Please Read This Important Message

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

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

SPANISH

Lea este importante mensaje

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

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

VIETNAMESE

Xin Đọc Tin Nhắn Quan Trọng Này

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

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

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

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

Leggere attentamente il presente messaggio

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

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

请阅读以下重要信息

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

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

Your health benefits are entirely funded by your employer. Highmark Blue Cross Blue Shield provides administrative and claims payment services only.
Introduction to Your Major Medical Benefits Program

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

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

And, as a member of your Major Medical program, you get important extras. Along with 24-hour assistance with any health care question or concern via Blues On Call™, your member Web site connects you to a range of self-service tools that can help you manage your coverage. The Web site also offers programs and services designed to help you "Have A Greater Hand in Your Health®" by helping you make and maintain healthy improvements.

You can review Preventive Care Guidelines, check eligibility information, order ID cards and medical claim forms, even review claims and Explanation of Benefits (EOB) information all online. You can also access health information such as the comprehensive Healthwise Knowledgebase®, full-color Health Encyclopedia, and the Health Crossroads® guide to treatment options. You can take an online Lifestyle Improvement course to manage stress, stop smoking or improve your nutrition. And the Web site connects you to a wide range of cost and quality tools to assure you spend your health care dollars wisely.

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

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

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

To help you understand your Major Medical coverage and how it works, here’s an explanation of some 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” and “coinsurance” describe methods of such payment.

**Benefit Period**

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

**Coinsurance**

The coinsurance is the specific percentage of the provider’s reasonable charge 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 include any charges for which benefits are excluded in whole or in part under the provisions of a managed care program under your Basic Plan.

**Lifetime Maximum**

The maximum benefit that the program will provide for any covered individual during his or her 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 $1,000) 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 plan will be added to any amount paid for benefits for that same individual under any other group health care expense plan for the purpose of calculating the benefit period or lifetime maximum applicable to each individual.
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.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Major Medical</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Provisions</strong></td>
<td></td>
</tr>
<tr>
<td>Benefit Period</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Deductible (per benefit period)</td>
<td>None</td>
</tr>
<tr>
<td>Plan Payment Level – Based on the provider's reasonable charge (PRC)</td>
<td>80%</td>
</tr>
<tr>
<td>Lifetime Maximum (per member)</td>
<td>$100,000</td>
</tr>
<tr>
<td><strong>Office Visits</strong></td>
<td></td>
</tr>
<tr>
<td>Clinic Visits/Outpatient Medical Visits</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td></td>
</tr>
<tr>
<td>Routine physical exams</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine gynecological exams, including a PAP Test</td>
<td>80%; lifetime maximum does not apply</td>
</tr>
<tr>
<td>Colorectal Cancer Screenings</td>
<td>80%</td>
</tr>
<tr>
<td>Mammograms, annual routine and medically necessary</td>
<td>80%</td>
</tr>
<tr>
<td>Pediatric</td>
<td></td>
</tr>
<tr>
<td>Routine physical exams</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Immunizations</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Emergency Room Services</strong></td>
<td></td>
</tr>
<tr>
<td>Emergency Accident Care</td>
<td>80%</td>
</tr>
<tr>
<td>Emergency Medical Care</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
</tr>
<tr>
<td>Hospital Services - Inpatient</td>
<td>80%</td>
</tr>
<tr>
<td>Hospital Services - Outpatient</td>
<td>80%</td>
</tr>
<tr>
<td>Inpatient Medical Care (professional)</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Therapy and Rehabilitation Services</strong></td>
<td></td>
</tr>
<tr>
<td>Spinal Manipulations</td>
<td>80%</td>
</tr>
<tr>
<td>Physical Medicine</td>
<td>80%</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>80%</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>80%</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>80%</td>
</tr>
<tr>
<td>Therapy and Rehabilitation Services</td>
<td>80%</td>
</tr>
<tr>
<td>Benefits</td>
<td>Major Medical</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>80%</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td></td>
</tr>
<tr>
<td>Mental Health - Inpatient</td>
<td>80%</td>
</tr>
<tr>
<td>Mental Health - Inpatient Detoxification</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse - Inpatient</td>
<td>80%</td>
</tr>
<tr>
<td>Substance Abuse - Inpatient Detoxification</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse - Inpatient Residential</td>
<td>80%</td>
</tr>
<tr>
<td>Substance Abuse - Outpatient</td>
<td>50% up to a payment maximum of $25 per visit</td>
</tr>
<tr>
<td>Other Services</td>
<td></td>
</tr>
<tr>
<td>Assisted Fertilization Treatment</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Ambulance</td>
<td>80%</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>80%</td>
</tr>
<tr>
<td>Dental Services Related to Accidental Injury</td>
<td>80%</td>
</tr>
<tr>
<td>Diabetes Treatment</td>
<td>80%</td>
</tr>
<tr>
<td>Durable Medical Equipment, Orthotics and</td>
<td>80%</td>
</tr>
<tr>
<td>Prosthetics</td>
<td></td>
</tr>
<tr>
<td>Enteral Formulae</td>
<td>80%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>80%</td>
</tr>
<tr>
<td>Hospice</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Infertility Counseling, Testing and Treatment</td>
<td>80%</td>
</tr>
<tr>
<td>Maternity (facility and professional services)</td>
<td>80%</td>
</tr>
<tr>
<td>Pediatric Extended Care Services</td>
<td>80%</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>80%</td>
</tr>
<tr>
<td>Skilled Nursing Facility Services</td>
<td>80% Limited to 365 days per illness per member</td>
</tr>
<tr>
<td>Surgical Services</td>
<td>80%</td>
</tr>
<tr>
<td>Assistant At Surgery</td>
<td>80%</td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>80%</td>
</tr>
<tr>
<td>Transplant Services</td>
<td>80%</td>
</tr>
</tbody>
</table>

