

# BLUE CROSS BLUE SHIELD

MAJOR MEDICAL PROGRAM

**Carnegie Mellon University**

**Group 50387-02**

**Effective January 1, 2018**

**Produced April, 2018**



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

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

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

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

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

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

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

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

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

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

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

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

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



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***Disclosure***

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



# Introduction to Your Major Medical Benefits Program

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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.

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

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

## ***Information for Non-English-Speaking Members***

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

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

# How Your Benefits Are Applied

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

The deductible does not 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.

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

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

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

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

<sup>2</sup> Services are limited to those on a predefined schedule. Gender, age and frequency limits may apply.

<sup>3</sup> The maximum payment limitation does not apply for the first instance or course of treatment.

<sup>4</sup> 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.

# Covered Services - Major Medical Program

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## 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.

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

### **Dental Services (Limited)**

#### ***Related to Accidental Injury***

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

### ***Anesthesia for Non-Covered Dental Procedures***

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

### **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'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 Foods**

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

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

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

### **Home Health Care Services**

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**

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.

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

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

## **Medical Services**

### ***Inpatient Medical Services***

Medical care 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 examination, diagnosis and treatment of an injury or illness when you are an outpatient for a condition not related to surgery.

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

- Physician's office, including those located in an outpatient hospital/hospital satellite setting
- Urgent Care Center
- Retail site, such as in a pharmacy or other retail store

Or you can interact with a professional provider as follows:

- A virtual visit between you and a physician or retail clinic via an audio and video telecommunications system
- A virtual visit between you and a specialist via the internet or similar electronic communications for the treatment of skin conditions or diseases
- A specialist virtual visit between you and a specialist at a remote location via interactive audio and video telecommunications. Benefits are provided for a specialist virtual visit which is subsequent to your initial visit with your treating specialist for the same condition. The provider-based location from which you

communicate with the specialist is referred to as the "originating site". Benefits will not be provided for a specialist virtual visit if the visit is related to the treatment of mental illness or substance abuse. (The specialist virtual visit is subject to availability within your service area.)

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

### **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 starting at 40 years of age or older pursuant to the 2002 recommendations by the United States Preventive Services Task Force;
- mammographic screenings for all members regardless of age when 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 the program maximum.

### ***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.

### ***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.

### ***Diabetes Prevention Program***

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

### **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, except when new cataract lenses are needed because of prescription change).

### **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, including behavioral health virtual visits between you and a specialist via an audio and video telecommunications system

- 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 any outpatient care cost-sharing amounts.

### ***Serious Mental Illness Care Services***

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

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

### **Skilled Nursing Facility Services**

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

### **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

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

<b><u>Key Word</u></b>	<b><u>Exclusion</u></b>
Abortion	<ul style="list-style-type: none"> <li>For elective abortions, except those abortions necessary to avert the death of the member or to terminate pregnancies caused by rape or incest;</li> </ul>
Acupuncture	<ul style="list-style-type: none"> <li>For acupuncture services.</li> </ul>
Allergy Testing	<ul style="list-style-type: none"> <li>For allergy testing, except as provided herein;</li> </ul>
Assisted Fertilization	<ul style="list-style-type: none"> <li>Related to treatment provided specifically for the purpose of assisted fertilization; including pharmacological or hormonal treatments used in conjunction with assisted fertilization;</li> </ul>
Ambulance	<ul style="list-style-type: none"> <li>For ambulance services, except as provided herein;</li> </ul>
Comfort/Convenience Items	<ul style="list-style-type: none"> <li>For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers or physical fitness equipment, stair glides, elevators/lifts or "barrier-free" home modifications, whether or not specifically recommended by a professional provider;</li> </ul>
Cosmetic Surgery	<ul style="list-style-type: none"> <li>For a cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except: a) as otherwise provided herein, b) when required to correct a condition directly resulting from an accident; c) when necessary to correct a functional impairment which directly results from a covered disease or injury, or d) to correct a congenital birth defect.</li> </ul>
Effective Date	<ul style="list-style-type: none"> <li>Incurred prior to your effective date;</li> </ul>
Experimental/Investigative	<ul style="list-style-type: none"> <li>Which are experimental/investigative in nature;</li> </ul>
Hearing Care Services	<ul style="list-style-type: none"> <li>For hearing aid devices, tinnitus maskers or examinations for the prescription or fitting of hearing aids;</li> </ul>
Legal Obligation	<ul style="list-style-type: none"> <li>For which you have no legal obligation to pay;</li> </ul>
Medically Necessary and Appropriate	<ul style="list-style-type: none"> <li>Which are not medically necessary or medically appropriate as determined by Highmark;</li> </ul>
Medicare	<ul style="list-style-type: none"> <li>For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or</li> </ul>

