BLUE CROSS BLUE SHIELD

Major Medical Program

Carnegie-Mellon University
Group 05038702
Effective January 01, 2024

HIGHMARK

www.myHighmark.com

Discrimination is Against the Law

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

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
    If a Member needs these services, the Member should contact the Civil Rights Coordinator.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

LANGUAGE ASSISTANCE SERVICES

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

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

请注意： 如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY： 711）。

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

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

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

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

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

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

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

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

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

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

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

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

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

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Disclosure

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

Non-Assignment

Unless otherwise required by law, Highmark is authorized by the member to make payments directly to providers furnishing Covered Services provided under the program described in this benefit booklet; however, Highmark reserves the right to make these payments directly to the member. The right of a member to receive payment for a Covered Service described in this benefit booklet is not assignable, except to the extent required by law, nor may benefits described in this benefit booklet be transferred either before or after Covered Services are rendered. Any (direct or indirect) attempt to accomplish such an assignment shall be null and void. Nothing contained in this benefit booklet shall be construed to make Highmark, the group health plan or the group health plan sponsor liable to any assignee to whom a member may be liable for medical care, treatment, or services.

Highmark will not honor requests not to pay the claims submitted by the provider nor shall Highmark be liable for its rejection of the request.

Introduction to Your Health Care Program

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

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

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

If you have any questions on your health care program, please call the Member Service toll-free telephone number on the back of your ID card. For TTY/TDD hearing impaired service, please dial 711 and the number on the back of your ID card.

Information for Non-English-Speaking Members

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

How Your Benefits Are Applied

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

Major Medical Cost-Sharing Provisions

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

Benefit Period

The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by your program. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made. Refer to the Summary of Benefits for the benefit period under this program.

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 Summary of Benefits for the percentage amounts paid by the program.

The deductible does not apply to the enteral foods benefit or the breast cancer screenings benefit.

The deductible does not apply to diabetes care management program (digitally monitored) services under the diabetes treatment benefit.

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

Maximum

The amount paid for covered services under the program will be added to any amount paid for benefits under any other group health care expense contract between the group and the Plan for the purpose of calculating the lifetime or benefit period maximum set forth in this section and applicable to each member.

Reinstatement

The amount that will be restored each benefit period to the member's lifetime maximum amount. However, the amount restored will not exceed the amount paid by the Plan for covered services rendered in the preceding benefit period.

Lifetime Maximum

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

At the start of each benefit period, the amount paid for covered services in the preceding benefit period up to 0 will be restored to the lifetime maximum of each person who used the benefits.

The amount paid for covered services for any individual covered under this program will be added to any amount paid for benefits for that same individual under any other group health care expense Highmark for the purpose of calculating the benefit period or lifetime maximum applicable to each individual.

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.

Covered Services - Medical Program

MAJOR MEDICAL SERVICES

Subject to exclusions, conditions, and limitations of this program, a member is entitled to the benefits of this section for covered services that are medically necessary and appropriate services rendered by a provider in the amounts specified in this section and Summary of Benefits. The benefits of this benefit section will only be provided to the extent not provided under the Basic Plan.

Highmark, in its sole discretion, reserves the right to limit access and/or modify benefit(s) for any individual member, regardless of disease or condition, when Highmark identifies utilization patterns that could potentially result in harm to such member or the public.

Outpatient Medical Care Services (Visits and Consultations)

Medical care rendered by a professional provider who is an outpatient for a condition not related to surgery, pregnancy, mental illness, or substance abuse, except as specifically provided. Covered services include medical care visits and consultations for the examination, diagnosis and treatment of an injury or illness.

You can also interact with a professional provider virtually, via telephone, internet or other electronic communication. Benefits are provided for a virtual visit when you communicate with the professional provider from any location, such as your home, office or another mobile location. Alternatively, a professional provider may want you to travel to a provider originating site where a virtual interaction with the provider can occur.

Professional providers may also request consultations from another professional provider for an advisory opinion regarding a diagnosis or management of your medical problem. These are called “provider-to-provider” consultations or “interprofessional consultations”. ***Interprofessional consultations do not include provider interaction with you.***

Different types of providers, their services and their locations may require different payment amounts and result in different charges. You may be responsible for a facility fee, clinic charge or similar fee (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. You may also be responsible for a charge for an interprofessional consultation, which may occur during your office visit or at a different time.

The specific amounts you are responsible for paying depend on your particular Highmark benefits.

Preventive Care Services

Adult Care

Colorectal Cancer Screenings

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

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

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

Colorectal cancer screenings are covered:

For all members forty-five (45) years of age or older as follows:

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

For members determined to be at high or increased risk, regardless of age:

- 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 2018.

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

Diabetes Prevention Program

Benefits are provided if you meet certain medical criteria of having a high risk of developing type 2 diabetes and when you are enrolled in a diabetes prevention program that is offered through a participating diabetes prevention provider. Coverage is limited to one (1) enrollment in a diabetes prevention program per year, regardless of whether you complete the diabetes prevention program.

Benefits are only available for charges submitted by participating diabetes prevention providers.

Hospital Services

Bed and Board

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

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

Ancillary Services

Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms and equipment;
- drugs and medicines provided to you when you are an inpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives. Expenses incurred for the first 2 one-pint units of whole blood or blood components are your responsibility.
- medical and surgical dressings, supplies, casts, and splints;
- oxygen and its administration.

Maternity Services

Services rendered by a hospital, professional provider or professional other provider for:

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

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

Newborn Care
Covered services provided to the newborn child from the moment of birth for the maximum of 31 days. This coverage includes 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. 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.

Benefits are not provided for nursery care for the newborn children of dependent children. Refer to the General Information section for further eligibility information.

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

Under Federal law, your self-insured group health program generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 as applicable). In any case, under Federal law, your self-insured program can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

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

Medical Care Services

You may be responsible for a facility or clinic-based coinsurance amount in addition to the professional provider charge if an office visit or service is provided at a hospital, facility other provider, retail clinic or urgent care center.

- Medical care and consultations of a professional provider for the diagnosis and treatment of an injury or illness on an Inpatient basis
- Medical care rendered by a professional provider or professional other provider to a member who is an outpatient for a condition not related to surgery, which is not a covered service under the Basic Plan and only as specifically provided below:

    - Medical care visits and consultation for the examination, diagnosis, and treatment of an injury or illness

- A specialist virtual visit between you and a specialist (including a behavioral health specialist) via audio and video telecommunications. Benefits are provided for a specialist virtual visit when you communicate with the specialist from any location, such as your home, office, or another mobile location, or if you travel to a provider-based location referred to as a provider originating site. If you communicate with the specialist from a provider originating site, you will be responsible for the specialist virtual visit provider originating site fee.

Surgical Services

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

Assistant at Surgery
Services of a physician or of the physician's employed physician assistant (PA), or certified registered nurse practitioner (CRNP) or certified nurse midwife (CNM), 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.

Anesthesia
Anesthesia, anesthesia supplies and services rendered in a Hospital or facility other provider by an employee of the hospital or facility other provider. Administration of anesthesia ordered by the attending physician and rendered by a professional provider other than the surgeon or assistant at surgery.

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
- 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 other emergency services provided by an ambulance service will be considered emergency ambulance service if the injury or condition is considered emergency care. Use of an ambulance as transportation to an emergency room of a facility provider for an injury or condition that is not considered

emergency care will not be covered as emergency ambulance services. Refer to the Terms You Should Know section for a definition of emergency care services.

Benefits are provided for emergency care services rendered by an ambulance service even when transport is not required or refused by you.

When you receive benefits for emergency ambulance services or ambulance services provided by air from a non-participating provider, you will not be responsible for any amounts billed by the non-participating provider that are in excess of the plan allowance.

Therapy and Rehabilitation Services

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

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

Spinal Manipulations

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

Mental Health Care - Psychiatric Care Services

Inpatient and outpatient medical care visits, individual and group psychotherapy, psychological testing, family counseling, convulsive therapy treatments and medication management for the treatment of mental illness when rendered to a member by a hospital, facility other provider, professional provider or partial hospitalization program. Inpatient facility services must be provided twenty-four hours a day, seven days a week by or under the direction of a psychiatrist, a psychiatric nurse practitioner or a psychologist when legally authorized by the state. Inpatient facility services are recommended for patients who are an acute danger to themselves or others or who are unable to provide required self-care and lack available support. Benefits are also provided for psychiatric care services received through an intensive outpatient program.

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. Inpatient facility services must be provided twenty-four hours a day, seven days a week by or under the direction of a psychiatrist, a psychiatric nurse practitioner or a psychologist who is legally authorized by the state. Inpatient facility services are recommended for patients who are an acute danger to themselves or others or who are

unable to provide required self-care and lack available support. Benefits are also provided for the treatment of serious mental illness when received through an intensive outpatient program or on a partial hospitalization basis only when received through a partial hospitalization program. A serious mental illness service provided on a partial hospitalization basis will be deemed to be an outpatient care visit subject to any outpatient cost-sharing amounts.

Substance Abuse Services

Individual and group counseling and psychotherapy, psychological testing, family counseling and detoxification services for the treatment of substance abuse when rendered to a member by a hospital, professional provider, intensive outpatient program or partial hospitalization program. Benefits are provided for non□hospital inpatient residential treatment and rehabilitation Services rendered by a professional provider to a member who is an inpatient in a substance abuse treatment facility. Residential treatment and rehabilitation services include medically monitored high intensity inpatient services with twenty-four hour nursing care and physician availability and medically managed intensive inpatient services with twenty-four hour nursing care and daily physician oversight. Benefits are also provided for substance abuse services rendered through an opioid treatment program or office based opioid treatment program.

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

Anesthesia for Non-Covered Dental Procedures (Limited)

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 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

Treatment of autism spectrum disorders may include the following medically necessary and appropriate services:

Pharmacy care

Prescription drugs approved by the Food and Drug Administration (FDA) and designated by Highmark for the treatment of autism spectrum disorders and which are prescribed by a physician, licensed physician assistant or certified registered nurse practitioner. Additionally, pharmacy care for autism spectrum disorders includes any assessment, evaluation or test prescribed or ordered by a physician, licensed

physician assistant or certified registered nurse practitioner to determine the need or effectiveness of such prescription drugs.

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.

NOTE: Certain services for the treatment of autism spectrum disorders described above, including but not limited to diagnostic services, pharmacy care, psychiatric and psychological care, rehabilitative care and therapeutic cares, are also described as services covered under other benefits as set forth within this covered services section. When you receive such services, they will be paid as specified in such other benefits as set forth in the Summary of Benefits. However, any visit limitations specified for such other benefits will not apply when those services are prescribed for the treatment of autism spectrum disorders. Applied behavioral analysis for the treatment of autism spectrum disorders will be paid as set forth in the Summary of Benefits.

