

**LCHC - Palmyra Area School
District
Group 25089-04
Effective July 1, 2004
Printed October, 2004**



Dear Member,

Welcome to *ClassicBlue Traditional*, an indemnity health insurance program from Highmark Blue Shield.

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

- *ClassicBlue Traditional gives you freedom of choice.* ClassicBlue Traditional gives you access to a broad network of physicians, hospitals, and other providers in Central Pennsylvania and the Lehigh Valley.
- *ClassicBlue Traditional* provides coverage for most hospital and medical-surgical services. Major Medical covered care is subject to an annual deductible and coinsurance.

And as a Highmark Blue Shield member, you get an important "extra" -- **24-hour assistance with any health care question or concern.**

Your *ClassicBlue Traditional Benefits* provides 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 *ClassicBlue Traditional*, 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.



Table of Contents

Terms You Should Know	1
Summary of Benefits	3
A Recognized Identification Card	11
Healthcare Management Services	12
Precertification	12
Continued Stay Review.....	13
Discharge Planning	13
Case Management.....	13
Your Guides to Good Care	15
Eligible Providers	15
Participating Providers	16
Non-Participating Providers	16
How Your Benefits Are Applied	17
Benefit Period	17
Provider's Reasonable Charge (Plan Allowance).....	17
Cost-Sharing Provisions.....	17
Major Medical Covered Services.....	17
Covered Services	19
Ambulance Services	19
Dental Services Related to Accidental Injury.....	19
Diabetes Treatment	19
Diagnostic Services	20
Durable Medical Equipment	20
Emergency Accident Care	20
Emergency Medical Care	20
Enteral Formulae	21
Home Health Care Services.....	21
Home Infusion Therapy	22
Hospice Care Services.....	22
Hospital Services-Inpatient	23
Hospital Services-Outpatient	23
Maternity Services.....	24
Medical Services	25
Mental Health Services	25
Orthotic Devices.....	26
Preventive Services	26
Private Duty Nursing Services	27
Prosthetic Appliances.....	27
Skilled Nursing Facility Services	28
Spinal Manipulations	28
Substance Abuse Services.....	28
Surgical Services	29
Therapy Services.....	30

Transplant Services	31
Prescription Drug Coverage.....	32
Covered Prescription Drugs.....	32
Prescription Drug Benefits.....	33
Premier Gold Pharmacies.....	33
Using the Mail Service Pharmacy Benefit	34
Provisions	34
Notice of Claim	35
What Is Not Covered	36
Optichoice Program	41
How Your Employee Only Benefits Are Applied.....	41
Covered Services	44
Limitations	45
Exclusions	47
Claim Appeal Procedure.....	49
Care Away From Home	50
The BlueCard Worldwide Program	50
BlueCard Program.....	50
Clear Guidance and Information.....	52
Who Is Eligible For Coverage.....	52
Changes in Membership Status.....	52
Medicare.....	52
Leave of Absence or Layoff.....	53
Continuation of Coverage.....	53
Conversion.....	53
Certificates of Creditable Coverage.....	54
Termination of Your Coverage Under the Employer Contract	54
Benefits after Termination of Coverage	54
Coordination of Benefits.....	55
Subrogation	56
How to File a Claim.....	57
Appeal Procedure.....	58
Your Explanation of Benefits Statement	58
Member Services Support Your Care.....	59
Member Service.....	59
Blues On Call	59
We Provide Service Where You Want It	60
We Work Hard To Keep You Healthy and Informed	61
Information for Non-English-Speaking Memers	61
NOTICE OF PRIVACY PRACTICES	62

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 Blue Cross and Blue Shield Association. This booklet contains merely a description of the principal features of your Traditional program.



Terms You Should Know

Blues On CallSM - A 24-hour health care assistance number that provides care information.

Coinsurance - The specific percentage of allowable charge for covered services that Highmark Blue Shield pays; the remaining percentage is the percentage you pay. Your coinsurance depends on the program your employer offers.

Deductible - A specified dollar amount you must pay for covered services each benefit period 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 not determined by Highmark to be medically effective for the condition being treated. Highmark 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.

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



Out-of-Pocket Limit - A specified dollar amount of coinsurance for covered services in a benefit period. When the specified dollar amount is attained, Highmark begins to pay 100% of all covered expenses.

Precertification – The process through which certain services are pre-approved by Highmark to determine their medical necessity and appropriateness, and you are covered for services.

