PPO BLUE

PPO Program

Highmark Inc. d/b/a Highmark Blue Shield

PAISBOA Health Benefit Trust PPO 1 Plan
Group 10862094,95,10918608,09
10918630,31,10918656,57,58,59
10918672, 73
Effective November 01, 2025

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  – Qualified sign language interpreters
  – Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  – Qualified interpreters
  – Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with:

Civil Rights Coordinator
P.O. Box 22492
Pittsburgh, PA 15222
Phone: 1-866-286-8295 (TTY: 711), Fax: 412-544-2475
Email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

Complaint forms are available at hhs.gov/ocr/office/file/index.html

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ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Для получения помощи позвоните по номеру, указанному на обратной стороне вашей идентификационной карты (TTY: 711).

ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero riportato sul retro della Sua tessera di identificazione (TTY: 711).

ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711) pour obtenir de l'aide.

ÀKÍYÈSÍ: Tí o bá nsQ èdè Yorùbá, àwQn i$$ ìtumQ ati òǥbufQ èdè wà ní àrQwQtó lQ'f$'e_ fún Q. AwQn i$$ ìtQ'jú ati ìrànlQ'wQ' ѓy$ (bíi tit$wé nla, ǥbigbQ ohùn, ati ìwé afQ' jú) lati pèsè iwifúnni ni awQn Qna ìrááyè si wà p$lu lQ' f$' e._Pe nQmba tó wà l$hin kaádì ìdánimQ r$ (TTY: 711) fún iràn lQwQ.

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CHÚ Ý: Ngu quý vh nói tigng Viit, chúng tôi có dhch vj biên dhch và phiên dhch ngôn ngk miln phí dành cho quý vh. Chúng tôi cmng cung cnp miln phí các dhch vj và ho trp bq sung thích hpp (nhr chk in lsn, tip âm thanh và chk nqi) đt cung cnp thông tin u các đhnh dvng dl tigp cwn. Vui lòng gQi sx điin thovi trên myt sau cza th{ nhwn dvng cza quý vh (TTY: 711) đt đrpc trp giúp.

ŘřŚś ŝŞśşŠšŢĬ řŝŞ ťŦŚŧ śŨŦŚūŪ ūšŬśşŠşŭŮ ůśŨ ťŦŚŧūŚŰ űśỤųşŬŴ ůŚŵŚ Ŷśşŷ ŚŞ Ÿ ŞšůŚŢŨ ŢŨŷŚŠŹ ŦŠşžĬřšðř
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Disclosure

Your health benefits are entirely funded by your employer. Highmark Blue Shield provides administrative and claims payment services only and does not assume any financial risk or obligation with respect to claims.

Non-Assignment

Unless otherwise required by law, Highmark is authorized by the member to make payments directly to providers furnishing Covered Services provided under the program described in this benefit booklet; however, Highmark reserves the right to make these payments directly to the member. The right of a member to receive payment for a Covered Service described in this benefit booklet is not assignable, except to the extent required by law, nor may benefits described in this benefit booklet be transferred either before or after Covered Services are rendered. Any (direct or indirect) attempt to accomplish such an assignment shall be null and void. Nothing contained in this benefit booklet shall be construed to make Highmark, the group health plan or the group health plan sponsor liable to any assignee to whom a member may be liable for medical care, treatment, or services.

Highmark will not honor requests not to pay the claims submitted by the provider nor shall Highmark be liable for its rejection of the request.

Introduction to Your Health Care Program

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

Refer to the Summary of Benefits at the end of this booklet. The Summary of Benefits will tell you what you need to know about your benefits, exclusions and how your plan works.

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

- ***Your health care program gives you freedom of choice.*** You are not required to select a primary care provider to receive covered care. You have access to a large provider network of physicians, hospitals, and other providers in Pennsylvania, as well as providers across the country who are part of the local PPO network. For a higher level of coverage, you need to receive care from a network provider. However, you can go outside the network and still receive care at the lower level of coverage. To locate a network provider near you, or to learn whether your current physician is in the network, log onto your Highmark member website, www.myhighmark.com.

- ***Your health care program gives you "stay healthy" care.*** You are covered for a range of preventive care, including physical examinations and selected diagnostic tests. Preventive care is a proactive approach to health management that can help you stay on top of your health status and prevent more serious, costly care down the road.

We understand that prescription drug coverage is of particular concern to our members. You'll find in-depth information on these benefits in this booklet.

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

Information for Non-English-Speaking Members

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

How Your Benefits Are Applied

To help you understand your coverage and how it works, here's an explanation of some benefit terms found on the Summary of Benefits, which is included at the end of this booklet. For specific amounts, refer to the Summary of Benefits.

Benefit Period

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

Medical and Prescription Drug Cost-Sharing Provisions

Cost sharing is a requirement that you pay part of your expenses for covered services. The terms "copayment," "deductible" and "coinsurance" describe methods of such payment.

Coinsurance

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

Copayment

The copayment for certain covered services is the specific, upfront dollar amount which will be deducted from the plan allowance and is your responsibility. See the Summary of Benefits for the copayment amounts.

Deductible

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

Unless otherwise indicated, deductible amounts are applicable to covered services provided to covered members per benefit period.

Family Deductible

The family deductible is a specified dollar amount of covered services that must be incurred by covered family members before the program begins to provide payment for benefits. See the Summary of Benefits for the family deductible amount.

For a family with several covered dependents, the deductible you pay for all covered family members, regardless of family size, is specified under family deductible. To reach this total, you can count the expenses incurred by 2 or more covered family members. However, the deductible contributed towards the total by any one covered family member will not be more than the amount of the individual deductible. If one family member meets the individual deductible and needs to use benefits, the program would begin to pay for that person's covered services even if the deductible for the entire family has not been met.

Inpatient Copayment

The inpatient copayment is the specific, upfront dollar amount which is deducted from the plan allowance for medically necessary and appropriate health care and is your responsibility.

Your inpatient copayment is specified in the Summary of Benefits. It applies to each covered person.

Out-of-Pocket Limit

The out-of-pocket limit refers to the specified dollar amount of expense incurred for covered services in a benefit period. When the specified dollar amount is attained, the level of benefit increases as specified in the Summary of Benefits. See the Summary of Benefits for the out-of-pocket limit. The out-of-pocket limit does not include copayments, deductibles, prescription drug expenses or amounts in excess of the plan allowance. All out-of-pocket amounts are based on the plan allowance.

Any manufacturer dollars applied under the Copay Armor Program for certain specialty medications will not apply toward the annual out-of-pocket maximum. See the "Overview of Copay Armor Program" below for additional information.

Total Maximum Out-of-Pocket

The total maximum out-of-pocket, as mandated by the federal government, refers to the specified dollar amount of deductible, coinsurance, copayments incurred for network covered services, covered medications and any qualified medical expenses in a benefit period. When the specified individual dollar amount is attained by you, or the specified family dollar amount is attained by you or your covered family members, your program begins to pay 100% of all covered expenses and no additional coinsurance, copayments and deductible will be incurred for network covered services and covered medications in that benefit period. See the Summary of Benefits for the total maximum out-of-pocket. The total maximum out-of-pocket does not include out-of-network cost-sharing or amounts in excess of the plan allowance.

The total maximum out-of-pocket does not include out-of-network cost sharing, amounts in excess of the plan allowance and manufacturer dollars applied under the Copay Armor Program. See the "Overview of the Copay Armor Program" below for additional information.

Overview of Copay Armor Program

The Copay Armor Program is a copayment assistance program that applies manufacturer dollars towards the cost of select high-cost medications. By enrolling in the program, your out-of-pocket costs for such medications may be covered up to 100%, meaning that these high-cost medications may be covered at no cost to you.

You are eligible to participate in the Copay Armor Program if and when you utilize high-cost specialty medications. These drugs are prescribed in connection with conditions such as:

- Hepatitis C
- Cystic Fibrosis
- Multiple Sclerosis
- Inflammatory
- Hemophilia
- Pulmonary Arterial Hypertension
- Blood Cell Deficiency
- Hereditary Angioedema
- Asthma & Allergy
- HIV

Enrollment in the Copay Armor Program is voluntary; however, if you choose not to enroll in Copay Armor Program, you will be responsible for the unreduced copayment for select high-cost medications. Note that due to the high cost of these medications, monthly copayments may be significant.

To receive select high-cost medications with a copayment as low as $0, you must enroll in the Copay Armor Program prior to purchasing such medications.

Maximum

The greatest amount of benefits that the program will provide for covered services within a prescribed period of time. This could be expressed in dollars, number of days or number of services. In connection with such day and/or visit limits, all services received by you during a benefit period will reduce the remaining number of days and/or visits available under that benefit, regardless of whether you have satisfied your deductible.

Covered Services - Medical Program

Your health care program may provide benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate. All benefit limits, deductibles and copayment amounts are described in the Summary of Benefits included at the end of this booklet. For specific covered services, refer to the Summary of Benefits.

Benefits for covered services are based upon the plan allowance at the time services are rendered. You are responsible for payment of any cost-sharing amounts due to the provider after the amounts paid by your program. The payments to a provider may be adjusted from time to time based on settlements with the providers. Such adjustments will not affect your deductible, coinsurance, or copayment obligation.

Network care is covered at a higher level of benefits than out-of-network care.
For the lowest out-of-pocket costs, use a network provider. To make sure that a provider is in the network, call Member Service at the number on the back of your member ID card. Or visit www.myhighmark.com.

Outpatient Medical Care Services (Visits and Consultations)

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

In addition to telemedicine services, a designated telemedicine provider may also provide other medical services. If provided, these services are covered under their corresponding benefit category, i.e., physician or primary care provider office visit, specialist office visit. For example, services provided by a designated telemedicine provider relating to the treatment of a dermatological issue are covered under your specialist office visit benefit and subject to the cost sharing amount in your Summary of Benefits.

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

- Primary care provider's (PCP) or specialist's office
- Physician's office located in an outpatient hospital/hospital satellite setting
- Urgent care center
- Retail site, such as in a pharmacy or other retail store

You can also interact with a professional provider virtually, via telephone, internet, or other electronic communication. Benefits are provided for a virtual visit when you communicate with the professional provider from any location, such as your home, office, or another mobile location. Alternatively, a professional provider may want you to travel to a provider originating site where a virtual interaction with the provider can occur.

Professional providers may also request consultations from another professional provider for an advisory opinion regarding a diagnosis or management of your medical problem. These are called “provider-to-provider” consultations or "interprofessional consultations". ***Interprofessional consultations do not include provider interaction with you.***

Different types of providers, their services and their locations may require different payment amounts and result in different charges. You may be responsible for a facility fee, clinic charge or similar fee (in addition to any professional fees) if your office visit or service is provided at a hospital, facility provider, ancillary provider,

retail clinic or urgent care center. You may also be responsible for a charge for an interprofessional consultation, which may occur during your office visit or at a different time.

The specific amounts you are responsible for paying depend on your program's particular benefits.

Preventive Care Services

Benefits will be provided for preventive care services in accordance with a predefined schedule*. Recommended annual services are based on a calendar year resetting January 1 of every year. Refer to the Summary of Benefits for your program's specific level of coverage.

Adult Care

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

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

Routine Gynecological Examination and Pap Test
Benefits are provided for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine Papanicolaou smear (Pap test) per calendar year. Benefits are not subject to program deductibles or maximums.

Breast Cancer Screenings
Benefits are provided for the following:

- An annual routine mammographic screening starting at 40 years of age or older pursuant to the 2002 recommendations by the United States Preventive Services Task Force.
- For members believed to be at an increased risk of breast cancer due to:
    1. personal history of atypical breast histologies;
    2. personal history or family history of breast cancer;
    3. genetic predisposition for breast cancer;
    4. prior therapeutic thoracic radiation therapy;
    5. heterogeneously dense breast tissue based on breast composition categories with any one of the following risk factors:
        i. lifetime risk of breast cancer of greater than 20%, according to risk assessment tools based on family history;

* This schedule is reviewed and updated periodically by Highmark based on the requirements of the ACA, and the advice of the American Academy of Pediatrics, U.S. Preventive Services Task Force, the Blue Cross Blue Shield Association and medical consultants. Accordingly, the frequency and eligibility of services is subject to change.

ii. personal history of BRCA1 or BRCA2 gene mutations;

iii. a first-degree relative with a BRCA1 or BRCA2 gene mutation;

iv. prior therapeutic thoracic radiation therapy between 10 and 30 years of age; or

v. personal history of Li-Fraumeni syndrome, Cowden syndrome or Bannayan-Riley-Ruvalcaba syndrome or a first-degree relative with one of these syndromes; or

6. extremely dense breast tissue based on breast composition categories;

one (1) supplemental breast screening every year using standard or abbreviated magnetic resonance imaging (MRI) or, if such imaging is not possible, ultrasound if recommended by the treating physician to screen for breast cancer when there is no abnormality seen or suspected in the breast.

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

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

Colorectal Cancer Screenings

Benefits are provided for the following tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer:

- Basic diagnostic laboratory and pathology screening services such as a fecal-occult blood or fecal immunochemical test
- Basic diagnostic standard imaging screening services such as barium enema
- Surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services
- Such other basic diagnostic laboratory and pathology, basic diagnostic standard imaging, surgical screening tests, basic diagnostic medical and advanced imaging screening services consistent with approved medical standards and practices for the detection of colon cancer

Benefits are provided for members 45 years of age or older as follows, or more frequently and regardless of age when prescribed by a physician:

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

For members determined to be at high or increased risk, regardless of age:

- A colonoscopy or any other combination of covered services related to colorectal cancer screening when prescribed by a physician and in accordance with the American Cancer Society guidelines on screening for colorectal cancer as of 2018.

Colorectal cancer screening services which are otherwise not described herein and are prescribed by a physician for a symptomatic member are not considered preventive care services. The payment for these services will be consistent with similar medically necessary and appropriate covered services.

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

Tobacco Use, Counseling and Interventions
Benefits are provided for screenings for tobacco use products and counseling sessions.

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

Pediatric Care

Routine Physical Examinations
Routine physical examinations, regardless of medical necessity and appropriateness, and other items and services.

Pediatric Immunizations
Benefits are provided to members under 21 years of age and dependent children 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 U.S. Department of Health and Human Services. Benefits are not subject to the program deductibles or dollar limits. Coinsurance must not be more restrictive than coinsurance levels for all other benefits.

Kidney Care Management

Kidney Care Management by Healthmap provides coordinated case management services for members with chronic kidney disease in stages 3-5 and end stage renal disease (ESRD).

Hospital Services

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

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

- a room with two or more beds;
- a private room; or

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

Ancillary Services
Hospital services and supplies including, but not restricted to:

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

Outpatient Services
Ancillary Services
Hospital services and supplies including, but not restricted to:

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

Pre-Admission Testing
Tests and studies, as indicated in the Basic Diagnostic Services subsection, 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.

Outpatient Evaluation and Management Services
Benefits are provided for outpatient medical care visits and consultations for the evaluation and management of your condition, including examination, diagnosis and treatment of an injury or illness.

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

Complications of Pregnancy

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

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

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

Newborn Care
Covered services provided to an enrolled newborn child includes care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity, and routine nursery care. Routine nursery care includes inpatient medical visits by a professional provider.

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

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.

Cost sharing amounts for medical services are in the Summary of Benefits section under Hospital and Medical/Surgical Expenses for Medical Care.

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

Consultation
Consultation services rendered to an inpatient by another professional provider at the request of the attending professional provider. Consultation does not include staff consultations which are required by facility provider rules and regulations. Benefits are limited to one (1) consultation per consultant per admission.

Inpatient Medical Care Visits
Benefits are provided for inpatient medical care visits.

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

Surgical Services

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

Anesthesia
Administration of anesthesia for covered surgery when ordered by the attending professional provider and rendered by a professional provider other than the surgeon or the assistant at surgery. Benefits will also be provided for the administration of anesthesia for covered oral surgical procedures in an outpatient setting when ordered and administered by the attending professional provider.

Assistant at Surgery
Services of a physician or of the physician's employed physician assistant (PA), or certified registered nurse practitioner (CRNP) or certified nurse midwife (CNM), who actively assists the operating surgeon in the performance of covered surgery.

Your condition or the type of surgery must require the active assistance of an assistant surgeon. Surgical assistance is not covered when performed by a professional provider who performs and bills for another surgical procedure during the same operative session.

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

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

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

Special Surgery
- Oral Surgery

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

  - Extraction of impacted third molars when partially or totally covered by bone
  - Extraction of teeth in preparation for radiation therapy
  - Mandibular staple implant, provided the procedure is not done to prepare the mouth for dentures
  - Lingual frenectomy, frenotomy or frenoplasty (to correct tongue-tie)
  - Facility provider and anesthesia services rendered in a facility setting in conjunction with non-covered dental procedures when determined by Highmark to be medically necessary and appropriate due to your age and/or medical condition
  - Accidental injury to the jaw or structures contiguous to the jaw except teeth

- The correction of a non-dental physiological condition which has resulted in a severe functional impairment
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth
- Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus

- Sterilization

- Sterilization and its reversal regardless of medical necessity and appropriateness.

Second Surgical Opinion

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

Keep in mind that:

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

For a second surgical opinion, you will be responsible for the same cost sharing that you have for a specialist office visit which can be found in the Summary of Benefits section.

