Evangelical Covenant Church
Group 11290-01, 03, 05, 71, 73, 75
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NOTICE

THIS IS IMPORTANT TO YOU
Please keep this attached to your benefits booklet.

Revisions to the Mental Health Care Services and Substance Abuse Service Benefits effective April 1, 2007

A definition for Partial Hospitalization is added to the Terms You Should Know section.

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.

In the Covered Services section, benefit descriptions for Mental Health Care Services and Substance Abuse Services are revised as follows (see Summary of Benefits for applicable program limits or cost-sharing provisions):

Partial Hospitalization Mental Health Care Services
Benefits are only available for mental health care services provided on a partial hospitalization basis when received through a partial hospitalization program. A mental health care service provided on a partial hospitalization basis will be deemed to be an outpatient care visit, will accumulate against any outpatient mental health visit limit and is subject to any outpatient care cost-sharing amounts.

Outpatient Mental Health Care Services
Inpatient facility service and inpatient medical benefits (except room and board) provided by a facility provider or professional provider when you are an outpatient. Once you have exhausted your benefit period outpatient care visits, additional outpatient care visits may be obtained in exchange for each unused inpatient care day on a two-for-one basis.

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

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Disclosure

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

Introduction to Your Comprehensive Benefits Program

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

We think you will be very pleased with the freedom and flexibility, the provider choice and the comprehensive coverage your program provides you.

And, as a Highmark member, you get important extras. Along with 24-hour assistance with any health care question or concern via Blues On Call℠, your member Web site connects you to a range of self-service tools that can help you manage your coverage. The Web site also offers programs and services designed to give you a "Greater Hand" in your health by helping you make and maintain healthy improvements.

You can review Preventive Care Guidelines, check eligibility information, order ID cards, medical and drug claim forms, even review claims and Explanation of Benefits (EOB) information all online. You can also access health information such as the comprehensive Healthwise Knowledgebase®, full-color Health Encyclopedia, and the Health Crossroads® guide to treatment options. You can take an online Lifestyle Improvement course to manage stress, stop smoking or improve your nutrition. And the Web site connects you to a wide range of cost and quality tools to assure you spend your health care dollars wisely.

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

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

How Your Benefits Are Applied

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

Benefit Period

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

Your benefit period is a calendar year starting on January 1.

Medical 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 provider's reasonable charge 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 Payment Level in your Summary of Benefits for the percentage amounts paid by the program.

Copayment

The copayment is the specific, upfront dollar amount you pay for certain covered services which will be deducted from the provider's reasonable charge. You may be responsible for multiple copayments per visit. See your Summary of Benefits for the copayment amounts.

The copayment does not apply toward your deductible or coinsurance, and does not accumulate toward the out-of-pocket limit. **You are expected to pay your copayment to the provider at the time of service.**

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. See the Summary of Benefits for the deductible amount. You may be required to pay any applicable deductible at the time you receive care from a provider.

Family Deductible

For a family with several covered dependents, the deductible you pay for all covered family members, regardless of family size, is specified under family deductible. To reach this total, you can count the expenses incurred by two 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.

When two or more covered family members are injured in the same accident, only one deductible will be applied to the aggregate of such charges.

Out-of-Pocket Limit

The out-of-pocket limit refers to the specified dollar amount of coinsurance incurred for covered services in a benefit period. When the specified dollar amount is attained, your program begins to pay 100% of all covered expenses. See your Summary of Benefits for the out-of-pocket limit. The out-of-pocket limit does not include copayments, deductibles,, prescription drug expenses or amounts in excess of the provider’s reasonable charge.

Family Out-of-Pocket Limit

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

Once all covered family members have incurred an amount equal to the family out-of-pocket limit, claims received for all covered family members during the remainder of the benefit period will be payable at 100% of the provider’s reasonable charge.

If your group changes group health care expense coverage during your benefit period, the amount you paid toward your out-of-pocket limit during the last partial benefit period for services covered under your prior coverage will be applied to the out-of-pocket limit of the initial benefit period under this program.

The dollar amounts listed in the Summary of Benefits do not include any charges for which benefits are excluded in whole or in part under the provisions in the Healthcare Management section.

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.

