

**LCHC - Palmyra Area School
District
Group 25089-00
Effective July 1, 2004
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Dear Member,

Welcome to **PPOBlue**, a Preferred-Provider Organization (PPO) program from Highmark Blue Shield.

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

- **PPOBlue gives you freedom of choice.** You are not required to select a Primary Care Physician to receive covered care. Instead, PPOBlue gives you access to a broad network of physicians, hospitals, and other providers. For a higher level of reimbursement, you need to receive care from one of these PPO "network" providers. However, you can go to a provider who is not in the network and still receive care that's covered.
- **PPOBlue gives you more choice.** The program offers the largest provider network throughout Central Pennsylvania and the Lehigh Valley.
- **PPOBlue includes "stay healthy" care.** You're covered for a wide range of preventive care, including routine check-ups and selected screening services.

And as a Highmark Blue Shield member, you get access to our toll-free **24-hour, Blues On Call nurse hotline for assistance with any health care question or concern.**

Your PPOBlue Program Benefits outlines your specific program benefits. If you have any questions after reading this material, call the Member Service toll-free number on your Identification Card.

We hope you're pleased with **PPOBlue**, and we wish you "good health."

Sincerely,

A handwritten signature in black ink that reads "Michael Fiaschetti".

Michael Fiaschetti
Senior Vice President
Mid-Atlantic Region

P.S. For all kinds of health and lifestyle information, we encourage you to log onto Highmark Blue Shield's site, www.highmarkblueshield.com. Our site gives you access to a comprehensive library of health-related information to help you make informed care and coverage decisions.



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This Booklet Is Not A Contract

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



PPOBluesm, Your PPO Program

Recently you enrolled in PPOBlue, a Preferred Provider Organization (PPO) program from Highmark Blue Shield. In these days of rapidly rising care costs and rapidly, dwindling options, you chose a program that can help control your costs while giving you control over your care.

PPOBlue gives you freedom of choice.

- You can receive care from the *health care provider of your choice*. PPOBlue does not require that you select a primary care physician to receive covered care. Instead, the program gives you access to a large network of physicians, hospitals, and other providers -- **the largest professional provider network in Central Pennsylvania and the Lehigh Valley**.

For a higher level of benefits coverage, you only need to receive care from a network provider. However, for most services you can also go "outside the network" and still receive care that's covered!

PPOBlue gives you control over your care.

- PPOBlue puts you in charge and gives you control over your care. *You*, not your plan or doctor, decide who provides your care. And *you* determine the level of benefit coverage you receive.
- You also enjoy a range of covered preventive services. These periodic exams and certain routine tests help you take a "proactive" approach to your health care and can help you avoid costly "reactive" care down the road.

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

Thank you for choosing PPOBlue.



Terms You Should Know

Authorization - The official agreement between the provider and Highmark Blue Shield's Healthcare Management Services (HMS) division that care meets the definition of “medically necessary and appropriate”.

Balance-Billed - The out-of-network provider’s bill for the difference between the Highmark Blue Shield payment and the provider’s actual charge.

Blues On CallSM - A 24-hour, 7 days a week health decision support number that provides health education and support services.

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. In the network, most of the physician’s are board-certified.

Coinsurance - The specific percentage of eligible expenses you and the program share. The exact coinsurance depends on the program your employer offers.

Copayment - The specific, up-front dollar amount you pay for certain covered services that is deducted from the Allowable Charge by the plan. Copayment amounts do not apply toward your deductible or coinsurance, and they do not accumulate toward the out-of-pocket limit.

Deductible - A specified dollar amount you must pay for covered services each year before the program begins to provide payment for benefits.

Experimental/Investigative - The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is determined by Highmark Blue Shield or its designated agent to not be medically effective for the condition being treated. Highmark Blue Shield will consider an intervention to be experimental/investigative if: the intervention does not have 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 or 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.

However, Highmark Blue Shield recognizes that situations may occur when you elect to pursue experimental/investigative treatment. If you are to receive a service that Highmark Blue Shield may consider to be experimental/investigative, you or the hospital and/or professional provider may contact Highmark Blue Shield's Member Service to determine whether Highmark Blue Shield considers a service to be experimental/investigative.

Medically Necessary and Appropriate - Services or supplies provided by a facility provider, professional provider or other professional provider that Highmark Blue Shield determines are: appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury; and provided for the diagnosis or the direct care and treatment of your condition, illness, disease or injury; and in accordance with standards of good medical practice; and not primarily for your or your provider's convenience; 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. Highmark Blue Shield reserves the right to determine, in its sole judgment, whether a service is medically necessary and appropriate. No benefits will be provided unless Highmark Blue Shield determines that the service or supply is medically necessary and appropriate.

Network Care – Care that you receive from network physicians, specialists, hospitals, rehabilitation centers, labs and other health care providers that have signed an agreement with Highmark Blue Shield. Network providers accept the allowed allowable charge as payment in full. They also file claims for you. Network care is paid at the higher level of benefits.

Out-of-Network Care – Care that you receive from health care providers who are not in the network. This care is covered at the lower out-of-network level when it is determined to be medically necessary and appropriate.

Out-of-Pocket Limit – The amount of money you pay out of your pocket for eligible health care expenses before the program begins to pay 100% for additional eligible expenses. The out-of-pocket limit does not include copayments, deductible, mental/health/substance abuse expenses, prescription drug expenses or amounts over the allowable Highmark Blue Shield charge.



Precertification – The process through which certain services are pre-approved by Highmark Blue Shield and the member is covered for services.

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, specialists, hospitals and other health care facilities. Using this provider network helps assure that the members receive maximum coverage for eligible services.

Provider's Reasonable Charge – The provider's reasonable charge is the amount agreed to by Highmark Blue Shield and the provider or an amount that Highmark Blue Shield determines is reasonable for covered services provided to a member. In the case of network providers, the provider's reasonable charge will be accepted as payment in full. You are responsible only for the cost sharing provisions such as copayment, deductible, and coinsurance as described in the following section, provided that you pay the provider within 60 days of the date in which the Plan finalized your claim. In the case of non-network providers, there is no agreement with the provider to accept the Plan allowance. You will be responsible for all amounts exceeding the Plan allowance.



Summary of Benefits

If you receive services in the Plan Service Area from a Network Provider or in the Highmark Managed Care network Service Area from a Preferred Professional Provider, Participating Facility Provider or Contracting Supplier, you will receive the highest level of benefits. If you choose to obtain medical care through another provider or a provider outside of the Plan Service Area or outside the Highmark Managed Care Network Service Area, you will receive the lower level of benefits.¹ There is no need to select a Primary Care Physician (PCP). No referrals are needed for specialty care. The specific benefit levels are set forth below.

Benefits	Network	Out-of-Network
Deductible <i>Per Calendar Year</i> Individual Family (<i>Aggregate</i>)	None None	\$100 \$200
Payment Level <i>Based on Provider's Reasonable Charge (PRC)</i>	100% PRC	80% PRC after deductible, until out-of-pocket limit is met; then 100% PRC
Out-of-Pocket Limit <i>Includes Coinsurance - See the section "How Your Benefits Are Applied" for exclusions/details</i> Individual Family (<i>Aggregate</i>)	None None	\$1,000 \$2,000
Lifetime Maximum <i>Per Person</i>	Unlimited	\$1,000,000
Ambulance Service	100% PRC	100% PRC no deductible emergency, 80% PRC non-emergency after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	100% PRC	80% PRC after deductible
Diabetes Treatment	100% PRC	80% PRC after deductible
Diagnostic Services (Lab, X-ray and Medical Tests)	100% PRC	80% PRC after deductible



Benefits	Network	Out-of-Network
Durable Medical Equipment, Orthotics and Prosthetics	100% PRC	80% PRC after deductible \$2,500 maximum for DME
Elective Abortions <i>Includes Dependent Daughters</i>	100% PRC	80% PRC after deductible
Emergency Care <i>Professional Services</i>	100% PRC	100% PRC deductible does not apply
Emergency Room Services <i>Facility Services</i>	100% PRC after \$35 copayment (waived if admitted)	
Enteral Formulae	100% PRC	80% PRC deductible does not apply
Hearing Care Services	Not Covered	
Home Health Care <i>Excludes Respite Care</i>	100% PRC	80% PRC after deductible
	Combined Limit: 60 visits per benefit period	
Hospice Care <i>Includes Respite Care</i>	100% PRC	80% PRC after deductible
	Combined Limit: \$12,500 per lifetime	
Hospital Services		
Inpatient	100% PRC	80% PRC after deductible
Outpatient	100% PRC	80% PRC after deductible
	365 days	
	3 pint blood deductible per benefit period	
Infertility Counseling, Testing and Treatment ²	100% PRC	80% PRC after deductible
Maternity Services <i>Includes Dependent Daughters</i>	100% PRC	80% PRC after deductible