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

2 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.
MAJOR MEDICAL SERVICES

Major Medical coverage is designed to supplement your Basic Plan benefits by providing additional protection against the expenses incurred due to non-occupational illness or accidents only when such services are determined to be medically necessary and appropriate for the proper treatment of the patient’s condition. Please refer to the section headed "Terms You Should Know" for specific details. Any benefit limits, deductibles and coinsurance amounts are described in the Summary of Benefits. Major Medical will reimburse you for certain covered medical expenses not covered by the Basic Plan.

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

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

Dental Services Related to Accidental Injury
Dental services rendered by a physician or dentist which are required as a result of accidental injury to the jaws, sound natural teeth, mouth or face. Injury caused by chewing or biting will not be considered accidental injury.

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

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

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

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

- Diagnostic X-ray consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine
- Diagnostic pathology, consisting of laboratory and pathology tests
- Diagnostic medical procedures consisting of ECG, EEG, and other electronic diagnostic medical procedures and physiological medical testing approved by Highmark
- Allergy testing, consisting of percutaneous, intracutaneous, and patch tests 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 Formulae**
Coverage is provided for enteral formulae when administered on an outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders. Benefits are exempt from all deductible requirements.

**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.

**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.
Mastectomy and Breast Cancer Reconstruction
The program covers a mastectomy performed on an inpatient or outpatient basis, as well as surgery to reestablish symmetry or alleviate functional impairment. This includes, but is not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy. Also covered is the use of initial and subsequent prosthetic devices to replace the removed breast or portions thereof. Physical complications of all stages of mastectomy are also covered, including lymphedema. The program covers one home health care visit, as determined by your physician, within 48 hours after discharge if discharge occurred within 48 hours after your admission for a mastectomy.

Maternity Services
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.

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

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

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

Nursery Care
Ordinary nursery care of the newborn infant, including inpatient medical visits by a professional provider. Benefits will continue for a maximum of 31 days. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within such period. Refer to the General Information section for further eligibility information.

Maternity Home Health Care Visit
Benefits for one maternity home health care visit will be provided at your home within 48 hours of discharge when the discharge from a facility provider occurs prior to: (a) 48 hours of inpatient care following a normal vaginal delivery; or (b) 96 hours of inpatient care following a cesarean delivery. This visit shall be made by a provider whose scope of practice includes postpartum care. The visit includes parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests, and the performance of any necessary maternal and neonatal physical assessments. The visit may, at the mother's sole discretion, occur at the office of the provider. The visit is subject to all the terms of this program and is exempt from any copayment, coinsurance or deductible amounts.
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 her newborn earlier than 48 hours (or 96 as applicable). In any case, under Federal law, your self-insured program can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

**Medical Services**

**Inpatient Medical Services**
Medical care and consultations by a professional provider for the diagnosis and treatment of an injury or illness to you when you are an inpatient.

**Outpatient Medical Care Services**
Medical care and consultations rendered by a professional provider for the diagnosis and treatment of an injury or illness when you are an outpatient for a condition not related to surgery.

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

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

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

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

Pediatric extended care services will be covered for children eight years of age or under, pursuant to the attending physician’s treatment plan only when provided in a pediatric extended care facility and when approved by Highmark.
A prescription from the child’s attending physician is necessary for admission to such facility.

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

**Preventive Care**

*Mammographic Screening*

Benefits will be provided for:
- an annual routine mammographic screening for all female members 40 years of age or older;
- mammographic examination for all female members regardless of age when prescribed by a physician;
- benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified by the Pennsylvania Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

*Pediatric Immunizations*

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

*Routine Gynecological Examination and Papanicolaou Smear*

Benefits are provided for one routine gynecological examination, including a pelvic examination and clinical breast examination and one routine Papanicolaou smear per calendar year for all female members. Benefits are exempt from all deductibles or maximums.