Lifetime Maximum

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

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

The amount paid for covered services for any individual covered under this program will be added to any amount paid for benefits for that same individual under any other group health care expense plan for the purpose of calculating the benefit period or lifetime maximum applicable to each individual.

Pre-Existing Conditions

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

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

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

If Highmark contests the accuracy of a certificate of creditable coverage or a certificate is unavailable, you and your covered dependents may demonstrate

creditable coverage through the presentation of other documents such as pay stubs that show a deduction for health coverage.

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

The pre-existing condition exclusion period will not be imposed on a newborn or adopted child, or a child placed for adoption, during the first 31 days from the date of birth, adoption or placement for adoption. The pre-existing condition exclusion period will not be applied thereafter, provided that such child is covered under any type of creditable coverage, as defined and determined under any applicable law, within 31 days from the date of birth, adoption or placement for adoption.

Summary of Benefits

This Summary of Benefits is a brief description of covered services. More details can be found in the Covered Services section of this benefit booklet.

Benefit	Coverage
Benefit Period	Calendar Year
Deductible (per benefit period) Individual Family	 $300 $600
Plan Payment Level - Based on the provider's reasonable charge (PRC)	80% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limit (Once met, plan payment level becomes 100%) Individual Family	 $1,500 $3,000
Lifetime Maximum (per member)	$5,000,000
Outpatient Medical Care Services (Physician Office Visits)	100% after $20 copayment; deductible does not apply
Preventive Care ***Adult*** Routine physical exams including labs and preventative x-rays	100% after $20 copayment; deductible does not apply
Adult Immunizations	80% after deductible
Blood Cholesterol Testing, Urinalysis and Complete Blood Count	100% after $20 copayment; deductible does not apply
	Limited to 1 test every 3 years for members age 18 through 49 and 1 test every year for members age 50 and over
Electrocardiogram (EKG)	100%; deductible does not apply
	Limited to 1 test per benefit period
First Colonoscopy and All Related Services	100%; deductible does not apply
	Limited to1 test per benefit period for members age 50 and over
Subsequent Colonoscopies	80% after deductible
Routine gynecological exams, including a PAP Test	100% after $20 copayment; deductible and maximum do not apply
Mammograms, annual routine and medically necessary	100%; deductible does not apply
Pediatric Routine physical exams including labs and preventative x-rays (applicable through age 18)	100% after $20 copayment; deductible does not apply
Pediatric immunizations (applicable through age 18)	100%; deductible and maximum do not apply
Emergency Room Services	80% after deductible
Spinal Manipulations	80% after deductible
	Combined Limit: 20 visits per benefit period
Acupuncture - by medical doctor (MD) only	80% after deductible
Allergy Extract and Injections	80% after deductible
Ambulance	80% after deductible
Assisted Fertilization Treatment	80% after deductible
	Limit: $15,000 per lifetime
Dental Services Related to Accidental Injury	80% after deductible
Diabetes Treatment	80% after deductible

Benefit	Coverage
Diagnostic Services Diagnostic Services - if performed in conjunction with office visits; otherwise program coinsurance applies Basic Diagnostic Service • standard imaging • lab/pathology • allergy testing • diagnostic medical	100%; deductible does not apply
Advanced Imaging Service • MRI • CAT Scan • PET Scan • other advanced imaging tests	80% after deductible
Durable Medical Equipment	80% after deductible
Orthotics	80% after deductible
Prosthetics	80% after deductible
Enteral Formulae	80%; deductible does not apply
Hearing Aids (applicable up to age 18)	80% after deductible Limit: $1,000 per lifetime
Home Infusion Therapy	80% after deductible
Home Health Care	80% after deductible Limit: 120 visits per benefit period
Hospice	80% after deductible Limit: $3,000 per episode for outpatient only Limit: 30 inpatient days per benefit period
Hospital Services - Inpatient	80% after deductible
Hospital Services - Outpatient	80% after deductible
Infertility Counseling, Testing and Treatment[1]	80% after deductible
Maternity (facility and professional services)	80% after deductible
Medical/Surgical Expenses (except office visits)	80% after deductible
Mental Health Care Services/Substance Abuse Services - Inpatient	80% after deductible Limit: 30 days per benefit period
Mental Health Care Services/Substance Abuse Services [2] **- Outpatient**	50% after deductible Limit: 52 visits per benefit period
Pediatric Extended Care Services	80% after deductible
Private Duty Nursing	80% after deductible
Respiration Therapy	80% after deductible
Skilled Nursing Facility Care	80% after deductible Limit: 120 days per benefit period
Therapy and Rehabilitation Services (Cardiac Rehabilitation, Occupational Therapy, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible
Transplant Services	80% after deductible
Precertification Requirements	Yes [3]
	Failure to precertify an admission, procedure or service will result in benefits payable being reduced by $400.