	any Medicare supplemental coverage;
Methadone Hydrochloride	<ul style="list-style-type: none"> <li>• For methadone hydrochloride treatment for which no additional functional progress is expected to occur.</li> </ul>
Miscellaneous	<ul style="list-style-type: none"> <li>• For telephone consultations, charges for failure to keep a scheduled visit or charges for completion of a claim form;</li> <li>• For any other medical or dental service or treatment or prescription drug except as provided in this booklet;</li> </ul>
Motor Vehicle Accident	<ul style="list-style-type: none"> <li>• For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act;</li> </ul>
Prescription Drugs (Medical Program)	<ul style="list-style-type: none"> <li>• For prescription drugs and medications, except those which are administered to an inpatient in a facility provider or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.;</li> </ul>
Preventive Care Services	<ul style="list-style-type: none"> <li>• For preventive care services, wellness services or programs, except as provided herein;</li> </ul>
Provider of Service	<ul style="list-style-type: none"> <li>• Which are not prescribed by, performed by or upon the direction of a professional provider;</li> <li>• Rendered by a provider not specifically listed in this booklet;</li> <li>• 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;</li> <li>• 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;</li> <li>• Rendered by a provider who is a member of your immediate family;</li> <li>• Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program;</li> </ul>

- Sexual Dysfunction
  - For treatment of sexual dysfunction that is not related to organic disease or injury;
- Skilled Nursing
  - For skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness;
- Termination Date
  - Incurred after the date of termination of your coverage except as provided herein;
- Therapy
  - For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur;
- TMJ
  - For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma;
- 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 and immunizations, except as provided herein;

***In addition, except as specifically provided in this program or as Highmark is mandated or required to provide based on state or federal law, no benefits will be provided under your Major Medical coverage for services, supplies, prescription drugs or charges:***

- Contraceptive Medications, Devices and Implants
  - For contraceptive services, including contraceptive prescription drugs, contraceptive devices, implants and injections, and all related services;
- Court Ordered Services
  - For otherwise covered services ordered by a court or other tribunal unless medically necessary and appropriate or if the reimbursement of such services is required by law;
- Custodial Care  
Dental Care
  - 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

	<p>teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, alveolectomy, services related to the placement of dentures and treatment of periodontal disease, except for limited dental services as provided herein;</p>
Enteral Foods	<ul style="list-style-type: none"> <li>• For any food including, but not limited to, enteral foods, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis, except as provided herein.</li> </ul>
Eyeglasses/Contact Lenses	<ul style="list-style-type: none"> <li>• 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) ;</li> </ul>
Foot Care	<ul style="list-style-type: none"> <li>• 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;</li> </ul>
High Cost Technological Equipment	<ul style="list-style-type: none"> <li>• Performed on high cost technological equipment such as, but 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;</li> </ul>
Home Health Care	<ul style="list-style-type: none"> <li>• 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;</li> </ul>
Inpatient Admissions	<ul style="list-style-type: none"> <li>• For inpatient admissions which are primarily for diagnostic study;</li> <li>• For inpatient admissions which are primarily for physical medicine services;</li> <li>• 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</li> </ul>

Medicare	<p style="margin-left: 40px;">date during that inpatient admission;</p> <ul style="list-style-type: none"> <li>• 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;</li> <li>• 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;</li> <li>• 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;</li> </ul>
Military Service	<ul style="list-style-type: none"> <li>• 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;</li> </ul>
Miscellaneous	<ul style="list-style-type: none"> <li>• For any amounts the patient is required to pay for under any deductible and/or coinsurance provisions of the basic program;</li> </ul>
Nutritional Counseling	<ul style="list-style-type: none"> <li>• For nutritional counseling and services intended to produce weight loss;</li> </ul>
Oral Surgery	<ul style="list-style-type: none"> <li>• For oral surgery procedures unless specifically provided, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face;</li> </ul>
Physical Examinations	<ul style="list-style-type: none"> <li>• For routine or periodic physical examinations, except as provided herein;</li> </ul>
Respite Care	<ul style="list-style-type: none"> <li>• For respite care;</li> </ul>
Sterilization	<ul style="list-style-type: none"> <li>• For sterilization and reversal of sterilization;</li> </ul>
Vision Correction Surgery	<ul style="list-style-type: none"> <li>• For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomeleusis, keratophakia, and radial keratotomy and all related services;</li> </ul>
War	<ul style="list-style-type: none"> <li>• For any illness or injury suffered after your effective date as a result of any act of war;</li> </ul>
Workers' Compensation	<ul style="list-style-type: none"> <li>• For any illness or injury eligible for or covered by any federal, state or local government's Worker's Compensation Act or Occupational Disease Law;</li> </ul>

