BLUE CROSS BLUE SHIELD

PPO PROGRAM

Franciscan University of Steubenville

Group 10310-00, 70

Effective January 1, 2014

Produced January, 2014

HIGHMARK

HIGHMARKBCBS.COM

Language Assistance Services Available for Multiple Languages

ENGLISH

Please Read This Important Message

It is important for you to understand all of the enclosed information about your health care coverage. This information includes rights you have and requirements you must meet to take full advantage of your health care benefits.

Language services are available to you, free of charge, upon request. Call the toll-free phone number on the back of your identification card for help.

SPANISH

Lea este importante mensaje

Es importante que comprenda toda la información adjunta sobre su cobertura de atención de salud. Esta información incluye los derechos con los que usted cuenta y los requisitos que debe cumplir para aprovechar al máximo los beneficios de atención de salud.

Si los solicita, se encuentran a su disposición servicios de idiomas gratuitos. Llame al número de teléfono gratuito en el reverso de su tarjeta de identificación.

VIETNAMESE

Xin Đọc Tin Nhắn QuanTrọng Này

Điều quan trọng là quý vị hiểu rõ tất cả các thông tin đính kèm về bảo hiểm sức khỏe của quý vị. Thông tin này bao gồm quyền lợi mà quý vị được và các đòi hỏi mà quý vị cần đáp ứng để tận dụng toàn bộ các quyền lợi chăm sóc sức khỏe của mình.

Quý vị sẽ được dịch vụ về ngôn ngữ miễn phí khi yêu cầu. Xin gọi số điện thoại miễn phí ghi ở phía sau thẻ ID của quý vị để được giúp đỡ.

RUSSIAN

Пожалуйста, ознакомьтесь с этой важной информацией

Очень важно, чтобы Вы хорошо понимали всю информацию, которая изложена в приложении и описывает Вашу программу страхового медицинского покрытия. В этой информации представлены права, которые Вам предоставлены, а также условия, которым Вы должны соответствовать, чтобы получить полный доступ к страховому медицинскому покрытию.

Вы имеете возможность воспользоваться языковыми услугами, которые предоставляются бесплатно и по требованию. Позвоните по бесплатному номеру телефона, указанному на обороте Вашей идентификационной карты, чтобы получить эту помощь.

ITALIAN

Leggere attentamente il presente messaggio

E' molto importante che comprenda perfettamente le informazioni allegate relative alla sua copertura sanitaria. Tali informazioni includono i diritti in suo possesso e i requisiti da soddisfare per usufruire dei vantaggi offerti dalla sua copertura sanitaria.

Sono disponibili servizi linguistici gratuiti su richiesta. Chiami il numero verde gratuito sul retro della sua tessera identificativa per un'ulteriore assistenza.

CHINESE (MANDARIN/SIMPLIFIED)

请阅读以下重要信息

理解随附的所有有关您的健康护理保赔的信息十分重要。该信息包括您享有的权利以及充分利用您的健康护理福利必须符合的要求。

可应您的请求免费向您提供语言服务。请拨印在您的会员卡背面的免费电话号码，获取帮助。

NOTICE

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Table of Contents

Introduction to Your PPO Program **1**

How Your Benefits Are Applied **3**
- Benefit Period 3
- Medical Cost-Sharing Provisions 3
- Maximum 5
- Prescription Drug Cost-Sharing Provisions 5
- Laws Affecting Program Benefits 5

Summary of Benefits **6**

Covered Services - Medical Program **10**
- Ambulance Service 10
- Anesthesia for Non-Covered Dental Procedures (Limited) 11
- Autism Spectrum Disorders 11
- Dental Services Related to Accidental Injury 12
- Diabetes Treatment 12
- Diagnostic Services 13
- Dr. Dean Ornish Program (For Reversing Heart Disease) 13
- Durable Medical Equipment 13
- Emergency Care Services 14
- Enteral Formulae 14
- Hearing Care Services 15
- Home Health Care/Hospice Care Services 15
- Home Infusion and Suite Infusion Therapy Services 16
- Hospital Services 16
- Maternity Services 18
- Medical Services 19
- Mental Health Care Services 21
- Orthotic Devices 22
- Pediatric Extended Care Services 22
- Preventive Care Services 23
- Private Duty Nursing Services 25
- Prosthetic Appliances 25
- Skilled Nursing Facility Services 25
- Spinal Manipulations 26
- Substance Abuse Services 26
- Surgical Services 26
- Therapy and Rehabilitation Services 28
- Transplant Services 29

Covered Services - Prescription Drug Program **31**
- Covered Drugs – Incentive Formulary 31

What Is Not Covered **33**

How Your PPO Program Works **42**

Network Care....42
Out-of-Network Care....42
Out-of-Area Care....42
Inter-Plan Programs....43
The BlueCard Worldwide Program....45
Your Provider Network....46
How to Get Your Physicians' Professional Qualifications....46
Eligible Providers....46
Network Pharmacies....48

Healthcare Management....49
Medical Management....49
Care Utilization Review Process....49
Prescription Drug Management....51
Precertification, Preauthorization and Pre-Service Claims Review Processes....52

General Information....54
Who is Eligible for Coverage....54
Changes in Membership Status....55
Medicare....55
Leave of Absence or Layoff....56
Continuation of Coverage....56
Conversion....56
Certificates of Creditable Coverage....57
Termination of Your Coverage Under the Employer Contract....57
Benefits After Termination of Coverage....58
Coordination of Benefits....59
Subrogation....60

A Recognized Identification Card....61

How to File a Claim....62
Your Plan Activity Statement....63
Using the Mail Service Pharmacy Benefit....64
Additional Information on How to File a Claim....64
Determinations on Benefit Claims....65
Appeal Procedure....66
Autism Spectrum Disorders Expedited Review and Appeal Procedures....67

Member Service....69
Blues On Call....69
myCare Navigator....70
Highmark Web Site....70
Baby BluePrints....71
Member Service....72

Member Rights and Responsibilities....73
How We Protect Your Right to Confidentiality....73

Terms You Should Know....75

Notice of Privacy Practices 83

This Booklet is not a Contract

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

Introduction to Your PPO Program

This booklet provides you with the information you need to understand your Highmark Blue Cross Blue Shield PPO program. We encourage you to take the time to review this information so you understand how your health care program works.

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

- ***Your PPO program gives you freedom of choice.*** You are not required to select a primary care physician to receive covered care. You have access to a large provider network of physicians, hospitals, and other providers throughout the country. For a higher level of coverage, you need to receive care from one of these network providers. However, you can go outside the network and still receive care at the lower level of coverage. To locate a network provider near you, or to learn whether your current physician is in the network, call 1-800-810-BLUE (2583), log onto www.bcbs.com, or log onto Highmark's Web site, www.highmarkbcbs.com.

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

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

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

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

Information for Non-English-Speaking Members

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

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

How Your Benefits Are Applied

To help you understand your coverage and how it works, here's an explanation of some benefit terms found in your Summary of Benefits.

Benefit Period

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

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

Medical Cost-Sharing Provisions

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

Coinsurance

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

Copayment

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

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

Deductible

The deductible is a specified dollar amount you must pay for covered services each benefit period before the program begins to provide payment for benefits. See the Summary of Benefits for the deductible amount. You may be required to pay any applicable deductible at the time you receive care from a provider.