Benefits	Network	Out-of-Network
Medical Care <i>Includes Inpatient Visits and Consultations</i>	100% PRC	80% PRC after deductible
Mental Health Services Inpatient ^{3 4} <i>Includes Partial Hospitalization (2 for 1 trade)</i>	100% PRC	50% PRC after deductible; partial hospitalization not covered
	Combined limit: 30 days per benefit period	
	Up to 30 for serious mental illness	
Outpatient ³	100% PRC after \$10 copayment	50% PRC after deductible
	Combined limit: 60 visits per benefit period	
	Up to 60 for serious mental illness	
Office Visits	100% PRC after \$10 copayment	80% PRC after deductible
Oral Surgery	100% PRC	80% PRC after deductible
Physical Therapy <i>Outpatient</i>	100% PRC	80% PRC after deductible
	Combined Limit: 30 visits per benefit period	
Preventive Care ⁵ Adult Preventive Care <i>includes:</i> Routine Physical Exam	100% PRC after \$10 copayment	80% PRC after deductible
Immunizations	100% PRC	80% PRC after deductible
Diagnostic Screening	100% PRC	80% PRC after deductible
Screening Mammography	100% PRC	80% PRC; deductible does not apply



Benefits	Network	Out-of-Network
Routine Gynecological Exam & PAP Test	100% PRC after \$10 copayment	80% PRC; deductible and maximum do not apply
<i>Pediatric Preventive Care includes:</i> Routine Physical Exam	100% PRC after \$10 copayment	80% PRC after deductible
Pediatric Immunizations	100% PRC	80% PRC; deductible and maximum do not apply
Diagnostic Screening	100% PRC	80% PRC after deductible
Private Duty Nursing	100% PRC	80% PRC after deductible
	Combined Limit: 240 hours maximum per benefit period	
Skilled Nursing Facility Care	100% PRC	50% PRC after deductible
	Combined Limit: 100 days per benefit period	
Speech & Occupational Therapy Outpatient	100% PRC	80% PRC after deductible
	Combined Limit: 30 visits per benefit period/Per Type of Therapy	
Spinal Manipulations	100% PRC	80% PRC after deductible
	Combined Limit: 20 visits per benefit period	



Benefits	Network	Out-of-Network
Substance Abuse Detoxification ⁴	100% PRC 7 days per admission 4 admissions per lifetime	80% PRC after deductible
Inpatient Rehabilitation ⁴ <i>Includes Partial Hospitalization (2 for 1 trade)</i>	100% PRC 30 days per year 90 days per lifetime	Not Covered
<i>Outpatient</i>	100% PRC 60 visits per year 120 visits per lifetime	Not Covered
Surgical Expenses <i>Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures</i> <i>Includes Neonatal Circumcision</i>	100% PRC	80% PRC after deductible
Therapy Services <i>Chemotherapy</i> <i>Radiation Therapy</i> <i>Dialysis</i> <i>Infusion Therapy</i> <i>Respiratory Therapy</i>	100% PRC	80% PRC after deductible
Transplant Services	100% PRC	80% PRC after deductible
Precertification Requirements for Inpatient Admissions ⁶ <i>No penalty for Non-Compliance</i>	Performed by Network Providers	Performed by Member
Condition Management	Case Management, Blues on Call, and Disease State Management	

¹ The Plan Service Area is all Pennsylvania counties except for 29 counties in western Pennsylvania. To obtain services at the maximum benefit level within the 29 western Pennsylvania counties, providers within the Highmark Managed Care Network must be used. To find a provider within the Highmark Managed Care Network, call the member services number on the back of your identification card.



- ² Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- ³ State mandated benefits (30 inpatient days and 60 outpatient visits annually, with the right to exchange inpatient days for outpatient visits on a one-for-two basis) apply to a diagnosis of serious mental illness. Serious mental illnesses include: schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive- compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa and delusional disorder. Once mental health limits are exhausted, both inpatient and outpatient serious mental illness services must be provided by a network provider (see Summary of Benefits for plan limits).
- ⁴ To obtain inpatient mental health and substance abuse services at the maximum benefit level, you must contact Highmark Blue Shield's Mental Health & Substance Abuse unit before seeking treatment.
- ⁵ The Schedule of covered preventive care services is outlined in Highmark's preventive care schedule, which is updated periodically based on changes in clinical practice guidelines.
- ⁶ If Blue Shield is not contacted prior to a non-emergency out-of-network inpatient admission and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the member will be responsible for any costs not covered.



Prescription Drug Benefits	Retail Pharmacy	Mail Service Pharmacy
Deductible	None	None
Generic Prescription Drug	80% coinsurance	\$5 copayment
Brand Prescription Drug	80% coinsurance	\$5 copayment
Days Supply (<i>per prescription</i>)	Up to 30-days	Up to 90-days
Generic Substitution	Not Applicable	
Out of Pocket Maximum	Not Applicable	
Claim Submission	Pharmacy Files at Point-of-Sale	
Non-Network Pharmacy	Not Covered	
Prescription Drug Categories		
Contraceptives (oral and injectable)	Covered when medically necessary with Prior Authorization	
Fertility Agents	Covered - with Prior Authorization	
Fluoride Products	Covered	
Insulin and Diabetic Supplies	Covered	
Smoking Deterrents (prescription)	Covered	
Vitamins (prescription)	Covered	
Weight Loss Drugs	Covered	
Allergy Serum	Not Covered	
Durable Medical Equipment	Not Covered	
Prescription Hair Growth Products	Not Covered	



Prescription Drug Benefits	Retail Pharmacy	Mail Service Pharmacy
Care Management Programs		
Quantity level Limits <i>on select prescription drugs</i>	Applies – the quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines.	
Managed Rx Coverage <i>on certain drug therapies</i>	Does not Apply	
Managed Prior Authorizations	Applies on select high cost drugs.	

- Under the mandatory generic provision, the member is responsible for the additional cost of a brand-name drug when a generic drug is available and the patient specifies a brand-name drug. The member payment is the price difference between the brand drug and generic drug in addition to the brand drug copayment amounts which may apply.
- Prescriptions obtained from a non-network pharmacy are not eligible for payment.
- Certain prescription drugs may require prior authorization.



Summary of Vision Benefits - Optichoice

OptiChoice [®] Benefits	In-Network Coverage	Out-of-Network Reimbursement
Eye Examination and Refraction	Covered-in-full	\$32
Frames	Covered -in-full (up to a \$60 value)	\$24
Eyeglass Lenses <i>per pair</i> <i>Standard Lenses</i> Single Vision Bifocal Trifocal Aphakic/Lenticular <i>Specialty Lenses</i> (including but not limited to: polycarbonate or progressive “no- line” bifocals)	Covered-in-full Covered -in-full Covered -in-full Covered -in-full You pay 90% of the difference between the provider’s full charge for specialty and standard lenses	\$24 \$36 \$46 \$72 Reimbursement as listed above, except for progressive lenses which are reimbursed at \$41
Contact Lens Evaluation and Fitting Daily wear Extended wear	Covered -in-full Covered -in-full	\$20 \$30
Contact Lenses <i>per pair</i>* <i>Standard</i> (Hard/Soft Daily Wear Spherical) <i>Specialty</i> (including but not limited to: Extended Wear, Hard/Soft Bifocal, Gas Permeable) <i>Disposables (unlimited lenses)</i>	Covered -in-full Covered -in-full (up to a \$75 value) Covered -in-full (up to \$75 throughout the benefit period)	\$48 \$48 \$75



OptiChoice [®] Benefits	In-Network Coverage	Out-of-Network Reimbursement
Lens Options (e.g. Tints, Coatings) Vision Care Supplies	10% Discount	Not Covered
Additional Eyewear and Examinations (excluding disposable contacts)	You only pay the Out-of-Network Reimbursement which is accepted as payment-in-full for all standard products**	Not Covered

*One pair of eyeglass lenses *or* one pair of contacts *or* an unlimited number of disposable contacts (up to \$75) is eligible within a benefit period.

**OptiChoice providers accept \$24 as payment in full for frames priced up to \$60 and \$48 as payment in full for contact lenses priced up to \$75.



A Recognized Identification Card

“Passport” to Quality Care

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

When you or one of your dependents receives health care services:

- show your ID card to the hospital or other professional health care providers; and
- ask the provider of service to file a claim for you.

The following information will be displayed on your ID card:

- the employee’s name
- identification number
- group number
- copayment for physician office visits and emergency room visits (if applicable)
- Premier Pharmacy network logo (when applicable)
- Member Service toll-free number (on back of card)
- your toll-free number for non-PPOBlue admissions (on back of card)
- precertification toll-free number (on back of card)
- "PPO in Suitcase" symbol

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

Protect Your Card

If your card is lost or stolen, please call Member Service immediately. Only you or your covered dependents are permitted to use this card. It is illegal to loan your card to persons who are not eligible to use your Highmark Blue Shield benefits.



To request additional ID cards, contact Member Service or request cards online by going to your My Shield Onlinesm page at www.highmarkblueshield.com.



How Your PPO Program Works

PPOBlue lets you get the medically necessary and appropriate care you want from the provider you prefer. 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 our network.

This network includes thousands of physicians and most hospitals in the service area. In fact, chances are good that your current doctors are already in this network.

When you receive health care within the PPOBlue network, you enjoy maximum coverage and maximum convenience. Your benefits are paid at the higher level for eligible services. And you don't need to fill out claim forms or obtain precertification. Providers do that for you.

Out-of-Network Care

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

Even when you go outside the network, you will still be covered for most eligible services. However, your benefits generally will be paid at your program's lower - level. You may be responsible for an annual deductible and your coinsurance. (Refer to the section “*Summary of Benefits*” for your program's specific amounts.)

You may be responsible for paying any difference between the provider's actual charge and the plan's allowed amount.

