

BLUE CROSS BLUE SHIELD

PPO PROGRAM

Christian Church Health Care Benefit Trust

Group 13145-06 & -07

Effective January 1, 2013

Produced March, 2013

Language Assistance Services Available for Multiple Languages

ENGLISH

Please Read This Important Message

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

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

SPANISH

Lea este importante mensaje

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

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

VIETNAMESE

Xin Đọc Tin Nhấn Quan Trọng Đây

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

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

RUSSIAN

Пожалуйста, ознакомьтесь с этой важной информацией

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

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

ITALIAN

Leggere attentamente il presente messaggio

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

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

CHINESE (MANDARIN/SIMPLIFIED)

请阅读以下重要信息

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

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

Table of Contents

Introduction to Your PPO Program	1
General Information	3
Who is Eligible for Coverage.....	3
Changes in Membership Status	4
Medicare	4
Leave of Absence or Layoff	5
Certificates of Creditable Coverage.....	5
Termination of Your Coverage Under the Employer Contract.....	5
Benefits After Termination of Coverage.....	6
Coordination of Benefits	6
Subrogation	8
How Your Benefits Are Applied	9
Benefit Period.....	9
Medical and Prescription Drug Cost-Sharing Provisions.....	9
Maximum.....	10
Pre-Existing Conditions	10
Summary of Benefits	12
Covered Services	15
Acupuncture Services.....	15
Ambulance Service	15
Dental Services Related to Accidental Injury	16
Diabetes Treatment.....	16
Diagnostic Services	17
Durable Medical Equipment.....	17
Enteral Formulae.....	17
Home Health Care/Hospice Care Services.....	18
Home Infusion and Suite Infusion Therapy Services	19
Hospital Services.....	19
Emergency Care Services	21
Maternity Services.....	21
Medical Services	23
Mental Health Care Services.....	24
Orthotic Devices	25
Pediatric Extended Care Services.....	25
Private Duty Nursing Services.....	26
Prosthetic Appliances.....	26
Skilled Nursing Facility Services	26
Spinal Manipulations.....	27
Substance Abuse Services.....	27
Surgical Services	27
Therapy and Rehabilitation Services	30
Transplant Services	30

Preventive Care Services	32
Summary of Benefits - Prescription Drug	34
What Is Not Covered	35
How Your PPO Program Works.....	42
Network Care.....	42
Out-of-Network Care	42
Out-of-Area Care.....	42
Inter-Plan Programs	43
The BlueCard Worldwide Program.....	45
Your Provider Network	46
How to Get Your Physicians' Professional Qualifications	46
Eligible Providers	46
Healthcare Management.....	49
Medical Management.....	49
Care Utilization Review Process	49
Precertification, Preauthorization and Pre-Service Claims Review Processes	51
A Recognized Identification Card	54
How to File a Claim.....	55
Your Explanation of Benefits Statement	56
Additional Information on How to File a Claim.....	56
Determinations on Benefit Claims	57
Appeal Procedure	58
Member Service	65
Blues On Call	65
myCare Navigator	66
Highmark Web Site	66
Baby BluePrints.....	67
Member Service.....	68
Health Savings Account	69
Flexible Spending Account.....	72
Member Rights and Responsibilities	75
Terms You Should Know	76
Notice of Privacy Practices	82

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 PPO Program

This booklet provides you with the information you need to understand your PPO 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.

This program is a **high deductible health plan** of inpatient and outpatient benefits, most of which are provided at both network and out-of-network benefit levels. Health care coverage is based on guidelines from the U.S. Treasury Department. These guidelines require: 1) a minimum deductible amount, 2) a maximum out-of-pocket amount, 3) all medical and drug services, with the exception of preventive care, must be applied toward the deductible, and 4) all medical and drug services must be applied toward the out-of-pocket amount. You must be enrolled in a qualified HDHP to establish and contribute to a health savings account.

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

- **Your PPO program gives you freedom of choice.** You are not required to select a primary care physician to receive covered care. You have access to a large provider network of physicians, hospitals, and other providers throughout the country. For a higher level of coverage, you need to receive care from one of these network providers. However, you can go outside the network and still receive care at the lower level of coverage. To locate a network provider near you, or to learn whether your current physician is in the network, call 1-800-810-BLUE (2583), log onto www.bcbs.com, or log onto Highmark's Web site, www.highmarkbcbs.com.
- **Your PPO program gives you "stay healthy" care.** You are covered for a range of preventive care, including physical examinations and selected diagnostic tests. Preventive care is a proactive approach to health management that can help you stay on top of your health status and help to prevent more costly care down the road.

You can review your Preventive Care Guidelines online at your member Web site. And, as a member of your PPO program, you get important extras. Along with 24-hour assistance with any health care question via Blues On Call, your member Web site connects you to a range of self-service tools that can help you manage your coverage. The Web site also offers programs and services

designed to help you make and maintain healthy improvements. And you can access a wide range of cost and quality tools to assure you spend your health care dollars wisely.

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

Information for Non-English-Speaking Members

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

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

General Information

Who is Eligible for Coverage

You may enroll your:

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

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

- Unmarried children over age 26 who are not able to support themselves due to mental retardation, physical disability, mental illness or developmental disability that started before age 26. Coverage automatically terminates and all benefits hereunder cease, except as otherwise indicated, on the day following the date on which the disability ceases, whether or not notice to terminate is received by Highmark.
- A domestic partner** shall be considered for eligibility as long as a domestic partnership (a voluntary relationship between two domestic partners) exists with you. In addition, the children of the domestic partner shall be considered for eligibility as if they were your children as long as the domestic partnership exists.

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

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

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

NOTE: Health Savings Account funds used to pay for medical expenses of dependent, unmarried children 23 years of age and older may affect your tax status. Please consult with your tax advisor for details.

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.

Medicare

Covered Active Employees Age 65 or Over

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

- the program will pay all eligible expenses first.

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

- or -

Non-Covered Active Employees Age 65 or Over

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

Spouses Age 65 or Over of Active Employees

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

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

Leave of Absence or Layoff

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

Certificates of Creditable Coverage

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

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

Termination of Your Coverage Under the Employer Contract

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

Benefits After Termination of Coverage

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

Coordination of Benefits

Most health care programs, including this PPO program, contain a coordination of benefits provision. This provision is used when you, your spouse or your covered dependents are eligible for payment under more than one health care 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.