If your group changes group health care expense coverage during your benefit period, the amount you paid toward your deductible during the last partial benefit period for

services covered under the prior Highmark coverage will be applied to the network and out-of-network deductible of the initial benefit period under this program.

Family Deductible

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

Out-of-Pocket Limit

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

Family Out-of-Pocket Limit

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

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

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

Maximum

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

Prescription Drug Cost-Sharing Provisions

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

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

Coinsurance

The coinsurance is the specific percentage of the provider's allowable price for covered medications that is your responsibility. See your Summary of Benefits for coinsurance amounts.

Minimum/Maximum Member Liability for Drug Coinsurance

You are responsible for a percentage of the provider's allowable price of every covered prescription drug. However, your program includes a maximum member liability amount for each covered prescription drug to limit your liability on very expensive prescription drugs, and a minimum member liability amount for each covered prescription drug that will establish your responsibility on less expensive prescription drugs. Your minimum coinsurance obligation is the amount specified in the Summary of Benefits, or the cost of the covered prescription drug, whichever is lower.

Here is how it works. Consider a 20% coinsurance with a $15 minimum and a $50 maximum. If your prescription costs less than $15, you will pay the actual cost of the prescription. If your prescription costs between $15 and $75, you will pay $15 since 20% of $75 is $15 and that is the minimum coinsurance. If your prescription costs between $75 and $250, you will pay 20% of the actual prescription cost.

The maximum member liability amount for coinsurance is the highest coinsurance amount that is your responsibility. Therefore, if your prescription costs more than $250, you will pay $50 (since 20% of $250 is $50 and that is a maximum amount you will pay for coinsurance for each prescription drug).

Laws Affecting Program Benefits

Employees in certain states may be subject to state and federal laws which impact health insurance coverage. The benefits of this program will be modified to reflect the provision of such laws.

Summary of Benefits

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

Benefits	Network	Out-of-Network
General Provisions		
Benefit Period	Calendar Year	
Deductible (per benefit period) Individual Family	 $500 $1,000	 $500 $1,000
Plan Payment Level - Based on the plan allowance	100% after deductible	80% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limits Individual Family	 None None	 $2,000 $4,000
Autism Spectrum Disorders maximum (per member) [1]	$40,000 maximum per benefit period (includes prescription drug expenses)	
Lifetime Maximum (per member)	Unlimited	
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after $20 copayment; deductible does not apply	80% after deductible
Primary Care Physician Office Visits[2 3]	100% after $15 copayment; deductible does not apply	80% after deductible
Specialist Office Visits[2] (including virtual visits)	100% after $20 copayment; deductible does not apply	80% after deductible
Virtual Visit Originating Site Fee[2]	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $20 copayment; deductible does not apply	80% after deductible
Preventive Care Services[4]		
Adult		
Routine physical exams	100% after $15 copayment; deductible does not apply	80% after deductible
Adult Immunizations	100%; deductible does not apply	80% after deductible
Diagnostic services and procedures	100% after deductible	80% after deductible
Routine gynecological exams, including a PAP Test	100% after $15 copayment; deductible does not apply	80%; deductible does not apply
Mammograms, annual routine and medically necessary	100%; deductible does not apply	80% after deductible
Colorectal Cancer Screening	100% after deductible	80% after deductible
Pediatric		
Routine physical exams	100% after $15 copayment; deductible does not apply	80% after deductible
Pediatric immunizations	100%; deductible does not apply	80%; deductible does not apply
Diagnostic services and procedures	100% after deductible	80% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Services - Inpatient	100% after deductible	80% after deductible
Hospital Services - Outpatient[5]	100% after deductible	80% after deductible
Maternity (non-preventive facility and professional services)	100% after deductible	80% after deductible
Medical/Surgical Expenses (except office visits)	100% after deductible	80% after deductible

Benefits	Network	Out-of-Network
Emergency Services		
Emergency Room Services	100% after $50 copayment (waived if admitted as an inpatient); deductible does not apply	Same as network services
Ambulance	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Infusion Therapy	100% after deductible	80% after deductible
Occupational Therapy, Physical Medicine, and Speech Therapy	100% after $20 copayment; deductible does not apply	80% after deductible
	Combined Occupational Therapy, Physical Medicine, and Speech Therapy visit limit: 60 per benefit period	
Radiation Therapy	100% after deductible	80% after deductible
Respiratory Therapy	100% after deductible	80% after deductible
Spinal Manipulations	100% after $20 copayment; deductible does not apply	80% after deductible
	Combined Limit: 20 visits per benefit period	
Other Therapy Services (Cardiac Rehabilitation, Chemotherapy, and Dialysis Treatment)	100% after deductible	80% after deductible
Mental Health/Substance Abuse Services		
Mental Health Care Services - Inpatient	100% after deductible	80% after deductible
Mental Health Care Services - Outpatient	100%; deductible does not apply	80% after deductible
Substance Abuse Services - Inpatient Detoxification	100% after deductible	80% after deductible
Substance Abuse Services - Inpatient Residential Treatment and Rehabilitation Services	100% after deductible	80% after deductible
Substance Abuse Services - Outpatient	100%; deductible does not apply	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Anesthesia for Non-Covered Dental Procedures (Limited)	100% after deductible	80% after deductible
Applied Behavior Analysis for Autism Spectrum Disorders (ASD)[1]	100% after deductible	80% after deductible
Assisted Fertilization Treatment	Not Covered	
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diabetes Treatment	100% after deductible	80% after deductible
Diagnostic Services (Lab, x-ray, allergy testing and other diagnostic medical tests)	100% after deductible	80% after deductible
Dr. Dean Ornish Program For Reversing Heart Disease[6]	100% after deductible	Same as network services
	Maximum of one enrollment per lifetime	
Durable Medical Equipment	100% after deductible	80% after deductible
Enteral Formulae	100%; deductible does not apply	80%; deductible does not apply
Hearing Care Services (Routine Hearing Screening)	100% after $15 copayment; deductible does not apply	80% after deductible
Home Infusion and Suite Infusion Therapy Services	100% after deductible	80% after deductible
Home Health Care[7]	100% after deductible	80% after deductible

Benefits	Network	Out-of-Network
Hospice	100% after deductible	80% after deductible
	Combined Limit: 90 inpatient days per benefit period	
Infertility Counseling, Testing and Treatment[8]	100% after deductible	80% after deductible
Orthotics	100% after deductible	80% after deductible
Pediatric Extended Care Services	100% after deductible	80% after deductible
	Combined Limit: 100 days per benefit period	
Private Duty Nursing	100% after deductible	80% after deductible
Prosthetics	100% after deductible	80% after deductible
Skilled Nursing Facility Care	100% after deductible	80% after deductible
	Combined Limit: 120 days per benefit period	
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements	Yes[9]	

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

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

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

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

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

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

6 The program may be subject to class size limits and is only offered at selected sites. Therefore, the availability of a Dr. Dean Ornish participating provider within a particular geographic area may be limited.

