.

Benefits are also provided for the administration of anesthesia for oral surgical procedures in an outpatient setting when ordered and administered by the attending professional provider.

Second Surgical Opinion

- **Services**
  A consulting opinion and directly related diagnostic services to confirm the need for recommended elective surgery.

- **Specifications**
  - The second opinion consultant must not be the physician who first recommended elective surgery.
  - Elective surgery is covered surgery that may be deferred and is not an emergency.
  - A second surgical opinion is your choice.
  - If the first opinion for elective surgery and the second opinion conflict, then a third opinion and directly related diagnostic services are covered services.
  - If the consulting opinion is against elective surgery and you decide to have the elective surgery, the surgery is a covered services. In such instances, 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.

Therapy and Rehabilitation Services

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

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

Transplant Services

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

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

- when both the recipient and the donor are members, each is entitled to the benefits of this 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:
  - the donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other

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

Covered Services - Prescription Drug Program

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

Covered Drugs

Covered drugs include:

- those which, under Federal law, are required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription;"
- legend drugs under applicable state law and dispensed by a licensed pharmacist;
- preventive drugs that are offered in accordance with a predefined schedule and are prescribed for preventive purposes. Highmark periodically reviews the schedule based on legislative requirements and the advice of the American Academy of Pediatrics, the U.S. Preventive Services Task Force, the Blue Cross Blue Shield Association and medical consultants. Therefore, the frequency and eligibility of services is subject to change. For a current schedule of covered preventive drugs, log onto your Highmark member website, www.highmarkblueshield.com, or call Member Service at the toll-free telephone number listed on the back of your ID card;
- prescribed injectable insulin;
- diabetic supplies, including needles and syringes.

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:

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;
Audiometric Testing	• For outpatient audiometric testing;
Bariatric Surgery	• For bariatric surgery including reversal, revision, repeat and staged surgery, except for the treatment of sickness or injury resulting from such bariatric surgery.
Blood	• For whole blood, blood components and blood derivatives which are not classified as drugs in the official formularies;
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 or other 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 dental services related to an accidental injury, anesthesia for non-covered dental procedures and orthodontic treatment for congenital cleft palates as provided herein;
Effective Date	• Rendered prior to your effective date;
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. This does not include those enteral foods, which are exempt from deductible requirements, that are either nutritional supplements prescribed solely for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria or amino acid-based elmental 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;
Experimental/ Investigative	• Which are experimental/investigative in nature;
Eyeglasses/Contact Lenses	• For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury) ;
Eye Refractions	• For outpatient eye refractions;
Felonies	• For any illness or injury you suffer during your commission of a felony;
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 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 aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids unless specifically provided;
Immunizations	• For immunizations required for foreign travel or employment;
Inpatient Admissions	• For inpatient admissions which are primarily for physical medicine services; • For inpatient admissions which are primarily for diagnostic studies;
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 or medically appropriate as determined by Highmark;
Medicare	• For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage;
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;
Mental Health	• For outpatient mental health examinations and outpatient psychological testing, except as provided herein;
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 duty and the National Health Service or to patients in Veteran's Administration facilities for service-connected illness or injury, unless you have a legal obligation to pay;
Miscellaneous	• For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form; • For any other medical or dental service or treatment except as provided herein; • 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 any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act;
Non-Participating Provider	• For treatment or services received as an outpatient in a non-participating hospital or facility except for emergency accident and emergency medical care, unnless required by law;
Nutritional Counseling	• For nutritional counseling and services intended to produce weight loss except as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information;
Obesity	• For treatment of obesity, except for medical and surgical treatment of morbid obesity or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information;
Oral Surgery	• For oral surgery procedures, unless specifically provided;
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	• 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 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 or other 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; • Performed in a facility by a professional provider who, in any case, is compensated by the facility for similar services performed for patients;
Screening Examinations	• For screening examinations including X-ray examinations made without film, except as provided herein;
Sexual Dysfunction	• For treatment of sexual dysfunction that is not related to organic disease or injury;
Smoking (nicotine) Cessation	• For nicotine cessation support programs and/or classes, except as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information;
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;
Surgical Procedures	• For pre-operative care when you are not an inpatient and any post-operative care other than that normally provided following surgical procedures;
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;