[1] Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug benefits.

[2] First instance or course of treatment for outpatient substance abuse is reimbursed at program coinsurance and/or copayment if applicable.

[3] You are required to contact Highmark Healthcare Management Services prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related admission. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

Covered Services - Medical Program

The Comprehensive program provides benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate. All benefit limits, deductibles and copayment amounts are described in the Summary of Benefits.

Ambulance Service

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

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

when such facility is the closest local facility 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 such facility outside the local area that can provide the necessary service.

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

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

Assisted Fertilization Treatment

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

Dental Services Related to Accidental Injury

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

Diabetes Treatment

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

- Equipment and supplies: Blood glucose monitors, monitor supplies, injection aides, syringes and insulin infusion devices
- Diabetes Education Program*: When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through a diabetes education program:
  - Visits medically necessary and appropriate upon the diagnosis of diabetes
  - Subsequent visits under circumstances whereby your physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in your self-management, or b) identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to your treatment and/or management of diabetes

***Diabetes Education Program –** an outpatient program of self-management, training and education, including medical nutrition therapy, for the treatment of diabetes. Such outpatient program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education services will be covered subject to Highmark Blue Cross Blue Shield'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 his/her license. Rental costs cannot exceed the total cost of purchase. Also includes one wig per lifetime following chemotherapy.

Enteral Formulae

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

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

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

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

– with modular components; or

– with standardized nutrients.

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

Additional coverage for enteral formulae <u>excludes</u> the following:

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

Hearing Aids

Benefits include coverage for the purchase of hearing aid devices, when prescribed by a professional provider.

The hearing aid must be purchased from a contracting provider.

Home Health Care

The program covers the following services rendered by a home health care agency or a hospital program for home health 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
- Oxygen and its administration

- Medical social service consultations
- Health aide services when you are also receiving covered nursing services or therapy and rehabilitation services

No home health care benefits will be provided for:

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

Hospice Care

The program covers the following services rendered by a home health care agency or a hospital program for 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 hospice care
- Oxygen and its administration
- Medical social service consultations
- Health aide services when you are also receiving covered nursing services or therapy and rehabilitation services
- Family counseling related to the member's terminal condition

No hospice care benefits will be provided for:

- dietitian services;
- homemaker services;
- maintenance therapy;

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

Home Infusion Therapy Services

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

Hospital Services

This program covers the following services you receive 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.

Bed and Board

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

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

Ancillary Services

Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms and equipment;
- drugs and medicines provided to you while you are an inpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives;
- anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by

the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;

- medical and surgical dressings, supplies, casts and splints;
- diagnostic services; or
- therapy and rehabilitation services.

Emergency Accident Care

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

Emergency Medical Care

Services and supplies for the outpatient emergency treatment of a medical condition manifesting itself by acute symptoms that require immediate medical attention and with which the absence of immediate medical attention could reasonably result in:

- placing the patient's health in jeopardy;
- causing serious impairment to bodily functions;
- causing serious dysfunction of any bodily organ or part; or
- causing other serious medical consequences.

Pre-Admission Testing

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

Surgery

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

Maternity Services

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

Normal Pregnancy

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

Complications of Pregnancy

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

Nursery Care

Covered services provided to the newborn child from the moment of birth, including care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Routine nursery care includes inpatient medical visits by a professional provider. Benefits will continue for a maximum of 31 days.

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 provider whose scope of practice includes postpartum care. The visit includes parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests, and the performance of any necessary maternal and neonatal physical assessments. The visit may, at your sole discretion, occur at the office of the provider.

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

Medical Services

Emergency Accident Care

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

Emergency Medical Care

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

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.

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.

Inpatient Medical Care Visits

Intensive Medical Care

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

Routine Newborn Care

Professional provider visits to examine the newborn infant while the mother is an inpatient. Benefits will continue for a maximum of 31 days.