NOTE: In the event the other coverage is a non-high deductible health plan, certain tax advantages of this high deductible health plan, when used in

connection with a Health Savings Account, may be lost. Please consult your tax advisor for information.

Prescription drug benefits are not coordinated against any other health care or drug benefit coverage.

Subrogation

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

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

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

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

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

Subrogation does not apply to an individual insurance policy you may have purchased for yourself or your dependents, or when enforcing this provision is prohibited by an applicable state or federal law.

How Your Benefits Are Applied

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

Benefit Period

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

Your benefit period is 12 consecutive months beginning on January 1.

Medical and Prescription Drug 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.

Coinsurance

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

Deductible

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

Family Deductible

For a family with several covered dependents, the deductible you pay for all covered family members, regardless of family size, is specified under family deductible. In the case of family coverage, if any individual member of the family has satisfied an amount equal to the individual deductible, before the entire family deductible amount is satisfied, the program would begin to pay for all or part of the remaining covered services received by that particular individual family member.

However, the entire family deductible must be satisfied in one benefit period by two or more family members before the program would begin to pay for covered services for all the remaining family members.

Out-of-Pocket Limit

The out-of-pocket limit refers to the specified dollar amount of coinsurance and deductible incurred for covered services and covered medications in a benefit period. When the specified dollar amount is attained, your program begins to pay 100% of all covered expenses. See your Summary of Benefits for the out-of-pocket limit. .

Family Out-of-Pocket Limit

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

Once all covered family members have incurred an amount equal to the family out-of-pocket limit, claims received for all covered family members during the remainder of the benefit period will be payable at 100% of the plan allowance for covered services or 100% of the provider's allowable price for covered medications.

However, if any covered family member has incurred an amount equal to the individual out-of-pocket limit, the benefits payable by your program for covered services for that particular individual family member will be payable at 100% of the plan allowance during the remainder of the benefit period.

Maximum

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

Pre-Existing Conditions

A pre-existing condition is a condition, other than pregnancy, for which medical advice, care, treatment or diagnosis has been recommended or received from a professional provider within a 90-day period immediately preceding the effective date of coverage or if applicable, the date the waiting period began under this program. During an exclusion period of 12 months following the effective date of coverage, or if applicable, the date the waiting period began, no benefits will be provided for care related to a pre-existing condition. Since pregnancy is not considered a pre-existing condition, benefits provided for care received in connection with a pregnancy are not subject to the exclusion period.

The pre-existing condition exclusion period will not be imposed on members under the age of 19.

In the event your coverage under this program is reinstated and your reemployment is protected under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the pre-existing condition exclusion period will not apply during the period of reinstated coverage unless such exclusion period would have continued to apply had your coverage not been interrupted during your period of uniformed service.

When the pre-existing condition exclusion period is applied in connection with reemployment under USERRA, it will apply only to a pre-existing condition as defined above on the initial date the waiting period began prior to your interruption of coverage as a result of your period of uniformed services.

You and your covered dependents may be able to reduce the program's pre-existing condition exclusion period by the length of coverage in a prior group health plan or other policy of insurance that is defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as "creditable coverage." Highmark will assist you if you are unable to obtain a certificate of creditable coverage from your prior plan or program.

Please note that Highmark will not credit prior coverage in a plan or program that occurred before a significant break in coverage. For purposes of HIPAA, a "significant break in coverage" means a period of 63 consecutive days during which you or your covered dependents did not have any creditable coverage.

If Highmark contests the accuracy of a certificate of creditable coverage or a certificate is unavailable, you and your covered dependents may demonstrate creditable coverage through the presentation of other documents such as pay stubs that show a deduction for health coverage.

Highmark will make a determination regarding the period of coverage that will be credited against the pre-existing condition exclusion within a reasonable period of time after its receipt of the certificate of creditable coverage or other evidence of creditable coverage. You and your covered dependents will then be notified in writing of the period in which the pre-existing condition exclusion will apply, and the basis for Highmark's determination. The notice will also inform you and your covered dependents of the right to appeal Highmark's determination, including the right to submit additional evidence of creditable coverage to support the appeal.

Summary of Benefits

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

Benefits	Network	Out-of-Network
General Provisions		
The following are your PPO program cost-sharing provisions which include your medical and prescription drug benefits		
Benefit Period¹	Contract Year	
Deductible (per benefit period)		
Individual	\$2,500	\$5,000
Family	\$5,000	\$10,000
Plan Payment Level - Based on the plan allowance	80% after deductible until out-of-pocket limit is met; then 100%	60% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limits		
Individual	\$6,050	\$10,000
Family	\$12,100	\$20,000
Lifetime Maximum (per member)	Unlimited	
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	80% after deductible	60% after deductible
Primary Care Physician Office Visits^{2 3}	80% after deductible	60% after deductible
Specialist Office Visits² (including virtual visits)	80% after deductible	60% after deductible
Virtual Visit Originating Site Fee ²	80% after deductible	60% after deductible
Urgent Care Center Visits	80% after deductible	60% after deductible
Preventive Care Services⁴		
Adult		
Routine physical exams	100%; deductible does not apply	Not Covered
Adult Immunizations	100%; deductible does not apply	60% after deductible
Diagnostic services and procedures (limited to those on the preventive schedule)	100%; deductible does not apply	Not Covered
Routine gynecological exams, including a PAP Test	100%; deductible does not apply	60% after deductible
Mammograms		
Routine	100%; deductible does not apply	60% after deductible
Medically Necessary	80% after deductible	60% after deductible
Pediatric		
Routine physical exams	100%; deductible does not apply	Not Covered
Pediatric immunizations	100%; deductible does not apply	60%
Diagnostic services and procedures (limited to those on the preventive schedule)	100%; deductible does not apply	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Services - Inpatient	80% after deductible	60% after deductible
Hospital Services - Outpatient⁵	80% after deductible	60% after deductible
Maternity (non-preventive facility and professional services)	80% after deductible	60% after deductible
Medical/Surgical Expenses (except office visits)	80% after deductible	60% after deductible
Emergency Services		
Emergency Room Services	80% after deductible	Same as network services
Ambulance	80% after deductible	Same as network services