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

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

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

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

**Prosthetic Appliances**
Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses).

**Psychiatric Care Services/Substance Abuse Treatment Services**
The following services are provided for the inpatient and outpatient treatment of mental illness and the treatment of alcoholism and drug abuse by a facility or professional provider:

- Inpatient and outpatient medical care visits
- Individual psychotherapy
- Group psychotherapy
- Psychological testing
- Counseling with family members to assist in the patient's diagnosis and treatment
• Services in a planned therapeutic treatment program on a day or night only basis

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

**Serious Mental Illness Care Services**

Coverage is provided for inpatient care for the treatment of serious mental illness for up to 30 days per benefit period.

Coverage is provided for outpatient care for the treatment of serious mental illness for up to 60 outpatient care visits per benefit period. 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.

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

**Skilled Nursing Facility Services**

Services rendered in a skilled nursing facility to the same extent benefits are available to an inpatient of a hospital. No benefits are payable:

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

**Spinal Manipulations**

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

**Surgical Services**

*Surgery*

Surgery performed by a professional provider. Separate payment will not be made for pre- and post-operative services.
Also covered is the orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

**Assistant At Surgery**
Services of a physician who actively assists the operating surgeon in performing a covered surgery if a house staff member, intern or resident is not available.

**Anesthesia**
Administration of anesthesia, anesthesia supplies and services ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery.

**Therapy and Rehabilitation Services**
Benefits will be provided for the following covered services only when such services are ordered by a professional provider:

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

**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 subject to the following additional limitations:
  - the donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, other Highmark coverage, or any government program; and
- benefits provided to the donor will be charged against the recipient's coverage under this program;

- when only the donor is a member, the donor is entitled to the benefits of 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

*You are not covered for the following Major Medical services, supplies or charges:*

<table>
<thead>
<tr>
<th>Key Word</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>• For elective abortions, except those abortions necessary to avert the death of the member or to terminate pregnancies caused by rape or incest;</td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>• For allergy testing, except as provided herein or as mandated by law;</td>
</tr>
<tr>
<td>Assisted Fertilization</td>
<td>• 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;</td>
</tr>
<tr>
<td>Comfort/Convenience Items</td>
<td>• For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers or physical fitness equipment, stair glides, elevators/lifts or &quot;barrier-free&quot; home modifications, whether or not specifically recommended by a professional provider;</td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>• For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise required by law. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; b) surgery to correct a congenital birth defect; and c) surgery to correct a functional impairment which results from a covered disease or injury;</td>
</tr>
<tr>
<td>Effective Date</td>
<td>• Incurred prior to your effective date;</td>
</tr>
<tr>
<td>Experimental/Investigative</td>
<td>• Which are experimental/investigative in nature;</td>
</tr>
<tr>
<td>Hearing Care Services</td>
<td>• For hearing aid devices, tinnitus maskers or examinations for the prescription or fitting of hearing aids;</td>
</tr>
<tr>
<td>Legal Obligation</td>
<td>• For which you have no legal obligation to pay;</td>
</tr>
<tr>
<td>Medically Necessary and Appropriate</td>
<td>• Which are not medically necessary or medically appropriate as determined by Highmark Blue Cross Blue Shield;</td>
</tr>
<tr>
<td>Medicare</td>
<td>• For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage;</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>• For telephone consultations, charges for failure to keep a scheduled visit or charges for completion of a claim form;</td>
</tr>
<tr>
<td></td>
<td>• For any other medical or dental service or treatment except as provided in this booklet or as mandated by law.</td>
</tr>
<tr>
<td>Motor Vehicle Accident</td>
<td>• For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or event is excluded.</td>
</tr>
</tbody>
</table>
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;

<table>
<thead>
<tr>
<th>Preventive Care Services</th>
<th>For preventive care services, wellness services or programs, except as provided herein or as mandated by law;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider of Service</td>
<td>Which are not prescribed by, performed by or upon the direction of a professional provider;</td>
</tr>
<tr>
<td></td>
<td>Rendered by a provider not specifically listed in this booklet;</td>
</tr>
<tr>
<td></td>
<td>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;</td>
</tr>
<tr>
<td></td>
<td>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;</td>
</tr>
<tr>
<td></td>
<td>Rendered by a provider who is a member of your immediate family;</td>
</tr>
<tr>
<td></td>
<td>Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program;</td>
</tr>
<tr>
<td>Sexual Dysfunction</td>
<td>For treatment of sexual dysfunction that is not related to organic disease or injury;</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>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;</td>
</tr>
<tr>
<td>Termination Date</td>
<td>Incurred after the date of termination of your coverage except as provided herein;</td>
</tr>
<tr>
<td>Therapy</td>
<td>For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate;</td>
</tr>
<tr>
<td>TMJ</td>
<td>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</td>
</tr>
</tbody>
</table>
the occlusion and treatment of temporomandibular joint
dysfunction not caused by documented organic joint disease
or physical trauma;