Provider's Reasonable Charge -The provider's reasonable charge is the amount agreed to by Highmark and the provider or an amount that Highmark determines is reasonable for covered services provided to a member. In the case of professional providers, the provider's reasonable charge will not exceed the usual, customary and reasonable allowance.

Usual, Customary and Reasonable (UCR) Method

Highmark reimbursement amounts are often referred to as UCR allowances. UCR is an abbreviation for usual, customary and reasonable. It is a method used to determine and pay providers on the basis of:

Usual – the allowed amount determined by Highmark for a professional provider based upon that individual provider's charges for the procedure performed;

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

Reasonable – the allowed amount (which may differ from the Usual or Customary allowed amounts) determined by Highmark by considering unusual clinical circumstances.

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



Summary of Benefits

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

BENEFITS	TRADITIONAL FACILITY PROGRAM	TRADITIONAL PROFESSIONAL PROGRAM	TRADITIONAL MAJOR MEDICAL PROGRAM
Deductible <i>Per Calendar Year</i>	None	None	\$1,000 Individual \$2,000 Family Non-Aggregate *Common accident provision applies
Payment Level <i>Based on Provider's Reasonable Charge (PRC)</i>	100% PRC participating providers, 80% of charge non-participating providers except as noted 0% for non-participating ambulatory surgical facility, freestanding outpatient facility, freestanding dialysis facility, long term acute care hospital, substance abuse treatment facility	100%	80% PRC after deductible until out-of-pocket is met; then 100% PRC
Out-of-Pocket Limit <i>Includes Coinsurance - See "How Benefits Are Applied" section for exclusions/details</i>	None	None	\$400 Individual \$800 Family Non-Aggregate
Lifetime Maximum	None	None	Unlimited
Ambulance <i>Includes Land and Air Emergency Transportation</i>	100% PRC Facility-billed only	Not Covered	100% PRC no deductible for emergency, 80% PRC non-participating after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered	Not Covered
Dental Services Related to an Accidental Injury	100% PRC	100% PRC	80% PRC after deductible
Diabetes Treatment	100% PRC	100% PRC	80% PRC after deductible
Diagnostic Services <i>Lab, X-ray and Medical Tests</i>	100% PRC	100% PRC	80% PRC after deductible
Durable Medical Equipment, Orthotics and Prosthetics	Not Covered	Not Covered	80% PRC after deductible
Elective Abortion <i>Includes Dependent Daughters</i>	100% PRC	100% PRC	80% PRC after deductible
Emergency Care <i>Professional Services</i>	100% PRC	100% PRC	100% PRC no deductible



BENEFITS	TRADITIONAL FACILITY PROGRAM	TRADITIONAL PROFESSIONAL PROGRAM	TRADITIONAL MAJOR MEDICAL PROGRAM
Emergency Room Services <i>Facility Services</i>	100% PRC	100% PRC	100% PRC no deductible
Enteral Formulae	100% PRC	100% PRC	80% PRC no deductible
Hearing Care Services	Not Covered	Not Covered	Not Covered
Home Health Care <i>Excludes Respite Care</i>	100% PRC participating providers, non-participating not covered ----- 30 visits/benefit period	Not Covered	80% PRC after deductible
Hospice <i>Includes Respite Care</i>	100% PRC participating providers, 80% of charge for non-participating providers ----- \$12,500/lifetime	Not Covered	Not Covered
Hospital Expenses <i>Inpatient and Outpatient</i>	100% PRC participating providers, 80% of charge for non-participating providers ----- 365 days ----- 0 pint blood deductible/benefit period	Not Covered (covered under Medical Care)	80% PRC after deductible ----- 3 pint blood deductible/benefit period
Infertility Counseling, Testing and Treatment ¹	100% PRC participating providers, 80% of charge for non-participating providers	100% PRC <i>Excludes Office Visits</i>	80% PRC after deductible
Maternity <i>Includes Dependent Daughters</i>	100% PRC	100% PRC	80% PRC after deductible
Medical Care <i>Includes Inpatient Visits and Consultations</i>	Not Covered	100% PRC	80% PRC after deductible
Mental Health - Inpatient ^{2,3} <i>Includes Partial Hospitalization (2 for 1 trade)</i>	100% PRC participating providers, 50% of charge for non-participating providers. 100% PRC participating providers for partial hospitalization, non-participating not covered ----- 30 days/benefit period (up to 30 days for serious mental illness)	100% PRC, partial hospitalization not covered ----- 30 days/benefit period	80% PRC after deductible, unlimited days 50% PRC for partial hospitalization
Mental Health - Outpatient ²	Not Covered	Not Covered	50% PRC after deductible ----- Unlimited visits
Office Visits	Not Covered	Not Covered	80% PRC after deductible