Therapy and Rehabilitation Services		
Infusion Therapy	80% after deductible	60% after deductible
Occupational Therapy	80% after deductible	60% after deductible
Combined Limit: 20 visits per benefit period		
Physical Medicine	80% after deductible	60% after deductible
Combined Limit: 20 visits per benefit period		
Radiation Therapy	80% after deductible	60% after deductible
Respiratory Therapy	80% after deductible	60% after deductible
Speech Therapy	80% after deductible	60% after deductible
Combined Limit: 20 visits per benefit period		
Spinal Manipulations	80% after deductible	60% after deductible
Combined Limit: 20 visits per benefit period		
Other Therapy Services (Cardiac Rehabilitation, Chemotherapy, and Dialysis Treatment)	80% after deductible	60% after deductible
Mental Health/Substance Abuse Services		
Mental Health Care Services - Inpatient	80% after deductible	60% after deductible
Mental Health Care Services - Outpatient	80% after deductible	60% after deductible
Substance Abuse Services - Inpatient Detoxification	80% after deductible	60% after deductible
Substance Abuse Services - Inpatient Residential Treatment and Rehabilitation Services	80% after deductible	60% after deductible
Substance Abuse Services - Outpatient	80% after deductible	60% after deductible
Other Services		
Acupuncture	80% after deductible	60% after deductible
Combined Limit: 20 visits per benefit period		
Allergy Extracts and Injections	80% after deductible	60% after deductible
Assisted Fertilization Treatment	Not Covered	
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Diabetes Treatment	80% after deductible	60% after deductible
Diagnostic Services (Lab, x-ray, allergy testing and other diagnostic medical tests)	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Enteral Formulae	80% after deductible	60% after deductible
Home Infusion and Suite Infusion Therapy Services	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
Combined Limit: 40 visits per benefit period		
Hospice	80% after deductible	60% after deductible
Combined Limit: 180 days per lifetime		
Infertility Counseling, Testing and Treatment⁶	80% after deductible	60% after deductible
Orthotics	80% after deductible	60% after deductible
Pediatric Extended Care Services	80% after deductible	60% after deductible
Combined Limit: 100 days per benefit period		
Private Duty Nursing	80% after deductible	60% after deductible
Prosthetics	80% after deductible	60% after deductible
Skilled Nursing Facility Care	80% after deductible	60% after deductible
Combined Limit: 120 days per benefit period		

Transplant Services	80% after deductible	60% after deductible
	Combined Limit: Maximum of \$10,000 per transplant for lodging, transportation and meals for recipient and travel companion	
Precertification Requirements	Yes ⁷	

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

- ¹ Your group's benefit period is based on a contract year. The contract year is a consecutive 12-month period beginning on January 1.
- ² You **may** be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a hospital, facility provider, retail clinic or urgent care center.
- ³ A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics.
- ⁴ Services are limited to those on a predefined schedule. Gender, age and frequency limits may apply.
- ⁵ Other cost sharing provisions and/or limits may apply to specific benefits, i.e., physical medicine, therapies, diagnostic services, mental health/substance abuse visits.
- ⁶ If testing is required, cost sharing may apply as outlined under Diagnostic Services. Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- ⁷ Highmark must be contacted prior to a planned inpatient admission or within 48 hours of an emergency inpatient admission. Some facility providers will contact Highmark and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Highmark for precertification. If not, you are responsible for contacting Highmark. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

Covered Services

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

Acupuncture Services

This program covers the following acupuncture services:

- Administration of acupuncture as anesthesia when ordered by the attending network professional provider and rendered by a network professional provider other than the surgeon or the assistant at surgery.
- Therapy services performed either on an inpatient or outpatient basis, which are medically necessary and appropriate, ordered by a physician and performed by a network provider.

Ambulance Service

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

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

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

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

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

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

Dental Services Related to Accidental Injury

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

Diabetes Treatment

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

- Equipment and supplies: Blood glucose monitors, monitor supplies, injection aides, 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 your self-management, or b) identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to your treatment and/or management of diabetes

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

Diagnostic Services

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

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

Durable Medical Equipment

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

Enteral Formulae

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

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

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

- when provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulae; or

- when provided orally and identified as one of the following types of defined formulae:
 - with hydrolyzed (pre-digested) protein or amino acids; or
 - with specialized content for special metabolic needs; or
 - with modular components; or
 - with standardized nutrients.

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

Additional coverage for enteral formulae excludes the following:

- Blenderized food, baby food, or regular shelf food when used with an enteral system
- Milk or soy-based infant formulae with intact proteins
- Any formulae, when used for the convenience of you or your family members
- Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance
- Semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally
- Normal food products used in the dietary management of rare hereditary genetic metabolic disorders

Home Health Care/Hospice Care Services

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

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

- Oxygen and its administration
- Medical social service consultations
- Health aide services when you are also receiving covered nursing services or therapy and rehabilitation services
- Family counseling related to the member's terminal condition

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

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

Home Infusion and Suite Infusion Therapy Services

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

Hospital Services

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

Inpatient Services

Bed and Board

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

- a room with two or more beds;
- a private room. Private room allowance is the average semi-private room charge;

- a bed in a special care unit which is a designated unit which has concentrated all facilities, equipment and supportive services for the provision of an intensive level of care for critically ill patients.

Ancillary Services

Hospital services and supplies including, but not restricted to:

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

Outpatient Services

Ancillary Services

Hospital services and supplies including, but not restricted to:

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

Pre-Admission Testing

Tests and studies required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.

Surgery

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

Emergency Care Services

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

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

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

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

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

Maternity Services

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

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

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

Complications of Pregnancy

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

Normal Pregnancy

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

Nursery Care

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

Maternity Home Health Care Visit

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

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

Medical Services

Inpatient Medical Services

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

Concurrent Care

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

Consultation

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

Inpatient Medical Care Visits

Benefits are provided for inpatient medical care visits.

Intensive Medical Care

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

Routine Newborn Care

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

Outpatient Medical Care Services (Office Visits)

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

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

- Primary care physician's (PCP) or specialist's office

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

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

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

Allergy Extract/Injections

Benefits are provided for allergy extract and allergy injections.