Dental Services Related to Accidental Injury

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

Diabetes Treatment

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

- Equipment and Supplies: Blood glucose monitors, monitor supplies, injection aids, syringes and insulin infusion devices.
- Outpatient Diabetes Education: When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through an outpatient diabetes education program as defined in the Terms You Should Know section and approved by Highmark:

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

Diagnostic Services

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

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

Durable Medical Equipment

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

Enteral Foods

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

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

Coverage for enteral foods excludes the following:

- Blenderized food, baby food, or regular shelf food;
- Milk or soy-based infant formulae with intact proteins;
- Any formulae, when used for the convenience of you or your family members;
- Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation, or maintenance;
- Semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally.

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

Home Health Care Services

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

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

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

No home health care benefits will be provided for:

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

Infertility Counseling, Testing and Treatment

Benefits will be provided for covered services in connection with the counseling, testing and treatment of infertility when such services are ordered by a physician and are determined to be medically necessary and appropriate.

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

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 services;
- Respiration 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.

Benefits will be provided for pediatric extended care services in the amounts specified in the Summary of Benefits.

Private Duty Nursing Services

Private duty nursing services of an actively practicing registered nurse (RN) or a 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.

- When you are an inpatient in a hospital or facility other 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.
- When you are at home, only when Highmark determines that the nursing services require the skills of a registered nurse (RN) or of a licensed practical nurse (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 (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses, except when new cataract lenses are needed because of prescription change).

Skilled Nursing Facility Services

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

Transplant Services

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

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

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

What Is Not Covered

Except as specifically provided in this booklet or as Highmark is mandated or required to cover based on state or federal law, regulation or other directive, no benefits will be provided for services, supplies or charges:

Key Word	Exclusion
Abortion	● For elective abortions, except those abortions necessary to avert the death of the member or to terminate pregnancies caused by rape or incest;
Acupuncture Therapy Services	● For acupuncture therapy services, except as otherwise set forth in the Covered Services - Medical Program section of this booklet;
Ambulance	● For ambulance services, except as provided herein;
Artificial Insemination	● For Artificial Insemination;
Assisted Fertilization *(in vitro fertilization)*	● For in vitro fertilization;
Assisted Fertilization	● Related to treatment provided specifically for the purpose of assisted fertilization; including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law;
Audiometric Testing	● For outpatient audiometric testing;
Bariatric Surgery	● For bariatric surgery including reversal, revision, repeat and staged surgery, except for the treatment of sickness or injury resulting from such bariatric surgery;
Compounded medications	● For compounded medications;
Comfort/Convenience Items	● For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers or physical fitness equipment, stair glides, elevators/lifts or "barrier-free" home modifications, whether or not specifically recommended by a professional provider or professional other provider;
Contraceptive Devices and Implants	● For contraceptive devices and contraceptive implants including services related to the provision of such devices or implants;
Cosmetic Surgery	● For a cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except: a) as otherwise provided herein, b) when required to correct a condition directly resulting from an accident; c) when necessary to correct a functional impairment which directly results from a covered disease or injury, or d) to correct a congenital birth defect;

Court Ordered Services	● For otherwise covered services ordered by a court or other tribunal unless medically necessary and appropriate or if the reimbursement of such services is required by law;
Custodial Care	● For custodial care, domicillary care or rest cures;
Dental Care	● Directly related to 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, alveolectomy, services related to the placement of dentures and treatment of periodontal disease;
Diabetes Prevention Program	● For a diabetes prevention program offered by other than a participating diabetes prevention provider;
Effective Date	● Incurred prior to your effective date or during an Inpatient admission that commenced prior to your effective date; except covered services will be provided for an eligible condition that commenced after your effective date;
Enteral Foods	● For any food including, but not limited to, enteral foods, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis, except as provided herein;
Experimental/Investigative	● Which are experimental/investigative in nature, except as provided herein for routine patient costs incurred in connection with an approved clinical trial;
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;
Foot Care	● For palliative or cosmetic foot care, including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
Hearing Care Services	● For hearing aid devices, tinnitus maskers or examinations for the prescription or fitting of hearing aids;
High Cost Technological Equipment	● Performed on high cost technological equipment such as, but not limited to, computed tomography scanners (CT scanners), lithotripters, and magnetic resonance imaging (MRI) scanners, as defined by

	Highmark, which is not approved through the certificate of need process if applicable and/or is not approved by Highmark;
Immunizations	● for immunizations required for employment or foreign travel;
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 learning disabilities, behavioral problems, or intellectual disabilities, but not including care related to autism spectrum disorders, which extends beyond traditional medical management or medically necessary and appropriate inpatient confinement. 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, 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 related to the treatment of learning disorders or learning disabilities; and d) services provided primarily for social or environmental change; or for respite care;
	● 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, 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 have no legal obligation to pay;
Managed Care Program	● For care, treatment, or service which has been disallowed under the provisions of the managed care program;
Medically Necessary and Appropriate	● Which are not medically necessary or medically 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 so elect this coverage as primary;
	● For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage;

	● For charges for services, other than emergency and urgent care services when a private contract has not been executed by the Medicare beneficiary, which are payable under Medicare rendered by a Medicare opt-out provider when Medicare is primary;
	● For charges for any services payable under Medicare and rendered by a Medicare non-participating provider in excess of the Medicare reasonable charge, when Medicare is primary;
Mental Health	● For treatment of all mental illness, except for the treatment of serious mental illness as provided herein or as required by law;
Military Service	● Benefits are provided to members of the armed forces and the National Health Service or to patients in Veteran's Administration facilities for service-connected illness or injury unless the Member has a legal obligation to pay;
	● For any illness or injury suffered after your effective date as a result of any act of war;
Miscellaneous	● For telephone consultations, charges for failure to keep a scheduled visit or charges for completion of a claim form;
	● For any other medical or dental service or treatment except as provided in this booklet;
	● For any tests, screenings, examinations or any other services required by: (a) an employer or governmental body or agency in order to begin or to continue working or as a condition to performing the functions of any employment in a particular setting; (b) a school, college or university in order to enter onto school property or a particular location regardless of purpose, or; (c) a governmental body or agency for public surveillance purposes; and that does not relate to the furnishing or administration of an individualized test, screening or evaluation determined by the member's attending professional provider as being medically appropriate;
	● Services for which coverage or reimbursement is determined to be illegal by your state of residence regardless of whether you travel to a state where the service can be legally performed;
Motor Vehicle Accident	● For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act;
Neonatal Circumcision	● For routine neonatal circumcision;
Nutritional Counseling	● For nutritional counseling and services intended to produce weight loss except 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, except as otherwise required by law or as provided herein; ● For screening examinations including x-ray examinations made without film, except as mandated by law;
Preventive Care Services	● For preventive care services, wellness services or programs, except as provided herein or as mandated by law;
Provider of Service	● Which are not prescribed by, performed by or upon the direction of a professional provider; ● Rendered by other than hospitals, facility other providers, professional providers or professional other 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 any 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;
Skilled Nursing	● For skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness;
Spinal Manipulations	● For spinal manipulation;
Sterilization	● For sterilization and reversal of sterilization;
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;

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;
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 and immunizations, except as provided herein;
Workers' Compensation	● For any illness or injury eligible for or covered by any federal, state, or local government Worker’s Compensation Act or Occupational Disease Law.

Participating and Non-Participating Provider Reimbursement

The benefits for covered services rendered by a participating provider which are regularly included in the charges billed by and payable to such provider, are as specified in the Summary of Benefits section.

The benefits for covered services rendered by a non-participating provider which are regularly included in the charges billed by and payable to such non-participating provider are as follows:

1. When rendered by a professional provider that is not participating with Highmark the benefit amount is the same as for a participating provider, i.e., Highmark's allowance for a professional provider that is not participating with Highmark will be the same as the plan allowance established for a participating professional provider.

2. When rendered by a hospital or facility other provider that is not participating with Highmark the benefit amount will be an indemnity allowance which at all times will be subject to the determination of Highmark.

   In the event covered services are provided by a non-participating provider, Highmark reserves the right to make payment to the member. Furthermore, when covered services are provided by a non-participating provider, you are responsible for the difference between Highmark's payment and the provider's billed charge. If you receive services which are not covered under this plan, you shall be responsible for all charges associated with those services.

3. When you receive benefits for emergency ambulance services or ambulance services provided by air from a non-participating provider, you will not be responsible for the difference between Highmark’s payment and the provider’s billed charge.

4. In very limited circumstances, you may not be liable for charges for non-emergency covered services received from certain professional providers who are not participating providers. A hospital or facility other provider that participates with Highmark may have an arrangement with a professional provider that does not participate with Highmark to render certain items and professional services (such as, but not limited to, equipment, devices, anesthesiology, radiology or pathology services) to patients of the hospital or facility other provider. The selection of such professional providers may be beyond your control. In that situation, you will not be liable, except for applicable deductible, copayment or coinsurance obligations, for the charges of that professional provider that does not participate with Highmark.

5. When Medicare provides primary coverage and the services rendered by a professional provider or professional other provider are payable under Medicare, Highmark will reimburse the professional provider or professional other provider as follows:

   a. Medicare Participating Providers

      i. When you have Medicare supplemental insurance coverage, no benefits will be paid by Highmark.

      ii. When you do not have Medicare supplemental insurance coverage, Highmark will reimburse the Medicare participating provider 20% of the Medicare reasonable charge. A Medicare participating provider will accept this amount and its Medicare reimbursement as payment in full.

b. Medicare Non-Participating Providers

i. When you have Medicare supplemental insurance coverage, no benefits will be paid by Highmark.

ii. When you do not have Medical supplemental insurance coverage, Highmark will reimburse the Medicare non-participating provider 20% of the Medicare reasonable charge.

c. Medicare Opt-Out Providers

Highmark will make no reimbursement to the Medicare opt-out provider, except in cases where the Medicare opt-out provider renders emergency or urgent care services, the Medicare beneficiary has not executed a private contract with that provider and you do not have Medicare supplemental insurance coverage.

In such situations, Highmark will reimburse the Medicare opt-out provider 20% of the Medicare reasonable charge.

Inter-Plan Arrangements

Out-of-Area Services

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

Typically, when accessing care outside Pennsylvania, members obtain care from providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, members may obtain care from providers in the Host Blue geographic area that do not have a contractual agreement ("non-participating providers") with the Host Blue. Highmark remains responsible for fulfilling our contractual obligations to you. Highmark's payment practices in both instances are described below.