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



Healthcare Management Services

For your benefits to be paid under PPOBlue at either the network or out-of-network level, services and supplies must be considered "**Medically Necessary and Appropriate.**"

Healthcare Management Services (HMS), a division of Highmark Blue Shield, is responsible to help ensure that quality care is delivered to members within the proper setting, at the appropriate cost, and with the right outcome.

An HMS nurse will review your request for an inpatient admission to ensure it is:

- appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury;
- provided for your diagnosis or the direct care and treatment of your condition, illness, disease or injury;
- not primarily for the convenience of you, your physician, hospital or health care provider;
- in accordance with standards of good medical practice;
- the most appropriate supply or level of service that can safely be provided to the member. 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.

Network Care

When you use a network provider for inpatient care, ***the provider will contact HMS*** for you to receive authorization for your care.

Out-of-Network Care

When you are admitted to an out-of-network facility provider for an inpatient admission, **you are responsible for contacting HMS** to determine whether your services are medically necessary and appropriate. Contact HMS prior to your admission to an out-of-network facility provider so that you know your financial responsibility. You should call 7 to 10 days prior to your planned admission. For emergency or maternity-related admissions, call HMS within 48 hours of the admission, or as soon as reasonably possible. You can contact HMS via the toll-free Member Service number of the back of your ID card.

If you do not call to certify your admission to an out-of-network facility, your care will be reviewed by HMS after services were received to



determine if it was medically necessary and appropriate. **If the admission is determined not to be medically necessary and appropriate, you will be responsible for all costs not covered by your program.**

Remember:

Out-of-network providers are not obligated to contact HMS or to abide by any determination of medical necessity or appropriateness rendered by HMS. Therefore, should you receive services which are not medically necessary and appropriate, you will be billed.

Continued Stay Review

While you or your covered dependent are in a facility as an inpatient, HMS will be in contact with facility personnel familiar with the case to make certain that continued hospitalization is appropriate. Determination of the need for continued inpatient coverage will be made in consultation with the patient's physician. Either HMS or the facility will notify the patient if the inpatient stay is determined to be no longer medically necessary and appropriate. If you or your covered dependent elect to remain in the facility after such notification, no further benefits will be provided for the remainder of the stay.

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, HMS or its designated agent will help plan for and coordinate your discharge to assure that you receive safe and uninterrupted care when needed at the time of discharge.

In planning for discharge, HMS assesses the member's:

- level of function pre- and post-admission;
- ability to perform self-care;
- primary caregiver and support system;
- living arrangements pre- and post-admission;
- special equipment, medication, and dietary needs and safety needs;
- obstacles to care;
- need for referral to case management or condition management;
- availability of benefits or need for benefit adjustments; and
- psychological needs.



Retrospective Review

Retrospective review occurs when a service or procedure has been rendered without the required authorization.

Case Management Services

Should you or a covered family member experience a serious injury or illness, the Case Management Program may be able to provide assistance.

If accepted into the program, and with the member's permission, the program will:

- work collaboratively with the member, family or significant others, and all providers to coordinate and implement a plan of care which meets the member's holistic needs;
- identify community-based support and educational services to assist with the member's ongoing health care needs; and
- assist in the coordination of benefits and alternative resources.



Your Guide to Good Care

Your Provider Network

Your PPO network directory is your key to receiving the higher, network level of benefits. Your directory lists the provider network which includes: primary care physicians, a wide range of specialists including mental health and substance abuse services, community and specialty hospitals, and laboratories.

This professional provider network is the largest in Central Pennsylvania and the Lehigh Valley, so chances are very good that your favorite doctor is in the network.

When you receive care from a network provider, your benefits are paid at the higher, network level for eligible services. And you don't need to fill out claim forms or obtain precertification for a hospital stay –your network physician takes care of that for you.

Please note that while you or a family member can use the services of any network physician or specialist and receive the maximum amount payable under your benefit program, you are encouraged to select a personal physician from the list of primary care physicians. This helps establish an ongoing relationship based on knowledge and trust. And 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. So you may want to double-check any provider recommendations to make sure the doctor or facility is in the network. Or you may want to share your Provider Directory with the referring physician so he/she refers you to a network provider.



Eligible Providers

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

Facility Providers

- Hospitals
- Psychiatric Hospitals
- Rehabilitation Hospitals

Other Facility Providers

- Ambulance service
- 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
- Home infusion therapy provider
- Hospice
- Outpatient substance abuse treatment facility
- Outpatient physical rehabilitation facility
- Outpatient psychiatric facility
- Skilled nursing facility
- Substance abuse treatment facility

Professional Providers

- Audiologist
- Certified registered nurse



- Chiropractor
- Clinical laboratory
- Dentist
- Nurse-midwife
- Optometrist
- Physical therapist
- Physician
- Podiatrist
- Psychologist
- Speech-language pathologist
- Teacher of hearing impaired

Other Providers

- Licensed practical nurse
- Occupational therapist
- Registered nurse
- Respiratory therapist
- Suppliers



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 period of time in which you can receive services without incurring a new deductible or out-of-pocket limit. Benefit periods are usually per calendar year or per 12-month period.

Cost-Sharing Provisions

Cost-sharing provisions require that you as the member, and your covered dependents pay part of your covered expenses or services. The terms "copayment," "deductible" and "coinsurance" describe different cost-sharing methods that may require you to pay for part of the cost for your medical expenses.

Copayment

The copayment is the fixed, up-front dollar amount you pay for eligible services. Copayments do not apply toward the deductible or out-of-pocket limits. This amount will be deducted from the allowable charge before a determination of benefits payable is made by Highmark Blue Shield. See your *Summary of Benefits* for the copayment amount(s).

The copayment you are required to pay does not vary with the cost of the services. **You are expected to pay the copayment to the provider at the time of service.**

Deductible

The deductible is a specified dollar amount you must pay for covered services each year before Highmark Blue Shield or the plan begins to pay all or part of the remaining covered expenses. See the section, *Summary of Benefits* for the deductible amount.

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



If you could not meet your deductible during a preceding benefit period, then any covered medical expenses incurred during the last three months of the calendar year and applied toward that benefit period's deductible may be carried over and applied against the deductible owed for the next calendar year.

Coinsurance

The coinsurance is the specific percentage of the allowable charge you must pay for certain eligible expenses after your deductible, if applicable, has been met. Refer to your *Summary of Benefits* for the percentage amounts paid by the program. The remaining coinsurance amounts are your responsibility.

Out-of-Pocket Limit

The out-of-pocket limit refers to the specified dollar amount of coinsurance you pay out of your pocket for eligible health care expenses before your program begins to pay 100% for additional expenses. See your *Summary of Benefits* for the out-of-pocket limit. The out-of-pocket limit does not include copayments, deductibles, mental health/substance abuse expenses or amounts in excess of the provider's reasonable charge. The family out-of-pocket limit refers to the amount you have paid out of your own pocket for total covered services your family received during the calendar year.

Lifetime Maximum

The maximum benefit that the program will provide for any covered individual during his or her lifetime as specified in your *Summary of Benefits*.

At the start of each benefit period, the amount paid for covered services in the preceding benefit period (up to \$1,000) will be restored to the lifetime maximum of each person who used the benefits.



Covered Services

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

Ambulance

Ambulance service providing local transportation by means of a specially designed and equipped vehicle used to transport the sick and injured:

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

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

Dental Services Related to Accidental Injury

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

Diabetes Treatment

Your program provides coverage for the following when required in connection with the treatment of diabetes and when prescribed by a physician legally authorized to prescribe such items under the law:

- Equipment and supplies: Blood glucose monitors, monitor supplies, and insulin infusion devices; and
- Outpatient Diabetes Education*: When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through an outpatient diabetes education program:
 - visits medically necessary and appropriate upon the diagnosis of diabetes; and



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

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

Diagnostic Services

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

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

Durable Medical Equipment

The rental or, at the option of the Plan, the purchase, adjustment, repair and replacement of durable medical equipment when prescribed by a professional provider, within the scope of his/her license and required for therapeutic use. Rental costs can not 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. Benefits for such enteral formulae are exempt from any applicable deductible requirements.

Home Health Care Services

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

- skilled nursing services of an RN or LPN;
- physical therapy, occupational therapy and speech therapy;
- medical and surgical supplies provided by the home health care agency or hospital program for home health care;
- oxygen and its administration;
- medical social service consultations; and
- health aide services to an individual who is receiving covered nursing or therapy services.
- family counseling related to the member's terminal condition.

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

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.

Group health plans and health insurance issuers like Highmark are generally prohibited by law from restricting benefits for any hospital



length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, these laws do not prohibit the mother's or newborn's attending provider from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable) if the mother and newborn meet the medical criteria for a safe discharge contained in guidelines which recognize treatment standards used to determine the appropriate length of stay. In any case, group health plans and health insurance issuers may not require that a provider obtain authorization from the group health plan or the health insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Home Infusion Therapy Services

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

Hospice Care Services

Hospice care services will be provided to members with a life expectancy of 180 days or less, as certified by a physician. Services rendered by a home health care agency or a hospital program for hospice care for which benefits are available as follows:

- skilled nursing services of an RN or LPN, excluding private duty nursing services;
- physical therapy, occupational therapy and speech therapy;
- medical and surgical supplies provided by the home health care agency or hospital program for hospice care;
- oxygen and its administration;
- medical social service consultations;
- health aide services to a member who is receiving covered nursing or therapy services;
- respite care; and
- family counseling related to the member's terminal condition.