Therapeutic Injections

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

Mental Health Care Services

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

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

Inpatient Facility Services

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

Inpatient Medical Services

Covered inpatient medical services provided by a professional provider:

- Individual psychotherapy

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

Partial Hospitalization Mental Health Care Services

Benefits are only available for mental health care services provided on a partial hospitalization basis when received through a partial hospitalization program. A mental health care service provided on a partial hospitalization basis will be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.

Outpatient Mental Health Care Services

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

Orthotic Devices

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

Pediatric Extended Care Services

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

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

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

- Ongoing assessments of health status, growth and development

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

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

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

Private Duty Nursing Services

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

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

Prosthetic Appliances

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

Skilled Nursing Facility Services

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

No benefits are payable:

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

Spinal Manipulations

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

Substance Abuse Services

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

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

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

Surgical Services

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

Anesthesia

Administration of anesthesia for covered surgery when ordered by the attending professional provider and rendered by a professional provider other than the surgeon or the assistant at surgery. Benefits will also be provided for the administration of

anesthesia for covered oral surgical procedures in an outpatient setting when ordered and administered by the attending professional provider.

Assistant at Surgery

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

Second Surgical Opinion

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

Keep in mind that:

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

Special Surgery

- Sterilization
 - Sterilization regardless of medical necessity and appropriateness.
- Oral surgery

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

- Extraction of impacted third molars when partially or totally covered by bone
- Extraction of teeth in preparation for radiation therapy
- Mandibular staple implant, provided the procedure is not done to prepare the mouth for dentures

- Lingual frenectomy, frenotomy or frenoplasty (to correct tongue-tie)
- Facility provider and anesthesia services rendered in a facility setting in conjunction with non-covered dental procedures when determined by Highmark to be medically necessary and appropriate due to your age and/or medical condition
- Accidental injury to the jaw or structures contiguous to the jaw except teeth
- The correction of a non-dental physiological condition which has resulted in a severe functional impairment
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth
- Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus
- Mastectomy and Breast Cancer Reconstruction

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

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

Surgery

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

Therapy and Rehabilitation Services

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

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

Transplant Services

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

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

- when both the recipient and the donor are members, each is entitled to the benefits of their program;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this program subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Cross or Blue Shield coverage or any government program; and 2) benefits provided to the donor will be charged against the recipient's coverage under this program to the extent that benefits remain and are available under this program after benefits for the recipient's own expenses have been paid;
- when only the donor is a member, the donor is entitled to the benefits of this program, subject to the following additional limitations: 1) the benefits are limited

to only those not provided or available to the donor from any other source in accordance with the terms of this program; and 2) no benefits will be provided to the non-member transplant recipient; and

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

Preventive Care Services

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

Adult and Pediatric Care

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

Well-woman benefits are provided for female members for items and services including, but not limited to, an initial physical examination to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods and counseling and breastfeeding support and counseling.

Adult Immunizations

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

Diagnostic Services and Procedures

Benefits are provided for routine screening tests and procedures limited to those on the Preventive Schedule, regardless of medical necessity and appropriateness.

Routine Gynecological Examination and Pap Test

All female members, regardless of age, are covered for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine Papanicolaou smear (pap test) per calendar year.

Mammographic Screening

Benefits are provided for the following:

- An annual routine mammographic screening for all female members 40 years of age or older.

- Mammographic examinations for all female members regardless of age when such services are prescribed by a physician.

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

Pediatric Immunizations

Benefits are provided to members through 18 years of age and dependent children for those pediatric immunizations, including the immunizing agents, which conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services.

Summary of Benefits - Prescription Drug

Prescription drug benefits are provided for covered drugs as described below.

Prescription Drug Benefits	Retail Pharmacy Up to 0-day supply	Maintenance Prescription Drugs through Mail Order Not Covered
Pharmacy Network		Express Scripts Pharmacy
The following are your PPO program cost-sharing provisions which include your medical and prescription drug benefits¹		
Plan Payment Level - Based on the provider's allowable price	80% after PPO program deductible until out-of-pocket limit is met; then 100%	
Preventive Medications		
Preventive Covered Drugs ² Plan Payment Level - Based on the provider's allowable price	100%; deductibles, coinsurance and/or copayments do not apply	

¹ At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member coinsurance or copayment required based on the plan payment level indicated above. You will pay this amount at the pharmacy when you have your prescription filled.

² This includes prescriptions and over-the-counter drugs that are set forth within the predefined schedule and that are prescribed for preventive purposes. Please refer to the Covered Services - Prescription Drug Program section for more information.

What Is Not Covered

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

Key Word	Exclusion
Allergy Testing	<ul style="list-style-type: none"> For allergy testing, except as provided herein.
Ambulance	<ul style="list-style-type: none"> For ambulance services, except as provided herein.
Assisted Fertilization	<ul style="list-style-type: none"> Related to treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization.
Comfort/Convenience Items	<ul style="list-style-type: none"> For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider.
Contraceptive Medications, Devices and Implants	<ul style="list-style-type: none"> For contraceptive services, including contraceptive prescription drugs, contraceptive devices, implants and injections, and all related services, except as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
Cosmetic Surgery	<ul style="list-style-type: none"> For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise provided herein. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; b) surgery to correct a congenital birth defect; and c) surgery to correct a functional impairment which results from a covered disease or injury.
Court Ordered Services	<ul style="list-style-type: none"> For otherwise covered services ordered by a court or other tribunal as part of your or your dependent's sentence.
Custodial Care	<ul style="list-style-type: none"> For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care.

Dental Care	<ul style="list-style-type: none"> • Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses otherwise covered because of accidental bodily injury to sound natural teeth and for orthodontic treatment for congenital cleft palates as provided herein.
Effective Date	<ul style="list-style-type: none"> • Rendered prior to your effective date of coverage.
Enteral Formulae	<ul style="list-style-type: none"> • For the following services associated with the additional enteral formulae benefits provided under your program: blenderized food, baby food, or regular shelf food when used with an enteral system; milk or soy-based infant formulae with intact proteins; any formulae, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance; semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally; normal food products used in the dietary management of rare hereditary genetic metabolic disorders.
Experimental/ Investigative	<ul style="list-style-type: none"> • Which are experimental/investigative in nature.
Eyeglasses/Contact Lenses	<ul style="list-style-type: none"> • For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury).
Felonies	<ul style="list-style-type: none"> • For any illness or injury you suffer during your commission of a felony, as long as such illness or injuries are not the result of a medical condition or an act of domestic violence.
Foot Care	<ul style="list-style-type: none"> • For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective

shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.