BlueCard® Program

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

Liability Calculation Method per Claim

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

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

- an actual price - An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases, or

- an estimated price - An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives, or
- an average price - An average price is a percentage of billed charges for covered services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual price, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices, (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Highmark in determining the member's premiums.

Special Cases: Value-Based Programs

BlueCard Program

Highmark has included a factor for bulk distributions from Host Blues in your premium for Value-Based Programs when applicable under your program. Additional information is available upon request.

Return of Overpayments

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

Inter-Plan Programs: Federal State Taxes/Surcharges/Fees

In some instances, federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, Highmark will include any such surcharge, tax or other fee in determining your premium.

Non-Participating Providers Outside Pennsylvania

Member Liability Calculation

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

Exceptions

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

by applicable law. In other exception cases, Highmark may pay such claims based on the payment Highmark would make if Highmark were paying a non-participating provider for the same covered service inside the Plan service area as described elsewhere in this document. This may occur where the Host Blue's corresponding payment would be more than the Plan in-service area non-participating provider payment. Highmark may choose to negotiate a payment with such a provider on an exception basis.

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

Blue Cross Blue Shield Global® Core Program

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

Inpatient Services

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

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

When members pay for covered services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, members should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center address on the form to initiate claims processing. The claim form is available from Highmark, the service center or online at www.bcbsglobalcore.com. If members need assistance with their claim submissions, they should call the service center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

Eligible Providers

Eligible network providers include facilities, general practitioners, internists, obstetricians/gynecologists and a wide range of specialists all licensed where required and performing within the scope of such licensure. Eligible Providers include:

Facility Providers:

- Ambulance service
- Ambulatory surgical facility
- Birthing facility
- Diabetes Prevention Provider
- Freestanding dialysis facility
- Freestanding nuclear magnetic resonance facility/magnetic resonance imaging
- Home health care agency
- Home infusion therapy provider
- Hospice
- Hospital
- Independent diagnostic testing facility
- Outpatient physical rehabilitation facility
- Outpatient psychiatric facility
- Outpatient substance abuse treatment facility
- Pharmacy provider
- Psychiatric hospital
- Rehabilitation hospital
- Residential Treatment Facility
- Skilled nursing facility
- State-owned psychiatric hospital
- Substance abuse treatment facility
- Suite infusion therapy provider

Professional Providers:

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

- Speech pathologist
- Speech therapist
- Teacher of hearing impaired

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

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

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

Participating Providers

Participating providers have a contract with Highmark pertaining to payment for covered services and agree to accept Highmark's allowance as full payment for covered services.

Non-Participating Providers

Some providers do not have an agreement with Highmark and do not accept Highmark's allowance as payment-in-full.

Health Care Management

Medical Management

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

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

IMPORTANT NOTICE REGARDING TREATMENT WHICH Highmark DETERMINES IS NOT MEDICALLY NECESSARY OR APPROPRIATE:

Highmark only pays for services which it determines to be medically necessary and appropriate. However, not all medically necessary and appropriate services are covered under this program. Highmark participating providers will accept this determination. A non-participating facility provider or a non-participating professional provider is not obligated to accept this determination and may bill you for services determined not to be medically necessary and appropriate. You are solely responsible for payment of such services rendered by a non-participating facility provider or a non-participating professional provider, subject to the conditions and limitations of your benefit program. You will not be financially liable when covered services are received from a Highmark participating provider unless you elect to receive services which have been determined not to be medically necessary and appropriate and you have been notified of this determination prior to receiving the services. If you elect to receive services from a non-participating facility provider or non-participating professional provider, you should contact Highmark to confirm the medical necessity and appropriateness of the services.

Refer to the Terms You Should Know section for a definition of medical necessity and appropriateness.

The health care management services provided by Highmark depend on your benefit program. They may include:

- precertification;
- pre-admission certification;
- admission certification;
- pre-procedure certification;
- pre-service certification;
- continued stay review;
- discharge planning; and
- case management.

Some portions of the program may affect your coverage. Please read the following information carefully.

Precertification

Precertification review is conducted by Highmark to determine whether a planned (scheduled admission, outpatient surgery procedure, home care) or unplanned (emergency or maternity-related admission) service request is medically necessary and appropriate and whether the requested treatment setting is the most appropriate for your care.

Precertification is required for the following services:

- Hospital admissions
- Inpatient rehabilitation admissions
- Psychiatric treatment
- Substance abuse

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

- Skilled nursing facility admissions
- Home health services
- Hospice services
- Outpatient surgery

If you use a Highmark Participating Provider:

A Highmark participating provider <u>WILL CONTACT Highmark FOR YOU</u> in order to determine whether services are medically necessary and appropriate. You are not financially liable for services performed by a Highmark participating provider unless you elect to receive services that have been determined by Highmark to be not medically necessary and appropriate.

When the Highmark participating provider contacts Highmark, a review will determine whether an admission, procedure or requested service is medically necessary and appropriate or whether a specific number of days or visits is required to adequately treat the condition. If Highmark determines that an entire admission, procedure or requested services is not medically necessary and appropriate, you and your provider will be notified in writing that the service will not be paid under your benefits program. If you and your provider decide to proceed with a service that is not medically necessary and appropriate, you will be responsible for full payment of the service. If a limited number of days or visits are approved, the days or visits which are not approved will be your financial responsibility.

If the Highmark participating provider does not contact Highmark prior to an admission, procedure or service when required, your care will be reviewed by Highmark after your services are received, at which time it will be determined whether the admission, procedure or service was medically necessary and appropriate. If Highmark determines that an admission, procedure or service was not medically necessary and appropriate, *you will not be financially liable for charges associated with those services.*

For an emergency or maternity-related admission, a Highmark participating provider is responsible for contacting Highmark following the admission, at which time the admission will be reviewed.

If the admission is found to be not medically necessary and appropriate, *you will not be financially liable for charges associated with those services.*

If You Use a Non-Participating Facility Provider or Non-Participating Professional Provider:

- **For Emergency or delivery-related Maternity Admissions:**
  YOU MUST CONTACT Highmark to certify any emergency or delivery-related maternity admission. For emergency or delivery-related maternity admissions, you should call Highmark within forty-eight (48) hours of the admission, or as soon as reasonably possible.

- **All Planned Admissions, Procedures and Services:**
  YOU MUST CONTACT Highmark PRIOR TO YOUR ADMISSION OR SERVICE. You should call Highmark 7 to 14 days prior to your planned admission or service.

IMPORTANT: **NON-PARTICIPATING FACILITY PROVIDERS OR NON-PARTICIPATING PROFESSIONAL PROVIDERS ARE NOT OBLIGATED TO CONTACT Highmark OR TO ABIDE BY ANY DETERMINATION OF MEDICAL NECESSITY AND APPROPRIATENESS RENDERED BY Highmark. A non-participating facility provider or non-participating professional provider may, therefore, bill you, the customer, for services that are not medically necessary and appropriate.**

You may certify emergency admissions, delivery-related maternity admissions, or any other service to a non-participating provider by calling the toll-free telephone number on your ID card. *If you do not call to certify your admission to or a service by a non-participating provider, your care will be reviewed by Highmark after your services are received, at which time it will be determined whether such services were medically necessary and appropriate.*

- If an admission, procedure or service is found to be medically necessary and appropriate, your benefit program will pay up to the non-participating facility provider or non-participating professional provider allowance for covered services and your provider can bill you for any balance of the charges which are not covered under your benefit program.
- If the entire admission/service is determined not to be medically necessary and appropriate, you will be responsible for full payment.
- If a specific number of days or visits for an admission or service are approved and you continue to receive services beyond the approved number of days or visits, you will be responsible for full payment of those days or visits which are not approved.

* * *

Depending on your benefit program, other components of the Highmark health care management program available to you as a Highmark member include the following: (These components apply regardless of whether or not you use a Highmark participating provider or a non-participating provider.)

Benefits after Provider Termination

If at the time you are receiving medical care from a participating provider, notice is received from Highmark that: Highmark intends to terminate or has terminated all or portions of the contract of that participating provider for reasons other than cause; or the contract of that participating provider will not be renewed, or the participation status of that provider is changing; you may, at your option, continue an active course of treatment with that provider until the treatment is complete or for a period of up to ninety (90) days from the date the notification of the termination or pending termination is received, whichever is shorter. For purposes of this section, active course of treatment means: (i) an ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (ii) an ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring specialized medical treatment to avoid the reasonable possibility of death or permanent harm or complex ongoing care which you are currently receiving, such as chemotherapy, radiation therapy or post-operative visits; (iii) confirmed pregnancy, through the postpartum period; (iv) scheduled non-elective surgery, through postoperative care; (v) an ongoing course of treatment for a health condition that is life-threatening, degenerative, potentially disabling, or congenital and that requires specialized medical care over a prolonged period of time or for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes; or (vi) treatment for a terminal illness. If, however, the network provider is terminated for cause and you continue to seek treatment from that provider, then your plan will not cover payment for health care services provided to you following the date of termination. Any services authorized under this section will be covered in accordance with the same terms and conditions as applicable to a network provider. Nothing in

this section shall require payment of benefits for health care services that are not otherwise provided under the terms and conditions of your plan.

Wellness Programs

Highmark may offer you the opportunity to participate in programs of health promotion and/or disease prevention. When offered, these programs will be available to you without regard to health status. Whether or not you decide to participate in such programs will not affect their continued eligibility, benefits, premiums, or cost-sharing obligations under this program.

At times, Highmark may offer rewards for your participation in certain of these programs. Any reward provided by Highmark in connection with these programs will not be offered or conditioned upon you satisfying a standard that is based on a health-related factor.

Health Improvement Services and Support

From time to time, Highmark may directly or indirectly make available to you information and access to non-medical items, services and support programs designed to address underlying social and environmental factors that may impact your health status. The provision of such information, items, services, and support programs shall not alter the benefits provided under this program.

General Information

Basic Plan

The "Basic Plan" refers to the regular hospital and medical-surgical benefits made available to you through your group. Dependents eligible for enrollment under the Basic Plan are also eligible under Major Medical.

Who is Eligible for Coverage

*The following eligibility information applies **only** if your group provides coverage for dependents. Your group administrator can determine if you have dependent coverage.*

The effective date for an individual member is the date specified by the group in writing or other documented communication received by Highmark unless an earlier effective date is required by law.