# Eligible Providers

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## ***Facility Providers***

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

## ***Professional Providers***

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

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

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

## **Non-Participating Providers**

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

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

# General Information

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## Basic Plan

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

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

## 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
- Spouse under a legally valid existing marriage between persons of the same sex entered within a state that sanctions such marriages by law and that is valid pursuant to such law at the time of the marriage. This does not include any spouse currently residing in a state that does not recognize such marriages.
- 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.
- 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.

## **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**

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

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

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

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

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

## A Recognized Identification Card

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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](http://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

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

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 can be downloaded from [blog.highmarkhealth.org](http://blog.highmarkhealth.org) by entering "forms" in the search box. Claim forms are also available from your employee benefits department, or call the Member Service telephone number on the back of your ID card.*

- **Attach Itemized Bills to the Claim Form and Mail.** After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the back of your ID card.

**Remember: Multiple services 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;
- 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



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 Health Care Management section of this benefit booklet.

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

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

## **Determinations on Benefit Claims**

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

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

– ***Notice of Adverse Benefit Determinations Involving Requests for Reimbursement and Other Post-Service Claims***

Highmark will notify you in writing of its determination on your request for reimbursement or other post-service claim within a reasonable period of time following receipt of your claim. That period of time will not exceed 30 days from the date your claim was received. However, this 30-day period of time may be extended one time by Highmark for an additional 15 days, provided that Highmark determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day post-service claim determination period. If an extension of time is necessary because

you failed to submit information necessary for Highmark to make a decision on your post-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your post-service claim.

If your request for reimbursement or other post-service claim is denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

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

## **Appeal Procedure**

Your benefit program maintains an appeal process involving 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

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

## **Blues On Call<sup>sm</sup> - 24/7 Health Decision Support**

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

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

### ***Help with common illnesses, injuries and questions***

Health Coaches can address any health topic that concerns you:

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

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

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

### ***Help with chronic conditions***

If you have diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease or coronary artery disease, you need to manage your condition every day in order to stay healthy and avoid hospital stays. That means keeping track of medications, tests, doctor appointments and your diet. Your Blues On Call Health

Coach can help you work more closely with your doctor and get more involved in taking good care of yourself.

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

## **myCare Navigator<sup>sm</sup> - 24/7 Health Advocate Support**

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

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

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

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

## **Highmark Website**

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

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

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

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

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

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

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

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

## **Baby Blueprints®**

### ***If You Are Pregnant, Now Is the Time to Enroll in Baby Blueprints***

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

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

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

### ***Easy Enrollment***

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



## **Member Service**

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

# Member Rights and Responsibilities

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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.

## **How We Protect Your Right to Confidentiality**

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

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

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

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

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

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

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



# Terms You Should Know

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**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 Signature 65 program.

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

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

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

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

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

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

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

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

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

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

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

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

A similar process is followed for evaluating new pharmaceuticals. The Pharmacy and Therapeutics (P & T) Committee assesses new pharmaceuticals based on national and international data, research that is currently underway and expert opinion from leading clinicians. The P & T Committee consists of at least one Highmark-employed pharmacist and/or medical director, five board-certified, actively practicing network physicians and two Doctors of Pharmacy currently providing clinical pharmacy services 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.

**Immediate Family** - Your spouse, child, parent, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, daughter-in-law or son-in-law.

**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.

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

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

The plan allowance for a state-owned psychiatric hospital is what is required by law.

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

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

Highmark is a registered mark of Highmark Inc.

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

Baby Blueprints, Blue Cross, Blue Shield and the Cross and Shield symbols are registered service marks of the Blue Cross Blue Shield Association.

The Blue Cross Blue Shield Association is an independent company that does not provide Highmark Blue Cross Blue Shield products and services.