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

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

9 Highmark must be contacted prior to a planned inpatient admission or within 48 hours of an emergency inpatient admission. Some facility providers will contact Highmark and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Highmark for precertification. If not, you are responsible for contacting Highmark. 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 Mandatory Generic[1]	**Retail Pharmacy** Up to 34-day supply	**Maintenance Prescription Drugs through Mail Order** Up to 90-day supply
Pharmacy Network	Premier 2012	Express Scripts Pharmacy
Generic Prescription Drug	20% coinsurance - based on the provider's allowable price	20% coinsurance - based on the provider's allowable price
Brand Formulary Prescription Drug[2]	20% coinsurance - based on the provider's allowable price	20% coinsurance - based on the provider's allowable price
Brand Non-Formulary Prescription Drug	20% coinsurance - based on the provider's allowable price	20% coinsurance - based on the provider's allowable price
Minimum/Maximum Coinsurance		
Minimum Generic Coinsurance	$5 payment per prescription	$10 payment per prescription
Minimum Brand Formulary Coinsurance	$25 payment per prescription	$50 payment per prescription
Minimum Brand Non-Formulary Coinsurance	$50 payment per prescription	$100 payment per prescription
Maximum Generic Coinsurance	$100 payment per prescription	$200 payment per prescription
Maximum Brand Formulary Coinsurance	$100 payment per prescription	$200 payment per prescription
Maximum Brand Non-Formulary Coinsurance	$100 payment per prescription	$200 payment per prescription

1 You are responsible for the payment differential when a generic drug is available and the doctor or patient specifies a brand name drug. Your payment is the price difference between the brand drug and generic drug in addition to the brand drug copayment or coinsurance amounts which may apply.

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

Covered Services - Medical Program

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

Ambulance Service

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

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

Local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

- from a hospital to your home, or
- from a skilled nursing facility to your home.

Anesthesia for Non-Covered Dental Procedures (Limited)

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

Autism Spectrum Disorders

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

Diagnostic Assessment of Autism Spectrum Disorders

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

Treatment of Autism Spectrum Disorders

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

Treatment may include the following medically necessary and appropriate services:

Pharmacy care

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

Psychiatric and psychological care

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

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

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

Dental Services Related to Accidental Injury

Dental services rendered by a physician immediately following an accidental injury to sound natural teeth. Follow-up services, if any, that are provided after the initial treatment to sound natural teeth are not covered. Injury as a result of chewing or biting shall not be considered an accidental injury.

Diabetes Treatment

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

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

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

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 electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by Highmark
- Allergy testing consisting of percutaneous, intracutaneous, and patch tests

Dr. Dean Ornish Program (For Reversing Heart Disease)®

- The Dr. Dean Ornish Program (For Reversing Heart Disease) is a comprehensive lifestyle modification program which emphasizes nutritional counseling, therapeutic exercise, stress management techniques, and regular participation in a professionally supervised support group, on an outpatient basis. It is designed to assist you in the management of coronary artery disease and/or to address key risk factors associated with the onset and progression of coronary artery disease.
- The program requires a minimum one year participation commitment and must be provided by a Dr. Dean Ornish participating provider.
- Coverage will be provided if you meet the specific benefit eligibility criteria and receive the approval of your attending physician.
- Coverage is limited to a one time enrollment in the program per lifetime, regardless of whether you complete the program.
- The program may be subject to class size limits and is only offered at selected sites. Therefore, the availability of a Dr. Dean Ornish participating provider within a particular geographic area may be limited.

Durable Medical Equipment

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

Emergency Care Services

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

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

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

Once the crisis has passed, call your physician to receive appropriate follow-up care.

Emergency care services are services and supplies, including drugs and medicines, for the outpatient emergency treatment of bodily injuries resulting from an accident or a medical condition. Also included is a medical screening examination and ancillary services necessary to evaluate such injury or emergency medical condition and further medical examination and treatment as required to stabilize the patient.

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

Enteral Formulae

Enteral formulae is a liquid source of nutrition administered under the direction of a physician that may contain some or all of the nutrients necessary to meet minimum daily nutritional requirements and is administered into the gastrointestinal tract either orally or through a tube.

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

Additional coverage for enteral formulae is provided when administered on an outpatient basis, when medically necessary and appropriate for your medical condition, when considered to be your sole source of nutrition and:

- when provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulae; or
- when provided orally and identified as one of the following types of defined formulae:

  – with hydrolyzed (pre-digested) protein or amino acids; or

  – with specialized content for special metabolic needs; or

  – with modular components; or

  – with standardized nutrients.

Once it is determined that you meet the above criteria, coverage for enteral formulae will continue as long as it represents at least 50% of your daily caloric requirement.

Additional coverage for enteral formulae <u>excludes</u> the following:

- Blenderized food, baby food, or regular shelf food when used with an enteral system
- 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
- Normal food products used in the dietary management of rare hereditary genetic metabolic disorders

Hearing Care Services

Benefits include coverage for an audiometric examination and, when prescribed by a professional provider.

Home Health Care/Hospice Care Services

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

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

No home health care/hospice benefits will be provided for:

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

Home Infusion and Suite Infusion Therapy Services

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

Hospital Services

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

Inpatient Services

Bed and Board

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

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

Ancillary Services

Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms and equipment;
- drugs and medicines provided to you while you are an inpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives;
- anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;
- medical and surgical dressings, supplies, casts and splints;
- diagnostic services; or
- therapy and rehabilitation services.

Outpatient Services

Ancillary Services

Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms and equipment;
- drugs and medicines provided to you while you are an outpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives;
- anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the

attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;

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

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

If you think you are pregnant, you may contact your physician or go to a network obstetrician or nurse midwife. When your pregnancy is confirmed, you may continue to receive follow-up care which includes prenatal visits, medically necessary and appropriate sonograms, delivery, postpartum and newborn care in the hospital.

Hospital, medical and surgical services rendered by a facility provider or professional provider for:

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

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

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

Maternity Home Health Care Visit

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

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

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

Medical Services

Inpatient Medical Services

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

Concurrent Care

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

Consultation

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

Inpatient Medical Care Visits

Benefits are provided for inpatient medical care visits.

Intensive Medical Care

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

Routine Newborn Care

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

Outpatient Medical Care Services (Office Visits)

Medical care rendered by a professional provider when you are an outpatient for a condition not related to surgery, pregnancy or mental illness, except as specifically provided. Benefits include medical care visits and consultations for the examination, diagnosis and treatment of an injury or illness.

Please note that as a Highmark member, you enjoy many convenient options for where you can receive outpatient care:

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

A specialist virtual visit is a real-time office visit with a specialist at a remote location, conducted via interactive audio and streaming video telecommunications. Benefits are provided for a specialist virtual visit which is subsequent to your initial visit with your treating specialist for the same condition. The provider-based location from which you communicate with the specialist is referred to as the "originating site". Benefits will not be provided for a specialist virtual visit if the visit is related to the treatment of mental illness or substance abuse. (The specialist virtual visit is subject to availability within your service area.)

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

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

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

Mental Health Care Services

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

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

Inpatient Facility Services
Inpatient hospital services provided by a facility provider for the treatment of mental illness.

Inpatient Medical Services
Covered inpatient medical services provided by a professional provider:

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

Partial Hospitalization Mental Health Care Services
Benefits are only available for mental health care services provided on a partial hospitalization basis when received through a partial hospitalization program. A

mental health care service provided on a partial hospitalization basis will be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.

Outpatient Mental Health Care Services

Inpatient facility service and inpatient medical benefits (except room and board) provided by a facility provider or professional provider as described above, are also available when you are an outpatient.