The group is responsible for determining if a person is eligible for coverage and for reporting such eligibility to Highmark. Highmark reserves the right to request, at any time, documentation relative to eligibility for coverage of any individual enrolled for coverage.

You may enroll your:

- Spouse under a legally valid existing marriage and does not include any spouse who is eligible for Medicare or Medicare disability coverage and who has elected Medicare coverage in lieu of coverage offered by the group
- 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 on the day following the date 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 intellectual disability, physical disability, mental illness or developmental disability that started before age 26. 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.

A dependent child who takes a medically necessary leave of absence from school, or who changes enrollment status (such as changing from full-time to part-time) due to a serious illness or injury may continue coverage for one year from the first day of the medically necessary leave of absence or other change in enrollment, or until the date coverage would otherwise terminate under the terms of this program, whichever is earlier. Highmark may require certification from the dependent child's treating physician in order to continue such coverage.

*The following domestic partner provision applies **only** if your group provides coverage for this benefit. Your group administrator can determine if you are eligible for this coverage.*

- A domestic partner** shall be considered for eligibility as long as a domestic partnership (a voluntary relationship between two domestic partners) exists with you. In addition, the children of the domestic partner shall be considered for eligibility as if they were your children as long as the domestic partnership exists.

**"Domestic Partner" means a member of a domestic partnership consisting of two partners, each of whom has registered with a domestic partner registry in effect in the municipality/governmental entity within which the domestic partner currently resides, or who meets the definition of a domestic partner as defined by the state or local government where the individual currently resides or meets all of the following:

- Is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time
- Is not related to the other partner by adoption or blood
- Is the sole domestic partner of the other partner and has been a member of this domestic partnership for the last six months
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner
- Meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for domestic partnerships which are currently enacted, or which may be enacted in the future

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

Your newborn child will be covered under your program for 31 days from the moment of birth and without having to enroll the child. However, to be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within the 31-day period.

This coverage is not available to newborn children of your dependents.

Changes in Membership Status

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

Medicare

Retirees or Dependents

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

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

Continuation of Coverage

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

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

Termination of Your Coverage Under the Group Contract

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

College Tuition Reward Program

1. Highmark provides access to a College Tuition Reward Program ("Program") made available by SAGE CTB LLC ("Sage"). Sage represents and has agreements with a consortium of private colleges and universities that participate in the Program.

2. Participation in the program is at the sole option of the member.

3. Members who wish to participate in the program can earn college tuition reward points that can be converted into equivalent cash credits which may be applied to the tuition expenses that eligible students incur when attending Sage participating colleges and universities. Credits are earned and accumulate during the period in which the member is enrolled under this plan.

4. Information regarding program details including a listing of participating colleges and universities will be provided by Sage.

5. Highmark makes no representations and assumes no liability in connection with the Program or its administration.

Coordination of Benefits

Most health care programs, including your health care 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 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 whose parents are married or are living together, whether or not they have ever been married, the contract which covers the person as a dependent of the parent whose birthday (month and day) falls earliest in the calendar year will be primary. 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 divorced or separated or not living together, whether or not they have ever been married, the following applies:

    - if a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage, that contract is the primary program;
    - if a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provision for married or living together above shall determine the order of benefits;
    - if a court decree states the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provision for married or living together above shall determine the order of benefits; or
    - if there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

        (i) the contract covering the custodial parent;

        (ii) the contract covering the spouse of custodial parent;

        (iii) the contract covering the non-custodial parent; and then

        (iv) the contract covering the spouse of the non-custodial parent

- If 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 ignored.

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

Force Majeure

No failure, delay or default in performance of any obligation of Highmark shall constitute an event of default or breach to the extent that such failure to perform, delay or default arises out of a cause, existing or future, that is beyond the reasonable control and not the result of the negligence of Highmark. Such events include, by way of illustration and not limitation, Acts of God, war (declared or undeclared), government regulation, acts or inaction of governmental authority, civil or military authority, unforeseen disruptions caused by suppliers, subcontractors, vendors or carriers, terrorism, disaster, strikes, civil disorder, curtailment of transportation facilities, fire, floods, blizzards, epidemics, pandemics, viral or communicable disease outbreaks, national emergency, quarantines, disruption of the labor force and/or any other cause which is beyond the reasonable control of Highmark (hereinafter a "force majeure event"), that makes it impossible, illegal or commercially impracticable for Highmark to perform its obligations in whole or in part.

Upon the occurrence of a force majeure event, Highmark shall take action to minimize the consequences of the Force Majeure Event. If Highmark relies on any of the foregoing as an excuse for failure, default or delay in performance, it shall give prompt written notice to the group of the facts that constitute such force majeure event, when it arose and when it is expected to cease.

Subrogation

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

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

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

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

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

A Recognized Identification Card

The Blue Cross and Blue Shield symbols on your Highmark identification (ID) card are recognized throughout the country and around the world. Each covered member will receive a member ID card. 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 Member Service immediately. You can also request additional or replacement cards online by logging onto the website located on the back of your member ID card. It's illegal to lend your ID card to anyone who is not eligible to use your benefits.

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

- Member name
- Member Identification number
- Group number
- Copayment for physician office visits and emergency room visits (if applicable)
- Plan Deductible (if applicable)
- Out-of-Pocket Limit (if applicable)
- Total Maximum Out-of-Pocket (if applicable)
- Pharmacy network logo (if applicable)
- Member Service toll-free number (on back of card)
- Member website (on back of card)
- Precertification toll-free number (on back of card)

How to File a Claim

Notice of Claim and Proof of Loss

(Applies to Post-service Claims Only)

Network providers have entered into an agreement with Highmark pertaining to the payment for covered services that they provide to you. When you receive covered services from a network provider, it is the responsibility of the network provider to submit its claim to Highmark in accordance with the terms of its participation agreement. Should the network provider fail to submit its claim in a timely manner or otherwise satisfy Highmark's requirements as they relate to the filing of claims, you will not be liable, and the network provider shall hold you harmless relative to payment of the covered services that you received.

When covered services are received from other than a network provider, you are responsible for submitting the claim to Highmark. In such instances, you must submit the claim in accordance with the following procedures:

Notice of Claim
Highmark will not be liable for any claims unless proper notice is furnished to Highmark that you have received covered services. Written notice of a claim must be given to Highmark within twenty (20) days or as soon as reasonably possible after you have received covered services. Notice given by you or on your behalf to Highmark that includes information sufficient to identify you shall constitute sufficient notice of a claim to Highmark. You can give notice to Highmark by writing to the Member Service Department. The address of the Member Service Department can be found on your ID card. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Claim Forms
Proof of loss for covered services must be submitted to Highmark on the appropriate claim form. Highmark, upon receipt of a notice of a claim will, within fifteen (15) days following the date a notice of a claim is received, furnish you with claim forms for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of such notice, you shall be deemed to have complied with the requirements of this subsection as to filing a proof of loss upon submitting, within the time fixed in this subsection for filing proofs of loss, itemized bills for covered services as described below. The proof of loss may be submitted to Highmark at the address appearing on your ID card.

Proof of Loss
Claims cannot be paid until a written proof of loss is submitted to Highmark. Written proof of loss must be provided to Highmark within twelve (12) months after the date of such loss. Proof of loss must include all data necessary for Highmark to determine benefits. Failure to submit a proof of loss to Highmark within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will Highmark be required to accept a proof of loss later than 1 year from the time proof is otherwise required.

Submission of Claim Forms
The completed claim form, with all itemized bills attached, must be forwarded to Highmark at the address appearing on your ID Card in order to satisfy the requirement of submitting a written proof of loss and to receive payment for covered services.

To avoid delay in handling claims that you submit, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing:

Person or organization providing the Service or supply

Type of Service or supply
Date of Service or supply
Amount charged
Name of patient

In addition to the above, private duty nursing bills must contain the shifts worked, the charge per day, the professional status of the nurse, and the signature of the professional provider prescribing the service. Professional provider bills must show specific treatment dates. Your attending professional provider must include a signature on all bills as certification that services have been prescribed, except for doctor bills or hospital bills. (Some bills requiring a signature of the professional provider include ambulance, prosthetic devices, rental of durable medical equipment, private duty nursing, etc.). Itemized bills cannot be returned.

A request for payment of a claim will not be reviewed and no payment will be made unless all of the information and evidence of payment required on the claim form has been submitted in the manner described above. Highmark reserves the right to require additional information and documents as needed to support a claim that a covered service has been rendered.

Notice of Highmark's claim determination will be issued within a reasonable period of time not to exceed thirty (30) days following the receipt of a proper proof of loss. This period of time may be extended one (1) time by Highmark for an additional period of time not to exceed fifteen (15) days provided the extension is due to matters outside the control of Highmark and a written explanation for the delay is provided to you.

In the event that Highmark renders an adverse decision on the claim, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement describing your right to file an appeal.

Time of Payment of Claims
Claim payments for benefits payable under this booklet will be processed immediately upon receipt of a proper proof of loss.

Authorized Representative
Nothing in this section shall preclude your duly authorized representative from filing or otherwise pursuing a claim on behalf of you. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

Limitation on Legal Actions

After a notice of claim has been given, you may not take legal action for sixty (60) days. You may not take legal action later than three years after the expiration of the time within which a notice of claim is required.

Physical Examinations and Autopsy

Highmark, at its own expense, shall have the right and opportunity to examine the person of the member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Your Explanation of Benefits Statement

When you submit a claim, you will receive an Explanation of Benefits (EOB) statement that lists:

- the provider's actual charge;
- the allowable amount as determined by Highmark;
- the copayment; deductible and coinsurance amounts, if any, that you are required to pay;
- total benefits payable; and
- the total amount you owe.

In those instances where you are not required to submit a claim because, for example, the provider will submit the bill as a claim for payment under its contract with Highmark, you will receive an EOB 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 EOBs, please notify Member Service by calling the number on the back of your ID card.

How to Voice a Complaint

In the event that you are dissatisfied with any aspect of your health care benefits or you have an objection regarding participating health care providers, coverage, operations or management policies, please contact Highmark via the toll-free Member Service telephone number located on the back of your ID card or by mail at the address listed below. Please include your identification and group numbers as displayed on your ID card.

Highmark Blue Cross Blue Shield
P.O. Box 535095
Pittsburgh, PA 15253

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

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

Fraud or Provider Abuse

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

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.

Appeal Procedure

Your benefit program maintains an appeal process involving two levels of review with the exception of urgent care claims (which involve a single level of review). At any time during the appeal process, you may choose to designate a representative to participate in the appeal process on your behalf. You or your representative shall notify Highmark in writing of the designation.