Transsexual Surgery

- For any treatment leading to or in connection with transsexual
  surgery, except for sickness or injury resulting from such
treatment or surgery;

Well-Baby Care

- For well-baby care visits, except as provided herein or as
  mandated by law;

In addition, Major Medical will not provide benefits for the following services, supplies or charges:

- For contraceptive services, including contraceptive
  prescription drugs, contraceptive devices, implants and
  injections, and all related services;

- For custodial care, domiciliary care or rest cures;

- Directly related to the care, filling, removal or replacement
  of teeth, the treatment of injuries to or diseases of the teeth,
gums or structures directly supporting or attached to the
  teeth. These include, but are not limited to, apicoectomy
  (dental root resection), root canal treatments, soft tissue
  impactions, alveolectomy and treatment of periodontal
disease, except orthodontic treatment for congenital cleft
  palates as provided herein;

- Any food, including but not limited to, enteral formulae,
  infant formulas, supplements, substances, products, enteral
  solutions or compounds used to provide nourishment
  through the gastrointestinal tract whether ingested orally or
  provided by tube, whether utilized as a sole or supplemental
  source of nutrition, and when provided on an outpatient
  basis. This does not include enteral formulae prescribed
  solely for the therapeutic treatment of phenylketonuria,
branched-chain ketonuria, galactosemia, and
  homocystinuria;

- For eyeglasses or contact lenses and the vision examination
  for prescribing or fitting eyeglasses and contact lenses
  (except for aphakic patients and soft lenses or sclera shells
  intended for use in the treatment of disease or injury);

- 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;

- Performed on high cost technological equipment such as, but
Equipment not limited to, computed tomography scanners (CT scanners), lithotriptors, 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;

Home Health Care
- The following services you receive from a home health care agency or a hospital program for home health care: dietitian services; homemaker services; maintenance therapy; custodial care; food or home-delivered meals; drugs and medications;

Inpatient Admissions
- For inpatient admissions which are primarily for diagnostic study;
- For inpatient admissions which are primarily for physical medicine services;
- Rendered 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 during that inpatient admission;

Learning Disabilities
- For any care related to autistic disease of childhood, learning disabilities, or mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change.

Medicare
- For any illness or injury to the extent that payment has been made by Medicare or any Medicare supplemental insurance program, when Medicare is primary;
- 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;

Military Service
- To the extent benefits are provided to members of the armed forces and National Health Service or to patients in Veteran's Administration facilities for service-connected illness or injury unless you have a legal obligation to pay;

Miscellaneous
- For any amounts the patient is required to pay for under any deductible and/or coinsurance provisions of the basic program;

Nutritional Counseling
- For nutritional counseling and services intended to produce
weight loss;

**Oral Surgery**
- For oral surgery procedures unless specifically provided, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face;

**Physical Examinations**
- For routine or periodic physical examinations, except as provided herein or as mandated by law;

**Respite Care**
- For respite care;

**Sterilization**
- For sterilization and reversal of sterilization;

**Vision Correction Surgery**
- For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomeleusis, keratophakia, and radial keratotomy and all related services;

**War**
- For any illness or injury suffered after your effective date as a result of an act of war;

**Workers' Compensation**
- For any illness or bodily injury for or covered by any federal, state or local government's Worker's Compensation Act or Occupational Disease Law;
Out-of-Area Care

The BlueCard Worldwide® Program

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

Services may include:

- making referrals and appointments for you with nearby physicians and hospitals;
- verbal translation from a multilingual service representative;
- providing assistance if special medical help is needed;
- making arrangements for medical evacuation services;
- processing inpatient hospitalization claims; and
- for outpatient or professional services received abroad, you should pay the provider, then complete an international claim form and send it to the BlueCard Worldwide Service Center. Claim forms can be obtained by calling 1-800-810-BLUE or the Member Service telephone number on your ID card. Claim forms can also be downloaded from www.bcbs.com.
Eligible Providers

Facility Providers

- Hospital
- Psychiatric hospital
- Rehabilitation hospital
- Ambulance service
- Ambulatory surgical facility
- Birthing facility
- Day/night psychiatric facility
- Freestanding dialysis facility
- Home health care agency
- Home infusion therapy provider
- Outpatient physical rehabilitation facility
- Outpatient psychiatric facility
- Outpatient substance abuse treatment facility
- Pharmacy provider
- Skilled nursing facility
- Substance abuse treatment facility

Professional Providers

- Audiologist
- Certified Clinical Nurse Specialist*
- Certified Community Health Nurse*
- Certified Enterostomal Therapy Nurse*
- Certified Psychiatric Mental Health Nurse*
- Certified Registered Nurse Anesthetist*
- Certified Registered Nurse Practitioner*
- Chiropractor
- Clinical laboratory
- Clinical social worker
- Dentist
- Licensed practical nurse
- Marriage and family therapist
- Nurse-midwife
- Occupational therapist
- Optometrist
- Physical therapist
- Physician
- Podiatrist
- Professional counselor
- Psychologist
- Registered nurse
- Respiratory therapist
- Speech pathologist
- Speech therapist
- Teacher of hearing impaired
*Excluded from eligibility are registered nurses employed by a health care facility or by an anesthesiology group.