Surgery

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

Emergency Care Services

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

Emergency care services are available seven (7) days a week, twenty-four (24) hours a day. Emergency care services are services and supplies, including drugs and medicines, for the outpatient emergency treatment of bodily injuries resulting from an accident or a medical condition described in the definition of emergency care services in the Terms You Should Know section. Also included is a medical screening examination and

ancillary services necessary to evaluate such injury or emergency medical condition and further medical examination and treatment as required to stabilize the patient.

In the event that you receive such emergency care services from an out-of-network provider and require an inpatient admission or observation immediately resulting from such injury or emergency medical condition and upon stabilization:

a. you are unable to travel using non-medical transportation or non-emergency medical transportation; or

b. you do not consent to be transferred,

covered services directly related to such injury or emergency medical condition and received during the inpatient admission or observation will be covered at the network services level of benefits as set forth in the Hospital Services benefit in the Summary of Benefits section of this booklet. You will not be subject to any balance billing amounts.

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

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

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

Ambulance Service

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

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

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

Ambulance service includes an emergency medical services (EMS) agency licensed by the state.

Transportation and other emergency services provided by an ambulance service will be considered emergency ambulance service if the injury or condition is considered emergency care. Refer to the Terms You Should Know section for a definition of emergency care services.

Use of an ambulance as transportation to an emergency room for an injury or condition that does not satisfy the criteria of emergency care will not be covered as emergency ambulance services.

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

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

Therapy Services

Benefits will be provided for the following services when such services are ordered by a physician:

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

Spinal Manipulations

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

Mental Health Care Services

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

Day and visit limits do not apply when services are prescribed for the treatment of mental illness.

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

Inpatient Facility Services

Hospital services are provided for the inpatient treatment of mental illness by a facility provider. Inpatient facility services must be provided twenty-four hours a day, seven days a week by or under the direction of a psychiatrist, a psychiatric nurse practitioner or a psychologist when legally authorized by the state. Inpatient facility services are recommended for patients who are an acute danger to themselves or others or who are unable to provide required self-care and lack available support.

Inpatient Medical Services

Covered inpatient medical services provided by a professional provider:

- Individual psychotherapy
- Group psychotherapy

- Psychological testing
- Family counseling
  Counseling with family members to assist in your diagnosis and treatment
- Convulsive therapy treatment; and
  Electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same professional provider
- Medication management

Partial Hospitalization Program

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

Outpatient Mental Health Care Services

Inpatient facility service and inpatient medical benefits provided by a facility provider or professional provider as previously described, are also available when provided for the outpatient treatment of mental illness by a facility provider, or a professional provider. Benefits are also provided for mental health care services received through an Intensive Outpatient Program.

A specialist virtual visit between you and a specialist (including a behavioral health specialist) via audio and video telecommunications. Benefits are provided for a specialist virtual visit when you communicate with the specialist from any location, such as your home, office, or another mobile location, or if you travel to a provider-based location referred to as a provider originating site. If you communicate with the specialist from a provider originating site, you will be responsible for the specialist virtual visit provider originating site fee.

In addition to telemedicine services, a designated telemedicine provider may also provide services related to the treatment of behavioral health. This would be covered under your outpatient mental health benefit and subject to the cost sharing amount in your Summary of Benefits.

Serious Mental Illness Care Services

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

Substance Abuse Services

Benefits are provided for detoxification services, individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance abuse when rendered by a facility provider or professional provider and include the following:

- Detoxification services rendered;

  - on an inpatient basis in a hospital or substance abuse treatment facility; or
  - on an outpatient basis

- Substance abuse treatment facility services for non-hospital inpatient residential treatment and rehabilitation services. Residential treatment and rehabilitation services include medically monitored high intensity inpatient services with twenty-four hour nursing care and physician availability and

medically managed intensive inpatient services with twenty-four hour nursing care and daily physician oversight; and
- Outpatient services rendered in a hospital, substance abuse treatment facility or through an Intensive Outpatient Program or Partial Hospitalization Program, and outpatient substance abuse treatment facility services for rehabilitation therapy

For purposes of this benefit, a substance abuse service provided on a partial hospitalization basis shall be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts. Benefits are also provided for substance abuse services rendered through an Opioid Treatment Program or Office Based Opioid Treatment Program.

Day and visit limits do not apply when services are prescribed for the treatment of substance abuse.

Other Services

Acupuncture Therapy Services

Benefits will be provided for acupuncture therapy services rendered by a professional provider which are determined to be medically necessary and appropriate. This benefit includes acupuncture therapy services when used to treat nausea associated with surgery, chemotherapy or pregnancy. Acupuncture therapy services are also covered as an adjunct to standard conservative therapy for the following chronic conditions when other conservative methods of treatment have failed: chronic low back pain and chronic headaches or migraine headaches. Coverage does not include acupuncture therapy services for the treatment of pain or maintenance treatment where the patient's symptoms are neither regressing nor improving.

Allergy Extract/Injections

Benefits are provided for allergy extract and allergy injections.

Anesthesia for Non-Covered Dental Procedures (Limited)

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

Any cost sharing amounts that are included with your program (deductible/coinsurance) will apply for anesthesia for non-covered dental procedures.

Autism Spectrum Disorders

Benefits are provided to members regardless of age for the following:

Autism Spectrum Disorders

Diagnostic Assessment of Autism Spectrum Disorders
Medically necessary and appropriate assessments, evaluations or tests performed by a physician, licensed physician assistant, psychologist, or certified registered nurse practitioner to diagnose whether an individual has an autism spectrum disorder.

Treatment of Autism Spectrum Disorders
Services must be specified in a treatment plan developed by a physician or psychologist following a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. Highmark may review a treatment plan for autism spectrum disorders once every six months, or as agreed upon between Highmark and the physician or psychologist developing the treatment plan.

Treatment may include the following medically necessary and appropriate services:

Pharmacy care
Pharmacy care for autism spectrum disorders includes any assessment, evaluation or test prescribed or ordered by a physician, licensed physician assistant or certified registered nurse practitioner to determine the need or effectiveness of a prescription drug approved by the Food and Drug Administration (FDA) and designated by Highmark for the treatment of autism spectrum disorders.

Psychiatric and psychological care
Direct or consultative services provided by a psychologist or by a physician who specializes in psychiatry.

Rehabilitative care
Professional services and treatment programs, including rehabilitative services related to applied behavioral analysis, provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of an attained skill or function.

Therapeutic care
Services that are provided by a speech language pathologist, occupational therapist or physical therapist.

NOTE: Certain services for the treatment of autism spectrum disorders described above, including but not limited to diagnostic services, pharmacy care, psychiatric and psychological care, rehabilitative care and therapeutic cares, are also described as services covered under other benefits as set forth within this Covered Services section. When you receive such services, they will be paid as specified in such other benefits as set forth in the Summary of Benefits. However, any visit limitations specified for such other benefits will not apply when those services are prescribed for the treatment of autism spectrum disorders. Applied behavioral analysis for the treatment of autism spectrum disorders will be paid as set forth in the Summary of Benefits.

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

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

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

Diagnostic Services

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

Advanced Imaging Services

Include, but are not limited to, computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET scan), positron emission tomography/computed tomography (PET/CT scan).

Basic Diagnostic Services

- **Standard Imaging Services** - procedures such as skeletal x-rays, ultrasound and fluoroscopy
- **Laboratory and Pathology Services** - procedures such as non-routine Papanicolaou (Pap) smears, blood tests, urinalysis, biopsies and cultures
- **Diagnostic Medical Services** - procedures such as electrocardiograms (ECG), electroencephalograms (EEG), echocardiograms, pulmonary studies, stress tests, audiology testing
- **Allergy Testing Services** - allergy testing procedures such as percutaneous, intracutaneous, and patch tests

Durable Medical Equipment

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

Enteral Foods

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

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

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

- enteral foods prescribed by a physician, when administered on an outpatient basis, considered to be your sole source of nutrition and provided:

    - through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulas; or
    - orally and identified as one of the following types of defined formulae with: hydrolyzed (pre-digested) protein or amino acids, specialized content for special metabolic needs, modular components, or standardized nutrients.

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

Coverage for enteral foods excludes the following:

- Blenderized food, baby food, or regular shelf food
- Milk or soy-based infant formulae with intact proteins
- Any formulae, when used for the convenience of you or your family members
- Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance
- Semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally

This coverage does not include normal food products used in the dietary management of the disorders included above.

Covered enteral foods are exempt from all deductibles.

Home Infusion and Suite Infusion Therapy Services

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

Home Health Care Services/Hospice Care Services

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

- Skilled nursing services of a registered nurse (RN) or licensed practical nurse (LPN), excluding private duty nursing services;
- Physical medicine, speech therapy and occupational therapy;
- Medical and surgical supplies provided by the home health care agency or hospital program for home health care or hospice care;
- Oxygen and its administration;
- Medical social service consultations;
- Health aide services when you are also receiving covered nursing services, rehabilitative services or therapy services;
- Respite care;
- Family counseling related to the member's terminal condition.

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

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

Infertility Counseling, Testing and Treatment

Benefits will be provided for covered services in connection with the counseling, testing and treatment of infertility when such services are ordered by a physician and are determined to be medically necessary and appropriate.

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.

Private Duty Nursing Services

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

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

Prosthetic Appliances

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

Skilled Nursing Facility Services

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

No benefits are payable:

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

Therapeutic Injections

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

Transplant Services

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

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

- when both the recipient and the donor are members, each is entitled to the benefits of their program;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this program. Benefits provided to the donor will be charged against the recipient's coverage under this program to the extent that benefits remain and are available under this program after benefits for the recipient's own expenses have been paid;
- when only the donor is a member, the donor is entitled to the benefits of this program, subject to the following additional limitations: 1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this program; and 2) no benefits will be provided to the non-member transplant recipient; and
- if any organ, tissue or blood stem cell is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the member recipient’s program limit.

Covered Services - Prescription Drug Program

Prescription drugs are covered when you purchase them through the pharmacy network applicable to your program. For convenience and choice, these pharmacies include both major chains and independent stores. To locate a network pharmacy, go to your member website, log in and choose **Prescriptions.** Or call member Service at the number on the back of your ID card.

Your program may also include a formulary. The formulary is a listing of prescription drugs and over-the-counter drugs selected for their quality, safety and effectiveness. This listing is subject to periodic review and modification by Highmark or a designated committee of physicians or pharmacists. Coverage is not provided for prescription drugs and over-the-counter drugs not appearing on the formulary unless an exception has been granted as described in the prescription drug or contraceptive exceptions processes described in the Health Care Management section of this booklet.

A drug formulary may restrict coverage of some drugs. To help manage costs, coverage will be for the generic drug if it's available. Generic drugs have the same active ingredient as brand names. Generic drugs must also meet the same FDA requirements.

Your program may also include SensibleRx Choice. The SensibleRx Choice provides that if you receive a brand name drug when a generic equivalent is available and authorized by your provider, you must pay the price difference between the brand and generic prices in addition to the applicable copayment or coinsurance amount.

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 requirements.

Should you purchase a brand name drug when a generic is available and authorized by your doctor, you must pay the price difference between the brand and generic prices in addition to the applicable copayment or coinsurance amount. However, for certain specified brand drugs, benefits are only provided if an appropriate authorization is received. See the subsection titled Step Therapy Program in the Prescription Drug Management section of this booklet for more information.

Covered Medications

Covered medications include:

- those which, under Federal law, are required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription;"
- legend drugs under applicable state law and dispensed by a licensed pharmacist;
- prescription drugs listed in your program's prescription drug formulary;
- preventive drugs that are offered in accordance with a predefined schedule and are prescribed for preventive purposes, upon presentation of a written prescription order is not required by Highmark as indicated on the formulary, including FDA-approved tobacco cessation drugs. Highmark periodically reviews the schedule based on legislative requirements and the advice of the American Academy of Pediatrics, the U.S. Preventive Services Task Force, the Blue Cross Blue Shield Association and medical consultants. Therefore, the frequency and eligibility of services is subject to change. For a current schedule of covered preventive drugs, log onto your member website, or call Member Service at the toll-free telephone number listed on the back of your ID card.
- prescribed injectable insulin;
- diabetic supplies, including needles and syringes;
- continuous glucose monitoring devices when prescribed by your provider in connection with a covered service and when purchased at a participating pharmacy provider for outpatient use; and

- certain drugs that may require prior authorization.

Exclusive Pharmacy Provider

Covered drugs also include selected prescription drugs within, but not limited to, the following drug classifications only when such drugs are covered medications and are dispensed through an exclusive pharmacy provider. These particular prescription drugs will be limited to your benefit program's retail cost-sharing provisions and retail days' supply.

These selected prescription drugs may be ordered by a physician or other health care provider on your behalf or you may submit the prescription order directly to the exclusive pharmacy provider. In either situation, the exclusive pharmacy provider will deliver the prescription to you.

- Oncology-related therapies
- Interferons
- Agents for multiple sclerosis and neurological related therapies
- Antiarthritic therapies
- Anticoagulants
- Hematinic agents
- Immunomodulators
- Growth hormones
- Antivirals
- Agents for chronic inflammatory diseases
- Pulmonary arterial hypertension therapies
- Agents for respiratory diseases
- Hereditary angioedema therapies
- Osteoporosis therapies
- Enzyme replacement therapies
- Thrombopoietin-receptor agonists

For a complete listing of those prescription drugs that must be obtained through an exclusive pharmacy provider, contact Member Service at the toll-free telephone number on the back of your ID card.

Continuous Glucose Monitoring Devices

Coverage is provided for continuous glucose monitoring devices prescribed by your provider in connection with a covered service, when purchased at a participating pharmacy provider for outpatient use. Receiver kits are limited to one (1) per benefit period. Sensor kits are limited to one (1) refill every thirty (30) days. Transmitter kits are limited to one (1) refill every ninety (90) days.

You may contact Highmark at the toll-free telephone number or the website appearing on the back of your identification card to verify whether a particular covered medication: a) appears on the formulary; b) does not require a prescription order for coverage; or c) is a specialty prescription drug and whether it may be purchased from a participating pharmacy provider or must be obtained through an exclusive pharmacy provider.

What Is Not Covered

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

Key Word	Exclusion
Allergy Testing	● For allergy testing, except as provided herein.
Ambulance	● For ambulance services, except as provided herein.
Assisted Fertilization	● For treatment provided specifically for the purpose of assisted reproductive technology, including pharmacological or hormonal treatments used in conjunction with assisted reproductive technology.
Comfort/Convenience Items	● 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.
Compounded Medications	● For compounded medications.
Cosmetic Surgery	● For a cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body and from which no improvement in physiological function can be expected, except: a) as otherwise provided herein; b) when required to correct a condition directly resulting from an accident; c) when necessary to correct a functional impairment which directly results from a covered disease or injury; or d) to correct a congenital birth defect.
Court Ordered Services	● For otherwise covered services ordered by a court or other tribunal unless medically necessary and appropriate or if the reimbursement of such services is required by law.
Custodial Care	● For custodial care, domiciliary care, protective and supportive care including educational services, rest cures and convalescent care.
Dental 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 for anesthesia for non-covered dental procedures and orthodontic treatment for congenital cleft palates as provided herein.
Diabetes Prevention Program	● For a diabetes prevention program offered by other than a network diabetes prevention provider.

Educational Services and Testing	●	For services that are primarily educational in nature, such as academic skills training and vocational training, including tutorial services.
Effective Date	●	Rendered prior to your effective date of coverage.
Enteral Foods	●	For the following services associated with the additional enteral foods benefits provided under your program: blenderized food, baby food, or regular shelf food; milk or soy-based infant formulae with intact proteins; any formulae, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance; semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally; normal food products used in the dietary management of the disorders provided herein.
Experimental/Investigative	●	Which are experimental/investigative in nature, except as provided herein for Routine Patient Costs incurred in connection with an Approved Clinical Trial.
Eyeglasses/Contact Lenses	●	For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses or sclera shells intended for use in the treatment of disease or injury).
Felonies	●	For any illness or injury you suffer during your commission of a felony, as long as such illness or injuries are not the result of a medical condition or an act of domestic violence.
Foot Care	●	For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
Health Care Management program	●	For any care, treatment, prescription drug or service which has been disallowed under the provisions of Health Care Management program.
Hearing Care Services	●	For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids.
Illegal Services	●	Services not permitted under applicable state law. Some state laws restrict the scope of health care services that a provider may render. In such cases, the plan will not cover such health care services. For detailed information about these excluded services, contact Member Services at the number on the back of your ID card.

Immunizations	● For immunizations required for foreign travel or employment, except as provided herein.
Inpatient Admissions	● For inpatient admissions which are primarily for diagnostic studies. ● For inpatient admissions which are primarily for physical medicine services.
Legal Obligation	● For which you would have no legal obligation to pay.
Medically Necessary and Appropriate	● Which are not medically necessary and appropriate as determined by Highmark.
Medicare	● To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program.
Military Service	● To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.
Miscellaneous	● For any type of interaction made through unsecured and unstructured services, such as, but not limited to skype and instant messaging, charges for failure to keep a scheduled visit or charges for completion of a claim form. ● For any other medical or dental service or treatment or prescription drugs except as provided herein. ● For any tests, screenings, examinations or any other services required by: (a) an employer or governmental body or agency in order to begin or to continue working or as a condition to performing the functions of any employment in a particular setting; (b) a school, college or university in order to enter onto school property or a particular location regardless of purpose, or; (c) a governmental body or agency for public surveillance purposes; and that does not relate to the furnishing or administration of an individualized test, screening or evaluation determined by the member's attending professional provider as being medically appropriate.
Motor Vehicle Accident	● For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.
Neuropsychological/ Educational Testing	● For neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment.