BENEFITS	TRADITIONAL FACILITY PROGRAM	TRADITIONAL PROFESSIONAL PROGRAM	TRADITIONAL MAJOR MEDICAL PROGRAM
Oral Surgery	100% PRC participating providers, 80% of charge for non-participating providers	100% PRC	80% PRC after deductible
Physical Therapy <i>Outpatient</i>	100% PRC Unlimited	Not Covered	80% PRC after deductible Unlimited
Preventive Care <i>Adult Preventive Care includes:</i> <i>Routine Physical Exam</i> <i>Immunizations</i> <i>Gynecological Exam & Pap Test</i> <i>Screening Mammography</i> <i>Diagnostic Screening</i>	Not Covered Not Covered 100% PRC 100% PRC Not Covered	Not Covered Not Covered 100% PRC 100% PRC Not Covered	Not Covered Not Covered 80% PRC no deductible 80% PRC no deductible Not Covered
<i>Pediatric Preventive Care includes:</i> <i>Routine Physical Exam</i>	Not Covered	Not Covered	Not Covered
<i>Pediatric Immunizations</i>	100% PRC	100% PRC	80% PRC no deductible
<i>Diagnostic Screening</i>	Not Covered	Not Covered	Not Covered
Private Duty Nursing	Not Covered	Not Covered	80% PRC after deductible 240 hours/benefit period
Skilled Nursing Facility Care	100% PRC participating providers, 80% of charge for non-participating providers 100 days/benefit period	100% PRC	80% PRC after deductible
Speech and Occupational Therapy <i>Outpatient</i>	Not Covered	Not Covered	80% PRC after deductible Unlimited
Spinal Manipulations	100% PRC	Not Covered	80% PRC after deductible Unlimited
Substance Abuse - Detoxification ³	100% PRC 7 days/admission; 4 admissions/lifetime	Not Covered	Not Covered
Substance Abuse - Inpatient Rehabilitation ³	100% PRC participating providers, non-participating not covered 30 days/benefit period; 90 days/lifetime	100% PRC 30 days/benefit period	Not Covered



BENEFITS	TRADITIONAL FACILITY PROGRAM	TRADITIONAL PROFESSIONAL PROGRAM	TRADITIONAL MAJOR MEDICAL PROGRAM
Substance Abuse - Outpatient	100% PRC participating providers, non-participating not covered ----- 60 visits/benefit period; 120 visits/lifetime	Not Covered	Not Covered
Surgical Expenses <i>Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures Includes Neonatal Circumcision</i>	100% PRC participating providers, 80% of charge for non-participating providers	100% PRC	80% PRC after deductible
Therapy Services <i>Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiration Therapy</i>	100% PRC for participating providers Radiation Therapy not covered for non-participating Respiratory Therapy 80% of charge for non-participating Chemotherapy and Dialysis 100% PRC for non-participating	100% PRC	80% PRC after deductible
Transplant Services	100% PRC participating providers, 80% of charge for non-participating providers	100% PRC	80% PRC after deductible
Preadmission Requirements for Inpatient Admissions⁴ <i>No Penalty for Non-compliance</i>	Performed by Provider	Performed by Provider	Performed by Provider
Condition Management	Case Management, Blues On Call, and Disease State Management	Case Management, Blues On Call, and Disease State Management	Case Management, Blues On Call, and Disease State Management

¹ 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.

² State mandated benefits (30 inpatient days and 60 outpatient visits annually) *may* apply for serious diagnosis. Serious diagnosis includes: schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa and delusional disorder.

³ 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.

⁴ If Blue Shield is not contacted prior to a non-emergency inpatient admission and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the participating provider (or member if services were received from a non-participating provider) will be responsible for any costs not covered.



Prescription Drug Benefits	Retail Pharmacy	Mail Service Pharmacy
Deductible	\$50 per person	None
Generic Prescription Drug	80% coinsurance	\$18 copayment
Brand Prescription Drug	80% coinsurance	\$18 copayment
Days Supply (<i>per prescription</i>)	Up to 30-days	Up to 90-days
Generic Substitution (<i>Soft</i>)	When you purchase a brand drug that has a generic equivalent you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs, unless your physician requests that the brand name drug be dispensed.	
Out of Pocket Maximum	Not Applicable	
Claim Submission	Member Files	
Non-Network Pharmacy	Not Covered	
Prescription Drug Categories		
Contraceptives (oral and injectable)	Covered when medically necessary with Prior Authorization	
Fertility Agents	Covered	
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>	Does Not Apply	
Managed Rx Coverage <i>on certain drug therapies</i>	Does Not Apply	
Managed Prior Authorizations	Prior authorization required for contraceptives only	

- Prescriptions obtained from a non-network pharmacy are not eligible for payment.