Serious Mental Illness Care Services

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

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

Orthotic Devices

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

Pediatric Extended Care Services

Benefits are provided for care received from a pediatric extended care facility that is licensed by the state and is primarily engaged in providing basic non-residential services to infants and/or young children who have complex medical needs requiring skilled nursing and therapeutic care and who may be technologically dependent.

Services rendered by a pediatric extended care facility pursuant to a treatment plan for which benefits may include one or more of the following:

- Skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN)
- Physical medicine, speech therapy and occupational therapy
- Respiratory therapy
- Medical and surgical supplies provided by the pediatric extended care facility
- Acute health care support

- Ongoing assessments of health status, growth and development

Pediatric extended care services will be covered for children eight years of age or under, pursuant to the attending physician's treatment plan only when provided in a pediatric extended care facility, and when approved by Highmark.

A prescription from the child's attending physician is necessary for admission to such facility.

No benefits are payable after the child has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care.

Preventive Care Services

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

Adult and Pediatric Care

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

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.

Routine Gynecological Examination and Pap Test

All female members, regardless of age, are covered for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine

Papanicolaou smear (pap test) per calendar year. Benefits are not subject to program deductibles or maximums.

Mammographic Screening

Benefits are provided for the following:

- An annual routine mammographic screening for all female members 40 years of age or older.
- Mammographic examinations for all female members regardless of age when such services are prescribed by a physician.

Benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified.

Pediatric Immunizations

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

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 laboratory and pathology 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, surgical screening tests and diagnostic 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.

Private Duty Nursing Services

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

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

Prosthetic Appliances

Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues, or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered.

Skilled Nursing Facility Services

Services rendered in a skilled nursing facility to the same extent benefits are available to an inpatient of a hospital.

No benefits are payable:

- after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care;

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

Spinal Manipulations

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

Substance Abuse Services

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

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

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

Surgical Services

This program covers the following services you receive from a professional provider. See the Healthcare Management section for additional information which may affect your benefits.

Anesthesia

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

Assistant at Surgery

Services of a physician who actively assists the operating surgeon in the performance of covered surgery. Benefits will be provided for an assistant at surgery only if a house staff member, intern or resident is not available.

Second Surgical Opinion

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

Keep in mind that:

- the second opinion consultant must not be the physician who first recommended elective surgery;
- elective surgery is covered surgery that may be deferred and is not an emergency;
- use of a second surgical opinion is at your option;
- if the first opinion for elective surgery and the second opinion conflict, then a third opinion and directly related diagnostic services are covered services; and
- if the consulting opinion is against elective surgery and you decide to have the elective surgery, the surgery is a covered service. In such instance, you will be eligible for a maximum of two such consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

Special Surgery

- Oral surgery

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

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

  – Extraction of teeth in preparation for radiation therapy

  – Mandibular staple implant, provided the procedure is not done to prepare the mouth for dentures

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

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

- Accidental injury to the jaw or structures contiguous to the jaw except teeth
- The correction of a non-dental physiological condition which has resulted in a severe functional impairment
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth
- Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus

- Mastectomy and Breast Cancer Reconstruction

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

  - All stages of reconstruction of the breast on which the mastectomy has been performed
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance
  - Prostheses; and
  - Treatment of physical complications of mastectomy, including lymphedema

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

Surgery

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

Therapy and Rehabilitation Services

This program covers the following services when such services are ordered by a physician:

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

Transplant Services

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

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

- when both the recipient and the donor are members, each is entitled to the benefits of their program;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this program subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Cross or Blue Shield coverage or any government program; and 2) benefits provided to the donor will be charged against the recipient's coverage under this program to the extent that benefits remain and are available under this program after benefits for the recipient's own expenses have been paid;
- when only the donor is a member, the donor is entitled to the benefits of this program, subject to the following additional limitations: 1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this program; and 2) no benefits will be provided to the non-member transplant recipient; and

- if any organ, tissue or blood stem cell is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the member recipient's program limit.

Covered Services - Prescription Drug Program

Prescription drugs are covered when you purchase them through the pharmacy network applicable to your program. 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*.

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

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

Covered Drugs – Incentive Formulary

Covered drugs include:

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

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

To receive a copy of the formulary, call your toll-free Member Service number. You can also look up the formulary via Highmark's Web site, www.highmarkbcbs.com.

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

What Is Not Covered

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

Key Word	Exclusion
Abortion	• For Abortion
Allergy Testing	• For allergy testing, except as provided herein.
Ambulance	• For ambulance services, except as provided herein.
Assisted Fertilization	• Related to treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization.
Comfort/Convenience Items	• For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider.
Contraceptive Medications, Devices and Implants	• For contraceptive services, including contraceptive prescription drugs, contraceptive devices, implants and injections, and all related services.
Cosmetic Surgery	• For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise provided herein. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; b) surgery to correct a congenital birth defect; and c) surgery to correct a functional impairment which results from a covered disease or injury.
Court Ordered Services	• For otherwise covered services ordered by a court or other tribunal as part of your or your dependent's sentence.
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 expenses related to 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 of coverage.
Enteral Formulae	• For the following services associated with the additional enteral formulae benefits provided under your program: blenderized food, baby food, or regular shelf food when used with an enteral system; 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; normal food products used in the dietary management of rare hereditary genetic metabolic disorders.
Experimental/ Investigative	• Which are experimental/investigative in nature.
Eyeglasses/Contact Lenses	• For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury).
Felonies	• For any illness or injury you suffer during your commission of a felony, as long as such illness or injuries are not the result of a medical condition or an act of domestic violence.
Foot Care	• For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses,

	toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
Healthcare Management program	• For any care, treatment, prescription drug or service which has been disallowed under the provisions of Healthcare Management program.
Home Health Care	• For the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: dietitian services; homemaker services; maintenance therapy; dialysis treatment; custodial care; food or home-delivered meals.
Immunizations	• For immunizations required for foreign travel or employment.
Inpatient Admissions	• For inpatient admissions which are primarily for diagnostic studies.
	• For inpatient admissions which are primarily for physical medicine services.
Learning Disabilities	• For any care that is related to conditions such as hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation, but not including care related to autism spectrum disorders, which extends beyond traditional medical management or for inpatient confinement for environmental change. Care which extends beyond traditional medical management or for inpatient confinement for environmental change includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services provided for purposes of behavioral modification and/or training; d) services related to the treatment of learning disorders or learning disabilities; e) services provided primarily for social or environmental change or for respite care; f) developmental

	or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the member has not yet attained; and g) services provided for which, based on medical standards, there is no established expectation of achieving measurable, sustainable improvement in a reasonable and predictable period of time.
	• For any care that is related to autism spectrum disorders which extends beyond traditional medical management, except as otherwise provided herein. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing); except for specific evaluation purposes directly related to medical treatment; and c) services provided primarily for respite care.
Legal Obligation	• For which you would have no legal obligation to pay.
Medically Necessary and Appropriate	• Which are not medically necessary and appropriate as determined by Highmark.
Medicare	• To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program and you elect this coverage as primary.
Methadone Hydrochloride	• For methadone hydrochloride treatment for which no additional functional progress is expected to occur.
Military Service	• To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.
Miscellaneous	• For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
	• For any other medical or dental service or treatment or