Nutritional Counseling	● For nutritional counseling, except as provided herein, or as otherwise set forth in the predefined preventive schedule. Please refer to the Covered Services - Preventive Care Services section for more information.
Obesity	● For the treatment of obesity, except for medical surgical treatment of morbid obesity, or as otherwise set forth in the predefined preventive schedule. Please refer to the Covered Services - Preventive Care Services section for more information.
Oral Surgery	● For oral surgery procedures, except as provided herein.
Physical Examinations	● For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein.
Prescription Drugs (Medical Program)	● For prescription drugs which were paid or are payable under a freestanding prescription drug program. ● For prescription drugs which require precertification and which such precertification is not obtained.
Preventive Care Services	● For preventive care services, wellness services or programs, except as provided herein.
Provider of Service	● Which are not prescribed by or performed by or upon the direction of a professional provider. ● Rendered by other than providers. ● Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group. ● Which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same member. ● Rendered by a provider who is a member of your immediate family. ● Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
Respite Care	● For respite care except as provided in connection with hospice care.
Sexual Dysfunction	● For treatment of sexual dysfunction that is not related to organic disease or injury.

Smoking (nicotine) Cessation	● For nicotine cessation support programs and/or classes, except as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of the Covered Services section for more information.
Social or Environmental Change	● For services provided primarily for social or environmental change.
Termination Date	● Incurred after the date of termination of your coverage except as provided herein.
Therapy	● For outpatient therapy and rehabilitative services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur.
TMJ	● For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
Vision Correction Surgery	● For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.
War	● For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.
Weight Reduction	● For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
Workers' Compensation	● For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.

In addition, under your Prescription Drug benefits, except as specifically provided in this booklet or as Highmark is mandated or required to cover based on state or federal law, regulation or other directive, no benefits will be provided for:

- Allergy serums.
- Antihemophilia drugs.
- Any amounts above the deductible, coinsurance, copayment or other cost-sharing amounts for each prescription order or refill that are your responsibility.

- Any amounts you are required to pay directly to the pharmacy for each prescription order or refill order.
- Any charges by any pharmacy provider or pharmacist except as provided herein.
- Any drug or medication except as provided herein.
- Any drug or medication which does not meet the definition of covered maintenance prescription drug, except those set forth in the predefined preventive schedule. Please refer to the Covered Drugs section for more information.
- Any drugs prescribed for cosmetic purposes only.
- Any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes.
- Any drugs used to abort a pregnancy.
- Any drugs which are experimental/investigative in nature, except as provided herein for Routine Patient Costs incurred in connection with an Approved Clinical Trial.
- Any prescription drug purchased through mail order but not dispensed by a designated mail order pharmacy provider.
- Any prescription drug which has been disallowed under the Prescription Drug Managed Care section of this booklet.
- Any prescription drugs or supplies purchased at a non-participating pharmacy provider, except in connection with emergency care services as described herein.
- Any prescription for more than the retail days' supply or mail-service days' supply as outlined in the Summary of Benefits.
- Any selected diagnostic agents.
- Blood products.
- Charges for a prescription drug when such drug or medication is used for unlabeled or unapproved indications and where such use has not been approved by the Food and Drug Administration (FDA).
- Charges for administration of prescription drugs and/or injectable insulin, whether by a physician or other person.
- Charges for any prescription drug for more than the retail days' supply or mail-service days' supply as outlined in the Summary of Benefits.
- Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances).

- Compounded medications.
- Drugs and supplies that are not medically necessary and appropriate or otherwise excluded herein.
- Food supplements.
- For any tests, screenings, examinations or any other services required by: (a) an employer or governmental body or agency in order to begin or to continue working or as a condition to performing the functions of any employment in a particular setting; (b) a school, college or university in order to enter onto school property or a particular location regardless of purpose or; (c) a governmental body or agency for public surveillance purposes; and that does not relate to the furnishing or administration of an individualized test, screening or evaluation determined by the member's attending professional provider as being medically appropriate.
- Services for which coverage or reimbursement is determined to be illegal by your state of residence regardless of whether you travel to a state where the service can be legally performed.
- For Market Watch Prescription Drugs, except as provided herein.
- Hair growth stimulants.
- Otherwise covered medications ordered by a court or other tribunal unless medically necessary and appropriate or if the reimbursement of such services is required by law.
- Over-the-counter drugs, except those set forth in the predefined preventive schedule. Please refer to the Covered Drugs section for more information.
- Prescription drugs dispensed for treatment of an illness or an injury for which the group is required by law to furnish hospital care in whole or in part-including, but not limited to-state or federal workers' compensation laws, occupational disease laws and other employer liability laws.
- Prescription drugs or refills dispensed by a non-participating pharmacy provider.
- Prescription drugs to which you are entitled, with or without charge, under a plan or program of any government or governmental body.
- Services of your attending physician, surgeon or other medical attendant.
- Weight control drugs.

- Any drug requiring refrigeration (if delivered through the mail) or injectables, except insulin and other injectables used to treat diabetes.

- Any drug or medication which is otherwise excluded under the terms of this program.

How Your Health Care Program Works

Your program is responsive, flexible coverage that lets you get the medically necessary and appropriate care you want from the health care provider you select.

Here is how your health care program works. When you or a covered family member needs certain medical services, including:

- Primary care provider office visits
- Specialist office visits
- Physical, speech and occupational therapy
- Diagnostic services
- Inpatient and outpatient hospital services
- Home health or hospice care

Network Care

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

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

Out-of-Network Care

Out-of-network care is care you receive from providers who are not in your program's network.

Out-of-network providers are not in the program's network. When using out-of-network providers, you may still have coverage for most eligible services, except you will share more financial and paperwork responsibilities. In addition, you may be responsible for paying any differences between the program's payments and the provider's actual charges. Finally, you may need to file your own claims and obtain precertification for inpatient care. You should always check with the provider before getting care to understand at what level your care will be covered.

Remember: If you want to enjoy maximum benefits coverage, you need to be sure you receive care from a network provider. See the Summary of Benefits for your coverage details.

There are instances where you may not have the opportunity to choose your provider. In such cases, claims for covered services will be processed at the network level of benefits and Highmark will prohibit the provider from balance billing you.

Provider Reimbursement and Member Liability

Highmark uses the Plan Allowance to calculate the benefit payable and the financial liability of the member for Medically Necessary and Appropriate Services covered under this plan. Refer to the Terms You Should Know section for the definition of Plan Allowance.

Highmark's payment is determined by first subtracting any deductible and/or copayment liability from the Plan Allowance. The coinsurance percentage set forth in the Summary of Benefits is then applied to that amount. This amount represents Highmark's payment. Any remaining coinsurance amount is the member's

responsibility. The member's total cost-sharing liability is the sum of the coinsurance plus any deductible and/or copayment obligations.

When you receive covered services from an out-of-network provider, in addition to your cost-sharing liability described above, you will be responsible for the difference between your plan's payment and the provider's billed charge. If you receive services which are not covered under your plan, you are responsible for all charges associated with those services. However, the following covered services when received from an out-of-network provider will be provided at the applicable network level of benefits and you will not be responsible for such difference:

1. Emergency care services provided in a hospital or freestanding emergency room; and

2. Air Ambulance services

Additionally, in very limited circumstances, you may not be liable for charges for non-emergency covered services received from certain professional providers or ancillary providers who are not part of the network. A network facility provider may have an arrangement with a professional provider or ancillary provider who is not part of the network to render certain items and professional services (such as, but not limited to, equipment, devices, anesthesiology, radiology, or pathology services) to patients of the network facility provider. The selection of such professional providers or ancillary providers may be beyond your control. In that situation, you will not be liable, except for applicable network deductible, copayment, or coinsurance obligations, for the charges of that professional provider or ancillary provider.

Please review the Booklet's schedule of benefits for further details on cost sharing for Emergency Services.

No Prior Approval Requirement or Pre-Certification Requirement Applies When Members Receive Emergency Care services.

Out-of-Area Care

Your program also provides coverage for you and your eligible dependents when you receive care from providers located outside of Pennsylvania. For specific details, see the Inter-Plan Arrangements section of this booklet.

If you are traveling and an urgent injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic: If the treatment results in an admission the provider must obtain precertification from Highmark. However, it is important that you confirm Highmark's determination of medical necessity and appropriateness. If precertification is not obtained and the admission is not considered to be medically necessary and appropriate, you will be responsible for all costs associated with the stay. For specific details, see the Health Care Management section of this booklet.

Inter-Plan Arrangements

Out-of-Area Services

Highmark has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "inter-plan arrangements." These inter-plan arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association. Whenever members access health care services outside Pennsylvania, the claim for those services may be processed through one of these inter-plan arrangements, as described generally below.

Typically, when accessing care outside Pennsylvania, members obtain care from providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that

other geographic area ("Host Blue"). In some instances, members may obtain care from providers in the Host Blue geographic area that do not have a contractual agreement ("non-participating providers") with the Host Blue. Highmark remains responsible for fulfilling our contractual obligations to you. Highmark's payment practices in both instances are described below.

BlueCard® Program

The BlueCard® Program is an inter-plan arrangement. Under this arrangement, when members access covered services outside Pennsylvania, the Host Blue will be responsible for contracting and handling all interactions with its participating health care providers.

The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method per Claim

Unless subject to a fixed dollar copayment, the calculation of the member liability on claims for covered services processed through the BlueCard Program will be based on the lower of the participating provider's billed charges for covered services or the negotiated price made available to Highmark by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's health care provider contracts. The negotiated price made available to Highmark by the Host Blue may be represented by one of the following:

- an actual price - An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases, or
- an estimated price - An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives, or
- an average price - An average price is a percentage of billed charges for covered services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual price, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices, (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Highmark in determining the member's premiums.

Special Cases: Value-Based Programs

BlueCard® Program

If members receive covered services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Highmark through average pricing or fee schedule adjustments.

Return of Overpayments

Recoveries of overpayments from a Host Blue or its participating and non-participating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections

will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to Highmark, they will be credited to your account. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to you as a percentage of the recovery.

Inter-Plan Programs: Federal State Taxes/Surcharges/Fees

In some instances, federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, Highmark will include any such surcharge, tax or other fee in determining your premium.

Non-Participating Providers Outside Pennsylvania

Member Liability Calculation

When covered services are provided outside Pennsylvania by non-participating providers, the amount(s) a member pays for such services will generally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable law. In these situations, the member may be responsible for the difference between the amount that the non-participating provider bills and the payment Highmark will make for the covered services as set forth in this paragraph. Payments for emergency services rendered by non-participating providers will be governed by applicable federal and state law.

Exceptions

In some exception cases, Highmark may pay claims from non-participating providers outside Pennsylvania based on the provider's billed charge. This may occur in situations where a member did not have reasonable access to the participating provider, as determined by Highmark in Highmark's sole and absolute discretion or by applicable law. In other exception cases, Highmark may pay such claims based on the payment Highmark would make if Highmark were paying a non-participating provider for the same covered service inside the Plan Service Area as described elsewhere in this document. This may occur where the Host Blue's corresponding payment would be more than the plan in-service area non-participating provider payment. Highmark may choose to negotiate a payment with such a provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the member may be responsible for the difference between the amount that the non-participating provider bills and payment Highmark will make for the covered services as set forth in this paragraph.

Blue Cross Blue Shield Global Core Program

If members are outside the United States (hereinafter "BlueCard service area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing covered services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when members receive care from providers outside the BlueCard service area, they will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if members contact the Blue Cross Blue Shield Global Core service center ("service center") for assistance, hospitals will not require members to pay for inpatient covered services, except for their cost-sharing amounts. In such cases, a Blue Cross Blue Shield Global Core contracting hospital will submit member claims to the service center to initiate claims processing. However, if the member paid in full at the time of service, the member must submit a claim to obtain reimbursement for covered services. **Members must contact Highmark to obtain precertification or preauthorization for non-emergency inpatient services.**

Outpatient Services
Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for covered services.

Submitting a Blue Cross Blue Shield Global Core Claim
When members pay for covered services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, members should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center address on the form to initiate claims processing. The claim form is available from Highmark, the service center or online at www.bcbsglobalcore.com. If members need assistance with their claim submissions, they should call the service center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

Your Provider Network

The network includes: primary care providers; a wide range of specialists; mental health and substance abuse providers; community and specialty hospitals; and laboratories.

To determine if your physician is in the network, call the Member Service toll-free telephone number on the back of your ID card, or log to www.myhighmark.com.

Getting your care "through the network" also assures you get quality care. All physicians are carefully evaluated before they are accepted into the network. We consider educational background, office procedures and performance history to determine eligibility. Then we monitor care on an ongoing basis through office record reviews and patient satisfaction surveys.

Please note that while you or a family member can use the services, including behavioral health and well-woman care, of any network physician or specialist without a referral and receive the maximum coverage under your benefit program, you are encouraged to select a personal or primary care provider. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal provider can help you select an appropriate specialist and work closely with that specialist when the need arises. In addition, primary care providers or their covering physicians are on call 24/7.

Remember:
It is *your* responsibility to ensure that you receive network care. You may want to double-check any provider recommendations to make sure the doctor or facility is in the network.

How to Obtain Information Regarding Your Physician

To view information regarding your PCP or network specialist, visit your member website at www.myhighmark.com and click on "Find a Doctor" to start your search. Search for the physician, then click on the provider's name to view the following information:

- Name, address, telephone numbers
- Professional qualifications
- Specialty
- Medical school attended
- Residency completion
- Board certification status
- Hospital affiliations

In addition to this information, to obtain more information on network providers, you may call Member Service at the toll-free telephone number on the back of your ID card.

Eligible Providers

Eligible network providers include facilities, general practitioners, internists, obstetricians/gynecologists and a wide range of specialists all licensed where required and performing within the scope of such licensure. Eligible Providers include:

Facility Providers:

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

Professional Providers:

- Acupuncturist;
- Audiologist;
- Behavior specialist;
- Certified registered nurse*;
- Chiropractor;
- Clinical social worker;
- Dentist;
- Dietitian-nutritionist;
- Licensed practical nurse;
- Marriage and family therapist;
- Nurse-midwife;
- Occupational therapist;
- Optometrist;
- Physical therapist;
- Physician;
- Podiatrist;
- Professional counselor;
- Psychologist;
- Registered nurse;
- Respiratory therapist;
- Speech-language pathologist;

- Teacher of hearing impaired.

Ancillary Providers:

- Ambulance service;
- Clinical laboratory;
- Diabetes prevention provider;
- Home infusion therapy provider;
- Independent diagnostic testing facility (IDTF);
- Suite infusion therapy provider;
- Suppliers.

Contracting Suppliers (for the sale or lease of):

- Durable medical equipment;
- Supplies;
- Orthotics;
- Prosthetics.

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

Prescription Drug Providers

You must purchase drugs from a network pharmacy to be eligible for benefits under this program. *No benefits are available if drugs are purchased from a non-network pharmacy.*

- **Network Pharmacy:** Network pharmacies have an arrangement with Highmark to provide prescription drugs to you at an agreed upon price. When you purchase covered drugs from a pharmacy in the network applicable to your program, present your prescription and ID card to the pharmacist. (Prescriptions that the pharmacy receives by phone from your physician or dentist may also be covered.) You should request and retain a receipt for any amounts you have paid if needed for income tax or any other purpose.

If you travel within the United States and need to refill a prescription, call Member Service for help. They can help you find a network pharmacy near the area you are visiting. You also can use the member website to find a pharmacy. Once you have the name and address of the network pharmacy, take the prescription bottle to that pharmacy. The pharmacist will contact your home pharmacy to start the refill process. **Note: Save the new medicine container. This will make it easier to transfer the prescription back to your pharmacy at home.**

- **Mail Order Pharmacy:** Express Scripts® is your program's mail order pharmacy. This option offers savings and convenience for prescriptions you may take on an ongoing basis.

To start using mail order:

1. Ask your doctor to write a prescription for up to a 90-day supply, plus refills for up to one year, if appropriate.

2. Complete the Pharmacy Mail Order Form and Health, Allergy & Medication Questionnaire. You can get these forms by calling Member Service or from your member website. After

logging in, click on the "Prescriptions" tab. Scroll down the page to "Forms to Manage Your Plan" and click on "Mail order form and health questionnaire (PDF)".

3. Send the completed forms and your payment to the address listed on the mail order form. It usually takes about five days to get your prescription after it has been processed.

Your mail order will include directions for ordering refills.

- **Exclusive Pharmacy Provider:** The exclusive pharmacy provider has an agreement, either directly or indirectly, with Highmark pertaining to the payment and exclusive dispensing of selected prescription drugs provided to you. In addition, this pharmacy provider may also, but is not limited to, exclusively dispensing drugs: a. that may require special handling; b. for which special instructions must be provided upon dispensing; or c. are considered to be limited distribution drugs. Please refer to the Covered Services - Prescription Drug Program section for a list of the selected prescription drug categories.

Health Care Management

Medical Management

For your benefits to be paid under your program, services and supplies must be considered medically necessary and appropriate. However, not all medically necessary and appropriate services and supplies are covered under your program.

In addition to in-patient admission and care utilization processes described below, your program may require preauthorization for certain covered services and supplies described in this booklet (for example, advanced imaging services). In general, network providers in the Plan's service area (as defined in this booklet) are responsible for obtaining preauthorization for these covered services and supplies; however, ***you are responsible*** for obtaining preauthorization before you receive covered services or supplies from network providers located outside of the Plan's service area (out-of-area network providers) or out-of-network providers. Therefore, it is important that you confirm Highmark's determination of medical necessity and appropriateness before obtaining covered services or supplies. If these services or supplies are determined not to be medically necessary and appropriate, then you may be responsible for the full amount of the provider's charge.