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

**Non-Participating Providers**
Some providers do not have an agreement and do not accept the allowance as payment-in-full.
General Information

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

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

Who is Eligible for Coverage
You may enroll your:

- Spouse
- Unmarried children under 19 years of age, including:
  - Newborn children
  - Stepchildren
  - Children legally placed for adoption
  - Legally adopted children or 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
- Unmarried children up to the age of 23, provided they are enrolled in and regularly attending a full-time accredited school, college or university or a licensed technical or specialized school and are dependent solely upon you for support. Except as otherwise indicated, coverage automatically terminates at the end of the month in which the student ceases to be eligible, whether or not notice to terminate is received by Highmark Blue Cross Blue Shield.

A student who takes a medically necessary leave of absence from school, or who changes his or her enrollment status (such as changing from full-time to part-time) due to a serious illness or injury may continue coverage for one 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 Blue Cross Blue Shield may require certification from the student's treating physician in order to continue such coverage.
• Unmarried children over age 19 who are not able to support themselves due to mental retardation, physical disability, mental illness or developmental disability.

NOTE: To the extent mandated by the requirements of Pennsylvania Act 83 of 2005, eligibility will be continued past the limiting age for unmarried 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 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. Furthermore, to be considered an eligible dependent, the domestic partner must demonstrate financial interdependence with you by submitting proof to the group of three or more of the following:
  – A domestic partner agreement or proof of registry with a domestic partner registry
  – A joint mortgage or lease
  – A designation of one of the partners as beneficiary in the other partner’s will
  – A durable property and health care powers of attorney
  – Joint title to an automobile, or joint bank account or credit account
  – Such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case

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

"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.

**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.

**Certificates of Creditable Coverage**

Your employer or insurance company is required to issue a certificate to you if you change jobs or lose your health care coverage. This Certificate of Coverage provides evidence of your prior coverage.

Certificates will be mailed automatically to everyone who changes or loses their health coverage. You can also request a certificate from your previous employer or insurance company.

**Termination of Your Coverage Under the Employer Contract**

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

**Benefits After Termination of Coverage**

- Major Medical benefits will be continued for covered services for a period of six months immediately following the date coverage terminates, provided the benefits are required for the treatment of an injury or illness which began prior to the termination of this program.

  This provision does not apply if your employer replaces this program with another group health care benefits program. In this event, all benefits will cease on the date this program is terminated.

**Coordination of Benefits**

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

Here is how the coordination of benefits provision works:
• When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your plan.

• When the person who received care is covered as an employee under one contract, and as a dependent under another, then the employee coverage pays first.

• When a dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the calendar year pays first. But, if both parents have the same birthday, the plan which covered the parent longer will be the primary plan. If the dependent child's parents are separated or divorced, the following applies:
  – The parent with custody of the child pays first.
  – The coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody.
  – Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

• When none of the above circumstances applies, the coverage you have had for the longest time pays first, provided that:
  – the benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person and if
  – the other plan does not have this provision regarding laid-off or retired employees, and, as a result, plans do not agree on the order of benefits, then this rule is disregarded.

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

**Subrogation**

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

For example, if you or one of your dependents receives benefits through your program for injuries caused by another person or organization, your program has the right, through subrogation, to seek repayment from the other person or organization or any applicable insurance company for benefits already paid.
Your program will provide eligible benefits when needed, but you may be asked to show documents or take other necessary actions to support your program in any subrogation efforts.

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

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

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

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

- Your name and your dependent’s name, if applicable
- Identification number
- Group number
- Premier Pharmacy network logo (when applicable)
- Member Service toll-free number (on back of card)
How to File a Claim

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

The procedure is simple. Just take the following steps:

• **Know Your Benefits.** Review this information to see if the services you received are eligible under your medical program.

• **Get an Itemized Bill.** Itemized bills must include:
  - The name and address of the service provider;
  - The patient’s full name;
  - The date of service or supply;
  - A description of the service or supply;
  - The amount charged;
  - The diagnosis or nature of illness;
  - For durable medical equipment, the doctor’s certification;
  - For private duty nursing, the nurse’s license number, charge per day and shift worked, and signature of provider prescribing the service;
  - For ambulance services, the total mileage.