	prescription drug except as provided herein.
Motor Vehicle Accident	• For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.
Nutritional Counseling	• For nutritional counseling, except as provided herein.
Obesity	• For treatment of obesity, except for medical and surgical treatment of morbid obesity or as provided herein.
Oral Surgery	• For oral surgery procedures, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, except as provided herein.
Physical Examinations	• For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein.
Prescription Drugs (Medical Program)	• For prescription drugs which were paid or are payable under a freestanding prescription drug program.
Preventive Care Services	• For preventive care services, wellness services or programs, except as provided herein.
Provider of Service	• Which are not prescribed by or performed by or upon the direction of a professional provider.
	• Rendered by other than ancillary providers, facility providers or professional providers.
	• Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.
	• Which are submitted by a certified registered nurse and another professional provider for the same services

	performed on the same date for the same 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.
Respite Care	• For respite care.
Sexual Dysfunction	• For treatment of sexual dysfunction that is not related to organic disease or injury.
Skilled Nursing	• For skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness.
Smoking (nicotine) Cessation	• For nicotine cessation support programs and/or classes.
Sterilization	• For sterilization and reversal of sterilization, except as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
Termination Date	• Incurred after the date of termination of your coverage except as provided herein.
Therapy	• For outpatient therapy and rehabilitation 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, unless medically necessary and appropriate.
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 the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.
War	• For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.
Weight Reduction	• For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
Well-Baby Care	• For well-baby care visits, except as provided herein.
Workers' Compensation	• For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.

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

Prescription Drugs (Drug Program)	• Services of your attending physician, surgeon or other medical attendant; • Prescription drugs dispensed for treatment of an illness or an injury for which the group is required by law to furnish hospital care in whole or in part–including, but not limited to–state or federal workers' compensation laws, occupational disease laws and other employer liability laws. • Prescription drugs to which you are entitled, with or without charge, under a plan or program of any government or governmental body. • Charges for therapeutic devices or appliances (e.g., support

garments and other non-medicinal substances).

- Charges for administration of prescription drugs and/or injectable insulin, whether by a physician or other person.
- Any charges by any pharmacy provider or pharmacist except as provided herein.
- Any drug or medication except as provided herein.
- Any amounts you are required to pay directly to the pharmacy for each prescription or refill.
- Charges for a prescription drug when such drug or medication is used for unlabeled or unapproved indications and where such use has not been approved by the Food and Drug Administration (FDA).
- Drugs and supplies that are not medically necessary and appropriate or otherwise excluded herein.
- Any amounts above the deductible, coinsurance, copayment or other cost-sharing amounts for each prescription order or refill that are your responsibility.
- 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 which does not meet the definition of covered maintenance prescription drug.
- For contraceptive prescription drugs except when prescribed for purposes other than birth control or except as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
- Fertility drugs.
- Pharmacological or hormonal treatment used in conjunction with assisted fertilization.
- Weight control drugs.
- Prescription vitamins, except vitamins prescribed during pregnancy and fluoride legend vitamins.

- Impotency treatment drugs.
- Oral impotency drugs.
- Hair growth stimulants.
- Food supplements.
- Immunizations/biologicals.
- Any drugs used to abort a pregnancy.
- Blood products.
- Antihemophilia drugs.
- Any drugs prescribed for cosmetic purposes only.
- Any prescription drug which has been disallowed under the Prescription Drug Management section of this booklet.
- Any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes.
- Any drugs which are experimental/investigative.
- Any drugs and supplies which can be purchased without a prescription order, including but not limited to blood glucose monitors and injection aids, unless specifically described as provided herein.
- Any prescription drugs or supplies purchased at a non-participating pharmacy provider, except in connection with emergency care described herein.
- Any prescription drug purchased through mail order but not dispensed by a designated mail order pharmacy provider.
- Any selected diagnostic agents.

How Your PPO Program Works

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

Network Care

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

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

Out-of-Network Care

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

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

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

When you receive care from an out-of-network provider, coverage is almost always paid at the lower level - *even if you are directed to an out-of-network provider by a network provider*. **That's why it is critical - in all cases - that you check to see that your provider is in the network before you receive care.**

Out-of-Area Care

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

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

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

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

Inter-Plan Programs

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 Programs." 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 Programs and presented to Highmark for payment in accordance with the rules of the Inter-Plan Programs policies then in effect.

Typically, members, when accessing care outside the geographic area Highmark serves, should obtain care from health care providers that have a contractual agreement (i.e., are "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 non-participating health care providers. Highmark's payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when members access covered services within the geographic area served by a Host Blue, Highmark will remain responsible to the group for fulfilling Highmark's contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for contracting with and handling substantially all interactions with its participating health care providers.

Whenever members access covered services outside the area Highmark serves and the claim is processed through the BlueCard Program, the amount members pay for covered services is calculated based on the **lower** of:

- The billed charges for covered services, or
- The negotiated price that the Host Blue makes available to Highmark.

Often, this "negotiated price" will be a simple discount which reflects the actual price that the Host Blue pays to the member's health care provider. Sometimes, it is an estimated price that takes into account special arrangements with the health care provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modification noted above. However, such adjustments will not affect the price Highmark uses for the claim because these adjustments will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to the calculation. If any state laws mandate other liability calculation methods including a surcharge, Highmark would then calculate member liability for any covered services according to applicable law.

Negotiated National Account Arrangements

As an alternative to the BlueCard Program, a member's claims for covered services may be processed through a negotiated national account arrangement with a Host Blue.

If Highmark has arranged for a Host Blue to make available a custom health care provider network in connection with this contract, then the terms and conditions set forth in Highmark's negotiated national account arrangements with such Host Blue shall apply.

Member liability calculation will be based on the lower of either billed covered charges or negotiated price made available to Highmark by the Host Blue that allows members access to negotiated participation agreement networks of specified participating health care providers outside of the geographic area Highmark serves.

Non-Participating Health Care Providers Outside of the Geographic Area Highmark Serves

Member Liability Calculation
When covered services are provided outside of the geographic area Highmark serves by non-participating health care providers, the amount a member pays for such services will generally be based on the Host Blue's non-participating health care provider local payment unless otherwise specified under the terms of this contract or as required by applicable state law. In these situations, the member may be responsible for the difference between the amount that the non-participating health care provider bills and the payment Highmark will make for the covered services as set forth in this paragraph.

Exceptions
In some exception cases, Highmark may pay claims from non-participating health care providers outside of the geographic area Highmark serves based on a case-specific negotiated rate in situations where, for example, a member did not have reasonable access to a participating provider, as determined by Highmark in Highmark's sole and absolute discretion or by applicable state law. 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 the payment Highmark will make for the covered services as set forth in this paragraph.

The BlueCard Worldwide® Program

Your coverage also travels abroad. The Blue Cross and Blue Shield symbols on your ID card are recognized around the world. That is important protection. Your PPO program provides all of the services of the BlueCard Worldwide Program. These services include access to a worldwide network of health care providers. Medical Assistance services are included as well. You can access these services by calling 1-800-810-BLUE or 804-673-1177 (collect) or by logging onto www.bcbs.com.

Services may include:

- making referrals and appointments for you with nearby physicians and hospitals;
- verbal translation from a multilingual service representative;
- providing assistance if special medical help is needed;
- making arrangements for medical evacuation services;
- processing inpatient hospitalization claims; and

- for outpatient or professional services received abroad, you should pay the provider, then complete an international claim form and send it to the BlueCard Worldwide Service Center. Claim forms can be obtained by calling 1-800-810-BLUE or 804-673-1177 (collect) or the Member Service telephone number on your ID card. Claim forms can also be downloaded from www.bcbs.com.