To determine whether a covered service or supply requires preauthorization, contact Member Services at the telephone number noted on the back of your ID card. This call starts the utilization review process when preauthorization is required. Once you have obtained preauthorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the preauthorization.

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

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

Benefits after Provider Termination from the Network

If at the time you are receiving medical care from a network provider, notice is received from Highmark that: Highmark intends to terminate or has terminated all or portions of the contract of that network provider for reasons other than cause; or the contract of that network provider will not be renewed, or the participation status of that network provider is changing; you may, at your option, continue an active course of treatment with that provider until the treatment is complete or for a period of up to ninety (90) days from the date the notification of the termination or pending termination is received, whichever is shorter. For purposes of this section, active course of treatment means: (i) an ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (ii) an ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring specialized medical treatment to avoid the reasonable possibility of death or permanent harm or complex ongoing care which you are currently receiving, such as chemotherapy, radiation therapy or post-operative visits; (iii) confirmed pregnancy, through the postpartum period; (iv) scheduled nonelective surgery, through postoperative care; (v) an ongoing course of treatment for a health condition that is life-threatening, degenerative, potentially disabling, or congenital and that requires specialized medical care over a prolonged period of time or for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with

anticipated outcomes; or (vi) treatment for a terminal illness. If, however, the network provider is terminated for cause and you continue to seek treatment from that provider, then your plan will not cover payment for health care services provided to you following the date of termination. Any Services authorized under this section will be covered in accordance with the same terms and conditions as applicable to a network provider. Nothing in this section shall require payment of benefits for health care services that are not otherwise provided under the terms and conditions of your plan.

Pre-Admission Certification

When you require inpatient facility care, benefits for covered services will be provided as follows:

In-Area Network Care

When you use a network facility provider for inpatient care for other than an emergency admission, the facility will contact Highmark prior to the proposed admission, or within 48 hours or as soon as reasonably possible after an emergency admission, to obtain precertification for the admission.

You will be held harmless whenever precertification for an admission is not obtained. If the admission is determined not to be medically necessary and appropriate, you will be held harmless, except when Highmark provides prior written notice to you that the admission will not be covered. In such case, you will be financially responsible for charges for that admission.

Out-of-Area Network Care

In the event of a proposed inpatient stay for other than an emergency admission to a network facility provider located out-of-area, the facility will contact Highmark prior to the proposed admission, or within 48 hours or as soon as reasonably possible after an emergency admission, to obtain precertification for the admission. ***You are also responsible*** for contacting Highmark at the toll-free number listed on the back of your ID card to confirm Highmark's determination of medical necessity and appropriateness.

If precertification for a medically necessary and appropriate inpatient admission has been obtained, benefits for covered services will be provided. If a network facility does not contact Highmark for precertification, the inpatient admission will be reviewed for medical necessity and appropriateness. **It is important that you confirm Highmark's determination of medical necessity and appropriateness. If your admission is determined not to be medically necessary and appropriate, you will be responsible for the full amount of the network facility provider's charge**.

If you elect to be admitted after receiving written notification from Highmark that any portion of the proposed admission is not medically necessary and appropriate, you will be financially responsible for all charges associated with that portion of care. In an emergency admission, if you elect to remain hospitalized after receiving written notification from Highmark that the level of care is no longer medically necessary and appropriate, you will be financially responsible for all charges from the date appearing on the written notification.

Out-of-area network providers are not obligated to abide by any determination of medical necessity and appropriateness rendered by Highmark. You may, therefore, receive services which are not medically necessary and appropriate for which you will be solely responsible.

Out-of-Network Care

In the event of a proposed inpatient stay for other than an emergency admission to an out-of-network facility provider, ***you are responsible*** for notifying Highmark prior to your proposed admission or within 48 hours or as soon as reasonably possible after an emergency admission. However, some facility providers will contact Highmark and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Highmark for precertification. If not, you are responsible for contacting Highmark.

If precertification for a medically necessary and appropriate inpatient admission has been obtained, benefits for covered services will be provided. If you do not contact Highmark for precertification as required, the inpatient admission will be reviewed for medical necessity and appropriateness**. If your admission is determined not to be medically necessary and appropriate, you will be responsible for the full amount of the out-of-network facility provider's charge**.

If you elect to be admitted after receiving written notification from Highmark that any portion of the proposed admission is not medically necessary and appropriate, you will be financially responsible for all charges associated with that portion of care. In an emergency admission, if you elect to remain hospitalized after receiving written notification from Highmark that the level of care is no longer medically necessary and appropriate, you will be financially responsible for all charges from the date appearing on the written notification.

Care Utilization Review Process

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

Prospective Review

Prospective review, also known as precertification or pre-service review, begins upon receipt of treatment information. Upon receipt and review of a precertification request from a provider, if Highmark determines that information is missing that is needed in order to make a decision, Highmark will notify the requesting provider that the information is missing. Highmark will identify the missing information with enough specificity so that the provider can submit the information needed to Highmark.

After receiving the request for care, Highmark:

- verifies your eligibility for coverage and availability of benefits;
- reviews diagnosis and plan of treatment;
- assesses whether care is medically necessary and appropriate;
- makes a decision regarding the request, and if approved, authorizes care and assigns an appropriate length of stay for inpatient admissions

In making a decision regarding the precertification request, Highmark will consider medical policies, administrative policies, your relevant medical information, and medical or scientific evidence submitted by your provider.

Concurrent Review

Concurrent review may occur during the course of ongoing treatment and is used to assess the medical necessity and appropriateness of the length of stay and level of care. At the time of the review, Highmark will verify your eligibility for coverage and availability of benefits and assess whether the care is medically necessary and appropriate. In making a decision, Highmark will consider its medical policies, administrative policies, your relevant medical information, and medical or scientific evidence submitted by your provider.

Discharge Planning

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

Outpatient Procedure or Covered Service Precertification

Precertification may be required to determine the medical necessity and appropriateness of certain outpatient procedures or covered services as determined by Highmark prior to the receipt of services.

In-Area Network Care

Network providers are responsible for the precertification of such procedure or covered service and you will not be financially responsible whenever certification for such procedure or covered service is not obtained by the network provider. If the procedure or covered service is deemed not to be medically necessary and appropriate, you will not be financially responsible, except when Highmark provides prior written notice to you that charges for the procedure or covered service will not be covered. In such case, you will be financially responsible for such procedure or covered service.

Out-of-Area Care

Whenever you utilize a network provider located out-of-area, it is your responsibility to first contact Highmark to confirm the medical necessity and appropriateness of such procedure or covered service. If you do not contact Highmark for certification, that procedure or covered service may be reviewed after it is received to determine medical necessity and appropriateness. If the procedure or covered service is determined to be medically necessary and appropriate, benefits will be paid in accordance with the plan. If the procedure or covered service is determined not to be medically necessary and appropriate, no benefits will be provided. In such case you will be financially responsible for the full amount of the charge of the network provider located out-of-area.

Out-of-Network Care

Whenever you utilize an out-of-network provider, it is your responsibility to first contact Highmark to confirm the medical necessity and appropriateness and/or obtain precertification of such procedure or covered service. If you do not contact Highmark for precertification, that procedure or covered service may be reviewed after it is received to determine medical necessity and appropriateness. If the procedure or covered service is determined to be medically necessary and appropriate, benefits will be paid in accordance with the plan. You will be financially responsible for the difference between what is covered by the plan and the full amount of the out-of-network provider's charge. If such procedure or covered service is determined not to be medically necessary and appropriate, no benefits will be provided. In such case, you will be financially responsible for the full amount of the out-of-network provider's charge.

If you have any questions regarding procedures and services subject to precertification or Highmark's precertification determination of a procedure or service for medical necessity and appropriateness of certain outpatient procedures or covered services, you can contact Highmark via the toll-free Member Service telephone number located on the back of your ID card or check the member website.

Retrospective Review

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

Case Management Services

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

Individual Case Management

Case Management is the process by which Highmark, in its sole discretion, identifies alternative treatment modalities commensurate with your diagnosis profile and consults with the patient and attending professional

provider(s). Notwithstanding the foregoing, all decisions regarding the treatment to be provided to you shall remain the responsibility of the treating professional provider(s) and you working with Highmark.

From time to time and as deemed appropriate by Highmark, based on program or clinical criteria, Highmark may also offer care management programs, including Prescription Drug care management programs. These programs are designed to help you in maintaining good health, manage chronic conditions, reduce health risk factors or prevent adverse medical events. Care management programs may include, but are not limited to, disease or other health condition monitoring, consultations with health care providers or other health care professionals participating in the care management program, health coaching, medication management and optimization. In some instances, consultations, remote monitoring equipment, devices and/or durable medical equipment are provided as part of the program. Such items and services will be subject to the same or more favorable member cost-sharing specified for such items and services under this program.

Highmark, in its sole discretion, reserves the right to limit access and/or modify benefit(s), regardless of the disease or condition, when Highmark identifies utilization patterns that could potentially result in harm to you or the public.

You can call and request case management services if you feel you need it by contacting Member Services at the telephone number listed on the back of your ID card.

Health Improvement Services and Support

From time to time, Highmark may directly or indirectly make available to you information and access to non-medical items, services and support programs designed to address underlying social and environmental factors that may impact your health status. Such information, items, services and support programs furnished directly by Highmark will be provided without charge and shall not alter the benefits provided under this program.

Selection of Providers

You have the option of choosing where and from whom to receive covered services. You may utilize a network provider or an out-of-network provider. However, covered services received from a network provider are usually provided at a higher level of benefits than those received from an out-of-network provider and certain non-emergency services may only be covered when rendered by a network provider. Please note that benefits for covered telemedicine services are only provided when such services are rendered by a designated telemedicine provider.

In the event you require non-emergency covered services that are not available within the network, Highmark may refer you to an out-of-network provider. You must notify Highmark prior to receiving a covered service from an out-of-network provider in order for Highmark to facilitate this arrangement. In such cases, services will be covered at the network level so that you will not be responsible for any greater out-of-pocket amount than if services had been rendered by a network provider. You will not be responsible for any difference between Highmark's payment and the out-of-network provider's billed charge.

The Provider Directory lists the health care providers who participate in the network, including their addresses and telephone numbers, and indicates whether a provider is accepting new patients. However, you should always contact the provider to verify whether that provider is still participating in the network and accepting new patients.

Wellness Programs

Highmark offers you the opportunity to participate in programs of health promotion and/or disease prevention. When offered, these programs will be available to you without regard to health status. Whether or not you

decide to participate in such programs will not affect your continued eligibility, benefits, premiums, or cost-sharing obligations.

Prescription Drug Management

Your prescription drug program provides the following provisions which will determine the medical necessity and appropriateness of covered medications and supplies.

Early Refill

Except for the purposes of Medication Synchronization, no coverage is provided for any refill of a covered medication that is dispensed before your predicted use of at least 75% of the days' supply of the previously dispensed covered medication, unless your physician obtains precertification from Highmark for an earlier refill.

Unexpected Event

If your prescription is lost or stolen due to an event such as a fire or theft, you may be able to get an early refill. Call Member Service at the number on your member ID card for help. You will need a copy of the report from the fire department, police department or other agency.

Please note: The early refill authorization does not apply to events that can be controlled, such as spilling or losing the medicine.

Traveling Abroad

If you will be out of the country when it is time to refill your prescription, call Member Service for help. Be sure to have your member ID card and your prescription information. Please allow at least five business days to complete the request.

Individual Case Management

From time to time, Highmark may offer you the opportunity to participate in Prescription Drug care management programs. These programs are designed to help you maintain good health, manage chronic conditions or special health care needs and reduce risk factors. Such care management programs may include the provision of devices or durable medical equipment at no additional cost to you. Participation in these programs is voluntary and Highmark reserves the right to modify or discontinue any such program at any time.

Highmark, in its sole discretion, reserves the right to limit access and/or modify benefit(s), regardless of the disease or condition, when Highmark identifies utilization patterns that could potentially result in harm to you or the public.

Quantity Level Limits

Quantity level limits may be imposed on certain prescription drugs by Highmark. Such limits are based on the manufacturer’s recommended daily dosage or as determined by Highmark. Quantity level limits control the quantity covered each time a new prescription order or refill is dispensed for selected prescription drugs. Each time a prescription order or refill is dispensed, the pharmacy provider may limit the amount dispensed.

Quantity Level Limits for Initial Prescription Orders

Additional quantity level limits may be imposed for your initial prescription order for certain covered medications. In such instances, the quantity dispensed will be reduced to the level necessary to establish that you can tolerate the covered medication. Consequently, the applicable cost-sharing amount will be adjusted according to the quantity level dispensed for the initial prescription order.

Managed Prescription Drug Coverage

A prescription order or refill which may exceed the manufacturer's recommended dosage over a specified period of time may be denied by Highmark when presented to the pharmacy provider. Highmark may contact the prescribing physician to determine if the covered medication is medically necessary and appropriate. The covered medication will be dispensed if it is determined by Highmark to be medically necessary and appropriate.

Preauthorization

Certain prescription drugs may require preauthorization to ensure the medical necessity and appropriateness of the prescription order. The prescribing physician must obtain authorization from Highmark prior to prescribing certain covered medications. The specific drugs or drug classifications which require preauthorization may be obtained by calling the toll-free Member Service telephone number appearing on your ID card.

Step Therapy Program

Coverage includes drugs dispensed on a "stepped basis", referred to as the Step Therapy Program. Within selected drug categories, benefits are only provided for specific prescription drugs when one or more alternative drugs prove ineffective or intolerable and the following criteria are met:

- You have used alternative drugs within the same therapeutic class/category as the specified prescription drug.
- You have used the alternative drugs for a length of time necessary to constitute an adequate trial.
- The specified prescription drug is being used for an FDA approved indication.

If these criteria are met, the participating pharmacy provider will dispense the specified prescription drug to you. You shall be responsible for any cost-sharing amounts and will be subject to any quantity limit requirements or other limitations described herein. When these criteria are not met, your treating physician may submit a request for authorization to dispense a specified prescription drug to you for Highmark's consideration.

The Step Therapy Program will not apply to covered medications prescribed for the treatment of stage 4 advanced metastatic cancer if: (1) the specified prescription drug is approved by the FDA for this indication and (2) the specified prescription drug is consistent with the best clinical practices for the treatment of stage 4 advanced metastatic cancer or a severe adverse health condition experienced as a result of stage 4 advanced metastatic cancer.

This authorization is not applicable to those brand drugs which are subject to the requirements described above in the Preauthorization subsection.

Market Watch Prescription Drug Exceptions

Coverage is not provided for Market Watch Prescription Drugs, unless an exception has been granted by Highmark. You, your authorized representative or your prescribing physician may request coverage of the Market Watch Prescription Drug. Highmark will review the exception request and notify you of its determination within two business days of the request, not to exceed seventy-two hours.

If you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a Market Watch Prescription Drug appearing on the Market Watch Program List, your, your authorized representative, or your prescribing physician may request an expedited review based on exigent circumstances. In the case of such an exigent circumstance, Highmark will notify you, your authorized representative, or your prescribing physician of its coverage determination with twenty-four hours of receiving sufficient information to begin its review of the request.

In the event that Highmark denies a request for exception, you, your authorized representative, or your prescribing physician may request that the exception request and subsequent denial of the request be reviewed by an independent review organization. Highmark must make its determination on the external exception request and notify you, your authorized representative or your prescribing physician of its coverage determination no later than seventy-two hours following its receipt of sufficient information to begin its review or the request, or if the request was an expedited, exception request, not later than twenty-four hours following its receipt of sufficient information to begin its review of the request.

If Highmark grants the request for an exception, the prescription drug will be covered for the duration of the prescription, or if pursuant to an expedited exception request, for the duration of the exigency. Coverage will be provided as described herein.

Prescription Drug Exceptions

Coverage is not provided for prescription drugs and over-the-counter drugs not appearing on the formulary unless an exception has been granted by the Plan. The member, the member's authorized representative or the member's prescribing physician may request coverage of a prescription drug not appearing on the formulary. The Plan will review the exception request and notify the member of its determination within two (2) business days but not more than seventy-two (72) hours of receiving sufficient information to begin its review of the request.

Contraceptive Exceptions

Your prescribing physician may request coverage of a non-formulary contraceptive service, including contraceptive prescription drugs, contraceptive devices, implants and injections, for the purposes of birth control, through your plan's contraceptive exception process. If the plan grants the request for an exception, the non-formulary contraceptive service will be covered for the calendar year. Coverage will be provided in accordance with the Preventive Care Services section of the Summary of Benefits.

Precertification, Preauthorization and Pre-Service Claims Review Processes

The precertification, preauthorization and pre-service claims review processes information described below applies to both medical and prescription drug management. If you have any questions regarding which covered services require precertification, preauthorization or pre-service claims review, please call the toll-free Member Service telephone number located on the back of your ID card.

Authorized Representatives

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

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

You will receive written notice of any decision on a request for precertification or other pre-service claim, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed fifteen (15) days from the date Highmark receives the claim unless otherwise extended by Highmark for reasons beyond its control where permitted by law.

If Highmark determines that sufficient information was not provided for Highmark to make a decision, your physician will be notified of additional facts or documents needed so that the review can be completed within the time frame referenced above.