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 and around the world. Carry your ID card with you at all times, destroy any previously issued cards, and show this card to the hospital, doctor, pharmacy, or other health care professional whenever you need medical care.

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

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

The following information will be displayed on your ID card:

- your name;
- identification number;
- group number;
- Premier Pharmacy network logo (when applicable);
- Member Service toll-free number (on back of card); and
- Precertification toll-free number (on back of card)

Protect Your Card

If your ID card is lost or stolen, please contact Highmark Member Service immediately. You can also request additional or replacement cards online by going to your My Shield Onlinesm page at www.highmarkblueshield.com. It is illegal to loan your card to persons who are not eligible to use your Highmark benefits.



Healthcare Management Services

For benefits to be paid under your program, services and supplies must be considered medically necessary and appropriate.

Healthcare Management Services (HMS), or its designated agent, is responsible for determining whether care is medically necessary and appropriate and delivered within a setting that best suits your individual treatment needs.

Participating Providers

When you use a participating provider, ***the provider will contact HMS*** when authorization for your care is required.

Non-Participating Providers

When you use a non-participating provider, ***you are responsible for contacting HMS*** for any required authorizations. Your call to HMS prior to receipt of care from a non-participating provider will help you know what your financial responsibility may be. You should call 7 to 10 days prior to your received services. For emergency or maternity-related admissions, call HMS within 48 hours of your admission, or as soon as reasonably possible. You can contact HMS via the toll-free Member Service number on the back of your ID card.

If you do not call to certify your admission to an out-of-network facility provider, HMS will review your care after services are 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.

IMPORTANT: Non-participating providers are not obligated to contact HMS or to abide by any determination of medical necessity or appropriateness rendered by HMS. You may, therefore, receive services which are not medically necessary and appropriate for which you will be responsible. Please contact HMS to avoid unnecessary out-of-pocket costs.

Precertification

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

Precertification is required for the following inpatient services:



- Hospital admissions
- Rehabilitation admissions
- Alcohol abuse treatment
- Drug abuse treatment
- Psychiatric treatment
- Skilled nursing facility admissions

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

- Home health services
- Hospice services
- Outpatient surgery

Continued Stay Review

While you or your covered dependent are in a facility where continued stay is required as an inpatient, HMS will be in contact with facility personnel familiar with your case to make certain that continued hospitalization is appropriate. Determination of the need for continued inpatient coverage will be made in consultation with your physician(s). Either HMS or its designated agent, the facility or the provider 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 designated agent personnel will help plan for and coordinate your discharge to ensure that any continued care is delivered in the most medically appropriate and cost-effective setting.

Case Management

Case Management is a voluntary program in which a case manager, with input from you and your health care providers, assists with the planning and coordination of your health care needs. Patients with a catastrophic illness or injury are referred to this program. If it is determined that case management intervention would be beneficial, you will be contacted regarding your willingness to participate in the program.





Your Guides to Good Care

Eligible Providers

Facility Providers

- Hospital
- Psychiatric hospital
- Rehabilitation hospital

Other Facility Providers

- Alcohol abuse treatment facility
- Ambulance service
- Ambulatory surgical facility
- Birthing facility
- Day/night psychiatric facility
- Drug abuse treatment facility
- Freestanding dialysis facility
- Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility
- Home health care agency
- Home infusion therapy provider
- Hospice
- Outpatient alcohol abuse treatment facility
- Outpatient drug abuse treatment facility
- Outpatient physical rehabilitation facility
- Outpatient psychiatric facility
- Skilled nursing facility

Professional Providers

- Audiologist
- Certified registered nurse*
- Chiropractor
- Clinical laboratory



- Dentist
- Licensed practical nurse
- Nurse-midwife
- Occupational therapist
- Optometrist
- Physical therapist
- Physician
- Podiatrist
- Psychologist
- Registered nurse
- Respiratory therapist
- Speech-language pathologist
- Suppliers
- Teacher of hearing impaired

Participating Providers

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

Non-Participating Providers

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



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

Your benefit period is a 12-month period beginning each January 1. The benefit period may also be referred to as “calendar year.”