For purposes of the appeal process, “you” includes designees, legal representatives and, in the case of a minor, parent(s) entitled or authorized to act on your behalf.

Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by Highmark shall, in the case of an urgent care claim, permit your physician or other provider of health care with knowledge of your medical condition to act as your representative.

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

Initial Review

If you receive notification that a claim has been denied by Highmark, in whole or in part, or is not subject to legal prohibitions against balance billing, you may appeal the decision. Your appeal must be submitted not later than one hundred-eighty (180) days from the date you received notice from Highmark of the adverse benefit determination.

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

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

In rendering a decision on your appeal, the Appeal Review Department will take into account all evidence, comments, testimony, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Highmark. The Appeal Review Department will also afford no deference to any previous adverse benefit determination regarding the claim that is the subject of your appeal.

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

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

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

In the event Highmark renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, the procedure for appealing the decision and, in the case of an adverse benefit determination involving a pre-service claim, a statement regarding your right to request an external review or pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Your decision to proceed with a second level review of a pre-service claim (other than an urgent care claim, which involves one level of review) is voluntary. In other words, you are not required to pursue the second level review of a pre-service claim before pursuing a claim for benefits in court under §502 of ERISA. Should you elect to pursue the second level review before filing a claim for benefits in court, your benefit program:

- Will not later assert in a court action under §502 of ERISA that you failed to exhaust administrative remedies (i.e. that you failed to proceed with a second level review) prior to the filing of the lawsuit;

- Agrees that any statute of limitations applicable to the claim for benefits under §502 of ERISA will not commence (i.e. run) during the second level review; and

- Will not impose any additional fee or cost in connection with the second level review.

If you have further questions regarding second level reviews of pre-service claims, you should contact Member Service using the telephone number on your ID card.

Second Level Review

If you are dissatisfied with the decision following the initial review of your appeal (other than the review of an urgent care claim), you may request to have the decision reviewed by Highmark. The request to have the decision reviewed must be submitted in writing (or communicated orally under special circumstances) within forty-five (45) days from the date of an adverse benefit determination.

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

A representative from the Appeal Review Department will review your second level appeal. The representative will be an individual who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the matter under review.

In rendering a decision on the second level appeal, the Appeal Review 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 Appeal Review Department will also afford no deference to any previous adverse benefit determination regarding the matter under review.

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

matter under review and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the matter under review.

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

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

- When the appeal involves a post-service claim, within a reasonable period of time not to exceed thirty (30) days following receipt of the appeal.

In the event Highmark renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination and, in the case of an adverse benefit determination involving a post-service claim, a statement regarding your right to request an external review or pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

External Review

You have four (4) months from the date you receive notice of a final Highmark adverse benefit determination to file a request for an external review with Highmark. Note that for pre-service claims, the four (4) month period begins to run from the date you received Highmark's first-level adverse benefit determination.

To be eligible for external review, the decision of Highmark must have involved (i) a claim that was denied involving medical judgment, including, application of Highmark's requirements as to medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered service or a determination that the treatment is experimental or investigational; (ii) a claim that Highmark has concluded is not subject to legal prohibitions against balance billing; or (iii) a determination made by your plan administrator to rescind your coverage.

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

Preliminary Review

Highmark will conduct a preliminary review of your external review request within five (5) business days following the date on which Highmark receives the request. Highmark's preliminary review will determine whether:

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

Highmark will notify you of the results of its preliminary review within one (1) business day following its completion of the review. This will include our reasons regarding the ineligibility of your request, if applicable, and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not complete, Highmark’s notification will describe the information or materials needed to make the request complete. You will then have the balance of the four (4) month filing period or, if later, forty-eight (48) hours from receipt of the notice, to perfect your request for external review; whichever is later.

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

Referral to an Independent Review Organization (IRO)
Highmark will, randomly or by rotation, select an IRO to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Within five (5) business days thereafter, Highmark will provide the IRO with documents and information we considered when making our final adverse benefit determination. The IRO may reverse Highmark's final adverse benefit determination if the documents and information are not provided to the IRO within the five-day time frame.

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

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

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

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

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

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

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

In the above circumstances, Highmark will immediately conduct a preliminary review and will immediately notify you of our reasons regarding the ineligibility of your request, if applicable, and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not complete, Highmark's notification will describe the information or materials needed to make the request complete. You will then have forty-eight (48) hours from receipt of the notice, to perfect your request for external review.

Referral to an Independent Review Organization (IRO)

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

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

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

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

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

Member Service

As a member of your program, you have access to a wide range of readily available health education tools and support services.

Blues On Call℠ - 24/7 Health Decision Support

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

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

Help with common illnesses, injuries and questions

Health Coaches can address any health topic that concerns you:

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

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

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

Help with chronic conditions

If you have diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease or coronary artery disease, you need to manage your condition every day in order to stay healthy and avoid hospital stays. That means keeping track of medications, tests, doctor appointments and your diet. Your Blues On Call Health Coach can help you work more closely with your doctor and get more involved in taking good care of yourself.

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

Highmark Website

As a 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.myhighmark.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.

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 women's health specialist available to you throughout your pregnancy.

Easy Enrollment

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

Member Service

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

Member Rights and Responsibilities

Your participation in your 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 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 physician.

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

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

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

Terms You Should Know

*The following terms apply **only** if your group provides coverage for this benefit. Depending on your health care program not all terms may apply. Your group administrator can determine if you are eligible for this coverage. Please refer to the Summary of Benefits section of this booklet.*

Affordable Care Act (ACA) - The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) and its implementing regulations.

Ambulance Service - An ancillary provider licensed by the state which, for compensation from its patients, provides local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured. Ambulance service includes an emergency medical services (EMS) agency licensed by the state.

Ambulatory Surgical Facility - A facility provider, with an organized staff of physicians, which is licensed as required by the state and which, for compensation from its patients:

a. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;

b. provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility;

c. does not provide inpatient accommodations; and

d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a professional provider.

Anesthesia - The administration of a regional or rectal anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, induce an altered state, loss of sensation or loss of consciousness.

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.

Approved Clinical Trial - A Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that has been federally funded, authorized or approved by one of the following:

a. The National Institutes of Health (NIH), including the National Cancer Institute (NCI);

b. The United States Food and Drug Administration (FDA) in the form of an investigational new drug (IND) exemption;

c. The United States Department of Defense (DOD);

d. The United States Department of Veterans Affairs (VA);

e. The Centers for Disease Control and Prevention (CDC);

f. The Agency for Healthcare Research and Quality (AHRQ);

g. The Centers for Medicare and Medicaid Services (CMS);

h. The Department of Energy; or

i. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support.

Highmark may, at its discretion, approve other clinical trials that do not satisfy the above criteria.

Autism Service Provider - A professional provider or a facility provider licensed or certified, where required, and performing within the scope of such license or certification providing treatment for autism spectrum disorders, pursuant to a treatment plan, as provided herein.

Autism Spectrum Disorders - Any disorder defined as an autism spectrum disorder by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor.

Basic Plan - The Blue Cross basic hospital benefits and the Blue Shield basic medical/surgical benefits and any additional Blue Cross or Blue Shield benefits, or any other group health care expense program providing similar hospital and/or medical/surgical benefits, other than as specified under the groups' program of benefits.

Behavior Specialist - An individual licensed or certified, where required, and performing within the scope of such licensure or certification, who designs, implements or evaluates a behavior modification intervention component of a treatment plan for the treatment of autism spectrum disorders, including those based on applied behavioral analysis, to produce socially significant improvements in human behavior or to prevent loss of attained skill or function through skill acquisition and the reduction of problematic behavior.

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

Birthing Facility - A facility provider licensed by the state which, for compensation from its patients, is primarily organized and staffed to provide maternity care and is under the supervision of a nurse-midwife.

Blues On Call (Health Education and Support Program) - A program administered by the designated agent through which you receive health education and support services, including assistance in the self-management of certain health conditions.

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.

Certified Registered Nurse - A certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any registered professional nurses employed by a health care facility, as defined in the Pennsylvania Health Care Facilities Act, or by an anesthesiology group.

Chiropractor - A licensed chiropractor performing services within the scope of such licensure.

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.

For purposes of the claim determination and appeal procedure provisions, whether a claim or an appeal of a denied claim involves a pre-service claim, an urgent care claim or a post-service claim will be determine at the time that the claim or appeal is filed with your program in accordance with its procedures for filing claims and appeals.

Clinical Laboratory - A medical laboratory licensed where required, performing within the scope of such licensure, and is not affiliated or associated with a hospital or physician.

Clinical Social Worker - A licensed clinical social worker performing within the scope of such licensure. Where there is no licensure law, the clinical social worker must be certified by the appropriate professional body.

Coinsurance - The percentage of the plan allowance for covered services that is your responsibility. The remaining percentage is the responsibility of Highmark subject to the provisions of this program.

Contracting Supplier - A supplier who has an agreement, either directly or indirectly, with Highmark, or with any licensee of the Blue Cross Blue Shield Association when the supplier is located out-of-area, pertaining to payment for the sale or lease of durable medical equipment, supplies, hearing aids, prosthetics, and orthotics to you.

Copayment - A specified dollar amount of eligible expenses which your are required to pay for a specified covered service and which will be deducted from the plan allowance before the determination of the benefits payable under this program is made.

Covered Service - A service or supply specified by your program which is eligible for payment when rendered by a provider.

Custodial Care - Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting the activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Multiple non-skilled nursing services/non-skilled rehabilitation services in the aggregate do not constitute skilled nursing services/skilled rehabilitation services. Custodial care includes but is not limited to help in walking, bathing, dressing, feeding, preparing special diets and supervising the administration of medications not requiring skilled nursing services/skilled rehabilitation services provided by trained and licensed medical personnel.

Deductible - A specified dollar amount of liability for covered services that must be incurred by you before your program will assume any liability for all or part of the remaining covered services.

a. Program deductible - a specified amount of expenses for covered services that must be incurred by you before Highmark will assume any liability for all or part of the remaining expenses for covered services.

b. Benefit deductible - a specified amount of expenses applied to a specific covered service for which you are responsible per benefit period.

The program deductible and any applicable benefit deductible must be satisfied before your program makes payment for the specific services to which the benefit deductible applies.

Dentist - A person who is a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.), licensed where required and performing services within the scope of such licensure.

Dependent - A member other than the employee as specified herein.

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

Detoxification Services (Withdrawal Management Services) - Inpatient and outpatient services for the treatment of withdrawal from alcohol or drugs. Inpatient services must include twenty-four hour nursing care and physician oversight.