- Healthcare Management program
 - For any care, treatment, prescription drug or service which has been disallowed under the provisions of Healthcare Management program.
- Hearing Care Services
 - For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids.
- Home Health Care
 - For the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: dietitian services; homemaker services; maintenance therapy; dialysis treatment; custodial care; food or home-delivered meals.
- Immunizations
 - For immunizations required for foreign travel or employment.
- Inpatient Admissions
 - For inpatient admissions which are primarily for diagnostic studies.
 - For inpatient admissions which are primarily for physical medicine services.
- Learning Disabilities
 - For any care that is related to conditions such as autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change. Care which extends beyond traditional medical management or for inpatient confinement for environmental change includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services provided for purposes of behavioral modification and/or training; d)

services related to the treatment of learning disorders or learning disabilities; e) services provided primarily for social or environmental change or for respite care; f) developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the member has not yet attained; and g) services provided for which, based on medical standards, there is no established expectation of achieving measurable, sustainable improvement in a reasonable and predictable period of time.

- Legal Obligation
 - For which you would have no legal obligation to pay.
- Medically Necessary and Appropriate
 - Which are not medically necessary and appropriate as determined by Highmark.
- Medicare
 - To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program.
- Methadone Hydrochloride
 - For methadone hydrochloride treatment for which no additional functional progress is expected to occur.
- Military Service
 - To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.
- Miscellaneous
 - For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
 - For any other medical or dental service or treatment or prescription drug except as provided herein.
- Motor Vehicle Accident
 - For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.
- Nutritional Counseling
 - For nutritional counseling, except as provided herein.

Obesity	<ul style="list-style-type: none"> • For treatment of obesity, except for medical and surgical treatment of morbid obesity or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
Oral Surgery	<ul style="list-style-type: none"> • For oral surgery procedures, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, except as provided herein.
Physical Examinations	<ul style="list-style-type: none"> • For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein.
Prescription Drugs (Medical Program)	<ul style="list-style-type: none"> • For any drug or medication which is otherwise excluded herein.
Pre-Existing Condition	<ul style="list-style-type: none"> • For a pre-existing condition, but only during the exclusion period as specified herein.
Preventive Care Services	<ul style="list-style-type: none"> • For preventive care services, wellness services or programs, except as provided herein.
Provider of Service	<ul style="list-style-type: none"> • Which are not prescribed by or performed by or upon the direction of a professional provider. • Rendered by other than ancillary providers, facility providers or professional providers. • Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group. • Which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same member. • Rendered by a provider who is a member of your immediate family. • Performed by a professional provider enrolled in an education or training program when such services are

	related to the education or training program.
Respite Care	<ul style="list-style-type: none"> • For respite care.
Sexual Dysfunction	<ul style="list-style-type: none"> • For treatment of sexual dysfunction that is not related to organic disease or injury.
Skilled Nursing	<ul style="list-style-type: none"> • For skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness.
Smoking (nicotine) Cessation	<ul style="list-style-type: none"> • For nicotine cessation support programs and/or classes.
Sterilization	<ul style="list-style-type: none"> • For reversal of sterilization.
Termination Date	<ul style="list-style-type: none"> • Incurred after the date of termination of your coverage except as provided herein.
Therapy	<ul style="list-style-type: none"> • For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate.
TMJ	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • For any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery.
Vision Correction Surgery	<ul style="list-style-type: none"> • For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.

- War
 - For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.
- Weight Reduction
 - For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
- Well-Baby Care
 - For well-baby care visits, except as provided herein.
- Workers' Compensation
 - For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.

How Your PPO Program Works

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

Network Care

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

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

Out-of-Network Care

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

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

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

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

Out-of-Area Care

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

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

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

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

Inter-Plan Programs

Out-of-Area Services

Highmark has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "Inter-Plan Programs." Whenever members access health care services outside the geographic area Highmark serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to Highmark for payment in accordance with the rules of the Inter-Plan Programs policies then in effect.

Typically, members, when accessing care outside the geographic area Highmark serves, should obtain care from health care providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, members may obtain care from non-participating health care providers. Highmark's payment practices in both instances are described below.

BlueCard® Program

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

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

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

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

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

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

Negotiated National Account Arrangements

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

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

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

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

Member Liability Calculation

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

Exceptions

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

The BlueCard Worldwide[®] Program

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

Services may include:

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

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

Your Provider Network

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

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

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

Remember:

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

How to Get Your Physicians' Professional Qualifications

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

Eligible Providers

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

Facility Providers

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

Professional Providers

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

Ancillary Providers:

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

Contracting Suppliers (for the sale or lease of):

- Durable medical equipment
- Supplies
- Orthotics
- Prosthetics

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

Healthcare Management

Medical Management

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

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

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

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

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

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

Care Utilization Review Process

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

Prospective Review

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

After receiving the request for care, Highmark:

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

Concurrent Review

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

Discharge Planning

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

Procedure or Covered Service Precertification

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

Retrospective Review

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

Case Management Services

Case Management is a voluntary program in which a case manager, with input from you and your health care providers, assists when you are facing and/or recovering from a hospital admission, dealing with multiple medical problems or facing catastrophic needs. Highmark case managers can provide educational support, assist in coordinating needed health care services, put you in touch with community resources, assist in addressing obstacles to your recovery such as benefit and caregiver issues and answer your questions.

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

Precertification, Preauthorization and Pre-Service Claims Review Processes

– Authorized Representatives

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

professional health care provider with knowledge of your medical condition to act as your authorized representative.