Decisions Involving Urgent Care Claims

If your request involves an urgent care claim, Highmark will make a decision on your request as soon as possible taking into account the medical exigencies involved. You will receive notice of the decision that has been made on your urgent care claim no later than seventy-two (72) hours following receipt of the claim.

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

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

If Highmark determines in connection with an urgent care claim that sufficient information was not provided for Highmark to make a decision, your physician will be notified of additional facts or documents needed so that the review can be completed within the time frames referenced above.

Decisions Involving Requests for Precertification Related to a Prescription Drug Request

If the request is urgent, Highmark will make a decision on the request within twenty-four (24) hours. If the request is not urgent, Highmark will make a decision on the request within two (2) business days but not more than seventy-two (72) hours of receiving the request.

If Highmark determines that sufficient information was not provided for Highmark to make a decision, your physician will be notified of additional facts or documents needed so that the review can be completed within the time frames referenced above.

Notices of Determination Involving Precertification Requests Including Prescription Drug Requests and Other Pre-Service Claims

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

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

General Information

Who is Eligible for Coverage

*The following eligibility information applies **only** if your group provides coverage for dependents. Your group administrator can determine if you have dependent coverage.*

The effective date for an individual member is the date specified by the group in writing or other documented communication received by Highmark, unless an earlier effective date is required by law.

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

You may enroll your:

- Spouse under a legally valid existing marriage
- Children under 26 years of age, unless otherwise extended pursuant to applicable state or federal law, including:

    - Newborn children
    - Stepchildren
    - Children legally placed for adoption
    - Legally adopted children and children for whom the employee or the employee's spouse is the child’s legal guardian
    - Children awarded coverage pursuant to an order of court

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

- Unmarried children over age 26 who are not able to support themselves due to intellectual disability, physical disability, mental illness or developmental disability that started before age 26. Coverage automatically terminates and all benefits hereunder cease, except as otherwise indicated, on the day following the date on which the disability ceases, whether or not notice to terminate is received by Highmark.

NOTE: To the extent mandated by the requirements of Pennsylvania Act 83 of 2005, eligibility will be continued past the limiting age for children who are enrolled as dependents under their parent’s coverage at the time they are called or ordered into active military duty. They must be a member of the Pennsylvania National Guard or any reserve component of the armed forces of the United States, who is called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days, or be a member of the Pennsylvania National Guard ordered to active state duty for a period of 30 or more consecutive days. If they become a full-time student for the first term or semester starting 60 or more days after their release from active duty, they shall be eligible for coverage as a dependent past the limiting age for a period equal to the duration of their service on active duty or active state duty.

For the purposes of this note, full-time student shall mean a dependent who is enrolled in, and regularly attending, an accredited school, college or university, or a licensed technical or specialized school for 15 or more credit hours per semester, or, if less than 15 credit hours per semester, the number of credit hours deemed by the school to constitute full-time student status.

A dependent child who takes a medically necessary leave of absence from school, or who changes enrollment status (such as changing from full-time to part-time) due to a serious illness or injury may continue coverage for one year from the first day of the medically necessary leave of absence or other change in enrollment, or until the date coverage would otherwise terminate under the terms of this program, whichever is earlier. Highmark may require certification from the dependent child's treating physician in order to continue such coverage.

*The following Domestic Partner provision applies **only** if your group provides coverage for this benefit. Your group administrator can determine if you are eligible for this coverage.*

- A domestic partner** shall be considered for eligibility as long as a domestic partnership (a voluntary relationship between two domestic partners) exists with you. In addition, the children of the domestic partner shall be considered for eligibility as if they were your children as long as the domestic partnership exists.

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

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

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

Changes in Membership Status

In order for there to be consistent coverage for you and your dependents, you must keep your Employee Benefit Department timely informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage. Please consult with your Employee Benefit Department regarding all applicable deadlines for enrollment.

Medicare

If you or a dependent are entitled to Medicare (either due to age or disability) benefits your program will not duplicate payments or benefits provided under Medicare. However, your program may supplement the Medicare benefits, including the deductible and coinsurance not covered by Medicare, provided the services are eligible under your group's program. Contact your plan administrator for specific details.

Covered Active Employees Age 65 or Over

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

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

- or -

Non-Covered Active Employees Age 65 or Over

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

Spouses Age 65 or Over of Active Employees

If you are actively employed in a group with twenty (20) or more employees, your spouse has the same choices for benefit coverage as indicated above for the employee age sixty-five (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 sixty-five (65). If you elect to be covered under the program, you may wait to enroll for Medicare Part B. You will be able to enroll for Part B later during special enrollment periods without penalty.

Leave of Absence or Layoff

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

Continuation of Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that covers group health plans sponsored by an employer (private sector or state/local government) that employed at least twenty (20) employees on more than fifty percent (50%) of its typical business days in the previous calendar year. Employers that are subject to COBRA must temporarily extend their health care coverage to certain categories of employees and their covered dependents when, due to certain "qualifying events," they are no longer eligible for group coverage.

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

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 may be able to enroll in an individual conversion program available from Highmark. Also, conversion is available to anyone who has elected continued coverage through your employer's program and the term of that coverage has expired. The coverage may be different from the coverage provided under your employer's program. If your coverage through your employer is discontinued for any reason, except as specified below, you may be able to 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.

Direct payment for coverage under the individual conversion program must be made from the date you cease to be a member under your employer's program.

Written application to enroll in an individual conversion program must be made no later than:

1. either thirty-one days after termination of membership under your employer's program; or

2. fifteen days after you have been given written notice of the existence of ability to enroll in an individual conversion program;

3. but in no event later than ninety days after termination of coverage through your employer's program.

*The following Domestic Partner provision applies **only** if your group provides coverage for this benefit. Your group administrator can determine if you are eligible for this coverage.*

Also, if a Domestic Partner ceases to be a member under this Contract, the individual and eligible dependents are eligible for coverage under a direct pay conversion agreement available from Highmark. The former Domestic Partner and any of the former Domestic Partner's previously covered children are entitled to direct pay coverage of the type for which the former Domestic Partner and children are then qualified at the rate then in effect. The coverage may be different from the coverage provided under this program.

Termination of Your Coverage Under the Group Contract

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

Benefits after Termination of Coverage

If you are an inpatient on the day your coverage terminates, facility provider benefits incurred for inpatient covered services will be continued until the maximum amount of benefits has been paid or until the inpatient stay ends, whichever occurs first.

Coordination of Benefits

Most health care programs, including your health care 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 ensure that your covered expenses will be paid, while preventing duplicate benefit payments.

Here is how the coordination of benefits provision works:

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your 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 whose parents are married or are living together, whether or not they have ever been married, the contract which covers the person as a dependent of the parent whose birthday (month and day) falls earliest in the calendar year will be primary. 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 divorced or separated or not living together, whether or not they have ever been married, the following applies:

    - if a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage, that contract is the primary program;
    - if a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provision for married or living together above shall determine the order of benefits;
    - if a court decree states the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provision for married or living together above shall determine the order of benefits; or
    - if there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

        i. the contract covering the custodial parent;

        ii. the contract covering the spouse of custodial parent;

        iii. the contract covering the non-custodial parent; and then

        iv. the contract covering the spouse of the non-custodial parent

- If none of the above circumstances applies, the coverage you have had for the longest time pays first, provided that:

    - 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, plans do not agree on the order of benefits, then this rule is ignored.

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

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

Force Majeure

No failure, delay or default in performance of any obligation of Highmark shall constitute an event of default or breach to the extent that such failure to perform, delay or default arises out of a cause, existing or future, that is beyond the reasonable control and not the result of the negligence of Highmark. Such events include, by way of illustration and not limitation, Acts of God, war (declared or undeclared), government regulation, acts or inaction of governmental authority, civil or military authority, unforeseen disruptions caused by suppliers, subcontractors, vendors or carriers, terrorism, disaster, strikes, civil disorder, curtailment of transportation facilities, fire, floods, blizzards, epidemics, pandemics, viral or communicable disease outbreaks, National Emergency, quarantines, disruption of the labor force and/or any other cause which is beyond the reasonable

control of Highmark (hereinafter a "Force Majeure Event"), that makes it impossible, illegal or commercially impracticable for Highmark to perform its obligations in whole or in part.

Upon the occurrence of a Force Majeure Event, Highmark shall take action to minimize the consequences of the Force Majeure Event. If Highmark relies on any of the foregoing as an excuse for failure, default or delay in performance, it shall give prompt written notice to the group of the facts that constitute such Force Majeure Event, when it arose and when it is expected to cease.

Subrogation

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

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

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

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

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

A Recognized Identification Card

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

If your card is lost or stolen, please contact Member Service immediately. You can also request additional or replacement cards online by logging onto the website located on the back of your member ID card. It's illegal to lend your ID card to anyone who is not eligible to use your benefits.

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

- Member name
- Member Identification number
- Group number
- Copayment for physician office visits and emergency room visits (if applicable)
- Plan deductible (if applicable)
- Out-of-pocket limit (if applicable)
- Total maximum out-of-pocket (if applicable)
- Pharmacy network logo (when applicable)
- Member Service toll-free number (on back of card)
- Member website (on back of card)
- Toll-free telephone number for out-of-network facility admissions (on back of card)
- Suitcase symbol

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

How to File a Claim

Notice of Claim and Proof of Loss

(Applies to Post-service Claims Only)

Network providers have entered into an agreement with Highmark pertaining to the payment for covered services that they provide to you. When you receive covered services from a network provider, it is the responsibility of the network provider to submit its claim to Highmark in accordance with the terms of its participation agreement. Should the network provider fail to submit its claim in a timely manner or otherwise satisfy Highmark's requirements as they relate to the filing of claims, you will not be liable, and the network provider shall hold you harmless relative to payment of the covered services that you received.

When covered services are received from other than a network provider, you are responsible for submitting the claim to Highmark. In such instances, you must submit the claim in accordance with the following procedures:

Notice of Claim
Highmark will not be liable for any claims unless proper notice is furnished to Highmark that you have received covered services. Written notice of a claim must be given to Highmark within twenty (20) days or as soon as reasonably possible after you have received covered services. Notice given by you or on your behalf to Highmark that includes information sufficient to identify you shall constitute sufficient notice of a claim to Highmark. You can give notice to Highmark by writing to the Member Service Department. The address of the Member Service Department can be found on your ID card. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Claim Forms
Proof of loss for covered services must be submitted to Highmark on the appropriate claim form. Highmark, upon receipt of a notice of a claim will, within fifteen (15) days following the date a notice of a claim is received, furnish you with claim forms for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of such notice, you shall be deemed to have complied with the requirements of this subsection as to filing a proof of loss upon submitting, within the time fixed in this subsection for filing proofs of loss, itemized bills for covered services as described below. The proof of loss may be submitted to Highmark at the address appearing on your ID card.

Proof of Loss
Claims cannot be paid until a written proof of loss is submitted to Highmark. Written proof of loss must be provided to Highmark within fifteen (15) months after the date of such loss. Proof of loss must include all data necessary for Highmark to determine benefits. Failure to submit a proof of loss to Highmark within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will Highmark be required to accept a proof of loss later than 1 year from the time proof is otherwise required.

Submission of Claim Forms
The completed claim form, with all itemized bills attached, must be forwarded to Highmark at the address appearing on your ID Card in order to satisfy the requirement of submitting a written proof of loss and to receive payment for covered services.

To avoid delay in handling claims that you submit, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing:

Person or organization providing the service, covered medication or supply

Type of service, covered medication or supply
Date of service or supply
Date covered medication was dispensed
Amount charged
Prescription number
Name of patient

In addition to the above, private duty nursing bills must contain the shifts worked, the charge per day, the professional status of the nurse, and the signature of the professional provider prescribing the service. Professional provider bills must show specific treatment dates. Drug and medicine bills must show prescription number, date of purchase, and the patient's name. Your attending professional provider must include a signature on all bills as certification that services have been prescribed, except for doctor bills, hospital bills, or prescription drug bills. (Some bills requiring a signature of the professional provider include ambulance, prosthetic devices, rental of durable medical equipment, private duty nursing, etc.). Itemized bills cannot be returned.

A request for payment of a claim will not be reviewed and no payment will be made unless all of the information and evidence of payment required on the claim form has been submitted in the manner described above. Highmark reserves the right to require additional information and documents as needed to support a claim that a covered service has been rendered.

Notice of Highmark's claim determination will be issued within a reasonable period of time not to exceed thirty (30) days following the receipt of a proper proof of loss. This period of time may be extended one (1) time by Highmark for an additional period of time not to exceed fifteen (15) days provided the extension is due to matters outside the control of Highmark and a written explanation for the delay is provided to you.

In the event that Highmark renders an adverse decision on the claim, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement describing your right to file an appeal.

Time of Payment of Claims
Claim payments for benefits payable under this program will be processed immediately upon receipt of a proper proof of loss.

Authorized Representative
Nothing in this section shall preclude your duly authorized representative from filing or otherwise pursuing a claim on behalf of you. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

Limitation on Legal Actions

After a notice of claim has been given, you may not take legal action for sixty days. You may not take legal action later than three years after the expiration of the time within which a notice of claim is required.

Physical Examinations and Autopsy

Highmark, at its own expense, shall have the right and opportunity to examine the person of the member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Your Explanation of Benefits Statement

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

- The provider's actual charge
- The allowable amount as determined by Highmark
- The copayment; deductible and coinsurance amounts, if any, that you are required to pay
- Total benefits payable
- The total amount you owe

In those instances when you are not required to submit a claim because, for example, the network provider will submit the bill as a claim for payment under its contract with Highmark, you will receive an EOB only when you are required to pay amounts other than your required copayment.

You can get your EOBs online. Simply register on your member website. Your EOB can also be mailed to you. If you do not owe a payment to the provider, you may not receive an EOB.

How to Voice a Complaint

In the event that you are dissatisfied with any aspect of your health care benefits or you have an objection regarding participating health care providers, coverage, operations or management policies, please contact Highmark via the toll-free Member Service telephone number located on the back of your ID card or by mail at the address listed below. Please include your identification and group numbers as displayed on your ID card.

Highmark
P.O. Box 226
Pittsburgh, PA 15222

A representative will review, research and respond to your inquiry as quickly as possible.

If the informal dissatisfaction process is not successful and does not meet your needs, you have the right to have your objection reviewed by our Member Grievance and Appeals Department. For details about how this process works, please refer to the Appeal Procedure section of this booklet or call Member Service at the number on your member ID card.

Fraud or Provider Abuse

If you think that a provider is committing fraud, please let us know. Examples of fraud include: Submitting claims for services that you did not get; Adding extra charges for services that you did not get; Giving you treatment for services you did not need. Please call the local state toll-free Fraud Hotline.

Additional Information on How to File a Claim

Member Inquiries

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

Filing Benefit Claims

- ***Authorized Representatives***
  You have the right to designate an authorized representative to file or pursue a request for reimbursement or other post-service claim on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

- ***Requests for Precertification and Other Pre-Service Claims***
  For a description of how to file a request for precertification or other pre-service claim, see the Precertification, Preauthorization and Pre-Service Claims Review Processes subsection in the Health Care Management section of this benefit booklet.

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

Determinations on Benefit Claims

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

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

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

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

Appeal Procedure

Your benefit program maintains an appeal process involving one level of review. At any time during the appeal process, you may choose to designate a representative to participate in the appeal process on your behalf. You or your representative shall notify Highmark in writing of the designation.

For purposes of the appeal process, "you" includes designees, legal representatives and, in the case of a minor, parent(s) entitled or authorized to act on your behalf.

Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by Highmark shall, in the case of an urgent care claim, permit your physician or other provider of health care with knowledge of your medical condition to act as your representative.

At any time during the appeal process, you may contact the Member Service Department at the toll-free telephone number listed on your ID card to inquire about the filing or status of your appeal.

If you receive notification that a claim has been denied by Highmark, in whole or in part, or is not subject to legal prohibitions against balance billing, you may appeal the decision. Your appeal must be submitted not later than one hundred-eighty (180) days from the date you received notice from Highmark of the adverse benefit determination.

Upon request to Highmark, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit or present additional evidence or testimony, which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of your appeal.

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

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

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal.

Your appeal will be promptly investigated and Highmark will provide you with written notification of its decision within the following time frames:

- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed thirty (30) days following receipt of the appeal;

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

- When the appeal involves a post-service claim, within a reasonable period of time not to exceed sixty (60) days following receipt of the appeal.

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

External Review

You have four (4) months from the date you receive notice of a final Highmark adverse benefit determination to file a request for an external review with Highmark.

To be eligible for external review, the decision of Highmark must have involved (i) a claim that was denied involving medical judgment, including, application of Highmark's requirements as to medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered service or a determination that the treatment is experimental or investigational; (ii) a claim that Highmark has concluded is not subject to legal prohibitions against balance billing; or (iii) a determination made by your plan administrator to rescind your coverage.

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

Preliminary Review

Highmark will conduct a preliminary review of your external review request within five (5) business days following the date on which Highmark receives the request. Highmark's preliminary review will determine whether:

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

Highmark will notify you of the results of its preliminary review within one (1) business day following its completion of the review. This will include our reasons regarding the ineligibility of your request. If your request is not complete, Highmark’s notification will describe the information or materials needed to make the request complete. You will then have the balance of the four (4) month filing period or, if later, forty eight (48) hours from receipt of the notice, to perfect your request for external review; whichever is later.