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 the criteria of your program. These criteria are based on the certification programs for outpatient diabetes education developed by the American Diabetes Association (ADA and the Pennsylvania Department of Health.

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

Diabetes Prevention Provider - An entity that offers a diabetes prevention program.

Diagnostic Service - A testing procedure ordered by a professional provider because of specific symptoms to determine a definite condition or disease.

Dietitian-Nutritionist - A licensed dietitian-nutritionist performing within the scope of such licensure. Where there is no licensure law, the dietitian-nutritionist must be certified by the appropriate professional body.

Domestic Partner - (Please check with your group administrator to see if the following is applicable.) A member of a domestic partnership consisting of two (2) partners, each of whom has registered with a domestic partner registry in effect in the municipality/governmental entity within which the domestic partner currently resides, or who meets the definition of a domestic partner as defined by the state or local government where the individual currently resides or meets all of the following:

- Is unmarried, at least eighteen (18) years of age, resides with the other partner and intend to continue to reside with the other partner for an indefinite period of time;
- Is not related to the other party by adoption or blood;
- Is the sole domestic partner of the other partner and has been a member of this domestic partnership for the last six (6) months;
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and
- Meets (or agrees to meet) the requirements of any applicable federal, state or local laws or ordinances for domestic partnerships which are currently enacted, or which may be enacted in the future.

Domestic Partnership - A voluntary relationship between two (2) domestic partners.

Durable Medical Equipment - Items which can withstand repeated use; are primarily and customarily used to serve a productive medical purpose; are generally not useful to a person in the absence of illness, injury or disease; are appropriate for use in the home and do not serve as comfort or convenience items.

Effective Date - The date when your coverage begins.

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

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

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

Transportation and other emergency services provided by an ambulance service shall constitute emergency ambulance services if the injury or the condition satisfies the criteria above.

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.

Employee - An individual who meets the eligibility requirements specified herein.

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

Exclusions - Services, supplies or charges that are not covered by your program.

Experimental/Investigative - The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by to be medically effective for the condition being treated. An intervention is considered to be experimental/investigative if: the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or, available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes;

or, the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or, the intervention does not improve health outcomes; or, the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date.

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

Facility Provider - An entity which is licensed, where required, to render covered services.

Facility providers include:

Ambulance Service
Ambulatory Surgical Facility
Birthing Facility
Diabetes Prevention Provider
Freestanding Dialysis Facility
Freestanding Nuclear Magnetic Resonance Facility/Magnetic Resonance Imaging Facility
Home Health Care Agency
Home Infusion Therapy Provider
Hospice
Hospital
Independent Diagnostic Testing Facility (IDTF)
Outpatient Physical Rehabilitation Facility
Outpatient Psychiatric Facility
Outpatient Substance Abuse Treatment Facility
Pharmacy Provider
Psychiatric Hospital
Rehabilitation Hospital
Residential Treatment Facility
Skilled Nursing Facility
State-Owned Psychiatric Hospital
Sutstance Abuse Treatment Facility
Suite Infusion Therapy Provider

Family Counseling - Counseling with family members in the assessment of the patient's diagnosis and treatment. Such counseling may assist family members to gain insight into the patient's illness and serve as an adjunct of the treatment regimen. Nevertheless, the services must primarily relate to the management of the patient's illness.

Family Coverage - Coverage for the employee and one (1) or more of the employee's dependents.

Family Deductible - The sum of the individual deductible amounts for a specified number of family members, who are covered under this program, and the point at which no further deductible amounts must be satisfied by any covered family member.

Freestanding Dialysis Facility - A facility provider licensed and approved by the appropriate governmental agency which, for compensation from its patients, is primarily engaged in providing dialysis treatment, maintenance or training to patients on an outpatient or home-care basis.

Freestanding Nuclear Magnetic Resonance Facility/Magnetic Resonance Imaging Facility - A facility provider which, for compensation from its patients, is primarily engaged in providing, through an organized professional staff, nuclear magnetic resonance/magnetic resonance imaging scanning. These facilities do not include Inpatient beds, medical or health-related services.

Group - The party entering into a contract on behalf of the members and the employer or representative of and remitting agent for the members who collects and remits premium payments on behalf of the members.

Highmark Blue Cross Blue Shield - An independent licensee of the Blue Cross Blue Shield Association. Any reference to Highmark Blue Cross Blue Shield may also include its Designated Agents with whom Highmark Blue Cross Blue Shield has contracted to perform a function or service.

Home Health Care Agency - A facility provider program for home health care, licensed by the state and certified by Medicare which, for compensation from its patients:

a. provides skilled nursing and other services on a visiting basis in the Member's home, and

b. is responsible for supervising the delivery of such services under a plan prescribed by the attending physician.

Home Infusion Therapy Provider - An ancillary provider licensed by the state, accredited by The Joint Commission, if appropriate, and organized to provide infusion therapy to patients at their place of residence.

Hospice Care - A program which provides an integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients and their families. Hospice services are centrally coordinated through an interdisciplinary team directed by a physician.

Hospital - A duly licensed facility provider that is a general or special hospital which has been approved by Medicare, The Joint Commission, or the American Osteopathic Hospital Association which, for compensation from its patients:

a. is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment and care of injured and sick persons, and

b. provides twenty-four hour nursing services by or under the supervision of registered nurses.

Identification Card (ID Card) - The currently effective card issued to you by Highmark.

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.

In-Area - The geographic area covering Pennsylvania.

Incurred - A charge is considered incurred on the date a member receives the Service or supply for which the charge is made.

Independent Diagnostic Testing Facility - An ancillary provider operating from a fixed or mobile location, which performs diagnostic testing services, other than clinical laboratory or pathology testing, using diagnostic testing and imaging equipment including, but not limited to, sleep centers/home sleep testing providers, mobile x-ray providers and cardiac event monitoring providers, and other diagnostic imaging providers. Such technical services do not include the interpretation of test results by a professional provider.

Infusion Therapy - The administration of medically necessary and appropriate fluid or medication via a central or peripheral vein to patients.

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

Intensive Outpatient Program - A time-limited, separate and distinct outpatient program that includes individual therapy, family therapy, group therapy and medication management following an individualized treatment plan. Participation in an intensive outpatient program may involve two (2) or more hours of programming a week. The program may be offered during the day or evening hours and can be a step-down from a higher level of care or a step-up to prevent the need for a higher level of care. The goals of an intensive outpatient program are to prevent or reduce the need for inpatient hospitalization and to reduce or stabilize symptoms and functional impairment of a psychiatric or co-occurring substance use disorder. Medically necessary treatment is provided within a structured therapeutic milieu.

Licensed Practical Nurse (LPN) - A nurse who has graduated from a formal practical nursing education program and is licensed by appropriate state authority.

Managed Care Program - Consists of any applicable pre-admission review, admission review, home health care review, mandatory second surgical opinion, individual case management, plan of treatment, or any other benefits management or utilization review provisions as defined in the groups' program of benefits.

Marriage and Family Therapist - A licensed marriage and family therapist performing within the scope of such licensure. Where there is no licensure law, the marriage and family therapist must be certified by the appropriate professional body.

Maximum - The greatest amount for which your program may be liable for covered services within a set amount of time. This could be expressed in dollars, number of days or number of services. In connection with such day and/or visit limits, all services received by a member during a benefit period will reduce the remaining number of days and/or visits available under that benefit, regardless of whether the member has satisfied the deductible. There are two types of maximums:

Program Maximum - The greatest amount payable by the program for all covered services.

Benefit Maximum - The greatest amount payable by the program for a specific covered service.

Medical Care - Professional services rendered by a professional provider for the treatment of an illness or injury.

Medically Necessary and Appropriate (Medical Necessity and Appropriateness) - Services, medications or supplies 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, sequence of services or site of service at least as likely to produce equivalent therapeutic or diagnostic results given the nature of the patient's diagnosis, treatment, illness, injury or disease, the severity of the patient's symptoms, or other clinical criteria.

Your program reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, medication or supply is medically necessary and appropriate. No benefits hereunder will be provided unless your program determines that the service, medication or supply is medically necessary and appropriate.

Medicare - The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

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

Medicare Non-Participating Provider - A professional provider or professional other provider eligible to provide services or supplies under Medicare Part B but who does not sign a participation agreement with Medicare, and may or may not elect to accept assignment on each Medicare claim that is filed. A Medicare non-participating provider who does not accept assignment does not accept the Medicare reasonable charge for a certain service or supply as payment in full, and may charge their patient more than the Medicare reasonable charge, unless otherwise prohibited by law.

Medicare Opt-Out Provider - A professional provider eligible to provide services or supplies under Medicare Part B but who has 'opted out' of Medicare such that they foregoe any payments from Medicare, to their patients or themselves, and enters into private contracts with Medicare beneficiaries to provide eligible services, and bills Medicare beneficiaries directly for services provided.

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

Member - An individual who meets the eligibility requirements specified in General Information section provided herein.

Mental Illness - An emotional or mental disorder characterized by a neurosis, psychoneurosis, psychopathy, or psychosis without demonstrable organic origin.

Non-Contracting Ancillary Provider - An ancillary provider that does not have an agreement with Highmark, either directly or indirectly, or with any licensee of the Blue Cross Blue Shield Association when the ancillary provder is located out-of-area, pertaining to payment for covered services rendered to you. A non-contracting ancillary provider shall be considered a non-participating provider when calculating the provider/supplier reimbursement and your liability.

Non-Contracting Supplier - A supplier who does not have an agreement with Highmark, either directly or indirectly, or with any licensee of the Blue Cross Blue Shield Association when the supplier is located out-of-area, pertaining to payment for the sale or lease of durable medical equipment, supplies, hearing aids, prosthetics and orthotics to you.

Non-Participating Facility Provider - A facility provider, licensed where required and performing within the scope of its license, that does not have an agreement with Highmark, either directly or indirectly, or with any licensee of the Blue Cross Blue Shield Association located out-of-area when the facility provider is located out-of-area, operating as a hospital plan corporation pertaining to payment for covered services rendered to you.

Non-Participating Professional Provider - A professional provider licensed where required and performing within the scope of such licensure, who does not have an agreement with Highmark, either directly or indirectly, or with any licensee of the Blue Cross Blue Shield Association when the professional provider or professional other provider is located out-of-area, pertaining to payment for covered services rendered to you.

Nurse-Midwife - A licensed nurse-midwife. Where there is no licensure law, the nurse-midwife must be certified by the appropriate professional body.

Occupational Therapist - A licensed occupational therapist performing within the scope of such licensure. Where there is no licensure law, the occupational therapist must be certified by the appropriate professional body.