Please note: If you’ve already made payment for the services you received, you must also submit proof of payment (receipt from the provider) with your claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

• **Copy Itemized Bills.** You must submit originals, so you may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.

• **Complete a Claim Form.** Make sure all information is completed properly, and then sign and date the form. *Claim forms are available from your employee benefits department, or call the Member Service telephone number on the back of your ID card.*

• **Attach Itemized Bills to the Claim Form and Mail.** After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the back of your ID card.
Remember: Multiple services for the same family member can be filed with one claim form. However, a separate claim form must be completed for each member.

Your claims must be submitted no later than the end of the benefit period following the benefit period for which benefits are payable.

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 Blue Cross Blue Shield;
- 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.

Additional Information on How to File a Claim

Member Inquiries
General inquiries regarding your eligibility for coverage and benefits do not involve the filing of a claim, and should be made by directly contacting the Member Service Department using the telephone number on your ID card.

Filing Benefit Claims

- Authorized Representatives
  You have the right to designate an authorized representative to file or pursue a request for reimbursement or other post-service claim on your behalf. Highmark Blue Cross Blue Shield reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.
- **Requests for Precertification and Other Pre-Service Claims**
  For a description of how to file a request for precertification or other pre-service claim, see the Precertification and Pre-Service Claims Review Processes subsection in the Healthcare Management section of this benefit booklet.

- **Requests for Reimbursement and Other Post-Service Claims**
  When a participating hospital, physician or other provider submits its own reimbursement claim, the amount paid to that participating provider will be determined in accordance with the provider’s agreement with Highmark or the local licensee of the Blue Cross and Blue Shield Association serving your area. Highmark will notify you of the amount that was paid to the provider. Any remaining amounts that you are required to pay in the form of a copayment, coinsurance or program deductible will also be identified in that EOB or notice. If you believe that the copayment, coinsurance or deductible amount identified in that EOB or notice is not correct or that any portion of those amounts are covered under your benefit program, you may file a claim with Highmark. For instructions on how to file such claims, you should contact the Member Service Department using the telephone number on your ID card.

**Determinations on Benefit Claims**

- **Notice of Benefit Determinations Involving Requests for Precertification and Other Pre-Service Claims**
  For a description of the time frames in which requests for precertification or other pre-service claims will be determined by Highmark and the notice you will receive concerning its decision, whether adverse or not, see the Precertification and Pre-Service Claims Review Processes subsection in the Healthcare Management section of this benefit booklet.

- **Notice of Adverse Benefit Determinations Involving Requests for Reimbursement and Other Post-Service Claims**
  Highmark will notify you in writing of its determination on your request for reimbursement or other post-service claim within a reasonable period of time following receipt of your claim. That period of time will not exceed 30 days from the date your claim was received. However, this 30-day period of time may be extended one time by Highmark for an additional 15 days, provided that Highmark determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day post-service claim determination period. If an extension of time is necessary because you failed to submit information necessary for Highmark to make a decision on your post-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your post-service claim.
If your request for reimbursement or other post-service claim is denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

For a description of your right to file an appeal concerning an adverse benefit determination of a request for reimbursement or any other post-service claim, see the Appeal Procedure subsection below.

**Appeal Procedure**

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, you may appeal the decision. Your appeal must be submitted not later than 180 days from the date you received notice from Highmark of the adverse benefit determination.

Upon request to Highmark, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit any written comments, 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 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 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 30 days following receipt of the appeal;

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

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

In the event Highmark renders an adverse 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 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 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 any written comments, 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 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 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 pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).
Member Service

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

Blues On Call

Blues On Call™ Your 24/7 Health Decision and Support Resource
One toll-free telephone call or a quick e-mail connects you to a Blues On Call Health Coach, a specially-trained registered nurse. Here’s how it works:

- Call 1-888-BLUE-428 (1-888-258-3428)
  Hearing impaired TTY users, call 1-877-888-7834
- Or visit www.highmarkbcbs.com, click on the region where you live or your employer is headquartered. Log in with your User ID and Password, then click on the “Your Health” tab and “Talk to a Health Coach.”

Help with common illnesses, injuries and questions
Health Coaches are available 24 hours a day, seven days a week to answer questions about 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 or e-mail 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 involved in taking care of yourself.

You can establish a relationship with a specific Health Coach, too, and schedule times to talk about your concerns and conditions. Of course, you can always speak with another Health Coach at any time of the day or night.

**Request videos to watch at home**
Your Health Coach can also send you a DVD or videotape with the latest information on a variety of conditions and their treatments, including lower back pain, breast cancer and breast reconstruction, menopause, prostate problems, osteoarthritis, ovarian cancer, colon cancer, bariatric surgery, end-of-life decisions and coronary artery disease. And they’re yours to keep.