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

Referral to an Independent Review Organization (IRO)

Highmark will, randomly or by rotation, select an IRO to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Within five (5) business days thereafter, Highmark will provide the IRO with documents and information we considered when making our final adverse benefit determination. The IRO may

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

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

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

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

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

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

Expedited External Review (Applies to Urgent Care Claims Only)

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

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

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

Referral to an Independent Review Organization (IRO) (Applies to Urgent Care Claims Only)

Highmark will, randomly or by rotation, select an IRO to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Thereafter, Highmark will immediately provide the IRO with documents and

information we considered when making our final adverse benefit determination via the most expeditious method (e.g., electronic, facsimile, etc.).

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

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

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

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

Member Service

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

As a Highmark member, you have access to a wide range of readily available health education tools and support services.

Blues On Call℠ - 24/7 Health Decision Support

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

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

Help with common illnesses, injuries and questions

Health coaches can address any health topic that concerns you:

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

You do not have to be ill to talk to a health coach. Call to learn about programs and other resources available to help you manage:

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

Help with chronic conditions

If you have diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease or coronary artery disease, you need to manage your condition every day in order to stay healthy and avoid hospital stays. That means keeping track of medications, tests, doctor appointments and your diet. Your Blues On Call health coach can help you work more closely with your doctor and get more involved in taking good care of yourself.

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

Highmark Website

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

Go to www.myhighmark.com. Then click on the Members tab and log in to your home page to take advantage of all kinds of programs and resources to help you understand your health status, including an online wellness profile. Then, take steps toward real health improvement.

Baby Blueprints®

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

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

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

By enrolling in this free program, you will have access to online information on all aspects of pregnancy and childbirth. Baby Blueprints will also provide you with personal support from a women’s health specialist available to you throughout your pregnancy.

Easy Enrollment

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

Member Rights and Responsibilities

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

You have the right to:

1. Receive information about your group health plan, its practitioners and providers, and your rights and responsibilities.

2. Be treated with respect and recognition of your dignity and right to privacy.

3. Participate with practitioners in decision-making regarding your health care. This includes the right to be informed of your diagnosis and treatment plan in terms that you understand and participate in decisions about your care.

4. Have a candid discussion of appropriate and/or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Highmark does not restrict the information shared between practitioners and patients and has policies in place, directing practitioners to openly communicate information with their patients regarding all treatment options regardless of benefit coverage.

5. Voice a complaint or file an appeal about Highmark or the care provided and receive a reply within a reasonable period of time.

6. Make recommendations regarding the Highmark Members' Rights and Responsibilities policies.

You have a responsibility to:

1. Supply to the extent possible, information that the organization needs in order to make care available to you, and that its practitioners and providers need in order to care for you.

2. Follow the plans and instructions for care that you have agreed on with your practitioners.

3. Communicate openly with the physician you choose. Ask questions and make sure you understand the explanations and instructions you are given and participate in developing mutually agreed upon treatment goals. Develop a relationship with your doctor based on trust and cooperation.

How We Protect Your Right to Confidentiality

We have established policies and procedures to protect the privacy of our members' protected health information ("PHI") in all forms, including PHI given verbally, from unauthorized or improper use. Some of the ways we protect your privacy include not discussing PHI outside of our offices, e.g., in hallways, elevators, as well as verifying your identity before we discuss PHI with you over the phone. As permitted by law, we may use or disclose protected health information for treatment, payment and health care operations, such as: claims management, routine audits, coordination of care, quality assessment and measurement, case management, utilization review, performance measurement, customer service, credentialing, medical review and underwriting. With the use of measurement data, we are able to manage members' health care needs, even targeting certain individuals for quality improvement programs, such as health, wellness and disease management programs.

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

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

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

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

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

Terms You Should Know

*The following terms apply **only** if your group provides coverage for this benefit. Depending on your health care program not all terms may apply. Your group administrator can determine if you are eligible for this coverage. Please refer to the Summary of Benefits section of this booklet.*

Acupuncturist - A licensed acupuncturist performing within the scope of such licensure. Where there is no licensure law, the acupuncturist must be certified by the appropriate professional body.

Affordable Care Act (ACA) - The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) and its implementing regulations.

Ambulance Service - An ancillary provider licensed by the state which, for compensation from its patients, provides local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured. Ambulance service includes an emergency medical services (EMS) agency licensed by the state.

Ambulatory Surgical Facility - A facility provider, with an organized staff of physicians, which is licensed as required by the state and which, for compensation from its patients:

a. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;

b. provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility;

c. does not provide inpatient accommodations; and

d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a professional provider.

Ancillary Provider - A person or entity licensed where required and performing services within the scope of such licensure.

Ambulance Service
Clinical Laboratory
Diabetes Prevention Provider
Home Infusion Therapy Provider
Independent Diagnostic Testing Facility (IDTF)
Suite Infusion Therapy Provider
Suppliers

Anesthesia - The administration of a regional or rectal anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, induce an altered state, loss of sensation or loss of consciousness.

Applied Behavioral Analysis - The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Approved Clinical Trial - A Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that has been federally funded, authorized or approved by one of the following:

a. The National Institutes of Health (NIH), including the National Cancer Institute (NCI);

b. The United States Food and Drug Administration (FDA) in the form of an investigational new drug (IND) exemption;

c. The United States Department of Defense (DOD);

d. The United States Department of Veterans Affairs (VA);

e. The Centers for Disease Control and Prevention (CDC);

f. The Agency for Healthcare Research and Quality (AHRQ);

g. The Centers for Medicare and Medicaid Services (CMS);

h. The Department of Energy; or

i. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support.

Highmark may, at its discretion, approve other clinical trials that do not satisfy the above criteria.

Autism Service Provider - A professional provider or a facility provider licensed or certified, where required, and performing within the scope of such license or certification providing treatment for autism spectrum disorders, pursuant to a treatment plan, as provided herein.

Autism Spectrum Disorders - Any disorder defined as an autism spectrum disorder by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor.

Bariatric Surgery - An operation on the stomach and/or intestines intended to help promote weight loss including, but not limited to, vertical banded gastroplasty, gastric stapling, laparoscopic adjustable gastric banding, mini-gastric bypass, gastric bypass with Roux-en-Y, biliopancreatic diversion, biliopancreatic diversion with duodenal switch, long-limb gastric bypass, intestinal gastric bypass, or any other surgical procedure designed to restrict an individual's ability to assimilate food.

Behavior Specialist - An individual licensed or certified, where required, and performing within the scope of such licensure or certification, who designs, implements or evaluates a behavior modification intervention component of a treatment plan for the treatment of autism spectrum disorders, including those based on applied behavioral analysis, to produce socially significant improvements in human behavior or to prevent loss of attained skill or function through skill acquisition and the reduction of problematic behavior.

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

Birthing Facility - A facility provider licensed by the state which, for compensation from its patients, is primarily organized and staffed to provide maternity care and is under the supervision of a nurse-midwife.

Blues On Call (Health Education and Support Program) - A program administered by the designated agent through which you receive health education and support services, including assistance in the self-management of certain health conditions.

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

Brand Drug - A recognized trade name prescription drug product, usually either the innovator product for new drugs still under patent protection or a more expensive product marketed under a brand name for multi-source drugs and noted as such in the pharmacy database used by Highmark.

Certified Registered Nurse - A certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any registered professional nurses employed by a health care facility, as defined in the Pennsylvania Health Care Facilities Act or by an anesthesiology group.

Chemotherapy Medication - A medication prescribed to kill or slow the growth of cancerous cells.

Claim - A request for precertification, preauthorization or prior approval of a covered service or for the payment or reimbursement of the charges or costs associated with a covered service. Claims include:

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

For purposes of the claim determination and appeal procedure provisions, whether a claim or an appeal of a denied claim involves a pre-service claim, an urgent care claim or a post-service claim will be determine at the time that the claim or appeal is filed with Highmark in accordance with its procedures for filing claims and appeals.

Clinical Laboratory - A medical laboratory licensed where required, performing within the scope of such licensure, and is not affiliated or associated with a hospital or physician.

Clinical Social Worker - A licensed clinical social worker performing within the scope of such licensure. Where there is no licensure law, the clinical social worker must be certified by the appropriate professional body.

Coinsurance - The percentage of the plan allowance for covered services that is your responsibility. The remaining percentage is the responsibility of Highmark subject to the provisions of this program.

Colorectal Cancer Screenings - Tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer. Colorectal cancer screenings are covered to the extent specified herein. Please refer to the Summary of Benefits section of this booklet.

Copayment - A specified dollar amount of eligible expenses which you are required to pay for a specified covered service and which will be deducted from the plan allowance before the determination of the benefits payable under this program is made.

Covered Maintenance Prescription Drug – A maintenance prescription drug, which your program is contractually obligated to pay or provide as a benefit to you under this program when dispensed by a participating maintenance pharmacy. Any prescription order for not less than a 1-day supply and not more than a 90-day supply of a legend drug shall be considered a covered maintenance prescription drug, unless otherwise expressly excluded.

Covered Medications - Prescription drugs ordered by a professional provider by means of a valid prescription order, which Highmark is contractually obligated to pay or provide as a benefit to you.

Covered Service - A service or supply specified by your program which is eligible for payment when rendered by a provider.

Custodial Care - Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting the activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Multiple non-skilled nursing services/non-skilled rehabilitation services in the aggregate do not constitute skilled nursing services/skilled rehabilitation services. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparing special diets and supervising the administration of medications not requiring skilled nursing services/skilled rehabilitation services provided by trained and licensed medical personnel.

Deductible - A specified dollar amount of liability for covered services that must be incurred by you before your program will assume any liability for all or part of the remaining covered services.

Dentist - A person who is a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.), licensed where required and performing services within the scope of such licensure.

Dependent - A member other than the employee as specified herein.

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

Designated Mail-Order Pharmacy Provider - A participating pharmacy provider which has been selected by Highmark as a "Designated Mail-Order Pharmacy Provider" and has entered into an agreement, either directly or indirectly, with Highmark to provide covered prescription drugs to members at a contractually agreed upon price.

Designated Telemedicine Provider - A Professional Provider, licensed where required and performing within the scope of such licensure, who has an agreement with a vendor that has contracted with Highmark to provide medical services, including telemedicine services.

Detoxification Services (Withdrawal Management Services) - Inpatient and outpatient services for the treatment of withdrawal from alcohol or drugs. Inpatient services must include twenty-four hour nursing care and physician oversight.

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

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

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

Diagnostic Service - A testing procedure ordered by a professional provider because of specific symptoms to determine a definite condition or disease.

Dietitian-Nutritionist - A licensed dietitian-nutritionist performing within the scope of such licensure. Where there is no licensure law, the dietitian-nutritionist must be certified by the appropriate professional body.

Domestic Partner - (Please check with your Group Administrator to see if the following is applicable.) A member of a domestic partnership consisting of two (2) partners, each of whom has registered with a domestic partner registry in effect in the municipality/governmental entity within which the domestic partner currently resides, or who meets the definition of a domestic partner as defined by the state or local government where the individual currently resides or meets all of the following:

- Is unmarried, at least eighteen (18) years of age, resides with the other partner and intend to continue to reside with the other partner for an indefinite period of time;
- Is not related to the other party by adoption or blood;
- Is the sole domestic partner of the other partner and has been a member of this domestic partnership for the last six (6) months;
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and
- Meets (or agrees to meet) the requirements of any applicable federal, state or local laws or ordinances for domestic partnerships which are currently enacted, or which may be enacted in the future.

Domestic Partnership - A voluntary relationship between two (2) domestic partners.

Durable Medical Equipment - Items which can withstand repeated use; are primarily and customarily used to serve a productive medical purpose; are generally not useful to a person in the absence of illness, injury or disease; are appropriate for use in the home and do not serve as comfort or convenience items.

Effective Date - The date when your coverage begins.

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

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

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

Employee - An individual who meets the eligibility requirements specified herein.

Exclusions - Services, supplies or charges that are not covered by your program.

Exclusive Pharmacy Provider - The exclusive pharmacy provider has an agreement, either directly or indirectly, with Highmark pertaining to the payment and exclusive dispensing of selected prescription provided to you. In addition, this pharmacy provider may also, but is not limited to, exclusively dispense drugs: a. that may require special handling; b. for which special instructions must be provided upon dispensing c. that are subject to a manufacturer's limited distribution plan; or d. are subject to a competitive price bidding process between Pharmacy Providers.

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

Facility Provider - An entity which is licensed, where required, to render covered services. Facility providers include:

Ambulatory Surgical Facility
Birthing Facility
Freestanding Dialysis Facility
Freestanding Nuclear Magnetic Resonance Facility/Magnetic Resonance Imaging Facility
Home Health Care Agency
Outpatient Psychiatric Facility
Outpatient Substance Abuse Treatment Facility
Pharmacy Provider
Psychiatric Hospital
Rehabilitation Hospital
Residential Treatment Facility
Skilled Nursing Facility

Hospice
Hospital
Outpatient Physical Rehabilitation Facility
State-Owned Psychiatric Hospital
Substance Abuse Treatment Facility

Family Counseling - Counseling with family members in the assessment of the patient's diagnosis and treatment. Such counseling may assist family members to gain insight into the patient's illness and serve as an adjunct of the treatment regimen. Nevertheless, the services must primarily relate to the management of the patient's illness.

Family Coverage - Coverage for the employee and one (1) or more of the employee's dependents.

Family Deductible - A specified dollar amount of liability for covered services that must be incurred by one (1) or more family members, who are covered, before Highmark will assume any liability for all or part of the remaining covered services. Once the family deductible is met, no further deductible amounts must be satisfied by any covered family member.

Formulary - A listing of prescription drugs and over-the-counter drugs selected by Highmark based on an analysis of clinical efficacy, unique value, safety, and pharmacoeconomic impact. This listing is subject to periodic review and modification by Highmark or a designated committee of Physicians and Pharmacists.

Freestanding Dialysis Facility - A facility provider licensed and approved by the appropriate governmental agency which, for compensation from its patients, is primarily engaged in providing dialysis treatment, maintenance or training to patients on an outpatient or home-care basis.

Freestanding Nuclear Magnetic Resonance Facility/Magnetic Resonance Imaging Facility - A facility provider which, for compensation from its patients, is primarily engaged in providing, through an organized professional staff, nuclear magnetic resonance/magnetic resonance imaging scanning. These facilities do not include Inpatient beds, medical or health-related services.

Generic Drug - A drug that is available from more than one manufacturing source and accepted by the FDA as a substitute for those products having the same active ingredients as a brand drug and listed in the FDA "Approved Drug Products with Therapeutic Equivalence Evaluations," otherwise known as the Orangebook, and noted as such in the pharmacy database used by your program.

Health Care Management Services - A program which integrates all activity related to managing your medical care from the time that an admission, surgical or diagnostic procedure, or certain services become necessary. The program consists of any applicable pre-admission certification, admission certification of emergency admissions, continued stay review, discharge planning, procedure or covered service precertification, case management and skilled nursing facility precertification.

Highmark Blue Cross Blue Shield - An independent licensee of the Blue Cross Blue Shield Association. Any reference to Highmark Blue Cross Blue Shield may also include its Designated Agents with whom Highmark Blue Cross Blue Shield has contracted to perform a function or service.

Highmark Blue Shield - An independent licensee of the Blue Cross Blue Shield Association. Any reference to Highmark Blue Shield may also include its designated agents with whom Highmark Blue Shield has contracted to perform a function or service.

Highmark Blue Shield Participating Facility Provider - A facility provider, licensed where required and performing within the scope of such licensure, that has an agreement, either directly or indirectly with

Highmark Blue Shield, operating as a hospital plan corporation, pertaining to payment for covered services rendered to you.

Highmark Blue Shield Participating Facility Provider Network - All Highmark Blue Shield Participating Facility Providers, approved as a network by the Pennsylvania Department of Health, that have entered into a network agreement, either directly or indirectly with Highmark Blue Shield to provide health care services to you.

Highmark Managed Care Facility Provider - A facility provider, licensed where required and performing within the scope of its license, that has entered into a Highmark Managed Care Network agreement, either directly or indirectly, with Highmark Inc. pertaining to payment as a participant in a managed care network for covered services rendered to you.

Highmark Managed Care Network - All Highmark managed care facility providers and professional providers, approved as a network by the Pennsylvania Department of Health, that have entered into a network agreement, either directly or indirectly, with Highmark Inc. pertaining to payment as a participant in a managed care network for covered services rendered to you.

Highmark Managed Care Professional Provider - A professional provider, licensed where required and performing within the scope of its license, that has entered into a Highmark Managed Care Network agreement, either directly or indirectly, with Highmark Inc. pertaining to payment as a participant in a managed care network for covered services rendered to you.

Highmark NE Participating Facility Provider – A facility provider, located in the Plan Service Area, licensed where required and performing within the scope of such licensure, that has an agreement, either directly or indirectly, with Highmark pertaining to payment for covered services rendered to you.

Highmark NE Participating Facility Provider Network – All Highmark NE participating facility providers, approved as a network by the Pennsylvania Department of Health, that have entered into an agreement, either directly or indirectly with Highmark Blue Cross Blue Shield to provide health care services to you.