Provider's Reasonable Charge (Plan Allowance)

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

Cost-Sharing Provisions

Cost-sharing is a requirement that you pay part of your covered expenses or services. The terms “deductible” and “coinsurance” describe methods that may require you to pay for part of your covered medical expenses.

Major Medical Covered Services

Benefit Period

Your benefit period is 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.

Deductible

The deductible is a specified dollar amount you must pay for covered Major Medical services each benefit period before Highmark begins to pay all or part of the remaining expenses. See your *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 had 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 benefit period and applied toward that benefit period's deductible may be carried over and applied against the deductible owed for the next benefit period.

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

Coinsurance

The coinsurance is the specific percentage of the allowable charge for eligible expenses that Highmark pays; the remaining percentage is the percentage you pay. Refer to your *Summary of Benefits* for the percentage amounts paid by the program.

Out-of-Pocket Limit

The out-of-pocket limit refers to the specified dollar amount of coinsurance incurred for covered services in a benefit period. When the specified dollar amount is attained, your program begins to pay 100% of all covered expenses. See your *Summary of Benefits* for the out-of-pocket limit. The out-of-pocket limit does not include deductibles, outpatient mental health 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 each of two members of your family for services received during the benefit period.

The out-of-pocket does not include any charges for which benefits are excluded in whole or in part under the provisions in the Healthcare Management Services section.



Covered Services

The program provides benefits for the following hospital, medical-surgical and major medical services you receive from an eligible provider.

The benefits in this section 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. Please refer to the section headed "Terms You Should Know" and also the section headed "Health Care Management Services" for specific details. Any benefit limits, deductibles and coinsurance amounts are described in the *Summary of Benefits*.

Ambulance Services

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

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

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

Dental Services Related to Accidental Injury

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

Diabetes Treatment

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

Equipment and Supplies

Blood glucose monitors, monitor supplies, injection aids, syringes and insulin infusion devices.



Outpatient Diabetes Education*

When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through an outpatient diabetes education program:

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

Diagnostic Services

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

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

Durable Medical Equipment

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

Emergency Accident Care

Medical care for the emergency treatment of traumatic bodily injuries resulting from an accident.

However, if the accident services are classified as surgery (e.g., suturing, fracture care, etc.) payment will be made as a surgical benefit.

Emergency Medical Care



Medical care for emergency treatment of a sudden onset of a medical condition manifesting itself by acute symptoms that require immediate attention.

Enteral Formulae

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

Home Health Care Services

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

- Skilled nursing services of an RN or LPN, excluding private duty nursing services
- Physical 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
- Health aide services to an individual who is receiving covered nursing or therapy services

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

No home health care benefits will be provided for:

- dietitian services;
- homemaker services;
- maintenance therapy;
- dialysis treatment;
- custodial care;
- 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

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
- 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-Inpatient

Bed and Board

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

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

Ancillary Services

Hospital services and supplies including, but not restricted to:

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

Hospital Services-Outpatient

Emergency Accident Care

Hospital services and supplies for the outpatient emergency treatment of traumatic bodily injuries resulting from an accident.

Emergency Medical Care

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

Pre-Admission Testing

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



Surgery

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

Maternity Services

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

Normal Pregnancy

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

Complications of Pregnancy

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

Interruptions of Pregnancy

Miscarriage

Non-elective Abortion

Elective Abortion

Nursery Care

Ordinary nursery care of the newborn infant, including inpatient medical visits by a professional provider.

Maternity Home Health Care Visit

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



Medical Services

Inpatient Medical Services

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

- *Inpatient Medical Care Visits*
- *Intensive Medical Care*
Medical care rendered to you when your condition requires a professional provider's constant attendance and treatment for a prolonged period of time
- *Concurrent Care*
 - Medical care rendered concurrently with surgery during one hospital stay by a professional provider other than the operating surgeon for treatment of a medical condition separate from the condition for which surgery was performed.
 - Medical care by two or more professional providers rendered concurrently during one hospital stay when the nature or severity of your condition requires the skills of separate physicians.
- *Consultation*
Consultation services rendered to an inpatient by another professional provider at the request of the attending professional provider.
Consultation does not include staff consultations which are required by hospital rules and regulations.
- *Routine Newborn Care*
Professional provider visits to examine the newborn infant while the mother is an inpatient.

Inpatient medical care is renewed when 90 days have elapsed between discharge from and subsequent admission to a hospital or skilled nursing facility.

Outpatient Medical Care Services (Office Visits)

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

Mental Health Services

Inpatient Facility Services

Hospital services are provided for the inpatient treatment of mental illness by a facility provider.