If you have a chronic health condition … or a question about any health concern … call or e-mail Blues On Call at any time of the day or night to learn more and find the help available to you.

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

**Highmark Web site**
As a Highmark member, you have a wealth of health information at your fingertips. And now it’s easier than ever 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 easy-to-use online tools and resources.

Go to www.highmarkbcbs.com. Then click on the "Members" tab and log in to your homepage to take advantage of all these health tools:

- **At "Your Coverage" you can:** research plan options, review your member information and benefits, get coverage information and request replacement identification cards.
- **At "Your Spending" you can:** view your claims, track your health care costs, get information about the costs of medical services and access information on your spending account if you have one.
- **At "Your Health" you can:** assess your wellness, link to health care decision support, explore treatment options, and get information on lifestyle improvement and
preventive health care recommendations. For example, this tool offers the following programs to you if you are interested in tobacco cessation:

- **Telephonic Smokeless®** offers two options for smoking cessation. This telephone-based program can be self-guided at your own pace or coordinated by a professional tobacco cessation specialist. Helpful topics include behavior modification, coping with withdrawal, stress reduction and weight management. Participants have unlimited toll-free access to a qualified tobacco cessation specialist to address additional concerns. Discounted nicotine replacement products are available to enrolled participants. Members can participate in one Smokeless program per year, determined from day of enrollment. For more information or to enroll, call Telephonic Smokeless at 1-800-345-2476.

- **HealthMedia® Breathe™** is an online smoking cessation program that provides a customized, four-part action plan. The program length is based on your chosen quit date. Participants receive one initial and three follow-up tailored action plans. The follow-up plans promote confidence and motivation, increase active participation in the change process and help prevent relapse.

Other lifestyle improvement programs include:

- **HealthMedia® Succeed™** is an online health risk assessment that identifies individual risk, readiness and confidence to make lifestyle changes. Each participant receives a personalized wellness plan with recommendations to improve or maintain their health.
- **HealthMedia® Nourish™** is an eight-week nutrition program, including a tailored action plan.
- **HealthMedia® Balance™** is a six-week weight management and physical activity program that offers a personally tailored action plan.
- **HealthMedia® Relax™** is a five-week stress management program, including a tailored action plan that helps adults effectively cope with stress.
- **HealthMedia® Care™ For Your Health** is a self-management program designed to help individuals take charge of their chronic conditions such as diabetes, asthma, migraines, high blood pressure and high cholesterol.
- **HealthMedia® Care™ For Your Back** is a self-management program designed to help participants with preventing back pain or managing existing back pain.
- **HealthMedia® Care™ For Diabetes** is a program that simulates a one-on-one session with a nurse counselor, providing a high-quality behavior change intervention addressing various diabetes management factors.
- **HealthMedia® Overcoming™ Depression** is a clinically sophisticated self-help online program providing 24/7 access to coping strategies and skills for a wide range of symptoms associated with depression.
– HealthMedia® Overcoming™ Insomnia is a six-week online program that uses proven techniques based on sound clinical evidence to help individuals recover from insomnia.

• At "Choose Providers" you can: access our provider directory which includes a wide range of information on doctors, hospitals and other providers; you can also take advantage of a Wellness Discount Program which offers discounts on complementary and alternative medicine, products and services such as fitness centers and spas, nutrition counseling, yoga and pilates, tai chi, massage and body work, health magazines, mind-body therapies, holistic practitioners, acupuncture, personal trainers, vitamins and chiropractic.

• At "Health Topics" you can: read articles, get information in the Health Encyclopedia, go "Inside the Human Body," and find the latest information on surgeries and procedures.

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

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 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 printed and online information on all aspects of pregnancy and childbirth. Baby BluePrints will also provide you with personal support from a nurse Health Coach available to you throughout your pregnancy. And you'll be sent valuable gifts for participating!

Easy Enrollment

Just call toll-free at 1-866-918-5267. You can enroll at any time during your pregnancy. Once you enroll, you will receive a Welcome Package that includes:

• a comprehensive Maternity Guide with important health information;
• a guide to educational resources found on your member Web site;
• flyers on available discount programs/services;
• a Childbirth Education Class Reimbursement form;
• a Child Immunization and Preventive Care pamphlet; and
• vouchers for the three free gifts:
  – gift at initial enrollment -- choice of book on pregnancy/childcare;
– gift at the end of the second trimester -- baby photo album; and

For More Information
If you have any questions about Baby BluePrints, please call Member Service at the number on your ID card. We encourage you to enroll early in your pregnancy to take full advantage of this exciting program.
Member Rights and Responsibilities

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

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

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

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

**Basic Plan** - The regular hospitalization and medical-surgical benefits made available to you through your group. The term "Basic Plan" as used herein is meant to include the following: Medicare Parts A and B, and Highmark Blue Cross Blue Shield Signature 65 program.