Outpatient Medical Care Services (Physician Visits)

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

Therapeutic Injections

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

Mental Health Care Services

Inpatient Facility Services

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

Inpatient Medical Services

Covered inpatient medical services provided by a professional provider.

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

Partial Hospitalization Mental Health Services

Partial hospitalization for mental health care services provided by a partial hospitalization program which has been approved by Highmark and is offered by a facility provider or professional provider. Such programs are subject to periodic review by Highmark. These benefits accumulate against the outpatient mental health visit limits (see Summary of Benefits for program limits).

Outpatient Mental Health Services

Inpatient facility services and inpatient medical services benefits as described in this section are also available when provided by a facility provider or professional provider for the outpatient treatment of mental illness.

Serious Mental Illness Care Services

You are covered for inpatient services for the treatment of serious mental illness for up to 30 days per benefit period. A maximum of 30 of these inpatient days may be exchanged on a one-for-two basis to secure up to 60 additional outpatient days or partial hospitalization services per benefit period.

You are covered for outpatient services for the treatment of serious mental illness for up to 60 outpatient days per benefit period. Each day of outpatient care constitutes one visit.

Orthotic Devices

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

Pediatric Extended Care Services

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

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

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

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

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

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

Preventive Care Services

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

Adult Care

Routine physical examinations, regardless of medical necessity and appropriateness, including a complete medical history.

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

All female members, regardless of age, are covered for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine Papanicolaou smear (pap test) per calendar year. Benefits are not subject to program deductibles or maximums.

Mammographic Screening

Benefits are provided for the following:

- An annual routine mammographic screening for all female members 40 years of age or older.
- Mammographic examinations for all female members regardless of age when such services are prescribed by a physician.

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

Pediatric Care

Routine physical examinations, regardless of medical necessity and appropriateness.

Pediatric Immunizations

Benefits are provided to members under 21 years of age and dependent children for those pediatric immunizations, including the immunizing agents, which

conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services. Benefits are not subject to the program deductibles or dollar limits.

Allergy Extract/Injections
Benefits are provided for allergy extract and allergy injections.

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; and

- for treatment of substance abuse or mental illness.

Spinal Manipulations

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

Substance Abuse Services

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

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

Surgical Services

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

Anesthesia

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

Assistant at Surgery

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

Second Surgical Opinion

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

Keep in mind that*:*

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

Special Surgery

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

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

  - – Extraction of impacted third molars when partially or totally covered by bone
  - – Extraction of teeth in preparation for radiation therapy
  - – Mandibular staple implant, provided the procedure is not done to prepare the mouth for dentures
  - – Mandibular frenectomy
  - – Facility provider and anesthesia services rendered 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
  - – 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 a congenital cleft palate involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus

- Mastectomy and Breast Cancer Reconstruction

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

  – Surgery to re-establish symmetry or alleviate functional impairment including but not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy
  – Initial and subsequent prosthetic devices to replace the removed breast or portions thereof; and
  – Physical complications of all stages of mastectomy, including lymphedemas.

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

Surgery

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

Therapy and Rehabilitation Services

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

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

- Physical medicine
- Radiation therapy
- Respiratory therapy

Transplant Services

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

What Is Not Covered

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

- Which are not medically necessary and appropriate as determined by Highmark Blue Cross Blue Shield.
- Which are not prescribed by or performed by or upon the direction of a professional provider.
- Rendered by other than facility providers, professional providers or suppliers.
- Which are experimental/investigative in nature.
- Rendered prior to your effective date of coverage.
- For a pre-existing condition, but only during the exclusion period as specified herein;
- Incurred after the date of termination of your coverage except as provided herein.
- For loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of an act of war, whether declared or undeclared.
- For which you would have no legal obligation to pay.
- Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.
- For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplement coverage.
- To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program and you elect this coverage as primary.
- For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type

legislation. This exclusion applies whether or not you file a claim for the benefits or compensation.