Transsexual Surgery	• For any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery;
Vision Correction Surgery	• For correction of myopia or 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 while on active duty as a member of the armed forces of any nation, or 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 or as otherwise required by applicable state or federal law;
Well-Baby Care	• For well-baby care visits and immunizations, except as provided herein;
Workers' Compensation	• For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease, or similar type legislation. This exclusion applies whether or not you file a claim for said benefits or compensation;

In addition, under your Prescription Drug benefits, except as specifically provided in this program or as Highmark is mandated or required to provide based on state or federal law, no benefits will be provided for:

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

provider;

- Any amounts above the deductible, coinsurance, copayment or other cost sharing amounts for each prescription order or refill that are your responsibility;
- 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.

Out-of-Area Care

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.

Eligible Providers

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
- Home infusion therapy provider
- Independent diagnostic testing facility
- Hospice
- Hospital
- Outpatient substance abuse treatment facility
- Outpatient physical rehabilitation facility
- Outpatient psychiatric facility
- Psychiatric hospital
- Rehabilitation hospital
- Ambulance service
- Skilled nursing facility
- State-owned psychiatric hospital
- Substance abuse treatment facility
- Suite infusion therapy provider

Professional Providers

- Audiologist
- Behavior specialist
- Certified registered nurse *
- Chiropractor
- Clinical laboratory
- 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

Suppliers and Contracting Suppliers (for the sale or lease of):

- Durable medical equipment
- Supplies
- Hearing aids
- Orthotics
- Prosthetics

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

***Covered services must be prescribed by a physician. Services of a respiratory therapist are only reimbursable through a facility provider.*

Participating Providers

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

Participating providers have a contract pertaining to payment for covered services and agree to accept the allowance as full payment for covered services.

Non-Participating Providers

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

Some providers do not have an agreement and do not accept the allowance as payment-in-full.

Network Pharmacies

Network Pharmacies

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

- **Network Pharmacy:** Network pharmacies have an arrangement with Highmark to provide prescription drugs to you at an agreed upon price. When you purchase covered drugs from a pharmacy in the network applicable to your program, present your prescription and ID card to the pharmacist. (Prescriptions which the pharmacy receives by phone from your physician or dentist may also be covered.) Upon presenting your ID card, you will be required to pay the agreed upon price to

the network pharmacy. If you fail to show your ID card to the pharmacy, you will be responsible for paying the full charge for your prescriptions. For a description on how to obtain reimbursement, see the How to File a Claim section of this benefit booklet.

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

- **Mail Order Pharmacy:** Express Scripts® is your program's mail order pharmacy. This option offers savings and convenience for prescriptions you may take on an ongoing basis.

  To start using mail order:

  1. Ask your doctor to write a prescription for up to a 90-day supply, plus refills for up to one year, if appropriate.

  2. Complete the Pharmacy Mail Order Form and Health, Allergy & Medication Questionnaire. You can get these forms by calling Member Service or from your member website. After logging in, click on 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.

Health Care Management

Medical Management

Your benefits are subject to review by Highmark, or its designated agent, as part of its health care management program. This program is to help ensure that you receive:

- care that is medically necessary and appropriate; and
- health care services in a setting which best meets your individual treatment needs.

Highmark only pays for services which it determines to be medically necessary and appropriate. However, not all medically necessary and appropriate services are covered under this program.

Participating Providers

When you use a participating provider, ***the provider will contact Highmark*** when authorization for your care is required.

Non-Participating Providers

When you use a non-participating provider, ***you are responsible for contacting Highmark*** for any required authorizations. Your call to Highmark prior to receipt of care from a non-participating provider will help you know what your financial responsibility may be. You should call 7 to 10 days prior to your received services. For emergency or maternity-related admissions, call Highmark within 48 hours of your admission, or as soon as reasonably possible. You can contact Highmark via the toll-free Member Service number on the back of your ID card.