Inpatient Medical Services

The following services are provided for the inpatient treatment of mental illness by a professional provider:

- Individual psychotherapy
- Group psychotherapy
- Psychological testing
- Family counseling
Counseling with family members to assist in the patient's diagnosis and treatment
- Convulsive therapy treatment
Electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same professional provider

Partial Hospitalization Psychiatric Care Services

Benefits are available when provided by a partial hospitalization program which has been approved by Highmark and is offered by a provider. Such programs are subject to periodic review by Highmark.

Outpatient Psychiatric Care Services

Covered inpatient facility and medical services when provided for the outpatient treatment of mental illness by a provider.

Serious Mental Illness Care Services

Covered inpatient services for the treatment of serious mental illness for up to 30 days per calendar year. A maximum of 30 of these inpatient days may be exchanged on a one-for-two basis to secure up to 60 additional outpatient days per calendar year. Covered outpatient services for the treatment of serious mental illness for up to 60 outpatient days per calendar year. Each day of outpatient care constitutes one 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.

However, replacements are covered only in the case of dependent children and only when Highmark determines that such replacement is medically necessary and appropriate.

Preventive Services

Pediatric Immunizations

Benefits are provided for those pediatric immunizations, including the immunizing agents, which, as determined by the Pennsylvania Department of Health, conform with the standards of the Advisory Committee on



Immunization Practices of the Center for Disease Control, and the U.S. Department of Health and Human Services. The Immunization Schedule is reviewed and updated periodically by Highmark Blue Shield based on the advice of the American Academy of Pediatrics, U.S. Preventive Service Task Force, the Blue Cross and Blue Shield Association, and the medical consultants. Accordingly, the frequency and eligibility of services is subject to change. Benefits are limited to members under age 21 and are not subject to program deductibles or maximums.

Routine Gynecological Examination and Papanicolaou Smear

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

Mammographic Screening

Benefits will be provided for:

- an annual routine mammographic screening for all female members 40 years of age or older; and
- mammographic examination for all female members regardless of age when prescribed by a physician.

Benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified by the Pennsylvania Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

Private Duty Nursing Services

Private duty nursing services of an actively practicing RN or a LPN when ordered by a physician, providing such nurse does not ordinarily reside in your home or is not a member of your immediate family.

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

Prosthetic Appliances

Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of



a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses).

Skilled Nursing Facility Services

Services rendered in a skilled nursing facility to the same extent benefits are available to an inpatient of a hospital. Two days of skilled nursing facility care are available for each unused day of the hospital benefit period. 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 in a skilled nursing facility is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience;
- for the treatment of alcohol abuse, drug abuse or mental illness.

Spinal Manipulations

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

Substance Abuse Services

Services include individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of alcohol abuse and drug abuse when rendered to you by a facility provider or professional provider.

- 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

Surgery

- Surgery performed by a professional provider. Separate payment will not be made for pre- and post-operative services.
- If more than one surgical procedure is performed by the same professional provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure; plus 50% of the amount that would have been payable for each of the additional procedures had those procedures been performed alone.

Special Surgery

- **Oral Surgery**
Benefits are provided for the surgical removal of impacted teeth which are partially or totally covered by bone.
- **Sterilization**
Sterilization and procedures to reverse sterilization regardless of their medical necessity and appropriateness.
- **Cleft Palate Surgery**
Benefits are provided for orthodontic treatment of a congenital cleft palate involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.
- **Mastectomy and Breast Cancer Reconstruction**
Benefits are provided for a mastectomy performed on an inpatient or outpatient basis for the following:
 - Surgery to reestablish symmetry or alleviate functional impairment including, but not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy
 - Initial and subsequent prosthetic devices to replace the removed breast or portions thereof
 - Physical complications of all stages of mastectomy, including lymphedemas

Benefits are also provided for one home health care visit, as determined by your physician, when received within 48 hours after discharge, if such discharge occurred within 48 hours after an admission for a mastectomy.

Assistant at Surgery

Services of a physician who actively assists the operating surgeon in the performance of covered surgery. Benefits will be provided for an assistant



at surgery only if an intern, resident or house staff member is not available.

Anesthesia

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

Benefits are also provided for the administration of anesthesia for oral surgical procedures in an outpatient setting when ordered and administered by the attending professional provider.

Second Surgical Opinion

- **Services**

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

- **Specifications**

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

Therapy Services

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

- Radiation therapy
- Chemotherapy
- Dialysis treatment
- Respiration 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

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

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

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



Prescription Drug Coverage

Under most 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.*

To help contain costs, if a generic drug is available, you will be given the generic. As you probably know, generic drugs have the same chemical composition and therapeutic effects as brand names and must meet the same FDA (Food and Drug Administration) requirements.