- To the extent benefits are provided to members of the armed forces or to patients in Veteran's Administration facilities for service-connected illness or injury unless you have a legal obligation to pay.
- For treatment or services for injuries resulting from the maintenance or use of a motor vehicle, if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.
- For nicotine cessation support programs and/or classes.
- For methadone hydrochloride treatment for which no additional functional progress is expected to occur.
- Which are submitted by a certified registered nurse and another professional provider 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.
- For ambulance services, except as provided herein.
- For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as provided herein. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; b) surgery to correct congenital birth defects; and c) surgery to correct a functional impairment which results from a covered disease or injury.
- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier-free" home modifications, whether or not specifically recommended by a professional provider.

- For inpatient admissions primarily for physical medicine services.
- For inpatient admissions which are primarily for diagnostic studies.
- For speech therapy
- For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care.
- For the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: dietitian services; homemaker services; maintenance therapy; dialysis treatment; custodial care; food or home-delivered meals.
- For skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness.
- For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate.
- For respite care.
- Directly related to the care, filling, removal or replacement of teeth, or the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses otherwise covered because of accidental bodily injury to sound natural teeth and for orthodontic treatment for congenital cleft palates as provided herein.
- For oral surgery procedures, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, except as provided herein.
- For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of

temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.

- For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
- For tinnitus maskers or examinations for the prescription or fitting of hearing aids.
- For any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery.
- For elective abortions, except those abortions necessary to avert your death or to terminate pregnancies caused by rape or incest.
- For reversal of sterilization
- For oral or injectable contraceptive medication, even if such medication is a prescription drug as provided herein.
- For contraceptive devices and contraceptive implants, including services related to the provision of such devices or implants.
- For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury).
- For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.
- For nutritional counseling, except as provided herein.
- For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
- For treatment of obesity, except for medical and surgical treatment of morbid obesity as provided herein.
- For the following services associated with the additional enteral formulae benefits provided under your program: blenderized food,

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

- For preventive care services, wellness services or programs, except as provided herein or as mandated by law.
- For the detection and correction by manual or mechanical means (including incidental x-rays) of structural imbalance or subluxation for the purpose of removing nerve interference resulting from or related to distortion, misalignment or subluxation of or in the vertebral column.
- For well-baby care visits, except as provided herein.
- For routine neonatal circumcision.
- For allergy testing, except as provided herein or as mandated by law.
- For routine or periodic physical examinations, the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein or as mandated by law.
- For immunizations required for foreign travel or employment.
- For treatment of sexual dysfunction that is not related to organic disease or injury.
- For any care that is related to conditions such as autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change. Care which extends beyond traditional medical management or inpatient confinement for environmental change includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting or tutorial service; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services

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

- For any care, treatment or service which has been disallowed under the provisions of the Healthcare Management section.
- For otherwise covered services ordered by a court or other tribunal as part of your or your dependent's sentence.
- For any illness or injury suffered during your commission of a felony.
- For any other medical or dental service or treatment, except as provided herein or as mandated by law.

Out-of-Area Care

The BlueCard Worldwide® Program

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

Services may include:

- making referrals and appointments for you with nearby physicians and hospitals;
- verbal translation from a multilingual service representative;
- providing assistance if special medical help is needed;
- making arrangements for medical evacuation services;
- processing inpatient hospitalization claims; and
- for outpatient or professional services received abroad, you should pay the provider, then complete an international claim form and send it to the BlueCard Worldwide Service Center. Claim forms can be obtained by calling 1-800-810-BLUE or the Member Service telephone number on your ID card. Claim forms can also be downloaded from www.bcbs.com.

Eligible Providers

Facility Providers

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

Professional Providers

- Audiologist
- Certified registered nurse*
- Chiropractor
- Clinical laboratory
- Dentist
- Licensed practical nurse
- Nurse-midwife
- Occupational therapist
- Optometrist
- Physical therapist
- Physician
- Podiatrist
- Psychologist
- Registered nurse
- Respiratory therapist
- Speech-language pathologist
- Teacher of hearing impaired

Contracting Suppliers (for the sale or lease of):

- Durable medical equipment
- Supplies
- Hearing aids
- Orthotics
- Prosthetics

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

Healthcare Management

Medical Management

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

Healthcare Management Services (HMS), or its designated agent, is responsible for ensuring that quality care is delivered to members within the proper setting. An HMS Care Manager will review your request for an inpatient admission to ensure it is:

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

Participating Providers

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

Non-Participating Providers

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

If you do not call to certify your admission to a non-participating facility provider, HMS will review your care after services are received to determine if it was medically necessary and appropriate. If the admission is determined ***not*** to be medically necessary and appropriate, you will be responsible for all costs not covered by your program.