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

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

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

**Experimental/Investigative** - The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined to be medically effective for the condition being treated. An intervention is considered to be experimental/investigative if: the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or, available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or, the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or, the intervention does not improve health outcomes; or, the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date.

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

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

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

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


**Medically Necessary and Appropriate (Medical Necessity and Appropriateness)** - Services, supplies or covered medications that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (iii) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that
patient's illness, injury or disease. Highmark reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply or covered medication is medically necessary and appropriate. No benefits will be provided unless Highmark determines that the service, supply or covered medication is medically necessary and appropriate.

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

**Medicare Opt-Out Provider** - A professional provider eligible to provide services or supplies under Medicare Part B but who has "opted out" of Medicare such that he or she forgoes any payments from Medicare to his or her patients or themselves, and enters into private contracts with Medicare beneficiaries to provide eligible services, and bills Medicare beneficiaries directly for services provided.

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

**Partial Hospitalization** - The provision of medical, nursing, counseling or therapeutic mental health care services or substance abuse services on a planned and regularly scheduled basis in a facility provider designed for a patient or client who would benefit from more intensive services than are generally offered through outpatient treatment but who does not require inpatient care.

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

**Provider's Reasonable Charge** - The provider's reasonable charge is the amount agreed to by your program and the provider or an amount that is determined to be reasonable for covered services provided to you. In the case of professional providers, the provider's reasonable charge will be the lesser of the usual, customary and reasonable allowance or the billed charge.

*Usual, Customary and Reasonable (UCR) Allowance*

Your program reimbursement amounts are often referred to as UCR allowances. UCR is an abbreviation for usual, customary and reasonable. A UCR allowance is an amount for payment of covered services that is determined by applying one or more of the following criteria:
**Usual** – the allowed amount that is determined for a professional provider based upon that individual provider’s charges for the procedure performed;

**Customary** – the allowed amount that is determined by considering relevant professional, economic and market factors, including but not limited to: charges of professional providers of the same or similar specialty for the procedure performed, the degree of professional involvement, the actual cost of equipment and facilities, or other factors which contribute to the cost of the procedure;

**Reasonable** – the allowed amount (which may differ from the usual or customary allowed amounts) that is determined by considering unusual clinical circumstances.

Allowed amounts are updated periodically to respond to changing economic and market circumstances. The timing of updates and methodology employed are subject to approval by the Insurance Department of the Commonwealth of Pennsylvania.

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

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

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

Blues On Call is a service mark of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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

Healthwise Knowledgebase is a registered trademark of Healthwise, Incorporated.

Health Crossroads is a registered mark of Health Dialog.

Telephonic Smokeless is a registered trademark of the American Institute for Preventive Medicine.
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, we are committed to protecting the privacy of your protected health information. “Protected health information” 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 will inform you of these practices the first time you become a Highmark Inc. customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice became effective April 1, 2003, 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.
You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. Uses and Disclosures of Protected Health Information

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

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

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

Payment

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

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

Health Care Operations

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

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

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

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

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

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

II. **Other Possible Uses and Disclosures of Protected Health Information**
In addition to uses and disclosures for payment, and health care operations, we may use and/or disclose your protected health information for the following purposes:

A. **To Plan Sponsors**

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

B. **Required by Law**

We may use or disclose your protected health information to the extent that federal or state law requires the use or disclosure. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.
C. **Public Health Activities**
   We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability.

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

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

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

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

H. **Coroners, Medical Examiners, Funeral Directors, and Organ Donation**
   We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.
I. **Research**
We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

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

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

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

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

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

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. 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, 1800 Center Street, Camp Hill, PA 17089. 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.
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, 1800 Center Street, Camp Hill, PA 17089. In your request tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

D. Right to Request Confidential Communications

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

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

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: 1-717-302-3601
Address: 1800 Center Street
Camp Hill, PA 17089

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

Highmark is committed to protecting its members' privacy. This notice describes our policies and practices for collecting, handling and protecting personal information about our members. We will inform each group of these policies the first time the group becomes a Highmark customer 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 (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: 1-717-302-3601
Address: 1800 Center Street
Camp Hill, PA 17089
You are hereby notified that Highmark Blue Cross Blue Shield provides administrative services only on behalf of your self-funded group health plan. Highmark Blue Cross Blue Shield is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield Plans throughout the United States. Although all of these independent Blue Cross and Blue Shield Plans operate from a license with the Association, each of them is a separate and distinct operation. The Association allows Highmark Blue Cross Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Highmark Blue Cross Blue Shield is neither the insurer nor the guarantor of benefits under your group health plan. Your Group remains fully responsible for the payment of group health plan benefits.