No hospice care benefits will be provided for:

- dietitian services;
- homemaker services;



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

Hospital Services

This program covers the following services you receive in a hospital or other facility provider. Benefits will be covered only when, and so long as, they are determined to be medically necessary and appropriate for the proper treatment of the patient's condition. If you use an out-of-network professional provider and an inpatient hospital admission is required, you must contact HMS prior to your admission.

Bed and Board

Bed, board and general nursing services in a facility provider when the member occupies:

- a room with two or more beds; or
- a private room; or
- a bed in a Special Care Unit where intensive care to the critically ill is provided.

Other Services

- 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
- expenses incurred for the first 3 one-pint units of whole blood or blood components are the responsibility of the member.
- anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the hospital or other 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
- therapy services

Surgery

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

Pre-Admission Testing

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

Emergency Care Services

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

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

Please keep in mind, however, if your care is determined not to be emergency in nature and you receive care at an out-of-network hospital, you may be subject to your program's deductible and coinsurance amounts, resulting in your benefits being paid at the lower out-of-network level.

You should use emergency services only when appropriate. In some situations, such as strains or sprains, fevers and sore throats, it may make sense to contact a network doctor. Doing this puts you in touch with the person who truly knows your health history. It can save you hours of waiting in a crowded emergency room where more critical injuries are being treated.

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 Accident Care

Services and supplies for the outpatient emergency treatment of bodily injuries resulting from an accident.

Emergency Medical Care

Outpatient emergency hospital services and supplies for the outpatient emergency treatment of a sudden onset of a condition manifesting itself by acute symptoms that require immediate attention.

Maternity Services

If you think you are pregnant, you may contact your physician or go to a network obstetrician or nurse midwife. When your pregnancy is confirmed, you may continue to receive follow-up care which includes prenatal visits, delivery, postpartum and newborn care in the hospital that is covered at the higher level of benefits.

This program provides services for:

- normal pregnancy;
- complications of pregnancy; and
- nursery care.

Maternity Home Health Care Visit

You are covered for one (1) maternity home health care visit provided at your home within forty-eight (48) hours of discharge when the discharge from a facility provider occurs prior to: (a) forty-eight (48) hours of inpatient care following a normal vaginal delivery, or (b) ninety-six (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 and is exempt from any copayment, coinsurance or deductible amounts.

Medical Services

Inpatient Medical Services

This program covers the following services you receive from a professional provider when you are an inpatient for a condition not related to surgery, pregnancy or mental illness:



- Concurrent Care
 - Care for a medical condition by a professional provider who is not your surgeon while you are in the hospital for surgery.
 - Care by two (2) or more professional providers during one (1) hospital stay when the nature or severity of your condition requires the skills of separate physicians.
- Consultation
 - Consultation by another professional provider when requested by the attending professional provider. Staff consultations which are required by the facility provider's rules and regulations are excluded.
- Inpatient Medical Care Visits
- Intensive Medical Care
 - Constant attendance and treatment by a professional provider when your condition requires it 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 (Physician Visits)

This program covers the following outpatient services:

- medical care rendered to you by a professional provider for a condition not related to surgery, pregnancy or mental illness, except as specifically provided herein; and
- medical care visits and consultations to examine, diagnose and treat an injury or illness; and
- therapeutic injections.

Mental Health Care Services

Should you need help with mental health problems, PPOBlue offers you professional, confidential care.

To receive the higher, network, level of benefits coverage for mental health, you should call one of the Mental Health Providers listed in your Provider Directory.



These professionals share our philosophy of providing responsive care. You're offered a wide selection of professional providers such as psychiatrists, doctoral-level psychologists and licensed certified social workers, so you can get the level and type of care appropriate to your situation.

You are covered for a full range of counseling and treatment services.

If you choose to receive mental health services from providers who are not in the network, your eligible care is covered at the lower, out-of-network level. Should you go to an out-of-network provider for an inpatient admission, *you, not the provider*, are responsible for precertifying your care; in these cases, call the toll-free number on your ID card to determine if care is medically necessary and appropriate.

You can also choose to receive non-emergency outpatient mental health or substance abuse services from an out-of-network provider. Preauthorization is not required for outpatient out-of-network services. All out-of-network non-emergency outpatient services are eligible at the lower benefit level of coverage.

Inpatient Facility Services

Covered inpatient hospital services provided by a hospital or other facility provider.

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; and
- 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

Partial hospitalization for mental health care services provided by a partial hospitalization program which has been approved by the plan. Such programs are subject to periodic review by the plan.



Outpatient Mental Health Care Services

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

Serious Mental Illness Care Services

You are covered for inpatient services for the treatment of serious mental illness for up to thirty (30) days per calendar year. A maximum of thirty (30) of these inpatient days may be exchanged on a one-for-two basis to secure up to sixty (60) additional outpatient days per calendar year.

You are covered for outpatient services for the treatment of serious mental illness for up to sixty (60) outpatient days per calendar year. Each day of outpatient care constitutes as one (1) visit.

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.

Preventive Care Services

PPOBlue provides excellent coverage for your network preventive care. This vital care can help you stay on top of your medical needs and establish a healthy, well-informed lifestyle.

That's why we encourage you to take advantage of our excellent preventive care benefits, including periodic physical examinations, well child visits, and a full scope of diagnostic testing such as cholesterol screenings, gynecological exams, and Pap tests. Refer to the section, “*Summary of Benefits*” for the specifics on your coverage.

Adult Preventive Care

Routine physical examinations, including a complete medical history, height and weight measurement and selected diagnostic services and immunizations. Adult preventive care is available to members eighteen (18) years of age or older in accordance with Highmark’s Preventive Care*

Routine Gynecological Examination and Pap Test

All female members, regardless of age, are covered for one (1) routine gynecological examination, including a pelvic and clinical breast examination, and one (1) routine Papanicolaou smear (pap test) per



calendar year. Benefits are not subject to program deductibles or maximums.

Mammographic Screening

- Women are covered for one routine mammographic screening annually, beginning at age 40.
- Mammographic examinations are covered 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 Preventive Care and Immunizations

This program covers the following services:

- routine physical examinations and selected diagnostic services. Benefits are provided for a medical history, height and weight measurement, physical examination and counseling, where appropriate. Pediatric Preventive Care is available to members seventeen (17) years of age or younger in accordance with Highmark's Preventive Care Schedule.*
- pediatric immunizations, when performed and billed by a hospital, facility, physician or other professional provider, are covered. Benefits are provided to members under 21 years of age and dependent children for those pediatric immunizations, including the immunizing agents, which conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services. Benefits are not subject to the program deductibles or maximums and are limited to members under age 21.

Allergy Extract/Injections

- Allergy extract and allergy injections.

*The schedule is reviewed and updated periodically by the Plan based on the advice of the American Academy of Pediatrics, U.S. Preventive Service Task Force, the Blue Cross and Blue Shield Association, and medical consultants. Accordingly, the frequency and eligibility of services is subject to changes.



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.

- For a member who is an inpatient in a hospital or other 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.
- For a member at home, only when the plan determines that the nursing services require the skills of a RN or of a LPN.

Prosthetic Appliances

Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies that:

- replace all or part of a missing body organ and its adjoining tissues; or
- replace all or part of the function of a permanently inoperative or malfunctioning body organ
- initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof, are also covered.

Dental appliances and the replacement of cataract lenses are not 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, the member with the activities of daily living or to provide an institutional environment for the convenience of a member; and
- for treatment of substance abuse or mental illness.

Spinal Manipulations

Benefits will be provided for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or



subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

Substance Abuse Services

PPOBlue gives you professional, confidential substance abuse care that addresses your individual needs.

To receive the higher, network level of benefits coverage for substance abuse, you should call one of the mental health providers listed in your Provider Directory or listed on the Web site at www.highmarkblueshield.com.

You are covered for a full range of counseling and treatment services.

If you choose to receive substance abuse services from providers who are not in the network, your eligible care is covered at the lower, out-of-network level. Should you go to an out-of-network provider for an inpatient admission, *you, not the provider*, are responsible for precertifying your care; in these cases, call the toll-free number on your ID card to determine if care is medically necessary and appropriate.

This program covers individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of alcohol abuse and drug abuse when rendered to a member by a facility provider or professional provider and include the following:

- Inpatient hospital or alcohol or drug abuse treatment facility services for detoxification for a maximum of 7 days per admission and a maximum of 4 admissions per lifetime.
- Alcohol or drug abuse treatment facility services for inpatient non-hospital residential and rehabilitation therapy for 30 days per calendar year and a maximum of 90 days per lifetime.
- Outpatient hospital or alcohol or drug abuse treatment facility or outpatient alcohol or drug abuse treatment facility services for rehabilitation therapy for 60 full or equivalent partial-session visits per calendar year. A maximum of 30 of these visits may be exchanged on a two-for-one basis to secure up to 15 additional days per calendar year of non-hospital inpatient residential and rehabilitation services beyond the otherwise applicable calendar year limit of 30 days for such services. Outpatient rehabilitation services are limited to a maximum of 120 days per lifetime.



Surgical Services

This program covers the following services you receive from a professional provider. If an inpatient hospital admission is required, you must contact HMS prior to your admission.

Anesthesia

Administration of anesthesia 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 oral surgical procedures in an outpatient setting when ordered and administered by the attending network professional provider.