Office Based Opioid Treatment Program - An outpatient treatment program for the treatment of opioid use disorder. The program is also known as medication assisted treatment.

Open Enrollment Period - The period during which you and your eligible dependents may enroll for coverage.

Opioid Treatment Program - An outpatient treatment program for the treatment of severe opioid use disorder. The program consists of daily or several times weekly medication and counseling available to maintain stability for those with severe opioid use disorder.

Optometrist - A licensed optometrist performing services within the scope of such licensure.

Out-of-Area - The geographic area outside Pennsylvania.

Out-of-Pocket Limit - A specified dollar amount of coinsurance incurred by you for covered services in a benefit period. It does not include the deductible amount or charges in excess of the plan allowance. When the out-of-pocket limit is reached, the level of benefits is increases as specified in the Summary of Benefits.

Outpatient - A member who receives services or supplies while not an inpatient.

Outpatient Physical Rehabilitation Facility - A Facility provider which, for compensation from its patients, is primarily engaged in providing a variety of rehabilitation services on an outpatient basis.

Outpatient Psychiatric Facility - A facility provider which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the treatment of mental illness on an outpatient basis.

Outpatient Substance Abuse Treatment Facility - A facility provider which, for compensation from its patients, is primarily engaged in providing detoxification services and/or rehabilitative counseling services for the treatment of substance abuse and diagnostic and therapeutic services for the treatment of substance abuse on an outpatient basis. This facility must also meet the minimum standards set by the Pennsylvania Department of Health, the Pennsylvania Office of Drug and Alcohol Programs, or another appropriate governmental agency.

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.

Partial Hospitalization Program - A time-limited, outpatient treatment program that is offered in the day or evening hours for a minimum of four (4) hours per day, three (3) days per week. A partial hospitalization program is a less restrictive alternative to inpatient hospitalization for individuals presenting with acute symptoms of a severe psychiatric disorder who cannot be effectively or safely treated in a lower level of care

and would otherwise require inpatient treatment. The goals of a partial hospitalization program are to prevent or reduce the need for inpatient hospitalization or re-hospitalization following discharge from inpatient treatment and to reduce or stabilize symptoms and functional impairment of a psychiatric or co-occurring substance use disorder. Medically necessary treatment is provided within a structured therapeutic milieu.

Participating Diabetes Prevention Provider - A diabetes prevention provider that contracts with:

- Your program to offer a diabetes prevention program based on a digital model; or
- Your program or the local licensee of the Blue Cross Blue Shield Association to offer a diabetes prevention program based on an in-person/onsite model.

Participating Facility Provider - A facility provider, licensed where required and performing within the scope of its license, that has an agreement with Highmark, either directly or indirectly, or any licensee of the Blue Cross Blue Shield Association located out-of-area pertaining to payment for covered services rendered to you.

Pediatric Extended Care Facility - A facility provider licensed by the state which, for compensation from its patients, 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.

Physical Therapist - A licensed physical therapist. Where there is no licensure law, the physical therapist must be certified by the appropriate professional body.

Physician - A person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed and legally entitled to practice medicine in all of its branches, perform surgery and dispense drugs.

Plan Allowance - The amount used to determine payment by your program for covered services provided to you and to determine your liability. Plan allowance is based on the type of provider who renders such services or as required by law.

Participating Provider Benefits
When covered medical services are received from a participating provider, then the plan allowance is determined in accordance with the provider's contract with Highmark or on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your health care program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

Non-Participating Provider Benefits
When covered medical services are received from a non-participating provider as described below, the plan allowance is determined as follows:

Non-Emergency Services Received at Certain Participating Facilities from Non-Participating Physicians
For non-emergency covered medical services received at certain participating facilities from non-participating physicians when such services are either ancillary, or non-ancillary that have not satisfied the notice and consent criteria required by federal law, the plan allowance may be based on the (i) the reference price (as defined below) if out of area; (iii) the recognized amount (as defined below); (iii) the amount agreed to by the out-of-network provider and Highmark; or (iv) the amount determined by Independent Dispute Resolution (IDR).

For the purpose of this preceding, "certain In-network facilities" are limited to a hospital, a hospital outpatient department, a critical access hospital, an ambulatory surgical center, and any other facility specified under federal law and regulation.

Emergency Services Provided by a Non-Participating Provider
For emergency services provided by a non-participating provider, the plan allowance is based on one of the following in the order listed below as applicable: (i) the reference price (as defined below) if out-of-area; (ii) recognized amount (as defined below) if out of area; (iii) the amount agreed to by the non-participating provider and Highmark; or (iv) the amount determined by Independent Dispute Resolution (IDR).

Air Ambulance Transportation Provided by a Non-Participating Provider
For Air Ambulance transportation provided by a non-participating provider, the plan allowance is based on one of the following in the order listed below as applicable: (i) the recognized amount (as defined below); (ii) the amount subsequently agreed to by the non-participating provider and Highmark; or (iii) the amount determined by Independent Dispute Resolution (IDR).

Your cost-sharing for each of the above non-participating providers will be based on the recognized amount.

In All Other Cases
If you receive covered medical services from a non-participating provider, the plan allowance for a non-participating provider located in the Highmark service area is based on an adjusted contractual allowance for like services rendered by a participating provider in the same geographic region. You will be responsible for any difference between the provider's billed charges and your program's payment.

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

When covered medical services are received from a non-participating provider outside of the Highmark service area, the plan allowance may be determined on the basis of the reference price (as defined below) or on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your health care program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

Recognized Amount - Except as otherwise provided, the plan allowance and the amount which coinsurance and applicable deductible is based on for covered medical services when provided by: (i) out-of-network emergency service providers; and (ii) non-emergency service received at certain participating facilities by participating providers, when such services are either ancillary or non-ancillary provider services that have not satisfied the notice and consent criteria under federal law and regulation. For the purpose of this definition, "certain facilities" are limited to a hospital (a hospital outpatient department, a critical access hospital, an ambulatory surgical center), as defined in federal law and regulation. The Recognized Amount is based on: (i) an all-payer model agreement, if adopted; (ii) state law; or (iii) the lesser of the qualifying payment amount as determined by Highmark (or the local licensee of the Blue Cross Blue Shield Association when the claim is incurred outside of the Highmark service area) under applicable law and regulation, or the amount billed by the provider or facility.

The recognized amount for air ambulance services provided by an out-of-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law and regulation or the amount billed by the air ambulance service provider.

Reference Price – means a percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market. When a rate is not published by CMS for the service, Highmark uses the price determined by a nationally recognized database or if no such price available, then 50% off billed charges.

Plan of Treatment - A managed care program through which you may obtain additional physical therapy and outpatient medical care visits if it has been determined by Highmark or its designated agent to meet the criteria as outlined herein.

Podiatrist - A licensed podiatrist performing services within the scope of such licensure.

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

Professional Counselor - A licensed professional counselor performing within the scope of such licensure. Where there is no licensure law, the professional counselor must be certified by the appropriate professional body.

Professional Other Provider - A person or entity other than a facility provider or professional provider who is licensed, where required, to render covered services as prescribed by a professional provider within the scope of such licensure or under the supervision of a professional provider within the scope of such licensure. Professional other providers include:

Behavioral Specialist
Licensed Practical Nurse
Respiratory Therapist
Registered Nurse

Professional Provider - A person or practitioner licensed where required and performing services within the scope of such licensure.

Audiologist
Behavior Specialist
Certified Registered Nurse
Chiropractor
Clinical Laboratory
Clinical Social Worker
Dentist
Dietitian-Nutritionists
Marriage and Family Therapist
Nurse-Midwife
Occupational Therapist
Optometrist
Physical Therapist
Physician
Podiatrist
Professional Counselor
Psychologist
Speech-Language Pathologist
Teacher of the Hearing Impaired

Provider - An ancillary provider, facility provider or professional provider, licensed where required and performing within the scope of such licensure.

a. **Participating Provider** - a provider that has an agreement with Highmark, either directly or indirectly, pertaining to payment for covered services rendered to you.

b. **Non-Participating Provider** - a provider that is not a participating provider.

c. **Medicare Participating Provider** - a provider which has been certified by the Department of Health and Human Services of the United States for participation in the Medicare program.

Psychiatric Hospital - A facility provider approved by The Joint Commission, the American Osteopathic Hospital Association, Council on Accreditation or Commission on Accreditation of Rehabilitation Facilities which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of mental illness. Such services are provided by or under the supervision of an

organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Psychologist - A licensed psychologist. When there is no licensure law, the psychologist must be certified by the appropriate professional body.

Rehabilitation Hospital - A facility provider approved by The Joint Commission or by the Commission on Accreditation of Rehabilitation Facilities or certified by Medicare which, for compensation from its patients, is primarily engaged in providing skilled rehabilitation services on an inpatient basis. Skilled rehabilitation services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Skilled rehabilitation services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Residential Care - Institutional care, often following inpatient hospitalization in a facility provider, which is intended to provide a structured living environment or simulate a structured school or work environment in a therapeutic setting provided or supervised by medical professionals.

Residential Treatment Facility - A licensed psychiatric residential facility that provides medical monitoring and twenty-four hour individualized treatment to a group of individuals. The treatment is provided by paid staff unrelated to the individual.

A residential treatment program must provide the following:

a. Awake adult supervision twenty-four hours per day;

b. Clinical assessment at least once a day;

c. Individual, group, or family therapy at least three times per week;

d. Medical history and physical examination of patient within six months prior to admission or within thirty days after admission;

e. Review of patient's current medication(s) initiated within twenty-four hours;

f. Initiation of a multidisciplinary treatment plan within one week;

g. Nursing staff on-site or on-call twenty-four hours per day;

h. Parent training for patient's/guardians or family if return to family is expected;

i. Discharge planning initiated within twenty-four hours;

j. Psychiatric evaluation/updated (initial within one business day, updates at least once a week);

k. Psychosocial assessment and substance evaluation within forty-eight hours;

l. School or vocational program as per the clinical needs and/or age of the patient; and

m. Toxicology screen, quantitative drug analysis, self-help, 12-step, or education group as needed.

Respite Care - Short-term care for a terminally ill member provided by a facility provider when necessary to relieve a person (caregiver) who is caring for the member at home free of charge.

Retail Clinic - A retail-based clinic that provides basic and preventive health care services seven days a week, including evenings and weekends. A retail clinic is generally staffed by certified registered nurses that diagnose and treat minor health problems and triage patients to appropriate levels of care.