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

IMPORTANT: Non-participating 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 responsible. Please contact Highmark to avoid unnecessary out-of-pocket costs.

Precertification

Precertification review is conducted by Highmark or its designated agent to determine whether a planned (scheduled admission, outpatient surgery procedure, home care)

or unplanned (emergency or maternity-related admission) service request is medically necessary and appropriate and whether the requested treatment setting is the most appropriate for your care.

Precertification is required for the following inpatient services:

* Hospital admissions
* Inpatient rehabilitation admissions
* Substance abuse
* Psychiatric treatment
* Skilled nursing facility admissions

Depending on your benefit program, precertification may be required for the following services:

* Home health services
* Hospice services
* Outpatient surgery

Continued Stay Review

While you or your covered dependent are in a facility where continued stay is required as an inpatient, Highmark will be in contact with facility personnel familiar with your case to make certain that continued hospitalization is appropriate. Determination of the need for continued inpatient coverage will be made in consultation with your physician(s). Either Highmark or its designated agent, the facility or the provider will notify the patient if the inpatient stay is determined to be no longer medically necessary and appropriate. If you or your covered dependent elect to remain in the facility after such notification, no further benefits will be provided for the remainder of the stay.

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 or designated agent personnel will help plan for and coordinate your discharge to ensure that any continued care is delivered in the most medically appropriate and cost-effective setting.

Case Management

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 if you feel you need it be contacting Member Services at the telephone number listed on the back of your ID card.

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.

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 this 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
- Member Service toll-free number (on back of card)
- Precertification toll-free number (on back of card)

How to File a Claim

In most instances, hospitals and physicians will submit a claim on your behalf directly to Highmark. If your claim is not submitted directly by the provider, you must submit itemized bills along with a special claim form.

If you receive medications from a network pharmacy and present your ID card, you will be required to pay the agreed upon price to the network pharmacy. You will need to submit a claim form yourself.

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.

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; deductible and coinsurance amounts, if any, you are required to pay; total benefits payable; and the total amount you owe.

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

You have the right to:

1. Receive information about 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.

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.

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.

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.

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.

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.

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.

Participating Provider - A health care provider who has signed an agreement with Highmark regarding payment of benefits for covered services.

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

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 non-participating facility or professional provider or in-area non-contracting supplier is based on an adjusted contractual allowance for like services rendered by a participating facility or professional provider or contracting supplier 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 Out-of-Area Care section of this booklet.

The plan allowance for a non-participating 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 procedure or service.

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.

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

Classic Blue is a registered mark 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 your plan. Highmark's allowance will be accepted as full payment for covered services from these UPMC providers. Be sure to check the provider directory for the most up-to-date listing of participating providers.

Under the Consent Decree, Highmark's allowance for covered services may be accepted as full payment from non-participating UPMC providers under your plan but only in the circumstances described below:

Continued Care

If you are in a continuingcourse of treatment from a non-participating UPMC provider, you may opt to continue treatment with that UPMC provider. You will not be responsible for any greater out-of-pocket amounts than if covered services had been rendered by a participating provider.

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 pregancy 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 a non-participating UPMC provider that renders oncology services, you may choose to request treatment from that UPMC provider. You will not be responsible for any greater out-of-pocket amounts than if covered services had been rendered by a participating provider. 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 a non-participating UPMC provider, you may receive covered services from that UPMC provider. You will not be responsible for any greater out-of-pocket amounts than if covered services had been rendered by a participating provider.

Emergency Care Services

When emergency care services are received from a non-participating 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. You will not be responsible for any greater out-of-pocket amounts than if covered services had been rendered by a participating provider.

Other Services Received from Non-Participating Providers

In other situations not specifically described above, if you receive covered services from a non-participating UPMC provider, that UPMC provider will not accept Highmark's allowance as payment-in-full. However, non-participating 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

HIGHMARK