Assistant at Surgery

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

Second Surgical Opinion

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

Keep in mind that:

- the second opinion must be from someone other than your first physician who recommended the elective surgery;
- elective surgery means a covered surgery that may be deferred and is not an emergency;
- use of a second surgical opinion is your option;
- a third opinion and directly related diagnostic services are covered if the first and second opinions conflict;
- you are covered for surgery even when the physicians opinions conflict.

You will be eligible for a maximum of two (2) such consultations involving the elective surgical procedure in question, but limited to one (1) consultation per consultant.

Special Surgery

- Sterilization



- Sterilization and procedures to reverse sterilization regardless of medical necessity and appropriateness.

- Oral surgery

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

- extraction of impacted third molars when partially or totally covered by bone;
- mandibular frenectomy;
- 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; and
- 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

This program covers a mastectomy performed on an inpatient or outpatient basis for the following:

- surgery to re-establish symmetry or alleviate functional impairment. This includes, but is not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy.
- The use of initial and subsequent prosthetic devices to replace the removed breast or portions thereof.
- Physical complications of all stages of mastectomy, including lymphedemas.

This program covers one (1) home health care visit within forty-eight (48) hours after discharge, as determined by your physician, if discharge occurred within forty-eight (48) hours after admission for a mastectomy.



Surgical Services

- Surgery performed by a professional provider. Payment includes visits before and after surgery.
- When more than one (1) 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 the program deems that an additional allowance is warranted.

Therapy Services

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

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

Transplant Services

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

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

- when both the recipient and the donor are members, each is entitled to the benefits of the contract;
- 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 Shield coverage or any government program; and 2) benefits provided to the donor will be charged against the recipient's coverage under this program;

- when only the donor is a member, the donor is entitled to the benefits of this program, subject to the following additional limitations: 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.



Prescription Drug Coverage

Under most PPOBlue programs, your prescriptions are covered with either a copayment or coinsurance when purchased through a network pharmacy. You may also have mail service, which can give you added convenience and cost-savings.

Affordable Rx Coverage

Prescription drugs are covered when you purchase them through the Premier Pharmacy network applicable to your plan. For convenience and choice, these pharmacies include both major chains and independent stores. *No benefits are available if drugs are purchased from a Non-Premier Pharmacy.*

Benefits are provided for covered prescription drugs under the Paid Card Prescription Drug program described below. All benefit limits, deductibles, copayments and coinsurance amounts are described in the *Summary of Benefits*. You may also have mail service, which can give you added cost-savings and convenience.

Covered Prescription Drugs

Covered drugs are those which, under federal law, are required to bear the legend: "Caution: Federal Law prohibits dispensing without a prescription" or which are specifically designated by Highmark Blue Shield.

Covered Drugs Include:

- Injectable insulin, which may not require a prescription;
- Diabetic supplies, including needles and syringes; and
- Certain drugs which may be subject to the Prescription Drug Care Management Programs and require prior authorization from Highmark Blue Shield.

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

The prescription drugs that are excluded under your program are outlined in the "What Is Not Covered" section.

Prescription Drug Benefits



Retail Pharmacy Benefit – When you visit a retail network pharmacy and present your identification card, you will be required to pay a copayment or coinsurance for each separate prescription order or refill order for up to the maximum retail days supply provided by your plan. You may be required to satisfy a prescription drug deductible. Refer to the *Summary of Benefits* for the maximum retail days supply, copayment, coinsurance and/or deductible amounts applicable to your prescription drug benefit.

Mail Service Pharmacy Benefit – When you use our mail service pharmacy, you will be required to pay a copayment or coinsurance for each separate prescription order or refill order for up to the maximum mail service days supply provided by your plan. Refer to the *Summary of Benefits* for the copayment, coinsurance and/or deductible amounts applicable to your prescription drug benefit.

Premier Gold Pharmacies

You must purchase drugs from a Premier Gold Pharmacy to be eligible for benefits under this program. *No benefits are available if drugs are purchased from a Non-Premier Gold Pharmacy.* For your convenience and choice, these pharmacies include both major chains and independent pharmacies. Visit our Web site at www.highmarkblueshield.com to search for a Premier Gold pharmacy in your area.

A Premier Gold Pharmacy has an arrangement with Highmark Blue Shield to provide prescription drugs to you at an agreed upon price. When you purchase covered drugs from any Premier Gold Pharmacy, present your prescription and identification card to the pharmacist. You will owe the pharmacy any copayment, coinsurance or deductible amounts that may apply. You should request and retain a paid receipt for any amounts that you paid to the pharmacy if you need it for income tax or any other purpose.

If you fail to show your identification card to the Pharmacy you will be responsible for paying the full charge for your prescriptions. To obtain reimbursement you will then need to submit a copy of your receipt along with a completed Prescription Drug Reimbursement Form to the address listed on the form no later than twelve (12) months from the date that the prescription drug was dispensed. Please contact Member Service to obtain a Prescription Drug Reimbursement Form.

Premier Gold Pharmacies also include mail service suppliers designated by Highmark Blue Shield. Mail service prescriptions or refills for covered drugs shall be dispensed for not more than a 90-day supply.



Using the Mail Service Pharmacy Benefit

Prescriptions that you take on an ongoing basis may be ordered through our mail service pharmacy for added savings and convenience. To order your prescription through our mail service pharmacy, ask your doctor to prescribe your medication for up to the maximum days allowed under your plan – typically 90 days - plus refills if appropriate. Mail your prescription and required copayment or coinsurance along with a Mail Service Pharmacy Order Form to the address listed below. You may pay by check, money order or credit card. Visit our Web site or call Member Service at the number listed on the back of your identification card to obtain a Mail Service Pharmacy Order Form and envelope or if you have any questions.

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PO Box 2201
Pittsburgh, PA 15230-9523

Your order will be processed promptly – usually within 48 hours of receipt – and your medication will be sent to you via U.S. Mail or UPS in 7 to 11 days. Included with your order will be instructions for ordering refills. Refills can be ordered by phone, mail or directly over the Internet at www.highmarkblueshield.com.

Prescription Drug Care Management Programs

Prescription Drug Care Management is comprised of several components that encourage the safe and effective use of targeted medications. Because the Quantity Level Limit and Prior Authorization Coverage programs can affect your coverage, it is important that you understand each program's requirements. Please visit our Web site or contact Member Service if you have a question as to whether a particular drug is included in our Prescription Drug Care Management Programs.

Quantity Level Limits

Certain prescription drugs may be subject to Quantity Level Limits. Quantity Level Limits control the number of tablets, patches, inhalers or nasal spray bottles that will be covered each time a new or refill prescription is dispensed, for a number of commonly prescribed drugs. These limits are based on the manufacturer's recommended daily dosage, as determined by the Plan. Each time a prescription order or refill is dispensed, the pharmacy may limit the quantity dispensed.

Drugs Requiring Prior Authorization

Some drugs require authorization by Highmark Blue Shield before they will be covered. The list of drugs that require Prior Authorization is modified periodically and includes but is not limited to the following:



Enbrel, fertility medications, growth hormones, Gleevec, Inteférons, Kineret, Provigil and Tracleer.

To obtain authorization, your doctor must submit a completed Prescription Drug Prior Authorization Form to Highmark Blue Shield. You and your doctor will receive a decision in writing within two business days after all of the supporting documentation is received.

How to Appeal a Determination

If you disagree with a determination under the Prior Authorization or Managed Prescription Drug coverage program, you may submit an appeal in writing to:

Highmark Blue Shield
Grievances and Appeals
PO Box 890174
Camp Hill, PA 17089-0174

If you do not understand the process or the decision, please call Member Service at the telephone number listed on your identification card.

Provisions

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

The Plan shall not exercise any subrogation rights against any person or organization for charges you incur in connection with the prescription drug benefits provided herein.

Notice of Claim

Highmark Blue Shield will not be liable for member-submitted prescription drug claims unless proper notice is submitted to the Plan or its agent that a covered prescription drug was received. Written notice must be given within 90 days from the date that the member received the covered prescription drug. The notice must include the data necessary for the Plan to determine benefits. In no event will the Plan be required to accept notice more than twelve (12) months after the prescription drug was dispensed, unless otherwise required by law.