Your Provider Network

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

To determine if your current provider is in the network or to locate the provider nearest you, call 1-800-810-BLUE (2583), log onto www.bcbs.com or log onto www.highmarkbcbs.com.

Please note that while you or a family member can use the services of any network physician or specialist and receive the maximum coverage under your benefit program, you are encouraged to select a personal or primary care physician. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal physician can help you select an appropriate specialist and work closely with that specialist when the need arises.

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

How to Get Your Physicians' Professional Qualifications

To view board certification information, hospital affiliation or other professional qualifications of your PCP or network specialist, visit your member Web site at www.highmarkbcbs.com. and click on "Find Providers". Type in your zip code and choose the type of professional. Click on the physician's name to view credentials and hospital affiliation. Or call a Member Service Representative at the telephone number printed on your ID card.

Eligible Providers

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

Facility Providers

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

Professional Providers

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

- Teacher of hearing impaired

Ancillary Providers:

- Ambulance service
- Clinical laboratory
- Home infusion and suite infusion therapy provider
- Suppliers

Contracting Suppliers (for the sale or lease of):

- Durable medical equipment
- Supplies
- Orthotics
- Prosthetics

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

Network 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 that the pharmacy receives by phone from your physician or dentist may also be covered.) You should request and retain a receipt for any amounts you have paid if needed for income tax or any other purpose.

- **Mail Suppliers:** Network pharmacies also include Mail Service suppliers designated by Highmark. Prescriptions that you take on an ongoing basis may be ordered through our mail service pharmacy for added savings and convenience. To order your prescription through our mail service pharmacy, ask your doctor to prescribe your medication for up to the maximum days allowed under your program, plus refills if appropriate. For a description on how to obtain your medication, see the How to File a Claim section of this benefit booklet.

Healthcare Management

Medical Management

For your benefits to be paid under your program, at either the network or out-of-network level, services and supplies must be considered medically necessary and appropriate.

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

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

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

You should call 7 to 10 days prior to your planned admission. For emergency admissions, call Highmark within 48 hours of the admission, or as soon as reasonably possible. You can contact Highmark via the toll-free Member Service telephone number located on the back of your ID card.

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

Care Utilization Review Process

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

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

After receiving the request for care, Highmark:

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

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

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

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

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

Case Management Services
Case Management is a voluntary program in which a case manager, with input from you and your health care providers, assists when you are facing and/or recovering

from a hospital admission, dealing with multiple medical problems or facing catastrophic needs. Highmark case managers can provide educational support, assist in coordinating needed health care services, put you in touch with community resources, assist in addressing obstacles to your recovery such as benefit and caregiver issues and answer your questions.

Highmark case managers are a free resource to all Highmark members. If you have an inpatient hospital admission, you may be contacted as part of our Outreach program. If your claims history indicates that your needs appear to be more complex, you may be contacted by a case manager from our Complex program. In either case, you are always free to call and request case management if you feel you need it by contacting Member Services at the telephone number listed on the back of your ID card.

Prescription Drug Management

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

Quantity Level Limits

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

Managed Prescription Drug Coverage

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

Preauthorization

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

Precertification, Preauthorization and Pre-Service Claims Review Processes

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

– ***Authorized Representatives***

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

– ***Decisions Involving Requests for Precertification and Other Non-Urgent Care Pre-Service Claims***

You will receive written notice of any decision on a request for precertification or other pre-service claim, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed 15 days from the date Highmark receives your claim. However, this 15-day period of time may be extended one time by Highmark for an additional 15 days, provided that Highmark determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 15-day pre-service claim determination period. If an extension of time is necessary because you failed to submit information necessary for Highmark to make a decision on your pre-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your pre-service claim.

– ***Decisions Involving Urgent Care Claims***

If your request involves an urgent care claim, Highmark will make a decision on your request as soon as possible, taking into account the medical exigencies involved. You will receive notice of the decision that has been made on your urgent care claim not later than 72 hours following receipt of your claim.

If Highmark determines in connection with an urgent care claim that you have not provided sufficient information to determine whether or to what extent benefits are provided under your coverage, you will be notified within 24 hours following

Highmark's receipt of your claim of the specific information needed to complete your claim. You will then be given not less than 48 hours to provide the specific information to Highmark. Highmark will thereafter notify you of its determination on your claim as soon as possible but not later than 48 hours after the earlier of (i) its receipt of the additional specific information, or (ii) the date Highmark informed you that it must receive the additional specific information.

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

– ***Notices of Determination Involving Precertification Requests and Other Pre-Service Claims***

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

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

General Information

Who is Eligible for Coverage

You may enroll your:

- Spouse under a legally valid existing marriage between persons of the opposite sex
- Children under 26 years of age, unless otherwise extended pursuant to applicable state or federal law, including:
  - Newborn children
  - Stepchildren
  - Children legally placed for adoption
  - Legally adopted children and children for whom the employee or the employee's spouse is the child's legal guardian
  - Children awarded coverage pursuant to an order of court

  An eligible dependent child's coverage automatically terminates and all benefits hereunder cease at the end of the month the dependent reaches the limiting age or ceases to be an eligible dependent as indicated above, whether or not notice to terminate is received by Highmark.

- Unmarried children over age 26 who are not able to support themselves due to mental retardation, physical disability, mental illness or developmental disability that started before age 26. Highmark may require proof of such disability from time to time. Coverage automatically terminates and all benefits hereunder cease, except as otherwise indicated, on the day following the date on which the disability ceases, whether or not notice to terminate is received by Highmark.

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. They 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 30 or more consecutive days, or be a member of the Pennsylvania National Guard ordered to active state duty for a period of 30 or more consecutive days. If they become a full-time student for the first term or semester starting 60 or more days after their release

from active duty, they shall be eligible for coverage as a dependent past the limiting age for a period equal to the duration of their 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 15 or more credit hours per semester, or, if less than 15 credit hours per semester, the number of credit hours deemed by the school to constitute full-time student status.

To be eligible for dependent coverage, proof that dependents meet the above criteria may be required.

Changes in Membership Status

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

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

Medicare

Covered Active Employees Age 65 or Over

If you are age 65 or over and actively employed in a group with 20 or more employees, you will remain covered under the program for the same benefits available to employees under age 65. As a result:

- the program will pay all eligible expenses first.
- Medicare will then pay for Medicare eligible expenses, if any, not paid for by the program.

- or -

Non-Covered Active Employees Age 65 or Over

If you are age 65 or over and actively employed, you may elect not to be covered under your program. In such a case, Medicare will be your only coverage. If you choose this option, you will not be eligible for any benefits under the program. Contact your plan administrator for specific details.

Spouses Age 65 or Over of Active Employees

If you are actively employed in a group with 20 or more employees, your spouse has the same choices for benefit coverage as indicated above for the employee age 65 and over.

Regardless of the choice made by you or your spouse, each one of you should apply for Medicare Part A coverage about three months prior to becoming age 65. If you elect to be covered under the program, you may wait to enroll for Medicare Part B. You will be able to enroll for Part B later during special enrollment periods without penalty.