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

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

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

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

If Highmark determines in connection with an urgent care claim that you have not provided sufficient information to determine whether or to what extent benefits are provided under your coverage, you will be notified within 24 hours following Highmark's receipt of your claim of the specific information needed to complete your claim. You will then be given not less than 48 hours to provide the specific information to Highmark. Highmark will thereafter notify you of its determination on your claim as soon as possible but not later than 48 hours after the earlier of (i) its receipt of the additional specific information, or (ii) the date Highmark informed you that it must receive the additional specific information.

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

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

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

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

A Recognized Identification Card

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

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

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

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

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

How to File a Claim

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

The procedure is simple. Just take the following steps:

- **Know Your Benefits.** Review this information to see if the services you received are eligible under your medical program.
- **Get an Itemized Bill.** Itemized bills must include:
 - The name and address of the service provider;
 - The patient's full name;
 - The date of service or supply;
 - A description of the service or supply;
 - The amount charged;
 - The diagnosis or nature of illness;
 - For durable medical equipment, the doctor's certification;
 - For private duty nursing, the nurse's license number, charge per day and shift worked, and signature of provider prescribing the service;
 - For ambulance services, the total mileage.

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

- **Copy Itemized Bills.** You must submit originals, so you may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.
- **Complete a Claim Form.** Make sure all information is completed properly, and then sign and date the form. *Claim forms are available from your employee benefits department, or call the Member Service telephone number on the back of your ID card.*
- **Attach Itemized Bills to the Claim Form and Mail.** After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the back of your ID card.

Remember: Multiple services for the same family member can be filed with one claim form. However, a separate claim form must be completed for each member.

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

Your Explanation of Benefits Statement

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

- the provider's actual charge;
- the allowable amount as determined by Highmark;
- the 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 network 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 any deductible or coinsurance amounts.

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 Healthcare Management section of this benefit booklet.

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

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

Determinations on Benefit Claims

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

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

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

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

45 days in which to submit the information before a decision is made on your post-service claim.

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

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

Appeal Procedure

Your benefit program maintains an appeal process. 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.

You have the right to have your appeal reviewed through the two-level process described below. However, when an appeal involves an urgent care claim, a single level review process is available. The review of an urgent care claim must be completed before you can institute an action in law or in equity in a court of competent jurisdiction as may be appropriate.

The initial review of an appeal is mandatory and must be exhausted before you can (i) seek a second level review or (ii) institute an action in law or in equity in a court of competent jurisdiction as may be appropriate.

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 or present additional evidence or testimony, which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of your appeal.

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

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

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including 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 60 days following receipt of the appeal.

In the event Highmark renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, the procedure for appealing the decision, and a statement regarding your right to request an external review or pursue a court action.

Your decision to proceed with a second level review of a claim is voluntary. In other words, you are not required to pursue the second level review of a claim before pursuing a court action. 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 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 court action 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 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 level review of your appeal, you may request to have the decision reviewed by your plan administrator in accordance with procedures established for your benefit program.

External Review

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

denied involving medical judgment, including, application of Highmark's requirements as to medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered service or a determination that the treatment is experimental or investigational; or (ii) a determination made by your plan administrator to rescind your coverage.

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

Preliminary Review

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

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

Highmark will notify you of the results of its preliminary review within one business day following its completion of the review. This will include our reasons regarding the ineligibility of your request. If your request is not complete, Highmark's notification will describe the information or materials needed to make the request complete. You will then have the balance of the four month filing period or, if later, 48 hours from receipt of the notice, to perfect your request for external review; whichever is later.

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

Referral to an Independent Review Organization (IRO)

Highmark will, randomly or by rotation, select an IRO to perform an external review of your claim if your request found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Within five business days thereafter, Highmark will provide the IRO with documents and information we considered when making our final adverse benefit determination. The IRO may reverse

Highmark's final adverse benefit determination if the documents and information are not provided to the IRO within the five-day time frame.

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

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

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

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

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

Expedited External Review (Applies to Urgent Care Claims Only)

You are entitled to the same procedural rights to an external review as described above on an expedited basis:

- If the final adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously

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

In the above circumstances, Highmark will immediately conduct a preliminary review and will immediately notify you of our reasons regarding the ineligibility of your request. If your request is not complete, Highmark's notification will describe the information or materials needed to make the request complete. You will then have 48 hours from receipt of the notice, to perfect your request for external review.

Referral to an Independent Review Organization (IRO)

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

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

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

- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

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

Member Service

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

Blues On Callsm - 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 Navigatorsm - 24/7 Health Advocate Support

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

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

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

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

Highmark Web Site

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

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

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

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

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

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

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

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

Baby BluePrints®

If You Are Pregnant, Now Is the Time to Enroll in Baby BluePrints

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

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

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

Easy Enrollment

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

Member Service

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

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

Health Savings Account

The Perfect Companion to Your qualified High-Deductible Health Plan

Your *PPO* qualified High-Deductible Health Plan comes with a critical component—a Health Savings Account, or HSA.

Your Highmark Blue Cross Blue Shield HSA is an employee-managed, tax-sheltered account similar to an IRA (Individual Retirement Account), but can be used for care expenses before you reach your *PPO* plan deductible.

Your HSA not only lets you use account funds for plan-covered expenses, it lets you use funds for a wide range of “qualified medical expenses.” So you can use your HSA to pay for a broad range of care services and products that include everything from acupuncture to chiropractic care... dental care to eyeglasses. You can even use account funds to improve your health by joining a weight loss or stop smoking program.

To access a complete list of eligible care services and products you can purchase through your HSA, log onto your Highmark member website at www.highmarkbcbs.com and click on “Your Spending” and “Eligible Expenses.”

Now and in The Future

Since your plan deductible amount you must pay before the plan covers benefits— is higher, establishing an HSA lets you:

- pay for your out-of-pocket care expenses before your deductible is met to address your immediate care needs; or
- save money in your account for future care expenses. You can even use your HSA as a “medical nest egg” to help cover care costs in your retirement years.

How to Enroll in the Account:

Your HSA is integrated with your *PPO* High-Deductible Health Plan. So managing your account is as quick and easy as managing your coverage.

If your employer has not chosen to automatically enroll you in the HSA, you can activate your account by logging onto your Highmark website at www.highmarkbcbs.com. Select “Your Spending” and “Start a Health Savings Account and save!” From this HSA link, you will be able to check your account balance, view deposits and transactions.