Highmark Northeastern Pennsylvania Service Area - The geographic area within northeastern Pennsylvania consisting of the following counties in Pennsylvania:

Bradford	Lycoming	Susquehanna
Carbon	Monroe	Tioga
Clinton	Pike	Wayne
Lackawanna	Sullivan	Wyoming
Luzerne		

Highmark Southeastern Pennsylvania Service Area - The geographic area within southeastern Pennsylvania consisting of the following counties in Pennsylvania:

Bucks	Chester	Delaware	Montgomery	Philadelphia

Highmark Western Pennsylvania Service Area - The geographic area, within western Pennsylvania, consisting of the following counties in Pennsylvania:

Allegheny	Centre (part)	Forest	Mercer
Armstrong	Clarion	Greene	Potter

Beaver	Clearfield	Huntingdon	Somerset
Bedford	Crawford	Indiana	Venango
Blair	Elk	Jefferson	Warren
Butler	Erie	Lawrence	Washington
Cambria	Fayette	McKean	Westmoreland
Cameron			

Home Health Care Agency - A facility provider program for home health care, licensed by the state and certified by Medicare which, for compensation from its patients:

a. provides skilled nursing and other services on a visiting basis in the Member's home, and

b. is responsible for supervising the delivery of such services under a plan prescribed by the attending physician.

Home Infusion Therapy Provider - An ancillary provider licensed by the state, accredited by The Joint Commission, if appropriate, and organized to provide infusion therapy to patients at their place of residence.

Hospice - A facility provider, licensed by the state which, for compensation from its patients, is primarily engaged in providing palliative care to terminally ill individuals.

Hospice Care - A program which provides an integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients and their families. Hospice services are centrally coordinated through an interdisciplinary team directed by a physician.

Hospital - A duly licensed facility provider that is a general or special hospital which has been approved by Medicare, The Joint Commission or the American Osteopathic Hospital Association which, for compensation from its patients:

a. is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment and care of injured and sick persons, and

b. provides twenty-four hour nursing services by or under the supervision of registered nurses.

Identification Card (ID Card) - The currently effective card issued to you by Highmark.

Immediate Family - Your spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, daughter-in-law, son-in-law, grandchild, grandparent, stepparent, stepbrother or stepsister.

In-Area - The geographic area covering Pennsylvania.

Incurred - A charge is considered incurred on the date the Member received the service or supply for which the charge is made. For purposes of this definition and this booklet, a "charge" encompasses the entire contracted unit/case rate based on a diagnosis related grouping (DRG) or other payment methodology for a service or supply (including outlier days) set forth in the applicable Provider Agreement.

Independent Diagnostic Testing Facility - An ancillary provider operating from a fixed or mobile location, which performs diagnostic testing services, other than clinical laboratory or pathology testing, using diagnostic testing and imaging equipment including, but not limited to, sleep centers/home sleep testing

providers, mobile x-ray providers and cardiac event monitoring providers, and other diagnostic imaging providers. Such technical services do not include the interpretation of test results by a professional provider.

Infertility - An interruption, cessation, or disorder of body functions, systems, or organs of the reproductive tract which prevents an individual or couple from the conception of a child or the ability to carry a pregnancy to delivery after regular, unprotected sexual intercourse without medical intervention or as diagnosed by a licensed physician based on the individual's medical, sexual, and reproductive history, age, physical findings, and/or diagnostic testing.

Infusion Therapy - The administration of medically necessary and appropriate fluid or medication via a central or peripheral vein to patients.

Inpatient - A member who is a registered bed patient in a hospital or skilled nursing facility and for whom a room and board charge is made.

Intensive Outpatient Program - A time-limited, separate and distinct outpatient program that includes individual therapy, family therapy, group therapy and medication management following an individualized treatment plan. Participation in an Intensive Outpatient Program may involve two (2) or more hours of programming a week. The program may be offered during the day or evening hours and can be a step-down from a higher level of care or a step-up to prevent the need for a higher level of care. The goals of an Intensive Outpatient Program are to prevent or reduce the need for inpatient hospitalization and to reduce or stabilize symptoms and functional impairment of a psychiatric or co-occurring substance use disorder. Medically necessary treatment is provided within a structured therapeutic milieu.

Local PPO Network - All providers who have entered into an agreement, either directly or indirectly, with any licensee of the Blue Cross Blue Shield Association located out-of-area pertaining to payment as a participant in that licensee's PPO network for covered services rendered to you.

Mail Order Pharmacy - A pharmacy provider that has an agreement, either directly or indirectly, with Highmark or its Designated Agent to supply covered medications to you by mail service at a contractually agreed upon price.

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

Market Watch Prescription Drug - A select prescription drug identified by your program as:

- having an over-the-counter drug equivalent.
- having relatively low value with respect to the cost in light of available alternative covered medications.
- being newly approved by the Food and Drug Administration for treating a condition for which there are existing covered medications have previously been approved.

Marriage and Family Therapist - A licensed marriage and family therapist performing within the scope of such licensure. Where there is no licensure law, the marriage and family therapist must be certified by the appropriate professional body.

Maximum - The greatest amount for which your program may be liable for Covered Services within a set amount of time. This could be expressed in dollars, number of days or number of services. In connection with

such day and/or Visit limits, all services received by a Member during a Benefit Period will reduce the remaining number of days and/or Visits available under that benefit, regardless of whether the Member has satisfied the Deductible. There are two types of maximums:

Program Maximum - The greatest amount payable by the program for all covered services.

Benefit Maximum - The greatest amount payable by the program for a specific covered service.

Medical Care - Professional services rendered by a professional provider for the treatment of an illness or injury.

Medically Necessary and Appropriate (Medical Necessity and Appropriateness) - Services, medications or supplies that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (iii) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service, sequence of services or site of service at least as likely to produce equivalent therapeutic or diagnostic results given the nature of the patient's diagnosis, treatment, illness, injury or disease, the severity of the patient's symptoms, or other clinical criteria.

Highmark reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, medication or supply is medically necessary and appropriate. No benefits hereunder will be provided unless Highmark determines that the service, medication or supply is medically necessary and appropriate.

Medicare - The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Medication Synchronization - The coordination of prescription drug filling or refilling by a pharmacist or dispensing physician for a member taking two or more maintenance prescription drugs for the purpose of improving medication adherence.

Member - An individual who meets the eligibility requirements specified in General Information section provided herein.

Mental Illness - An emotional or mental disorder characterized by a neurosis, psychoneurosis, psychopathy, or psychosis without demonstrable organic origin.

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

- When you receive Covered Services within the Highmark Western Pennsylvania Service Area, the designated network for Professional Providers, Facility Providers and Ancillary Providers is the Highmark Managed Care Network.
- When you receive covered services within the Highmark Blue Shield Service Area or the Highmark Southeastern Pennsylvania Service Area, the designated network for professional providers is the PremierBlue Shield preferred professional provider network and the designated network for facility providers is the Highmark Blue Shield participating facility provider network. Also included are ancillary providers who have an agreement, directly or indirectly, with Highmark pertaining to payment for covered services rendered to you as a network participant.

- When you receive covered services within the Highmark Northeastern Pennsylvania Service Area, the designated network for professional providers is the PremierBlue Shield preferred professional provider network and the designated network for facility providers is the Highmark NE Participating facility provider network. Also included are ancillary providers who have an agreement, directly or indirectly with Highmark pertaining to payment for covered services rendered to you as a network participant.
- When you receive covered services outside Pennsylvania, the designated network for professional providers and facility providers is the Local PPO network. Also included are ancillary providers who have an agreement, directly or indirectly, with Highmark pertaining to payment for covered services rendered to you as a network participant.

Notwithstanding the above, when you receive outpatient prescription drugs the network is designated by Highmark.

For the purposes of this definition, when you receive covered services from a clinical laboratory, you are deemed to receive covered services at the site the specimen is collected from you.

Network Diabetes Prevention Provider - A diabetes prevention provider that contracts with:

a. Highmark to offer a diabetes prevention program based on a digital model; or

b. Highmark or the local licensee of the Blue Cross Blue Shield Association to offer a diabetes prevention program based on an in-person/onsite model.

Network Facility Provider - A facility provider that has an agreement, either directly or indirectly, with Highmark pertaining to payment as a network participant for covered services rendered to a member.

Network Provider - An ancillary provider, professional provider or facility provider who has entered into an agreement, either directly or indirectly, with Highmark or a Highmark affiliate, or with any licensee of the Blue Cross Blue Shield Association located in a service area other than a Highmark or Highmark affiliate service area, pertaining to payment as a participant in your network for covered services rendered to a member.

Network Service - A service, treatment or care that is provided by a network provider.

Nurse-Midwife - A licensed nurse-midwife. Where there is no licensure law, the nurse-midwife must be certified by the appropriate professional body.

Occupational Therapist - A licensed occupational therapist performing within the scope of such licensure. Where there is no licensure law, the occupational therapist must be certified by the appropriate professional body.

Office Based Opioid Treatment Program - An outpatient treatment program for the treatment of opioid use disorder. The program is also known as medication assisted treatment.

Open Enrollment Period - The period during which you and your eligible dependents may enroll for coverage.

Opioid Treatment Program - An outpatient treatment program for the treatment of severe opioid use disorder. The program consists of daily or several times weekly medication and counseling available to maintain stability for those with severe opioid use disorder.

Out-of-Area - The geographic area outside of Pennsylvania.

Out-of-Network Provider - An ancillary provider, professional provider or facility provider who has not entered into an agreement, either directly or indirectly, with Highmark or a Highmark affiliate, or with any licensee of the Blue Cross Blue Shield Association located in a service area other than a Highmark or Highmark affiliate service area, pertaining to payment as a participant in your network for covered services rendered to a member.

Out-of-Network Service - A service, treatment or care that is provided by an out-of-network provider.

Out-of-Pocket Limit - The out-of-pocket limit refers to the specified dollar amount of expense incurred for covered services in a benefit period. When the specified dollar amount is attained, the level of benefit increases as specified in the Summary of Benefits. See the Summary of Benefits for the out-of-pocket limit.

Outpatient - A member who receives services or supplies while not an inpatient.

Outpatient Psychiatric Facility - A facility provider which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the treatment of mental illness on an outpatient basis.

Outpatient Substance Abuse Treatment Facility - A facility provider which, for compensation from its patients, is primarily engaged in providing detoxification services and/or rehabilitative counseling services for the treatment of substance abuse and diagnostic and therapeutic services for the treatment of substance abuse on an outpatient basis. This facility must also meet the minimum standards set by the Pennsylvania Department of Health, the Pennsylvania Office of Drug and Alcohol Programs, or another appropriate governmental agency.

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

Partial Hospitalization Program - A time-limited, outpatient treatment program that is offered in the day or evening hours for a minimum of four (4) hours per day, three (3) days per week. A Partial Hospitalization Program is a less restrictive alternative to inpatient hospitalization for individuals presenting with acute symptoms of a severe psychiatric disorder who cannot be effectively or safely treated in a lower level of care, and would otherwise require inpatient treatment. The goals of a Partial Hospitalization Program are to prevent or reduce the need for inpatient hospitalization or re-hospitalization following discharge from inpatient treatment and to reduce or stabilize symptoms and functional impairment of a psychiatric or co-occurring substance use disorder. Medically necessary treatment is provided within a structured therapeutic milieu.

Participating Pharmacy Provider - A pharmacy provider that has an agreement, either directly or indirectly, with Highmark pertaining to the payment of covered medications or specific covered medical devices provided to the member. To the extent permitted by state and federal law, participating pharmacy providers with the capability to provide certain immunizations as specified by Highmark, may also receive payment under the agreement for such immunizations and for the administration thereof, provided to members.

Pharmacy Provider - A facility provider licensed by the state which is engaged in dispensing prescription drugs through a licensed pharmacist.

Physical Therapist - A licensed physical therapist. Where there is no licensure law, the physical therapist must be certified by the appropriate professional body.

Physician - A person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed and legally entitled to practice medicine in all of its branches, perform Surgery and dispense drugs.

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

In-Network Benefits
When covered medical services are received from a network provider, then the plan allowance is determined in accordance with the provider's contract with Highmark or on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your health care program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

Out-of-Network Benefits
When covered medical services are received from an out-of-network provider as described below, the plan allowance is determined as follows:

Non-Emergency Services Received at Certain In-Network Facilities from Out-of-Network Physicians
For non-emergency covered medical services received at certain in-network facilities from out-of-network physicians when such services are either ancillary, or non-ancillary that have not satisfied the notice and consent criteria required by federal law, the plan allowance may be based on the (i) the reference price (as defined below) if out of area; (iii) the recognized amount (as defined below); (iii) the amount agreed to by the out-of-network provider and Highmark; or (iv) the amount determined by Independent Dispute Resolution (IDR).

For the purpose of this preceding, "certain In-network facilities" are limited to a hospital, a hospital outpatient department, a critical access hospital, an ambulatory surgical center, and any other facility specified under federal law and regulation.

Emergency Services Provided by an Out-of-Network Provider
For emergency services provided by an out-of-network provider, the plan allowance is based on one of the following in the order listed below as applicable: (i) the reference price (as defined below) if out-of-area; (ii) recognized amount (as defined below) if out of area; (iii) the amount agreed to by the out-of-network provider and Highmark; or (iv) the amount determined by Independent Dispute Resolution (IDR).

Air Ambulance Transportation Provided by an Out-of-Network Provider
For Air Ambulance transportation provided by an out-of-network provider, the plan allowance is based on one of the following in the order listed below as applicable: (i) the recognized amount (as defined below); (ii) the amount subsequently agreed to by the out-of-network provider and Highmark; or (iii) the amount determined by Independent Dispute Resolution (IDR).

In All Other Cases
If you receive covered medical services from an out-of-network provider, the plan allowance for an out-of-network provider located in the Highmark service area is based on an adjusted contractual allowance for like services rendered by a network provider in the same geographic region. You will be responsible for any difference between the provider's billed charges and your program's payment.

The plan allowance for an out-of-area network state-owned psychiatric hospital is what is required by law.

When covered medical services are received from an out-of-network provider outside of the Highmark service area, the plan allowance may be determined on the basis of the reference price (as defined below) or on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your health care program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

Recognized Amount - Except as otherwise provided, the plan allowance and the amount which coinsurance and applicable deductible is based on for covered medical services when provided by: (i) out-of-network emergency service providers; and (ii) non-emergency service received at certain in-network facilities by non-network providers, when such services are either ancillary or non-ancillary provider services that have not satisfied the notice and consent criteria under federal law and regulation. For the purpose of this definition, "certain facilities" are limited to a hospital (a hospital outpatient department, a critical access hospital, an ambulatory surgical center), as defined in federal law and regulation. The Recognized Amount is based on: (i) an all-payer model agreement, if adopted; (ii) state law; or (iii) the lesser of the qualifying payment amount as determined by Highmark (or the local licensee of the Blue Cross Blue Shield Association when the claim is incurred outside of the Highmark service area) under applicable law and regulation, or the amount billed by the provider or facility.

The recognized amount for air ambulance services provided by an out-of-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law and regulation or the amount billed by the air ambulance service provider.

Reference Price - means a percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market. When a rate is not published by CMS for the service, Highmark uses the price determined by a nationally recognized database or if no such price available, then 50% off billed charges.

Plan Service Area - The geographic area consisting of the Highmark Blue Shield Service Area.

Precertification (Preauthorization/Certification) - The process through which medical necessity and appropriateness of inpatient admissions, services or place of services is determined by Highmark prior to or after an admission or the performance of a procedure or service.

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

PremierBlue Shield Preferred Professional Provider - A professional provider who has an agreement, either directly or indirectly, with Highmark or Highmark Blue Shield pertaining to payment as a participant in the PremierBlue Shield Professional Provider Network for covered service rendered to you.

PremierBlue Shield Preferred Professional Provider Network - All PremierBlue Shield Preferred Providers approved as a network by the Pennsylvania Department of Health, who have an agreement, either directly or indirectly, with Highmark to provide health care services to you.

Prescription Drugs - Any drugs or medications ordered by a professional provider by means of a valid prescription order, bearing the federal legend: "Caution: Federal law prohibits dispensing without a prescription," or a legend drug under applicable state law and dispensed by a licensed pharmacist. Also included are prescribed injectable insulin and other pharmacological agents used to control blood sugar,

diabetic supplies, disposable insulin syringes, as well as compounded medications, consisting of the mixture of at least two ingredients other than water, one of which must be a legend drug.

Prescription Order - The request for medication issued by a professional provider.

Primary Care Provider (PCP) - A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics, or a certified registered nurse practitioner each of whom has an agreement with Highmark pertaining to payment as a network participant and has specifically contracted with Highmark to: a) be designated as a PCP; b) supervise, coordinate and provide specific basic medical services to you; and c) maintain continuity of patient care.

Professional Counselor - A licensed professional counselor performing within the scope of such licensure. Where there is no licensure law, the professional counselor must be certified by the appropriate professional body.

Professional Provider - A person or practitioner licensed where required and performing services within the scope of such licensure.

Acupuncturist
Audiologist
Behavioral Specialist
Certified Registered Nurse
Chiropractor
Clinical Social Worker
Dietitian-Nutritionists
Dentist
Licensed Practical Nurse
Marriage and Family Therapist
Nurse-Midwife
Occupational Therapist
Optometrist
Physical Therapist
Physician
Podiatrist
Professional Counselor
Psychologist
Registered Nurse
Respiratory Therapist
Speech-Language Pathologist
Teacher of the Hearing Impaired

Provider - An ancillary provider, facility provider or professional provider, licensed where required and performing within the scope of such licensure.

Provider's Allowable Price - The amount at which a participating pharmacy provider has agreed, either directly or indirectly, with the health plan to provide covered medications or specific medical devices to you under this program.

Provider Directory - A listing of network providers, which is updated periodically. The provider directory contains a description of network providers, including contact information, areas of expertise and whether the network provider is accepting new patients. Your plan’s provider directory can be accessed at the website appearing on the back of your ID card or by calling the number on the back of your ID card.