Leave of Absence or Layoff

Upon your return to work following a leave of absence or layoff that continued beyond the period of your coverage, your group's program may, in some cases, allow you to resume your coverage. You should consult with your plan administrator/employer to determine whether your group program has adopted such a policy.

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.

Act 2 of 2009 is a Pennsylvania law that is sometimes referred to as "mini-COBRA" since it is similar in purpose to federal COBRA. However, unlike federal COBRA, mini-COBRA only applies to employers who employed between 2 and 19 employees on a typical business day during the previous calendar year.

Contact your employer for more information about COBRA and mini-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. Also, conversion is available to anyone who has

elected continued coverage through your employer's program and the term of that coverage has expired.

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

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

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

Certificates of Creditable Coverage

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

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

Termination of Your Coverage Under the Employer Contract

Your coverage can be terminated in the following instances:

- When you cease to be an employee, the group shall promptly notify Highmark that you are no longer eligible for coverage and that your coverage should be terminated as follows:
  - When prompt notification is received, coverage will be terminated no earlier than the date on which you cease to be eligible.
  - When a group requests a retroactive termination of coverage, coverage will be terminated no earlier than the first day of the month preceding the month in which Highmark received notice from the group.
- When you fail to pay the required contribution, your coverage will terminate at the end of the last month for which payment was made.

- Termination of the employer contract automatically terminates the coverage of all the members. It is the responsibility of the employer to notify you of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given to you by the employer.
- If it is proven that you obtained or attempted to obtain benefits or payment for benefits through fraud or intentional misrepresentation of a material fact, Highmark may, upon 30-day advance written notice to you, terminate your coverage under the program.

Benefits After Termination of Coverage

- If you are an inpatient on the day your coverage terminates, benefits for inpatient covered services will be continued as follows:
  - Until the maximum amount of benefits has been paid; or
  - Until the inpatient stay ends; or
  - Until you become covered, without limitation as to the condition for which you are receiving inpatient care, under another group program; whichever occurs first.
- If you are pregnant on the date coverage terminates, no additional coverage will be provided.
- If you are totally disabled at the time your coverage terminates due to termination of active employment, medical benefits, excluding outpatient prescription drug benefits, will be continued for covered services directly related to the condition causing such total disability. This benefit extension does not apply to covered services relating to other conditions, illnesses, diseases or injuries and is not available if your termination was due to fraud or intentional misrepresentation of a material fact. This total disability extension of benefits will be provided as long as you remain so disabled as follows:
  - Up to a maximum period of 12 consecutive months; or
  - Until the maximum amount of benefits has been paid; or
  - Until the total disability ends; or
  - Until you become covered without limitation as to the disabling condition under other group coverage, whichever occurs first.

- If you are required to pay any premium, your benefits will not be continued if your coverage is terminated because you failed to pay the required premium.

Coordination of Benefits

Most health care programs, including your PPO 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 program. 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 in your Highmark coverage 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 program.
- 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 program which covered the parent longer will be the primary program. 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 program 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 program covering the person as a laid-off or retired employee or as a dependent of such person and if

- the other program 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

Subrogation means that if you incur health care expenses for injuries caused by another person or organization, the person or organization causing the accident may be responsible for paying these expenses.

For example, if you or one of your dependents receives benefits through your program for injuries caused by another person or organization, Highmark has the right, through subrogation, to seek repayment from the other person or organization or any applicable insurance company for benefits already paid.

Highmark will provide eligible benefits when needed, but you may be asked to show documents or take other necessary actions to support Highmark in any subrogation efforts.

Subrogation does not apply to an individual insurance policy you may have purchased for yourself or your dependents or where subrogation is specifically prohibited by law.

A Recognized Identification Card

The Blue Cross and Blue Shield symbols on your Highmark identification (ID) card are 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.highmarkbcbs.com.

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

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

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

How to File a Claim

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

If you receive medications from a network pharmacy and present your ID card, you will not have to file a claim. 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;
  - For a medical service, the diagnosis or nature of illness;
  - For durable medical equipment, the doctor's certification;
  - For private duty nursing, the nurse's license number, charge per day and shift worked, and signature of provider prescribing the service;
  - For ambulance services, the total mileage;
  - Drug and medicine bills must show the prescription name and number and the prescribing provider's name.

  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 are 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 claim must be submitted within 12 months of the date of service, but in no event will it be accepted later than one year from the 12-month timeframe.

Your Plan Activity Statement

When you submit a claim, you will receive a plan activity statement when you have both medical coverage and an active, eligible spending account.

The plan activity statement includes the following features:

- plan contact information;
- claims for each person in your family are grouped together by name;
- summary of the total amount you spent out of your spending account(s) during the statement period;
- summary of all the medical claims submitted, how much was paid, and the amount you may owe;
- shows which health spending account paid the medical claim and the date the payment was made;
- shows your medical approved amount you are responsible for, how much was paid and what you still may owe; and
- tells you exactly how much was paid out of your spending account or why payment was not made.

In those instances where you are not required to submit a claim because, for example, the network provider will submit the bill as a claim for payment under its contract with Highmark, you will receive a plan activity statement only when you are required to pay amounts other than your required copayment.

If you do not have access to a computer or prefer to continue receiving printed plan activity statements, please notify Member Service by calling the number on the back of your ID card.

Using the Mail Service Pharmacy Benefit

To order your prescription through our mail service pharmacy, visit our Web site or call Member Service using the telephone number on the back of your ID card to obtain a Mail Service Pharmacy Order Form and envelope. Mail your prescription and any applicable copayment or coinsurance, along with the Mail Service Pharmacy Order Form to the address listed on the form. Your order will be processed promptly and your medication will be sent to you via U.S. mail or UPS. Included with your order will be instructions for ordering refills. Refills can be ordered by phone, mail or online.

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 Healthcare 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 plan activity statement or notice. If you believe that the copayment, coinsurance or deductible amount identified in that plan activity statement 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 Healthcare 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

Highmark maintains an appeal process involving one level of review. This appeal process is mandatory and must be exhausted before you are permitted to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

At any time during the appeal process, you may choose to designate an authorized representative to participate in the appeal process on your behalf. You or your authorized 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, parents entitled or authorized to act on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by Highmark shall, in the case of an urgent care claim, permit a physician or other health care provider with knowledge of your medical condition to act as your authorized representative.

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

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

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

Each appeal will be promptly investigated and Highmark will provide written notification of its decision within 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 involved 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 30 days following receipt of the appeal.

In the event Highmark renders an adverse decision on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding your right to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Autism Spectrum Disorders Expedited Review and Appeal Procedures

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

An appeal of a denial of a claim for services for the diagnostic assessment or treatment of an autism spectrum disorder is subject to review by a Review Committee. The request to have the decision reviewed by the Review Committee may be communicated orally or be submitted in writing within 180 days from the date the denial of the claim is received, and may include any written information from you or the health care provider. The Review Committee shall be comprised of three employees of Highmark who were not involved or the subordinate of any individual

that was previously involved in any decision to deny coverage or payment for the health care service. The Review Committee will hold an informal hearing to consider the appeal. When arranging the hearing, Highmark will notify you or the health care provider of the hearing procedures and rights at such hearing, including your or the health care provider's right to be present at the review and to present a case. If you or the health care provider cannot appear in person at the review, Highmark shall provide you or the health care provider the opportunity to communicate with the Review Committee by telephone or other appropriate means.