Should you choose a brand name drug when a generic is available, you must pay the price difference between the brand and generic prices in addition to the applicable copayment or coinsurance amount. If your physician specifically requests a brand drug or if no generic equivalent is available, only the brand drug copay or coinsurance applies.

Benefits are provided for covered prescription drugs under the Paid Direct 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

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, the pharmacy will provide your prescription at a discounted rate. You must then file a claim to be reimbursed for covered prescription orders or refills for up to the maximum days supply provided by your plan less any copayment or coinsurance required under 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.

Mandatory Generic Pricing – When a generic drug is authorized by your physician and you elect to purchase a brand drug, you are responsible for the difference in cost between the brand drug and its generic alternative in addition to the applicable brand drug copayment or coinsurance. If your physician specifically requests a brand drug or if no generic equivalent is available, only the brand drug copay or coinsurance applies.

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.

Premier Gold Pharmacies have 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. (Prescriptions which the pharmacy receives by phone from your physician or dentist may also be covered.) Upon presenting your identification card you will be required to pay the agreed upon price to the network pharmacy. 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 must 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.

Medco Health
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.

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 Highmark;
- Which are not prescribed by or performed by or upon the direction of a professional provider;
- Rendered by other than providers;
- Which are experimental/investigative in nature;
- Rendered prior to your effective date;
- Incurred after the date of termination of your coverage except as provided herein;
- For any illness or injury suffered after your effective date as a result of any act of war;
- 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 the contract and you so elect this coverage as primary;
- For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage;
- For 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 file a claim for said benefits or compensation;
- To the extent benefits are provided to members of the armed forces and the National Health Service or to patients in Veteran's Administration facilities for service-connected illness or injury, unless you have 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 any 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;
 - 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 member;
 - Rendered by a provider who is a member of your 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 required by law or 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 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 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;
 - 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;
- 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, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
- For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids unless specifically provided;
- For treatment of obesity, except for medical and surgical treatment of morbid obesity when weight is at least twice the ideal weight specified for frame, age, height and sex;
- 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 aphakic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury);
- For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;
- For nutritional counseling and services intended to produce weight loss;
- 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 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 screening examinations including X-ray examinations made without film, except as provided herein;
 - For immunizations required for foreign travel;
 - For the treatment of sexual dysfunction that is not related to organic disease or injury;
 - For any care related to autistic disease of childhood, learning disabilities, and mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change;
 - For any care, treatment, or service which has been disallowed under the provisions of the Health Care Management Services program;
 - For otherwise covered services ordered by a court or other tribunal as part of your or your dependent's sentence;
 - For therapy services for which there is no expectation of restoring or improving a level of function, or when no additional functional progress is expected to occur, unless medically necessary and appropriate;
 - For local infiltration anesthetic;
 - For any illness or injury suffered after your effective date during your commission of a felony;
 - For any other medical or dental service or treatment except as provided herein or as mandated by law.

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 above Highmark Blue Shield's network pharmacy allowance for each prescription order or refill;



- § Any deductible, coinsurance or copayment;
- § 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.



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.



Care Away From Home

The BlueCard® Worldwide Program

This program provides assistance with medical problems you may incur while traveling outside of the United States. Services 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 Service telephone number on your ID card. Claim forms can also be downloaded from www.bcbs.com.

BlueCard Program

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

When you obtain covered services through BlueCard outside the geographic area Highmark Blue Shield serves, the amount you pay for covered services is calculated on the **lower** of:

- The billed charges for your covered services, or
- The negotiated prices that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to Highmark.

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, withholdings, any other contingent payment arrangements and non-claims transactions with your 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 your health care provider or with a specified 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 price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay 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 paragraph one of this section or require a surcharge, Highmark would then calculate your liability for any covered services in accordance with the applicable state statute in effect at the time you received care.



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, 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, mental retardation, mental illness or developmental disability. Highmark may require proof of such disability from time to time.

Changes in Membership Status

For Highmark to administer consistent coverage for you and your dependents, you must keep your Employee Benefit Department or Highmark Member Service 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

Active Employees Age 65 and Over

If you are age 65 or over and actively employed, you will continue coverage 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 -



- You may elect Medicare as your primary coverage. If you choose this option, contact your Personnel Department for specific details.