Psychiatric Hospital - A facility provider approved by The Joint Commission, the American Osteopathic Hospital Association, Council on Accreditation or Commission on Accreditation of Rehabilitation Facilities which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of mental illness. Such services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Psychologist - A licensed psychologist. When there is no licensure law, the psychologist must be certified by the appropriate professional body.

Rehabilitation Hospital - A facility provider approved by The Joint Commission or by the Commission on Accreditation of Rehabilitation Facilities or certified by Medicare which, for compensation from its patients, is primarily engaged in providing skilled rehabilitation services on an inpatient basis.

Residential Treatment Facility - A licensed psychiatric residential facility that provides medical monitoring and twenty-four hour individualized treatment to a group of individuals. The treatment is provided by paid staff unrelated to the individual.

A residential treatment program must provide the following:

a. Awake adult supervision twenty-four hours per day;

b. Clinical assessment at least once a day;

c. Individual, group, or family therapy at least three times per week;

d. Medical history and physical examination of patient within six months prior to admission or within thirty days after admission;

e. Review of patient's current medication(s) initiated within twenty-four hours;

f. Initiation of a multidisciplinary treatment plan within one week;

g. Nursing staff on-site or on-call twenty-four hours per day;

h. Parent training for patient's/guardians or family if return to family is expected;

i. Discharge planning initiated within twenty-four hours;

j. Psychiatric evaluation/updated (initial within one business day, updates at least once a week);

k. Psychosocial assessment and substance evaluation within forty-eight hours;

l. School or vocational program as per the clinical needs and/or age of the patient; and

m. Toxicology screen, quantitative drug analysis, self-help, 12-step, or education group as needed.

Respite Care - Short-term care for a terminally ill member provided by a facility provider when necessary to relieve a person (caregiver) who is caring for the member at home free of charge.

Retail Clinic - A retail-based clinic that provides basic and preventive health care services seven days a week, including evenings and weekends. A retail clinic is generally staffed by certified registered nurses that diagnose and treat minor health problems and triage patients to appropriate levels of care.

Routine Patient Costs - Costs associated with covered services furnished when participating in an Approved Clinical Trial and that Highmark has determined are medically necessary and appropriate. Such costs do not include:

- the costs of investigational drugs or devices themselves;
- the costs of non-health services required by you when receiving treatments or interventions in the course of participating in an Approved Clinical Trial (e.g. transportation, lodging, meals and other travel expenses);
- items or services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of you; and
- a service clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Serious Mental Illness - Any of the following mental illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.

Service - Each treatment rendered by a provider to you for a covered service.

Skilled Nursing Facility - A facility provider approved by the state and certified by Medicare, which, for compensation from its patients, is primarily engaged in providing skilled nursing services on an inpatient basis to patients requiring twenty-four (24) hour skilled nursing Services but not requiring confinement in an acute care general hospital. Such care is rendered by or under the supervision of physicians. A skilled nursing facility is not, other than incidentally, a place that provides:

a. minimal care, custodial care, ambulatory care, or part-time care services; or

b. care or treatment of mental illness, substance abuse or pulmonary tuberculosis.

Skilled Nursing Services/Skilled Rehabilitation Services - Services which have been ordered by and under the direction of a physician and are provided either directly by or under the supervision of a medical professional, e.g., registered nurse, physical therapist, licensed practical nurse, occupational therapist, speech pathologist or audiologist with the treatment described and documented in the patient's medical records. Unless otherwise determined in the sole discretion of Highmark, skilled nursing services/skilled rehabilitation services shall be subject to the following:

a. the skilled nursing services/skilled rehabilitation services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified licensed medical professional and must be such that the care could not be performed by a non-medical individual instructed to deliver such services.

b. the skilled rehabilitation services must be provided with the expectation that the patient has restorative potential and the condition will improve materially in a reasonable and generally predictable period of time. Once a maintenance level has been established or no further progress is attained, the services are no longer classified as skilled rehabilitation and will be considered to be custodial care.

The mere fact that a physician has ordered or prescribed a therapeutic regimen does not, in itself, determine whether a service is a skilled nursing service or a skilled rehabilitation service.

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

Specialist Virtual Visit - A real-time office visit with a specialist at a remote location, conducted via interactive audio and streaming video telecommunications.

Specialty Prescription Drugs - Selected prescription drugs which are typically used to treat rare or complex conditions and which may require special handling, monitoring and/or special or limited distribution systems, including dispensing through an exclusive pharmacy provider.

State-Owned Psychiatric Hospital - A facility provider, that is owned and operated by the Commonwealth of Pennsylvania, which is primarily engaged in providing treatment and/or care for the Inpatient treatment of mental illness for individuals aged eighteen and older whose hospitalization is ordered by a court of competent jurisdiction through a civil commitment proceeding.

Substance Abuse - Any use of alcohol or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Substance Abuse Treatment Facility - A facility provider licensed by the state and approved by an external accreditation body (i.e., The Joint Commission, Commission on Accreditation of Rehabilitation Facilities, Council on Accreditation) which, for compensation from its patients, is primarily engaged in providing detoxification and/or rehabilitation treatment for alcohol abuse and/or drug abuse. This facility must also meet the minimum standards set by the Pennsylvania Department of Health, the Pennsylvania Office of Drug and Alcohol Programs, or another appropriate governmental agency.

Suite Infusion Therapy Provider - An ancillary provider licensed by the state, accredited by The Joint Commission, if appropriate, and organized to provide infusion therapy to patients at an infusion suite.

Supplier - An individual or entity that is in the business of leasing and selling durable medical equipment and supplies. Suppliers include, but are not limited to, the following:

- durable medical equipment suppliers,
- vendors/fitters,
- orthotic and prosthetic suppliers,
- pharmacy/durable medical equipment suppliers.

Surgery - a.) The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures; b.) the correction of fractures and dislocations; and c.) usual and related inpatient pre-operative and post-operative care.

Telemedicine Service - A real time interaction between a member and a designated telemedicine provider that is available on-demand 24 hours a day, 7 days a week, 365 days a year and is conducted by means of telephonic or audio and video telecommunications system, for the purpose of providing immediate, one-on-one access to a clinical consultation for the diagnosis and treatment of non-emergency medical conditions which are serious or acute but pose no immediate threat to life and health but which require medical attention within 24 hours.

Therapy and Rehabilitation Service - The following services or supplies ordered by a professional provider to promote your recovery. Therapy and rehabilitation services are covered to the extent specified in the Summary of Benefits provided herein.

a. **Cardiac Rehabilitation** - the physiological and psychological rehabilitation of patients with cardiac conditions through regulated exercise programs.

b. **Chemotherapy** - the treatment of malignant disease by chemical or biological antineoplastic agents.

c. **Dialysis Treatments** - the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body through hemodialysis or peritoneal dialysis. Dialysis treatment includes home dialysis.

d. **Infusion Therapy** - the treatment by the administration of medically necessary and appropriate fluid or medication via a central or peripheral vein when performed, furnished, and billed by a facility provider or ancillary provider in accordance with accepted medical practice.

e. **Occupational Therapy** - the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational.

f. **Physical Medicine** - the treatment by physical means or modalities such as, but not limited to, mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities, and rehabilitative procedures, performed to relieve pain and restore level of function following disease, illness, or injury.

g. **Radiation Therapy** - the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

h. **Respiratory Therapy** - the introduction of dry or moist gases into the lungs for treatment purposes.

i. **Speech Therapy** - the treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

Total Maximum Out-of-Pocket - The total maximum out-of-pocket, as mandated by the federal government, is **the most you have to pay for covered services in a benefit period**. After you spend this amount on deductibles, copayments, and coinsurance for network care and services, your program pays 100% of the costs of covered services. See How Your Benefits are Applied and the Summary of Benefits for the total maximum out-of-pocket applicable to you.

Urgent Care Center - A formally structured hospital-based or freestanding full-service, walk-in health care clinic, outside of a hospital-based emergency room, that is open twelve hours a day, Monday through Friday and eight hours a day on Saturdays and Sundays, that primarily treats patients who have an injury or illness that requires immediate care, but is not serious enough to warrant a visit to an emergency room. An urgent care center can also provide the same services as a family physician or primary care provider, such as treatment of minor illnesses and injuries, physicals, x-rays and immunizations.

Vision Provider - A physician or professional provider licensed, where required, and performing services related to the examination, diagnosis and treatment of conditions of the eye and associated structures.

Visit - An interaction between you and a professional provider for the purpose of providing covered services. This may include seeking advice for the purpose of determining what medical examinations, procedures, or

treatment if any, are appropriate for your condition. A visit may be performed in-person or via telephone, internet or other electronic communication.

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

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Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association.

PPO Blue and Blues On Call are service marks of the Blue Cross and Blue Shield Association.

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

The Blue Cross Blue Shield Association is an independent company that does not provide Highmark Blue Shield products and services. It is solely responsible for the services described in this booklet.

Express Scripts is a registered trademark of Express Scripts Holding Company.

You are hereby notified that Highmark Blue Shield provides administrative services only on behalf of your self-funded group health plan. Highmark Blue Shield is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield companies throughout the United States. Although all of these independent Blue Cross and Blue Shield companies operate from a license with the Association, each of them is a separate and distinct operation. The Association allows Highmark Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Highmark Blue Shield is neither the insurer nor the guarantor of benefits under your group health plan. Your Group remains fully responsible for the payment of group health plan benefits.

PAISBOA Health Benefit Trust

HIGHMARK. | PPO Blue

PAISBOA Health Benefit Trust | PPO 1 Plan Summary

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Effective Date	November 1, 2025	
Benefit Period (1)	Contract Year (November 1st – October 31st)	
Deductible (per benefit period) Individual Family	 $2,000 $4,000	 $4,000 $8,000
Plan Pays – payment based on the plan allowance	100% after deductible	50% after deductible
Out-of-Pocket Limit (Includes coinsurance) Once met, the plan pays 100% coinsurance for the rest of the benefit period. Individual Family	 None None	 $10,000 $30,000
Total Maximum Out-of-Pocket (Includes any medical and prescription drug deductibles, coinsurance, and copays, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $6,350 $12,700	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $20 copay	50% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $20 copay	50% after deductible
Specialist Office Visits & Virtual Visits	100% after $40 copay	50% after deductible
Virtual Visit Provider Originating Site Fee	100% (deductible does not apply)	50% after deductible
Urgent Care Center Visits	100% after $50 copay	50% after deductible
	copay does not apply to urgent care center visits prescribed for the treatment of mental health or substance abuse	
Telemedicine Services (3)	100% after $10 copay	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 50% after deductible
Adult Immunizations	100% (deductible does not apply)	50% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	50% (deductible does not apply)
Breast Cancer Screenings	100% (deductible does not apply)	50% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	50% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 50% after deductible
Pediatric Immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible
Emergency Services		
Emergency Room Services (5)	100% after $150 copay (waived if admitted)	
Ambulance - Emergency (6)	100% (deductible does not apply)	
Ambulance - Non-Emergency (6)	100% (deductible does not apply)	50% after deductible
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	$150 inpatient copay/day after deductible; benefit maximum of $750/admission	50% after deductible
Hospital Outpatient	100% after deductible	50% after deductible
Outpatient Surgery (facility)	$75 copay after deductible	50% after deductible
Surgical Services (professional)	100% after deductible	50% after deductible
Maternity (non-preventive professional services) including dependent daughter	100% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)	100% after deductible	50% after deductible
Therapy Services		
Physical Medicine	100% after $40 copay	50% after deductible
	limit: 30 visits/benefit period - limit does not apply to therapy services prescribed for the treatment of mental health or substance abuse	
Speech Therapy	100% after $40 copay	50% after deductible
	limit: 20 visits/benefit period - limit does not apply to therapy services prescribed for the treatment of mental health or substance abuse	

Benefit	In Network	Out of Network
Occupational Therapy	100% after $40 copay	50% after deductible
	limit: 30 visits/benefit period - limit does not apply to therapy services prescribed for the treatment of mental health or substance abuse	
Respiratory Therapy	100% after deductible	50% after deductible
Spinal Manipulations	100% after $40 copay	50% after deductible
	limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% (deductible does not apply)	50% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	$150 inpatient copay/day after deductible; benefit maximum of $750/admission	50% after deductible
Inpatient Detoxification / Rehabilitation	$150 inpatient copay/day after deductible; benefit maximum of $750/admission	50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $40 copay	50% after deductible
Substance Abuse Services	100% after $40 copay	50% after deductible
Other Services		
Acupuncture	100% after $40 copay	50% after deductible
	limit: 18 visits/benefit period	
Allergy Extracts and Injections	100% (deductible does not apply)	50% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	100% after deductible	50% after deductible
Assisted Fertilization Procedures	not covered	
Dental Services Related to Accidental Injury	not covered	
Diabetes Treatment Equipment and Supplies	50% after deductible	50% after deductible
Diabetes Education Program	100% after deductible	50% after deductible
Diagnostic Services	copay does not apply to diagnostic services prescribed for the treatment of mental health or substance abuse	
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after $80 copay	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after $40 copay	50% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	50% after deductible	50% after deductible
Home Health Care	100% after deductible	50% after deductible
	limit: 60 visits/benefit period aggregate with visiting nurse	
Hospice	100% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (8)	100% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	50% after deductible
	limit: 240 hours/benefit period	
Skilled Nursing Facility Care	$75 inpatient copay/day after deductible; benefit maximum of $375/admission	50% after deductible
	limit: 120 days/benefit period	
Transplant Services	100% after deductible	50% after deductible
Precertification/Authorization Requirements (9)	Yes	
Prescription Drugs		
Prescription Drug Deductible Individual / Family	none	
Prescription Drug Program (10) SensibleRx Choice Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design Select Specialty Drugs are limited to 31-day Supply	Retail Drugs (31/60/90-day Supply) $20 / $40 / $60 Generic copay $40 / $80 / $120 Formulary brand copay $60 / $120 / $180 Non-Formulary brand copay Maintenance Drugs through Mail Order (90-day Supply) $40 Generic copay $80 Formulary brand copay $120 Non-Formulary brand copay	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).

(5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.

(6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.

(7) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist, or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant, or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services-Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g., speech therapy, diagnostic services). Services for the treatment of Autism Spectrum Disorders do not reduce visit/day limits.

(8) 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.

(9) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.

(10) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under SensibleRx Choice, 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 doctor requests that the brand drug be dispensed. Your plan requires that you use Accredo specialty pharmacy for select specialty medications. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment.

Highmark Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

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

HIGHMARK INC.
NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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

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

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

On an ongoing basis, we will review and monitor our privacy practices to ensure the privacy of our members' protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this Notice. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will become effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. Before we make a material change in our privacy practices, we will change this Notice and notify all affected members in writing in advance of the change. Any change to this notice will be posted on our website and we will further notify you of any changes in our annual mailing.

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

I. Uses and Disclosures of Protected Health Information

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

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

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

Payment

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

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

Health Care Operations

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

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

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

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

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

(ii) Other Covered Entities.

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

II. Other Possible Uses and Disclosures of Protected Health Information

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

A. To Plan Sponsors

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

B. Required by Law

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

C. Public Health Activities

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

D. Health Oversight Activities

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

E. Abuse or Neglect

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

F. Legal Proceedings

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

G. Law Enforcement

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

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

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

I. Research

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

J. To Prevent a Serious Threat to Health or Safety

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

K. Military Activity and National Security, Protective Services

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

L. Inmates

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

M. Workers' Compensation

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

N. Others Involved in Your Health Care

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

O. Underwriting

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

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

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

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

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

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

In order to opt-out, you must call the customer service number located on the back of your membership card. You should be aware, if you choose to opt-out, your health care providers will not be able to access your health information through the HIE. Even if you chose to opt-out, your information will be sent to the HIE, but providers will not be able to access this information. Additionally, your opt-out does not affect the ability of participating providers to access health information entered into the HIE prior to your opt-out submission.

III. Required Disclosures of Your Protected Health Information
The following is a description of disclosures that we are required by law to make:

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

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

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

1. For marketing purposes
2. If we intend to sell your PHI
3. For use of Psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. An Authorization for use of psychotherapy notes is required unless:

   a. Used by the person who created the psychotherapy note for treatment purposes, or
   b. Used or disclosed for the following purposes:
   (i) the provider's own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;
   (ii) for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;
   (iii) if required for enforcement purposes;
   (iv) if mandated by law;
   (v) if permitted for oversight of the provider that created the note,
   (vi) to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or
   (vi) if needed to avert a serious and imminent threat to health or safety.

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

V. Your Individual Rights
The following is a description of your rights with respect to your protected health information:

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

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

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

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

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

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

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or submitting your request in writing to the Highmark Privacy Department, 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.

- We collect and create information about our members' transactions with Highmark, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits/payments (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

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

- We use personal information internally to manage enrollment, process claims, monitor the quality of the health services provided to our members, prevent fraud, audit our own performance or to respond to members' requests for information, products or services.

- We share personal information with our affiliated companies, health care providers, agents, other insurers, peer review organizations, auditors, attorneys or consultants who assist us in administering our programs and delivering health services to our members. Our contracts with all such service providers require them to protect the confidentiality of our members' personal information.

- We may share personal information with other insurers that cooperate with us to jointly market or administer health insurance products or services. All contracts with other insurers for this purpose require them to protect the confidentiality of our members personal information.

- We may disclose information under order of a court of law in connection with a legal proceeding.

- We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.

- We may disclose information under a subpoena or summons to government agencies that investigate fraud or other violations of law.

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

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