Highmark shall conduct the expedited internal review and notify you or your authorized representative of its decision as soon as possible but not later than 48 hours following the receipt of your request for an expedited review. The notification to you and the health care provider shall include, among other items, the specific reason or reasons for the adverse decision including any clinical rationale, the procedure for obtaining an expedited external review and a statement regarding your right to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

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

Member Service

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

Blues On 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 Web Site

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.highmarkbcbs.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 your health 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

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

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

Member Rights and Responsibilities

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

You have the right to:

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

You have a responsibility to:

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

How We Protect Your Right to Confidentiality

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

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

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

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

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

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

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

Terms You Should Know

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

Assisted Fertilization - Any method used to enhance the possibility of conception through retrieval or manipulation of the sperm or ovum. This includes, but is not limited to, artificial insemination, In Vitro Fertilization (IVF), Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), Tubal Embryo Transfer (TET), Peritoneal Ovum Sperm Transfer, Zona Drilling, and sperm microinjection.

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

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

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

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

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

- **Pre-Service Claim** – A request for precertification or prior approval of a covered service which under the terms of your coverage must be approved before you receive the covered service.

- **Urgent Care Claim** – A pre-service claim which, if decided within the time periods established for making non-urgent care pre-service claim decisions, could seriously

jeopardize your life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service.

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

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

Custodial Care - Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition.

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

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

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

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

Experimental/Investigative - The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by

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

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

Highmark believes that decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. That is why a panel of more than 400 medical professionals works with our nationally recognized Medical Affairs Committee to review new technologies and new applications for existing technologies for medical and behavioral health procedures and devices. To stay current and patient-responsive, these reviews are ongoing and all-encompassing, considering factors such as product efficiency, safety and effectiveness. If the technology passes the test, the Medical Affairs Committee recommends it be considered as acceptable medical practice and a covered benefit. Technology that does not merit this status is usually considered "experimental/investigative" and is not generally covered. However, it may be re-evaluated in the future.

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

specialist input and pharmacoeconomic impact. After the review is complete, the P & T Committee makes recommendations.

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

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 Blue Shield Service Area - The geographic area, within Pennsylvania, in which Highmark Blue Shield operates as a hospital plan corporation 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			

Immediate Family - Your spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-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 a male and female partner for a period of at least 12 months. The inability to conceive may be due to either the male or female 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.

Methadone Maintenance - The treatment of heroin or other morphine-like drug dependence where you are taking methadone hydrochloride daily in prescribed doses to replace the previous heroin or other morphine-like drug abuse.

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

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

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

Partial Hospitalization - The provision of medical, nursing, counseling or therapeutic mental health care services or substance abuse services on a planned and regularly scheduled basis in a facility provider designed for a patient or client who

would benefit from more intensive services than are generally offered through outpatient treatment but who does not require inpatient care.

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

Plan Allowance - The amount used to determine payment by Highmark for covered services provided to you and to determine your liability. Plan allowance is based on the type of provider who renders such services or as required by law. The plan allowance for an in-area out-of-network provider is based on an adjusted contractual allowance for like services rendered by a network provider in the same geographic region. You will be responsible for any difference between the provider's billed charges and Highmark'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 Highmark's participation in the BlueCard program described in the How Your PPO Program Works section of this booklet.

Plan 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			

Precertification (Preauthorization) - The process through which selected covered services are pre-approved by Highmark.

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

Primary Care Physician (PCP) - A physician who limits his or her practice to family practice, general practice, internal medicine or pediatrics and who may

supervise, coordinate and provide specific basic medical services and maintain continuity of patient care.

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

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

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

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

Highmark and Have A Greater Hand in Your Health are registered marks of Highmark Health Services.

Blues On Call, myCare Navigator are service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield companies.

Baby BluePrints, BlueCard, BlueCard Worldwide, Blue Cross, Blue Shield and the Cross and Shield symbols are registered service marks of the Blue Cross Blue Shield Association.

The Dr. Dean Ornish Program for Reversing Heart Disease is a registered trademark of Dr. Dean Ornish.

The Blue Cross Blue Shield Association and Dr. Dean Ornish are independent companies that do not provide Highmark Blue Cross Blue Shield products and services. They are solely responsible for the services described in this booklet.

You are hereby notified, your health care benefit program is between the Group, on behalf of itself and its employees and Highmark Blue Cross Blue Shield. Highmark Blue Cross 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 Cross Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Highmark Blue Cross Blue Shield shall be liable to the Group, on behalf of itself and its employees, for any Highmark Blue Cross Blue Shield obligations under your health care benefit program.

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

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

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

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

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

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

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

I. Uses and Disclosures of Protected Health Information

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

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

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

Payment

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

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

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

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

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

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

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

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

II. Other Possible Uses and Disclosures of Protected Health Information

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

1. **To Plan Sponsors**
We may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us regarding a member's question, concern, issue regarding claim, benefits, service, coverage, etc. We

may also disclose summary health information (this type of information is defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

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

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

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

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

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

7. **Law Enforcement**
   Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; or (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person.

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

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

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

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

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

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

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

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

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

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

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

All participating providers who provide services to you will have the ability to access your information. Providers that do not provide services to you will not have access to your information. Information may be provided to others as necessary for referral, consultation, treatment or the provision of other healthcare services, such as pharmacy or laboratory services. All participating providers have agreed to a set of standards relating to their use and disclosure of the information available through the HIE. Your health information shall be available to all participating providers through the HIE.

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

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

III. Required Disclosures of Your Protected Health Information

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

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

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

B. Disclosures to You

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

IV. Other Uses and Disclosures of Your Protected Health Information

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

1. For marketing purposes

2. If we intend to see your PHI
3. For use of Psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. An Authorization for use of psychotherapy notes is required unless:

    a. Used by the person who created the psychotherapy note for treatment purposes, or
    b. Used or disclosed for the following purposes:
        (i) the provider's own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;
        (ii) for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;
        (iii) if required for enforcement purposes;
        (iv) if mandated by law;
        (v) if permitted for oversight of the provider that created the note;
        (vi) to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or
        (vii) if needed to avert a serious and imminent threat to health or safety.

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

V. Your Individual Rights

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

A. Right to Access

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

copy psychotherapy notes or certain other information that may be contained in a designated record set.

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

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

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

B. Right to an Accounting

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

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

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or submitting your request in writing to the Highmark Health Services 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 Health Services 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 Health Services 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 Health Services is committed to protecting its members' privacy. This notice describes our policies and practices for collecting, handling and protecting personal information about our members. We will inform each group of these policies the first time the group becomes an HMHS member and will annually reaffirm our privacy policy for as long as the group remains an HMHS customer. We will continually review our privacy policy and monitor our business practices to help ensure the security of our members' personal information. Due to changing circumstances, it may become necessary to revise our privacy policy in the future. Should such a change be required, we will notify all affected customers in writing in advance of the change.

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

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

- We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.

- We collect and create information about our members' transactions with HMHS, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits/payments (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

Information we may disclose and the purpose: We do not sell any personal information about our members or former members for marketing purposes. We use and disclose the personal information we collect (as described above) only as necessary to deliver health care products and services to our members or to comply with legal requirements. Some examples are:

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

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

For questions about this Privacy Notice, please contact:

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

HIGHMARK®