Spouses Age 65 and 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 after 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 program 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 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, you will be able to enroll in a Highmark 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 program or other health insurance program defined under the Health Insurance Portability and Accountability Act of 1996.

Upon termination from a group health program 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) for up to 24 months after coverage under this program 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 may, upon notice to you, terminate your coverage under this contract.

Benefits after Termination of Coverage

If you are totally disabled on the day your coverage terminates, benefits will be continued for covered services directly related to the condition causing such total disability, and for no other condition, illness, disease or injury, as follows:

- up to a maximum period of 12 consecutive months; or



- until the maximum amount of benefits has been paid; or
- until the total disability ends; or
- until you become covered without limitation as to the disabling condition under another group coverage; whichever occurs first.

Coordination of Benefits

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

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your program.
- When the person who received care is covered as an employee under one contract, and as a dependent under another, then the employee coverage pays first.
- When a dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the calendar year pays first. But, if both parents have the same birthday, the program which covered the parent longer will be the primary program. If the dependent child's parents are 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.



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

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 due to an accident caused by another person or organization, the person or organization causing the accident may be responsible for paying these expenses.

For example, if you or one of your dependents receive s Highmark benefits for injuries caused by another person or organization, Highmark has the right, through subrogation, to seek repayment from the other person or his/her insurance company for benefits already paid. Examples are duplicate amounts you receive through a lawsuit, a settlement or from any third party or his or her insurer. You have the legal obligation to help the Highmark Plan in all possible ways when they try to recover the amount they paid.

Highmark will provide eligible benefits when needed, but you may be asked to show documents or take other necessary actions to support Highmark in its 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

In most instances, hospitals and physicians will submit a claim on your behalf directly to Highmark Blue Shield. If your claim is not submitted directly by the provider, you must submit itemized bills along with a special claim form. The procedure is simple. Just take the following steps:

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

- **Get an Itemized Bill.** Itemized bills must include:
 - The name and address of the service provider;
 - The patient's full name;
 - The date of service or supply;
 - A description of the service or supply;
 - The amount charged;
 - The diagnosis or nature of illness;
 - For durable medical equipment, the doctor's certification;
 - For private duty nursing, the nurse's license number, charge per day and shift worked;
 - 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 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 may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.

- **Complete a Claim Form.** Make sure all information is completed properly, and then sign and date the form. *Claim forms are available from your employee benefits department or Highmark's 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 member.

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

Highmark will process your claim within 30 days of receipt, unless special circumstances require an extension of time. If additional information is required, Highmark may request additional data from you or the provider. When benefits cannot be provided under this health care program, you will be notified by Highmark that the claim has been denied with an explanation of the reasons for the denial.

Appeal Procedure

You have the right to appeal any determination made by Highmark, or its designated agent(s) with which you disagree. You must submit an appeal in writing to Highmark or its designated agent(s) no later than 180 days from the date you were notified that benefits were denied. The written appeal should include specific information in support of your claim for benefits. Highmark or its designated agent(s) will review the information and make a final decision concerning your eligibility for benefits and notify you, in writing, no later than 30 days following receipt of the appeal. If additional time is needed for a decision, you will be notified of the reason for the delay.

Your Explanation of Benefits Statement

Once your claim is processed, you will receive an Explanation of Benefits (EOB) statement. 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.



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, connect to My Shield Online, and click on "Messages." A Highmark Member Service representative can help you with any coverage inquiry. Representatives are trained to answer your questions quickly, politely and accurately.

Blues On Call

This 24-hour toll-free number, 1-888-BLUE428, is your one connection to:

Personal Health Care Assistance

A Health Coach is available 25 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 Health Coach.

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 is 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's Web site

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

As a Highmark member, on 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 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

Through our multi-graphics bus, we take education and health screenings and immunizations into communities or worksites. Board the bus at work or in your neighborhood!

We Work Hard To Keep You Healthy and Informed

Highmark realizes the importance of a healthy lifestyle. Our goal is to help you reach yours! Log onto www.highmarkblueshield.com and click the "HealthyLiving" section on "My Shield Online" page for fitness tools, calculators, personal wellness profile and more.

Information for Non-English Speaking Members

Non-English speaking members have access to clear benefits information. They can call the toll-free Member Service number on their ID card to be connected to an AT&T Interpreter line. Highmark's Member Service representatives are trained to make the connection.

Blues On Call is a service mark of the Blue Cross and Blue Shield Association.

My Shield Online is a service mark of the Blue Cross and Blue Shield Association.

Healthwise Knowledgebase is a registered mark of Healthwise, Inc.

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