What Is Not Covered

Your program will not provide benefits for services, supplies or charges:

- Which are not medically necessary or medically appropriate as determined by the Plan;
- Which are not prescribed by or performed by or upon the direction of a professional provider;
- Rendered by other than facility providers, professional providers or other professional providers or suppliers;
- Which are experimental/investigative in nature;
- Rendered prior to the your effective date;
- Incurred after the date of termination of your coverage except as provided herein;
- For loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of an act of war whether declared or undeclared;
- For which you would have no legal obligation to pay;
- 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;
- To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program and you elect this coverage as primary;
- For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage;
- 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;
- To the extent benefits are provided to members of the armed forces or to patients in Veteran's Administration facilities for service-connected illness or injury, unless the Member has a legal obligation to pay;



- 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;
- For prescription drugs and medications, except those which are administered to an inpatient in a facility provider;
- For nicotine cessation support programs and/or classes.
- For methadone hydrochloride treatment for which no additional functional progress is expected to occur.
- Which are submitted by a certified registered nurse and another professional provider or other provider for the same services performed on the same date for the same patient;
- Rendered by a provider who is a member of the member's immediate family;
- Performed by a professional provider or other provider enrolled in an education or training program when such services are related to the education or training program;
- For ambulance services, except as provided herein;
- 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 congenital birth defects; and c) surgery to correct a functional impairment which results from a covered disease or injury;
- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier-free" home modifications, whether or not specifically recommended by a professional provider or other professional provider;
- For inpatient admissions which are primarily for diagnostic studies;
- For inpatient admissions which are primarily for physical therapy;



- For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care;
- For therapy services for which 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;
- Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates as provided herein;
- For oral surgery procedures unless specifically provided, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, except as provided herein;
- 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;
- 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;
- For hearing aids, tinnitus maskers, or examinations for the prescription or fitting of hearing aids, unless specifically provided;
- For any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery;
- Related to treatment provided specifically for the purpose of assisted fertilization; including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law;
- 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);

- 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;
- For nutritional counseling, except as provided herein;
- For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate;
- For treatment of obesity, except for medical and surgical treatment of morbid obesity;
- For any food including, but not limited to, enteral formulae, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis. This does not include enteral formulae prescribed solely for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria;
- For preventive care services, wellness services or programs, except as provided herein or as mandated by law;
- For well-baby care visits, except as provided herein;
- For allergy testing, except as provided herein or as mandated by law;
- 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 or as mandated by law;
- For immunizations required for foreign travel;
- For the treatment of sexual dysfunction that is not related to organic disease or injury;
- 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. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type



- setting; 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 learning disorders or learning disabilities; e) services provided primarily for social or environmental change unrelated to medical treatment; 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 improvement in a reasonable and predictable period of time;
- For any care, treatment, or service which has been disallowed under the provisions of Healthcare Management Services;
 - For any other medical or dental service or treatment except as provided in the contract or as mandated by law;
 - For otherwise Covered Services ordered by a court or other tribunal as part of the Member's or Dependent's sentence;
 - For any illness or injury suffered during the Member's commission of a felony.

In addition, under your Prescription Drug benefits, the following are also excluded:

- Any drug or medication which is provided by a non-participating pharmacy provider;
- Any amounts the member is required to pay directly to the pharmacy for each prescription order or refill order;
- Prescription drugs to which you are entitled, with or without charge, under a plan or program of any government or governmental body;
- Charges for a prescription drug when such drug or medication is used for unlabeled or unapproved indications where such use has not been approved by the Food and Drug Administration (FDA);
- Any prescription for more than the retail days supply or mail service days supply as outlined in the *Summary of Benefits*;
- Any drug or medication except as provided for herein;
- Allergy serums;
- Hair growth stimulants or other drugs used for cosmetic purposes;
- Food supplements;



- Immunizations and biologicals;
- Drugs used to abort a pregnancy;
- Any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes;
- Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances);
- Any drug that can be purchased without a prescription order unless otherwise specified herein;
- Any prescription drug which is experimental/investigational in nature as determined by Highmark Blue Shield in accordance with this program.



Care Away From Home

Out-of-Area Care

PPOBlue also covers care when you're away from home. 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 paid at the network benefit level. If the treatment results in an admission, you have certain responsibilities under Healthcare Management Services (please refer to the Healthcare Management Section).

If the illness or injury is not an emergency and you receive care from an out-of-network provider, benefits for eligible services will be provided at the lower, out-of-network level.

Out-of-Area Coverage for Eligible Dependents

For a child or spouse who permanently resides outside the Highmark Blue Shield service area or who is temporarily away from home:

- emergency care will be reimbursed at the higher network level in an emergency situation;
- for non-emergency care, the eligible dependent is required to use network providers in order to be reimbursed at the higher benefit level;
- dependents who receive covered services from a provider who does not belong to the network will receive the *lower* level of benefits. This is considered out-of-network care; and
- student dependents and other family members should schedule visits for eligible preventive services, including routine physical examinations, with network physicians while at home.

Services provided for a student while away at school:

- care provided by the school's medical center is usually included in the tuition, and therefore, not normally filed under the parent's health insurance plan;
- for emergency care to be reimbursed at the higher network level, the condition must be a true emergency situation; and



- if other medical care is needed and is not provided by the school's medical center, the student is required to use network providers to receive the higher level of benefits.

The BlueCard Worldwide^R Program

It's reassuring to know that no matter where you travel, you are covered for your critical and urgent care. Your PPOBlue program provides all of the services of the *BlueCard Worldwide Program*. These services include access to a worldwide network of care providers. Medical Assistance services are included as well. You access these services by calling 1-800-810-BLUE (2583). Remember, the Shield symbol on your ID card is recognized around the world – that's *important* protection.

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 help is needed;
- making arrangements for medical evacuation services;
- processing inpatient hospitalization claims; and
- for outpatient or professional services received abroad, you should pay the provider, then complete an international claim form and send it to the BlueCard Worldwide Service Center. Claim forms can be obtained by calling 1-800-810-BLUE or the Member Services telephone number on your ID card. Claim forms can also be downloaded from www.bcbs.com.

BlueCard^R Program

The following are specific provisions provided by the Blue Cross and Blue Shield Association:

When a Member obtains covered health care services through BlueCard outside the geographic area the Plan serves, the amount a Member pays for Covered Services is calculated on the lower of:

- The billed charges for a Member's Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to the Plan.



Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with a Member's health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with a Member's health care Provider or with a specific group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated prices. However, the amount a member pays is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above in this section or require a surcharge, the Plan would then calculate a Member's liability for any Covered Services in accordance with the applicable state statute in effect at the time a Member received care.



Optichoice Program

How Your Employee Only Benefits Are Applied

Who is eligible to render services under the OptiChoice program?

- Professional providers who are licensed doctors of medicine or osteopathic medicine, including a specialist in ophthalmology (Ophthalmologist) or a licensed doctor of optometry (Optometrist).
- Suppliers who are engaged in dispensing ophthalmic lenses, (e.g. contact lenses and/or eyeglass lenses) in accordance with a prescription written by a professional provider, which includes opticians and retail optical dispensing firms.

You maximize your benefits by using a preferred provider or contracting supplier who has an agreement with the Plan pertaining to payment for covered services rendered to a member enrolled in the Plan's preferred provider managed vision care programs.

Payment For Professional Services

Payment for covered eye examination and refractive services and contact lens evaluation and fitting is made on the basis of the provider's reasonable charge (the charge that Highmark Blue Shield determines is reasonable for covered services provided to a member). The provider's reasonable charge will be the program allowance or the billed charge, whichever is lower.

Highmark Blue Shield payments for professional services determined according to the above criteria are accepted as payment-in-full by a preferred provider. Preferred providers are professional providers who have an agreement with the Plan pertaining to payment for covered services rendered to a member enrolled in the Plan's preferred provider managed vision care programs. For services of a non-preferred provider, Highmark Blue Shield makes payment on the same basis; however, payment is made directly to the member and constitutes full discharge of Highmark Blue Shield's responsibility under the program.



Payment For Post-Refractive Services

A . Eyeglasses

- Frames:
Preferred providers and contracting suppliers agree to accept the lower of the program allowance or the amount charged as payment-in-full for any frames which have a charge of \$60 or less. If the member chooses frames with a charge over \$60, the member is responsible at the point of purchase for the difference between \$60 and the charge.
- Lenses:
Preferred providers and contracting suppliers agree to accept the lower of the program allowance or the amount charged as payment-in-full for standard lenses. If the member chooses nonstandard lenses, the member is responsible for 90% of the difference between the charge for standard lenses and the charge for nonstandard lenses. Nonstandard lenses are those that have, as a part of their manufacturing process, been provided with features that enhance their desirability to consumers. Such lenses include, but are not limited to, polycarbonate lenses and progressive "no-line" bifocals. This differential payment must be made at the point of purchase. Contracting suppliers and preferred providers agree to accept these payments--the program allowance plus the differential payment--as payment-in-full for nonstandard lenses.

B. Contact Lenses

Preferred providers and contracting suppliers agree to accept the lower of the program allowance or the amount charged as payment-in-full for standard contact lenses. If the member chooses specialty contact lenses, the preferred provider or contracting supplier agrees to accept the program allowance as payment-in-full for lenses that have a charge of \$75 or less. The member is responsible at the point of purchase for the difference between \$75 and the charge for the specialty lenses. Specialty lenses include, but are not limited to, hard or soft bifocal, hard or soft toric, soft extended wear and gas permeable. An unlimited number of disposable contact lenses (up to \$75) are eligible throughout the benefit period. Payment for eyeglasses or contact lenses obtained from a non-contracting supplier or non-preferred provider will be made to the member on the basis of the program allowance or the amount charged, whichever is less. Such payment constitutes full discharge of Highmark Blue Shield's responsibility under the program. The member is responsible for payment of the remaining charge.

Either one pair of eyeglass lenses *or* one pair of standard or specialty contact lenses, *or* unlimited number of disposable contact lenses (up to \$75) are eligible within the benefit period.



Vision Care Options

Preferred providers and contracting suppliers agree to sell all other post-refractive supplies and related services at 10% below charge to members covered under this program. Such items include, but are not limited to: special lens treatments applied at the member's option, such as ultraviolet coating, anti-reflective coating, or scratch-resistant treatment; tints (including tints #1 and #2); gradient tints; tinting for sunglasses; contact lens solutions and supplies; and pre-fabricated, "off-the-shelf" sunglasses.