How to Fund your Account:

Your employer may contribute to the account. And you contribute—either through payroll deduction or through direct payment to the account.

In 2011, the maximum amount that can be contributed to your HSA each calendar year is \$3,050 for an individual or \$6,150 for a family. In 2012, these amounts increase to \$3,100 for an individual and \$6,250 for a family. If you are 55 or older, you may also be able to make an annual “catch-up” contribution of \$1,000. (These amounts are adjusted yearly by the IRS for inflation and are displayed at your Highmark member website.)

How to Manage your Account:

Everything you need to manage your care spending is at your Highmark member website. So in one convenient, central location you can:

- Contribute to your account
- Pay a care provider directly from the account
- Enter claims for reimbursement for out-of-pocket costs
- View deposits, transactions and claims
- Track your care costs
- Look up typical care costs through health education tools.

With your Highmark HSA, you enjoy triple-tax savings!

1. Contributions are tax-deductible.
2. Earnings accumulate tax-free.
3. Withdrawals for qualified medical expenses are free from Federal income tax.

Those are savings that *add* up!

How to Invest in Your Account:

If you're like many people with a Health Savings Account, you want to maximize your savings year after year.

Highmark HSA is offered through a respected industry leader who serves as custodian: Bank of America. Once your HSA balance reaches \$500 you may invest any portion of your HSA balance above this level. You have a wide selection of mutual funds*— from conservative options such as a U.S. Treasury fund to more aggressive stock funds. Your choice or choices depend on your risk tolerance and time frame.

*Shares of mutual funds are not deposits or obligations or guaranteed or endorsed by any bank; nor are they federally insured or otherwise supported by the FDIC or any governmental agency, and may lose value.

An Added Convenience – Your Own Personal Health Care Visa® Debit Card!

Using your Highmark Health Savings Account to pay for health care services is now easier than ever.

When you enroll in your Highmark HSA, you will receive a Visa debit card that you can use exclusively for purchases at:

- Doctors' and dentists' offices
- Pharmacies
- Discount chains and club stores
- Other merchants who sell health care products and services and accept Visa

Take control of your health care spending— take advantage of this valued health coverage option!

And learn why more than 10 million people trust Health Savings Accounts to help them manage their care costs!

“Studies have shown that people with Health Savings Accounts take better care of themselves than people with traditional health coverage.”

U.S News & World Report, May, 2010

Why Highmark Health Savings Account May be Perfect for You

- It's *your* money. *You* choose how to pay for care services.
- It's portable. It goes where you go, even if you change jobs.
- Account funds roll over from year to year.
- You can pay for an exceptional range of health care services and products. That includes services—such as dental and vision care—that may not be covered by your *PPO Blue* plan.
- You get “triple-tax savings.” HSA contributions and earnings are tax exempt. Withdrawals from your HSA are also tax exempt as long as they are used for qualified medical services.
- Once you reach a \$500 account balance, you can invest in a wide range of mutual funds for short- or long-term growth potential.
- It's *convenient*. You access and track all of your health care spending online at your Highmark member website.
- Your account is offered through a trusted industry leader, Bank of America, who serves as the custodian.

Visa is a registered mark of Visa, Inc.

Flexible Spending Account

The Perfect Companion To Your Health Plan

Your employer is offering you a valued addition to your Highmark Blue Cross Blue Shield health plan—a Flexible Spending Account, or FSA. Even if you are not enrolled in our medical plan, you can still open an FSA with us. FSAs are tax-deferred accounts established by employers to handle an expense later in your plan year.

Your FSA lets you contribute a specified amount from your paycheck into an account that can help you pay for plan expenses such as copayments and coinsurance. You can even use your account funds to pay for medical expenses not covered by your health plan. There are hundreds of these care-related services and products, including:

- Chiropractic care
- Dental care/orthodontia
- Eye exams
- Hearing aids
- Laser eye surgery
- Nicotine gum or patches/smoking cessation programs
- Vision care products such as glasses and contact lenses

You can also use FSA funds for other items such as alternative drugs and medicines, exercise equipment and programs, even vitamins when they are prescribed by your physician.

To access a complete list of care services and products you can purchase through your FSA, log onto your Highmark member website at www.highmarkbcbs.com and click on *Your Spending and Eligible Expenses*.

Right Now or in the Future!

When you enroll in your Highmark health plan, you designate how much you want to deduct from your paycheck to put into your FSA. Once enrolled, you can access your account funds up to your annual deduction at any time during your health plan benefit year. So you don't have to wait to save to handle an immediate care need! Of course, you can also let your account funds accumulate over time to handle an expense later in your plan year.

Tax Savings Add Up!

Since you contribute to your FSA through payroll deduction, you enjoy pre-tax savings. In most cases, FSA contributions are not subject to Federal Income Tax, FICA tax, and in some states, state tax. As the example on the following page shows, funding health-related services and products through a Flexible Spending Account not only helps you better manage your costs, it can put more money in your wallet.

It's Easy to Manage Your Account

It's just logical. Adding a spending account to your Highmark health plan makes money management convenient. And, because all your spending information is centralized, it makes money management efficient.

Simply log onto your Highmark member website at www.highmarkbcbs.com and click on *Members* then *Your Spending*. From the FSA link, you will be able to check your account balance, view your deposits and transactions history.

Using Your Account Funds

There are two ways to use your account funds: for services covered under your Highmark health plan, and for services and products not covered by your plan. For plan-covered services, you can use the money in your account to cover your out-of-pocket costs. For ultimate convenience, you may opt to have your care claims automatically submitted to your account and have account funds sent directly to you or your care provider. For services and products not covered by your health plan, you can conveniently submit claims online and even upload receipts to save time and expenses.

An Added Convenience—Your Own Personal Health Care Visa® Debit Card!

Using your Flexible Spending Account to pay for health care services and products is now easier than ever. When you enroll in your Highmark FSA, your employer may also offer you a Visa debit card that you can use exclusively for purchases at:

- Doctors' and dentists' offices
- Pharmacies
- Discount chains and club stores
- Other merchants who sell health care products and services and accept Visa.