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 companies throughout the United States. Although all of these independent Blue Cross and Blue Shield companies operate from a license with the Association, each of them is a separate and distinct operation. The Association allows Highmark Blue Cross Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Highmark Blue Cross Blue Shield is neither the insurer nor the guarantor of benefits under your group health plan. Your Group remains fully responsible for the payment of group health plan benefits.



# Consent Decree Addendum to Your Benefit Booklet

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

Please be aware that certain UPMC providers may still continue to participate in your plan. Highmark's allowance will be accepted as full payment for covered services from these UPMC providers. Be sure to check the provider directory for the most up-to-date listing of participating providers.

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

## **Continued Care**

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

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

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

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

### **Oncology Services (Cancer Care)**

If you have been diagnosed with cancer and your treating physician determines that you should be treated by a non-participating UPMC provider that renders oncology services, you may choose to request treatment from that UPMC provider. You will not be responsible for any greater out-of-pocket amounts than if covered services had been rendered by a participating provider. Treatment includes care for illnesses resulting from the cancer treatment such as, but not limited to, mental health, endocrinology, orthopedics and cardiology. The need for a treatment of a resulting illness shall be determined, in the first instance, by your treating physician acting in consultation with and in accordance with your wishes or your authorized representative.

### **Local Community Needs**

If your treating physician believes that you require certain medical services and the Pennsylvania Department of Health has determined that such services are not available from another source locally other than from a non-participating UPMC provider, you may receive covered services from that UPMC provider. You will not be responsible for any greater out-of-pocket amounts than if covered services had been rendered by a participating provider.

### **Other Services Received from Non-Participating Providers**

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

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

## **HIGHMARK INC. NOTICE OF PRIVACY PRACTICES**

### **PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)**

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**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.**

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

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#### **Our Legal Duties**

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

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

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

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

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

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

## **I. Uses and Disclosures of Protected Health Information**

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

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

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

#### **Payment**

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

#### ***For example:***

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

#### **Health Care Operations**

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

***For example:***

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

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

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

(i) Business Associates.

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

(ii) Other Covered Entities.

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

**II. Other Possible Uses and Disclosures of Protected Health Information**

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

**A. To Plan Sponsors**

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

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

**B. Required by Law**

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

**C. Public Health Activities**

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

**D. Health Oversight Activities**

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

**E. Abuse or Neglect**

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

**F. Legal Proceedings**

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

#### **G. Law Enforcement**

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

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

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

#### **I. Research**

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

#### **J. To Prevent a Serious Threat to Health or Safety**

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

#### **K. Military Activity and National Security, Protective Services**

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

#### **L. Inmates**

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

**M. Workers' Compensation**

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

**N. Others Involved in Your Health Care**

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

**O. Underwriting**

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

**P. Health Information Exchange**

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

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

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



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

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

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

### **III. Required Disclosures of Your Protected Health Information**

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

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

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

#### **B. Disclosures to You**

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

### **IV. Other Uses and Disclosures of Your Protected Health Information**

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

1. For marketing purposes

2. If we intend to see your PHI
3. For use of Psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. An Authorization for use of psychotherapy notes is required unless:
  - a. Used by the person who created the psychotherapy note for treatment purposes, or
  - b. Used or disclosed for the following purposes:
    - (i) the provider's own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;
    - (ii) for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;
    - (iii) if required for enforcement purposes;
    - (iv) if mandated by law;
    - (v) if permitted for oversight of the provider that created the note;
    - (vi) to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or
    - (vii) if needed to avert a serious and imminent threat to health or safety.

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

## **V. Your Individual Rights**

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

### **A. Right to Access**

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

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

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

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

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

## **B. Right to an Accounting**

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

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

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or submitting your request in writing to the Highmark Privacy Department, 120 Fifth Avenue Place

1814, Pittsburgh, PA 15222. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

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

### **C. Right to Request a Restriction**

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

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

### **D. Right to Request Confidential Communications**

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

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

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

#### **E. Right to Request Amendment**

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

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

#### **F. Right to a Paper Copy of this Notice**

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

### **VI. Questions and Complaints**

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

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

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

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

Contact Office: Highmark Privacy Department  
Telephone: 1-866-228-9424 (toll free)

Fax: 1-412-544-4320  
Address: 120 Fifth Avenue Place 1814  
Pittsburgh, PA 15222

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

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

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

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

- We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.
- We collect and create information about our members' transactions with Highmark, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits/payments (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

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

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

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

For questions about this Privacy Notice, please contact:

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