This 10% discount is in addition to, and not in lieu of, any other special promotions and/or sale prices which affect the charge at the time the member purchases post-refractive products and related services. The member must pay the contracting supplier or preferred provider at the point of purchase to receive the discounted price. Highmark Blue Shield is not responsible for payment of, or reimbursement for, vision care options. Such payment is the sole responsibility of the member.

Non-preferred providers and non-contracting suppliers do not agree to offer a 10% discount off the charge for vision care options.



Covered Services

Eye Examination and Refractive Services

Eye examination and refractive services include, but are not limited to, the following:

- Case history
- Visual acuity, near and distance
- External examination, including pupils, motilities, color vision test (when indicated), etc.
- Tonometry
- Refraction, subjective, objective
- Binocular vision testing when indicated
- Slit lamp examination of the anterior segment including the crystalline lens
- Fundus examination, including dilated fundus exam when indicated
- Assessment
- Plans

Contact Lens Evaluation and Fitting

Such services shall include, but are not limited to, the following:

- Keratometry
- Proper fitting of appropriate contact lenses, including the application of trial contact lenses to the patient's corneas
- Training of a new contact lens wearer
- Release of prescription
- Post-dispensing contact lens follow-up care, including the correction of any ill-fitting or unsuitable lenses for a period of 90 days*

*If the contact lens fitting and evaluation is concluded without contact lenses being dispensed by the provider, but rather, the prescription is



released to the member, the provider is not obligated to provide 90 days of contact lens fitting follow-up care.

Post-Refractive Services

Post-refractive services consist of the following:

- Ordering lenses and frames (facial measurements, lenticular formula, and other specifications)
- Cost of the materials
- Verification of the completed prescription upon return from the laboratory
- Adjustment of the completed glasses
- Subsequent servicing (refitting, realigning, readjusting, tightening) for a period not to exceed 90 days

Limitations

Payment for covered services will be limited in the following manner:

- Payment for frames, lenses and/or contact lenses not supplied by a professional provider will be made only if prescribed by a professional provider.
- Payment for an eye examination and refraction is limited to once every 12 months for members under 19 years of age and once every 24 months for members 19 years of age and older.
- Payment for a contact lens evaluation and fitting is limited to once every 12 months for members under 19 years of age and once every 24 months for members 19 years of age and older.
- Payment for lenses or contact lenses is limited to once every 12 months for members under 19 years of age and once every 24 months for members 19 years of age and older.
- Regardless of the age of the member, payment is limited to one set of frames in any 24-month period.
- Eligibility will be determined from the date of the last previous similar service paid under this agreement or any other Highmark Blue Shield vision agreement for this group.



- Group members may use their coverage for either contacts or eyeglasses; however, OptiChoice will not cover the cost of purchasing both contact lenses and eyeglass lenses within the same benefit period. In addition to traditional frames and lenses, frames and lenses for prescription sunglasses, prescription safety glasses and prescription athletic lenses may also be purchased in lieu of traditional frames and lenses.

Additional Savings

In circumstances where the services or products are covered, but exceed the frequency limitations outlined above, preferred providers and contracting supplies agree to furnish services or products at discounted prices (excluding disposable contacts) provided payment is made by the member at the point of purchase.

Preferred Providers' Special Sale or Package Prices

Preferred providers and contracting suppliers are not obligated to accept the OptiChoice program allowance when the member elects their special sale or package price. The provider will still submit the claim, however, the member is required to pay the entire sale or package price at the point of purchase. The member will then be reimbursed directly from Highmark Blue Shield the out-of-network reimbursement for covered services.

NOTE: This does not affect the 10% discount on vision care options. The 10% discount is in addition to, and not in lieu of, any other special promotions and/or sale prices.



Exclusions

Except as specifically provided in this booklet, you are not covered for services, supplies or charges that:

- are the cost of any insurance premiums indemnifying against losses for lenses or frames;
- are 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 legislation of any governmental unit. This exclusion applies whether or not you claim the benefits or compensation;
- are provided by any governmental unit unless payment is required by law;
- you would have no legal obligation to pay in the absence of this or any similar coverage;
- are received from a medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
- are performed prior to the effective date;
- are incurred after your termination date except for lenses and frames prescribed prior to such termination and delivered within 31 days from such date;
- are not billed by the professional provider or contracting supplier;
- the cost of which has been or is later recovered in any action at law or in compromise or settlement of any claim except where prohibited by law;
- are in a facility, performed by a professional provider or supplier who, in any case, is compensated by the facility for similar covered services performed for patients;
- are to the extent payment has been made under Medicare when Medicare is primary or would have been made if the member had applied for Medicare and claimed Medicare benefits; however, this exclusion shall not apply when the group is obligated by law to offer the members all the benefits of this program and the members so elect this coverage as primary.



You are not covered for:

- medical or surgical treatment of the eye;
- procedures determined by Highmark Blue Shield to be special or unusual, such as but not limited to, orthoptics, vision training, subnormal vision aids, and tonography;
- examinations and or materials which are not listed herein as a covered service or item of supply;
- any lenses which do not require a prescription;
- replacement of lost, stolen, broken or damaged lenses, contact lenses or frames unless the frequency limitations are met;
- non-prescription industrial safety glasses and safety goggles;
- eye examinations or materials necessitated by employment or furnished as a condition of employment;
- telephone consultations, charges for failure to keep a scheduled appointment, or charges for completion of a claim form;
- temporary devices, appliances, and services;
- services in which the member incurs no charge;
- duplicate devices, appliances and services;
- 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 self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;
- diagnostic services, such as diagnostic X-rays, cardiographic, encephalographic examinations and pathological or laboratory tests;
- drugs or any other medications;
- any other service or treatment except as provided in this booklet.



Claim Appeal Procedure

If your claim has been denied in whole or in part, you will be notified by Highmark Blue Shield. This rejection letter will set forth the specific reasons for such denial. If you wish to appeal this decision, you may write to your company's employee benefits department or write directly to the address which appears on the rejection letter (marked to the attention of the person, if any, who signed the letter).

First, however, it is important for you to understand the reasons for the denial of benefits in order to decide whether you want to appeal and request that the claim be reviewed again. You should examine your group agreement, which is on file with your employer. The group agreement is a legal document setting forth the full terms and conditions of your professional coverages and excluded services. You may request a fuller explanation of the rejection decision by calling 1-800-541-2039.

You may appeal a denial of benefits within 60 days of the date of the rejection by sending a letter stating why you think your claim should not have been denied, including a copy of the denial letter and any additional claim. Be sure to include in your letter your group number, your identification number, claim number, if any, your employer's name and the date of service for which benefits were denied.

Please send your appeal to:

Vision Claims Processing
P.O. Box 890500
Camp Hill, PA 17089-0500

Upon receipt of your letter and any additional information you provide, your records will be reviewed; and the results of this review will be sent to you normally within 60 days. In unusual cases, as when review of your claim requires examination by qualified medical personnel, including consulting, the physicians review may take longer than 60 days.



Clear Guidance and Information

Who is Eligible for Coverage

You may enroll your:

- Spouse
- Unmarried children 19 years of age and younger, including:
 - Newborn children
 - Stepchildren
 - Children legally placed for adoption
 - Legally adopted children
 - Children awarded coverage pursuant to an order of court
- Unmarried children up to the age of 23, provided they are enrolled in and regularly attending a full-time accredited school, college or university or a licensed technical or specialized school and are dependent solely upon you for support.
- Unmarried children over age 19 who are not able to support themselves due to a physical disability or mental retardation or developmental disability. The plan may require proof of such disability from time to time.

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

Changes in Membership Status

For Highmark Blue Shield to administer consistent coverage for you and your dependents, you must keep your employee Benefit Department informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage. Changes must be reported within 31 days of their occurrence.

Medicare

Covered Active Employees Age 65 or Over

If you are age 65 or over and actively employed, you will remain covered under the employer-sponsored program for the same benefits available to employees under age 65. With this option:

- The employer-sponsored program will pay all eligible expenses first.



- Medicare will then pay for Medicare eligible expenses, if any, not paid for by the employer-sponsored 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 employer-sponsored program. In such case, Medicare will be your only coverage. If you choose this option, you will not be eligible for any benefits under the employer-sponsored program. Contact your Personnel Department for specific details.

Spouses Age 65 or Over of Active Employees

If you are actively employed, 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 choose the employer-sponsored program as primary, 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 plan may, in some cases, allow you to resume your coverage. You should consult with your plan administrator/employer to determine whether your group plan has adopted such a policy.

Continuation of Coverage

In general, the Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers, (other than certain Church employers) who normally employed at least twenty (20) or more employees in the prior calendar year, to extend temporary health care coverage to certain categories of employees and their covered dependents when they are no longer eligible for group coverage.



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

Conversion

If your employer does not offer continuation of coverage, or if you do not wish to continue coverage through your employer's program, or your coverage is discontinued for any reason, you will be able to enroll in a Highmark Blue Shield Direct Payment program. Also, conversion is available to anyone who has elected continued coverage through your employer's program and the term of that coverage has expired.

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

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

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

Certificates of Creditable Coverage

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

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



Termination of Your Coverage Under the Employer Contract

Your coverage can be terminated in the following instances:

- When you cease to be an employee or eligible dependent or the required contribution is not paid, your coverage will terminate at the end of the last month for which payment was made.
- Termination of the employer contract automatically terminates the coverage of all the members. It is the responsibility of the employer to notify you of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given to you by the group.
- If it is proven that you obtained or attempted to obtain benefits or payment for benefits through fraud or intentional misrepresentation of a material fact, Highmark Blue Shield may, upon notice to you, terminate your coverage under the employer's contract.