Example of Savings through an FSA

This chart illustrates tax savings that can be generated through a Flexible Spending Account for a family with gross income of \$45,000 and with an annual FSA contribution of \$2,000. Using a 25 percent tax bracket, this family would have saved \$600 in taxes by contributing to a health care FSA.

EXPENSE CATEGORY	WITH FSA	WITHOUT FSA
Annual Income	\$45,000	\$45,000
FSA Contribution	(\$2,000)	\$0
Taxable Income	\$43,000	\$45,000
Estimated Federal Income Tax	(\$10,750)	(\$11,250)
Total	\$32,250	\$33,750
Social Security Pay	(\$2,144)	(\$2,244)

Total	\$30,106	\$31,506
Health Care Expenses	\$0	(\$2,000)
Net Pay	\$30,106	\$29,506
Health Care FSA Savings	\$600	\$0

Why Highmark’s Flexible Spending Account May be Perfect for You

- It’s your money. You choose how to use it—for your health plan’s copayments or coinsurance or for services and products not covered by your health plan.
- You also can choose who can use account funds since they’re also available to Highmark-covered spouses and dependents.
- It’s flexible. Use all or part of your funds when you need your funds.
- You can save for an expense incurred any time in the plan year. (Any money not used by end of plan year will be forfeited.)
- You can pay for an exceptional range of health care services— such as dental and vision care— that may not be covered by your health plan.
- You get pre-tax savings that can add up to hundreds of dollars.
- It’s convenient. You can access and track all of your health care spending online at your Highmark member website.

To establish payroll deduction and open your Flexible Spending Account, contact your employer.

Visa is a registered mark of Visa Inc.

Member Rights and Responsibilities

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

You have the right to:

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

You have a responsibility to:

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

Terms You Should Know

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

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

- **Pre-Service Claim** – A request for precertification or prior approval of a covered service which under the terms of your coverage must be approved before you receive the covered service.
- **Urgent Care Claim** – A pre-service claim which, if decided within the time periods established for making non-urgent care pre-service claim decisions, could seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service. Whether a request involves an urgent care claim will be determined by your attending physician or provider.
- **Post-Service Claim** – A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

Covered Maintenance Prescription Drug – A maintenance prescription drug, which your program is contractually obligated to pay or provide as a benefit to you under this program when dispensed by a participating maintenance pharmacy. Any prescription order for not less than a 0-day supply and not more than a 90-day supply of a legend drug shall be considered a covered maintenance prescription drug, unless otherwise expressly excluded.

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

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

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

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

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

Experimental/Investigative - The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined 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, stepchild, parent, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, daughter-in-law, son-in-law, grandchild, grandparent, stepparent, stepbrother or stepsister.

Infertility - The medically documented inability to conceive with unprotected sexual intercourse between a male and female partner for a period of at least 12 months. The inability to conceive may be due to either the male or female partner.

Maintenance Prescription Drug - A prescription drug prescribed for the control of a chronic disease or illness, or to alleviate the pain and discomfort associated with a chronic disease or illness.

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

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

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

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

Network Provider - An ancillary provider, professional provider or facility provider who has entered into an agreement, either directly or indirectly, with Highmark or

with any licensee of the Blue Cross Blue Shield Association located out-of-area, pertaining to payment as a participant in a PPO network for covered services rendered to a member.

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

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

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

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

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

Primary Care Physician (PCP) - A physician who limits his or her practice to family practice, general practice, internal medicine or pediatrics and who may supervise, coordinate and provide specific basic medical services and maintain continuity of patient care.

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

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

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

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

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

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

The Blue Cross Blue Shield Association, and American Institute for Preventive Medicine are independent companies that do not provide Highmark Blue Cross Blue Shield products and services. They are solely responsible for the services described in this booklet.

You are hereby notified 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.

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 NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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

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

Our Legal Duties

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

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

We will inform you of these practices the first time you become a Highmark customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice became effective April 1, 2003, and will remain in effect unless we replace it.

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

practices, we will change this Notice and notify all affected members in writing in advance of the change.

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

I. Uses and Disclosures of Protected Health Information

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

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

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

Payment

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

For example:

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

Health Care Operations

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

For example:

We may use and disclose your protected health information to rate our risk and determine the premium for your health plan, to conduct quality assessment and improvement activities, to credential health care providers, to engage in

care coordination or case management, and/or to manage our business and the like.

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

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

(i) Business Associates.

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

(ii) Other Covered Entities.

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

II. Other Possible Uses and Disclosures of Protected Health Information

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

A. To Plan Sponsors

We may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us regarding a member’s question, concern, issue regarding claim, benefits, service, coverage, etc. We may also disclose summary health information (this type of information is defined in the HIPAA Privacy Rule) about the enrollees in your group health

plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

B. Required by Law

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

C. Public Health Activities

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

D. Health Oversight Activities

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

E. Abuse or Neglect

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

F. Legal Proceedings

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

G. Law Enforcement

Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or

some other legal process; or (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person.

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

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

I. Research

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

J. To Prevent a Serious Threat to Health or Safety

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

K. Military Activity and National Security, Protective Services

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

L. Inmates

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

M. Workers' Compensation

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

N. Others Involved in Your Health Care

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

III. Required Disclosures of Your Protected Health Information

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

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

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

B. Disclosures to You

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

IV. Other Uses and Disclosures of Your Protected Health Information

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

V. Your Individual Rights

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

A. Right to Access

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

You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your protected health information.

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

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

B. Right to an Accounting

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

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

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

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, Fifth Avenue Place, 120 Fifth Avenue, 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.

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: Fifth Avenue Place
120 Fifth Avenue
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 customer and will annually reaffirm our privacy policy for as long as the group remains a Highmark customer. We will continually review our privacy policy and monitor our business practices to help ensure the security of our members' personal information. Due to changing circumstances, it may become necessary to revise our privacy policy in the future. Should such a change be required, we will notify all affected customers in writing in advance of the change.

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

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

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

Information we may disclose and the purpose: We do not sell any personal information about our members or former members for marketing purposes. We use and disclose the personal information we collect (as described above) only as

necessary to deliver health care products and services to our members or to comply with legal requirements. Some examples are:

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

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

For questions about this Privacy Notice, please contact:

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