Routine Patient Costs - Costs associated with covered services furnished when participating in an approved clinical trial and that Highmark has determined are medically necessary and appropriate. Such costs do not include:

- the costs of investigational drugs or devices themselves;
- the costs of non-health services required by you when receiving treatments or interventions in the course of participating in an approved clinical trial (e.g. transportation, lodging, meals and other travel expenses);
- items or services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of you; and
- a service clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Service - Each treatment rendered by a provider to a member for a covered service.

Skilled Nursing Facility - A facility provider approved by the state and certified by Medicare, which, for compensation from its patients, is primarily engaged in providing skilled nursing services on an inpatient basis to patients requiring twenty-four (24) hour skilled nursing services but not requiring confinement in an acute care general hospital. Such care is rendered by or under the supervision of physicians. A skilled nursing facility is not, other than incidentally, a place that provides:

a. minimal care, custodial care, ambulatory care, or part-time care services; or

b. care or treatment of mental illness, substance abuse or pulmonary tuberculosis.

Skilled Nursing Services/Skilled Rehabilitation Services - Services which have been ordered by and under the direction of a physician and are provided either directly by or under the supervision of a medical professional, e.g., registered nurse, physical therapist, licensed practical nurse, occupational therapist, speech pathologist or audiologist with the treatment described and documented in the patient's medical records. Unless otherwise determined in the sole discretion of Highmark, skilled nursing services/skilled rehabilitation services shall be subject to the following:

a. the skilled nursing services/skilled rehabilitation services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified licensed medical professional and must be such that the care could not be performed by a non-medical individual instructed to deliver such services.

b. the skilled rehabilitation services must be provided with the expectation that the patient has restorative potential and the condition will improve materially in a reasonable and generally predictable period of time. Once a maintenance level has been established or no further progress

is attained, the services are no longer classified as skilled rehabilitation and will be considered to be custodial care.

The mere fact that a physician has ordered or prescribed a therapeutic regimen does not, in itself, determine whether a service is a skilled nursing service or a skilled rehabilitation service.

Special Enrollment Period - The period during which you and your eligible dependents who experience(s) certain qualifying events may enroll for coverage outside of the open enrollment period.

Specialist - A physician, other than a primary care provider, whose practice is limited to a particular branch of medicine or surgery.

Specialist Virtual Visit - A real-time office visit with a specialist at a remote location, conducted via interactive audio and streaming video telecommunications.

State-Owned Psychiatric Hospital - A facility provider, that is owned and operated by the Commonwealth of Pennsylvania, which is primarily engaged in providing treatment and/or care for the Inpatient treatment of mental illness for individuals aged eighteen and older whose hospitalization is ordered by a court of competent jurisdiction through a civil commitment proceeding.

Substance Abuse - Any use of alcohol or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Substance Abuse Treatment Facility - A facility provider licensed by the state and approved by an external accreditation body (i.e., The Joint Commission, Commission on Accreditation of Rehabilitation Facilities, Council on Accreditation) which, for compensation from its patients, is primarily engaged in providing detoxification and/or rehabilitation treatment for alcohol abuse and/or drug abuse. This facility must also meet the minimum standards set by the Pennsylvania Department of Health, the Pennsylvania Office of Drug and Alcohol Programs, or another appropriate governmental agency.

Suite Infusion Therapy Provider - An ancillary provider licensed by the state, accredited by The Joint Commission, if appropriate, and organized to provide infusion therapy to patients at an infusion suite.

Supplier - An individual or entity that is in the business of leasing and selling durable medical equipment and supplies. Suppliers include, but are not limited to, the following: durable medical equipment suppliers, hearing aid device vendors, vendors/fitters, orthotic and prosthetic suppliers, pharmacy/durable medical equipment suppliers.

Surgery -

a. the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures;

b. the correction of fractures and dislocations; and

c. usual and related Inpatient pre-operative and post-operative care.

Therapy and Rehabilitation Service - The following services or supplies ordered by a professional provider to promote your recovery. Therapy and rehabilitation services are covered to the extent specified in the Summary of Benefits provided herein.

a. Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.

b. Dialysis Treatments - the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body through hemodialysis or peritoneal dialysis. Dialysis treatment includes home dialysis.

c. Infusion Therapy - the treatment by the administration of medically necessary and appropriate fluid or medication via a central or peripheral vein when performed, furnished and billed by a facility provider in accordance with accepted medical practice.

d. Occupational Therapy - the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

e. Physical Medicine - the treatment by physical means or modalities such as, but not limited to, mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities, and rehabilitative procedures, performed to relieve pain and restore level of function following disease, illness or injury.

f. Radiation Therapy - the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

g. Respiratory Therapy - the introduction of dry or moist gases into the lungs for treatment purposes.

h. Speech Therapy - the treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

Urgent Care Center - A formally structured hospital-based or freestanding full-service, walk-in health care clinic, outside of a hospital-based emergency room, that is open twelve hours a day, Monday through Friday and eight hours a day on Saturdays and Sundays, that primarily treats patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room. An urgent care center can also provide the same services as a family physician or primary care provider, such as treatment of minor illnesses and injuries, physicals, x-rays and immunizations.

Vision Provider - A physician or professional provider licensed, where required, and performing services related to the examination, diagnosis and treatment of conditions of the eye and associated structures.

Visit - An interaction between you and a professional provider for the purpose of providing covered services. This may include seeking advice for the purpose of determining what medical examinations, procedures, or treatment if any, are appropriate for your condition. A visit may be performed in-person or via telephone, internet or other electronic communication.

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

Summary of Benefits - Major Medical

Under the Major Medical benefits program, benefits include coverage for both facility and professional services as well as many other services. Most Major Medical benefits are subject to deductible and coinsurance provisions which require you to share a portion of the medical costs. Below are specific benefit levels.

Benefits	Major Medical
General Provisions	
Benefit Period	Calendar Year
Deductible (per benefit period)	None
Plan Payment Level -- Based on the plan allowance	80% after deductible
Lifetime Maximum (per member)	$100,000
Office/Clinic/Urgent Care Visits	
Outpatient Medical Visits Physician Office Visits[1] (including virtual visits)	80% after deductible
Virtual Visit Originating Site Fee[1]	80% after deductible
Retail Clinic Visits (including virtual visits)	80% after deductible
Urgent Care Center Visits	80% after deductible
Preventive Care Services[2]	
Adult Routine physical exams	Not Covered
Immunizations	Not Covered
Routine gynecological exams, including a PAP Test	80% after deductible; maximum does not apply
Mammograms, annual routine and medically necessary	80% after deductible
Pediatric Routine physical exams	Not Covered
Immunizations	80% after deductible; maximum does not apply
Hospital and Medical/Surgical Expenses (including maternity)	
Hospital Services - Inpatient[0]	80% after deductible
Hospital Services - Outpatient[0]	80% after deductible
Inpatient Medical Care (professional)	80% after deductible
Maternity (non-preventive facility and professional services)	80% after deductible
Surgical Services	80% after deductible
Assistant At Surgery	80% after deductible
Second Surgical Opinion	80% after deductible
Emergency Services	
Emergency Room Care	80% after deductible
Ambulance	80% after deductible

Therapy and RehabilitationServices	
Occupational Therapy	80% after deductible
Radiation Therapy	80% after deductible
Physical Medicine	80% after deductible
Speech Therapy	80% after deductible
Spinal Manipulations	80% after deductible
Other Therapy and Rehabilitation Services	80% after deductible
Mental Health/Substance Abuse Services	
Mental Health - Inpatient	80% after deductible
Mental Health - Outpatient (including virtual visits)	100% after deductible up to maximum payment of $25 per visit
Substance Abuse -Inpatient Detoxification	80% after deductible
Substance Abuse - Inpatient Residential Treatment and Rehabilitation Services	80% after deductible
Substance Abuse - Outpatient	100% after deductible up to maximum payment of $25 per visit[3]
Other Services	
Anesthesia	80% after deductible
Anesthesia for Non-Covered Dental Procedures (Limited)	80% after deductible
Assisted Fertilization Treatment	Not Covered
Dental Services Related to Accidental Injury	80% after deductible
Diabetes Treatment	80% after deductible
Diagnostic Services	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible
Enteral Foods	80%; deductible does not apply
Home Health Care	80% after deductible
	Limit: 365 days for same or related illness or injury
Hospice	Not Covered
Infertility Counseling, Testing and Treatment[4]	80% after deductible
Pediatric Extended Care Services	Not Covered
Prescription Drugs	Not Covered
Private Duty Nursing	80% after deductible
Skilled Nursing Facility Services	80% after deductible Limited to 365 days per illness per member
Transplant Services	80% after deductible

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

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

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

[3] The maximum payment limitation does not apply for the first instance or course of treatment.

[4] 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.

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

HIGHMARK INC.
NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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

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

Our Legal Duties

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

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

We will inform you of these practices the first time you become a Highmark customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice becomes 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/payments 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 services to our members.

(i) Business Associates.

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

(ii) Other Covered Entities.

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

II. Other Possible Uses and Disclosures of Protected Health Information

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

A. To Plan Sponsors

We may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us regarding a member's question, concern, issue regarding claim, benefits, service, coverage, etc. We may also disclose summary health information (this type of information is defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

B. Required by Law

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

C. Public Health Activities

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

D. Health Oversight Activities

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

E. Abuse or Neglect

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

F. Legal Proceedings

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

G. Law Enforcement

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

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

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

I. Research

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

J. To Prevent a Serious Threat to Health or Safety

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

K. Military Activity and National Security, Protective Services

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

L. Inmates

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

M. Workers' Compensation

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

N. Others Involved in Your Health Care

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

O. Underwriting

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

P. Health Information Exchange
We will 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 call 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 providers 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 sell 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
   (vi) if needed to avert a serious and imminent threat to health or safety.

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

V. Your Individual Rights
The following is a description of your rights with respect to your protected health information:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- We use personal information internally to manage enrollment, process claims, monitor the quality of the health services provided to our members, prevent fraud, audit our own performance or to respond to members' requests for information, products or services.

- We share personal information with our affiliated companies, health care providers, agents, other insurers, peer review organizations, auditors, attorneys or consultants who assist us in administering our programs and delivering health services to our members. Our contracts with all such service providers require them to protect the confidentiality of our members' personal information.

- We may share personal information with other insurers that cooperate with us to jointly market or administer health insurance products or services. All contracts with other insurers for this purpose require them to protect the confidentiality of our members personal information.

- We may disclose information under order of a court of law in connection with a legal proceeding.

- We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.

- We may disclose information under a subpoena or summons to government agencies that investigate fraud or other violations of law.

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

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