Benefits After Termination of Coverage

If you are totally disabled on the day your coverage terminates, benefits will be continued for services directly related to the condition causing such total disability, and for no other condition, illness, disease or injury, provided such termination is not due to fraud or intentional misrepresentation of a material fact, as follows:

- up to a maximum period of 12 consecutive months; or
- until the total disability ends; or
- until you become covered without limitation as to the disabling condition under another group plan; whichever occurs first.

If you are pregnant on the date coverage terminates, no additional coverage will be provided.

Your benefits will not be continued if your coverage is terminated because of failure to pay any required premium.

Coordination of Benefits

Most health care plans, including your PPOBlue 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 assure you that your covered expenses will be paid, while preventing duplicate benefit payments.



Here is how the coordination of benefits provision in your Highmark Blue Shield coverage works:

- When your other coverage does not mention "coordination of benefits," that coverage pays first. Benefits paid or payable by the other coverage will be taken into account when 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 that covered the parent longer will be the primary program. If the dependent child's parents are separated or divorced, the following applies:
 - The parent with custody of the child pays first.
 - The coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody.
 - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.
- When none of the above circumstances apply, 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
 - The other program does not have this provision regarding laid-off or retired employees, and, as a result, plans do not agree on the order of benefits, then this rule is disregarded.

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

Coordination of benefits prevents duplication and works to the advantage of all members of the group.



Subrogation

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

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

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

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



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/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;
 - 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 doctor) 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'll 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 company's employee benefits department or Highmark Blue Shield Member Service Department.*
- **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 form.



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 patient.

Your claims must be submitted within one year from the date of service.

Your Explanation of Benefits Statement

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

Claim Review Procedure

If, under this plan, you have a claim denied, you may request in writing a full review of that denial to Highmark Blue Shield. The written request must be made within 60 days following receipt of a denial notice and must include the member's name and identification number. You may, upon request to Highmark Blue Shield, review documents in our possession and submit written comments pertinent to your claim.

Highmark Blue Shield will complete a review of the claim within 30 days of receipt of the request unless special circumstances require an extension of time. Upon completion of the review by Highmark Blue Shield, you'll be advised, in writing, of the final outcome of your claim.



Member Services Support Your Care

Good health care is more than just doctor visits. It's also the service that supports your care.

Member Service

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

Blues On CallSM

This 24-hour toll-free number, 1-888-BLUE-428, is your one connection to:

Personal Health Care Assistance

A Health Coach (registered nurse) is available 24 hours a day, 7 days a week for a confidential discussion on any health care topic. Examples of topics you can discuss with the Health Coach include:

- Your doctor has recommended a certain medical test and you'd like more information about it;
- You or a family member has been diagnosed with a particular illness and you want to know what to expect;
- Your doctor suggests surgery for low back pain, but you want information about possible alternatives.

These are examples only. You can phone Blues On Call whenever you would want to discuss any health care problem or issue, in confidence, with a nurse.

Immediate Health Care Assessment

You can also phone Blues On Call about an immediate illness or injury. When you do so, the Health Coach can perform a comprehensive health care assessment to help you determine your next step.



Educational Audiotapes & Videotapes

Information and preparation are the key to taking an active role in the medical and surgical decisions that affect you. Blues On Call can help you with both.

- For specific medical information, you can access audiotapes on more than 400 health care topics ranging from acne to weight management. These tapes contain the most up-to-date information available and are reviewed for accuracy by a panel of care professionals.
- For more in-depth, comprehensive information on a health care problem facing you, the Blues On Call Health Coach may send you a videotape and accompanying brochure. Video topics include: low back pain; heart disease; breast cancer; prostate cancer; prostate enlargement; benign uterine conditions; hormone replacement therapy; and high blood pressure.

Chronic Care Support

Should you have a chronic medical condition such as asthma, arthritis, Chronic Obstructive Pulmonary Disease (COPD), diabetes, depression, or heart disease, your Blues On Call Health Coach may provide you with valuable information to help you reduce your medical risks and manage your illness more effectively. Improving your health habits helps you take charge of your life and can make a real difference in the way you feel.

Service is Provided Where You Want It

Highmark Blue Shield's Web site

Visit www.highmarkblueshield.com for a wide range of health-related information, interactive tools and services.

As a Highmark Blue Shield member, at My Shield Online, your personal Web page, you have access to health and wellness information, user-friendly services related to your health care coverage and valuable tools for managing your own health and well-being. Simply go to www.highmarkblueshield.com, and log onto My Shield Online where, you can:

Utilize Online Self-Service Capabilities

Access a variety of services related to your Highmark Blue Shield coverage—find a physician, review claim status, order an ID card or claim form, check your prescription drug benefits or locate a network pharmacy. Have questions for Member Service? Send a secure message—just use



your My Shield Online Message Center to send the message and check for a response from Member Service.

Access Health and Wellness Content and Tools

Customize your content to include the latest in breaking health news, diet and exercise tips, or articles specific to your health-related interests. Access valuable online health resources: you can contact a Blues On Call Health Coach, or look up any medical topic in the Healthwise Knowledgebase[®] and the illustrated health encyclopedia, two comprehensive health information resources.

Find out just what to expect from a surgery or procedure in the illustrated *Surgeries and Procedures Guide*, or track the progress of a pregnancy in our Pregnancy Center. You can also complete the Personal Wellness Profile, which helps you identify your personal health risks and set goals to improve your wellness. Stay on the track to wellness with our interactive calculators, including body mass index, ideal weight, and nutritional needs.

Health and Wellness Bus

Our multi-graphics bus takes health and education screenings and immunizations into communities or worksites. Board the bus at work or in your neighborhood!

We Work Hard to Keep You Informed

We also keep you informed via your quarterly 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!

Highmark is a registered service mark of Highmark Inc.

Blue Shield, Blue Card Worldwide, Blue Card and the Blue Shield symbol are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

PPOBlue, Blues On Call and My Shield Online are service marks of the Blue Cross and Blue Shield Association.

Healthwise Knowledgebase is a registered mark of Healthwise, Incorporated.

HIGHMARK INC. NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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

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

Our Legal Duties

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

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

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

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

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

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

I. Uses and Disclosures of Protected Health Information

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

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

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

Payment

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

For example:

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

Health Care Operations

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

For example:

We may use and disclose your protected health information to rate our risk and determine the premium for your health plan, to

conduct quality assessment and improvement activities, to credential health care providers, to engage in care coordination or case management, and/or to manage our business and the like.

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

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

(i) Business Associates.

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

(ii) Other Covered Entities.

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

II. Other Possible Uses and Disclosures of Protected Health Information

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

A. To Plan Sponsors

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

B. Required by Law

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

C. Public Health Activities

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

D. Health Oversight Activities

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

E. Abuse or Neglect

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

F. Legal Proceedings

We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response

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

G. Law Enforcement

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

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

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

I. Research

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

J. To Prevent a Serious Threat to Health or Safety

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

K. Military Activity and National Security, Protective Services

Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the

foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

L. Inmates

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

M. Workers' Compensation

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

N. Others Involved in Your Health Care

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

III. Required Disclosures of Your Protected Health Information

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

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

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

B. Disclosures to You

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

of your protected health information that are for reasons other than payment and health care operations.

IV. Other Uses and Disclosures of Your Protected Health Information

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

V. Your Individual Rights

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

A. Right to Access

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

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

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

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

B. Right to an Accounting

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

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

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or submitting your request in writing to the Highmark Privacy Department, 1800 Center Street, Camp Hill, PA 17089. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

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

C. Right to Request a Restriction

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

You may request a restriction by contacting us at the Customer Service phone number on the back of your identification card, or writing to the Highmark Privacy Department, 1800 Center Street, Camp Hill, PA 17089. In your request tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

D. Right to Request Confidential Communications

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

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

E. Right to Request Amendment

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

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

F. Right to a Paper Copy of this Notice

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

VI. Questions and Complaints

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

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

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

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

Contact Office: Highmark Privacy Department

Telephone: 1-866-228-9424 (toll free)

Fax: 1-717-302-3601

Address: 1800 Center Street

Camp Hill, PA 17089

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

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

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

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

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

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

- We use personal information internally to manage enrollment, process claims, monitor the quality of the health services provided to our members, prevent fraud, audit our own performance or to respond to members' requests for information, products or services.
- We share personal information with our affiliated companies, health care providers, agents, other insurers, peer review organizations,

auditors, attorneys or consultants who assist us in administering our programs and delivering health services to our members. Our contracts with all such service providers require them to protect the confidentiality of our members' personal information.

- We may share personal information with other insurers that cooperate with us to jointly market or administer health insurance products or services. All contracts with other insurers for this purpose require them to protect the confidentiality of our members' personal information.
- We may disclose information under order of a court of law in connection with a legal proceeding.
- We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.
- We may disclose information under a subpoena or summons to government agencies that investigate fraud or other violations of law.

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

For questions about this Privacy Notice, please contact:

Contact Office: Highmark Privacy Department

Telephone: 1-866-228-9424 (toll free)

Fax: 1-717-302-3601

Address: 1800 Center Street

Camp Hill, PA 17089