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

If HMS is not contacted, you will be responsible for a reduction of benefits as specified in your Summary of Benefits.

Discharge Planning

Discharge planning is a review of the case to identify your discharge needs. The process begins prior to admission and extends throughout your stay in a facility. Discharge planning ensures continuous, quality care and is coordinated with input from your physician. To plan effectively, the HMS manager assesses your:

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

Case Management

Should you or a covered family member fall victim to a serious injury or chronic illness, Highmark's Case Management Services can provide critical care support. We can help:

- coordinate a treatment plan to enable you to reach optimum recovery in a timely manner;
- identify alternatives to an acute care setting such as rehabilitative therapies or specialized home care services when appropriate; and
- work with you to obtain the maximum level of health care coverage.

Continued Stay Review

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

Precertification and Pre-Service Claims Review Processes

Authorized Representatives

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

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

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

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

If your request involves an urgent care claim, Highmark will make a decision on your request as soon as possible, taking into account the medical exigencies involved. You will receive notice of the decision that has been made on your urgent care claim not later than 72 hours following receipt of 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, you will be notified within 24 hours following Highmark's receipt of the claim of the specific information needed to complete your claim. You will then be given not less than 48 hours to provide the specific information to Highmark. Highmark will thereafter notify you of its determination on your claim as soon as possible but not later than 48 hours after the earlier of (i) its receipt of the additional specific information, or (ii) the date Highmark informed you that it must receive the additional specific information.

In addition, the 72-hour time frame may be shortened in those cases where your urgent care claim seeks to extend a previously approved course of treatment and that request is made at least 24 hours prior to the expiration of the previously approved course of treatment. In that situation, Highmark will notify you of its decision concerning your urgent care claim seeking to extend that course of treatment not later than 24 hours following receipt of your claim.

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

Any time your request for precertification or any other pre-service claim is approved, you will be notified in writing 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 and a statement describing your right to file an appeal.

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

General Information

Who is Eligible for Coverage

You may enroll your:

- Spouse
- Unmarried children under 19 years of age, including:
  - Newborn children
  - Stepchildren
  - Children legally placed for adoption
  - Legally adopted children or children for whom the employee or the employee's spouse is the child's legal guardian
  - Children awarded coverage pursuant to an order of court
- Unmarried children up to the age of 25, provided they are enrolled in and regularly attending a full-time accredited school, college or university or a licensed technical or specialized school and are dependent solely upon you for support.
- Unmarried children over age 19 who are not able to support themselves due to mental retardation, physical disability, mental illness or developmental disability.

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 or Highmark Member Service informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage. Changes must be reported within 31 days of their occurrence.

Medicare

Retirees or Dependents

If you or a dependent are entitled to Medicare 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.

The deductible and coinsurance will not be covered if the services are not covered under your Highmark program, even if they are covered under Medicare.

Continuation of Coverage

In general, the Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers, (other than certain church employers) who normally employed at least 20 or more employees in the prior calendar year, to extend temporary health care coverage to 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.

Certificates of Creditable Coverage

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

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

Termination of Your Coverage Under the Employer Contract

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

Benefits After Termination of Coverage

If you are an inpatient on the day your coverage terminates, benefits for inpatient covered services will be continued as follows:

- Until the maximum amount of benefits has been paid; or
- Until the inpatient stay ends; or

- Until you become covered, without limitation as to the condition for which you are receiving inpatient care, under another group program; whichever occurs first.

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

If you are totally disabled at the time your coverage terminates due to termination of active employment, benefits will be continued for covered services directly related to the condition causing such total disability. This benefit extension does not apply to covered services relating to other conditions, illnesses, diseases or injuries and is not available if your termination was due to fraud or intentional misrepresentation of a material fact. This total disability extension of benefits will be provided as long as you remain so disabled as follows:

- Up to a maximum period of 12 consecutive months; or
- Until the maximum amount of benefits has been paid; or
- Until the total disability ends; or
- Until you become covered without limitation as to the disabling condition under other group coverage, whichever occurs first.

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

Coordination of Benefits

Most health care programs, including this program, contain a coordination of benefits provision. This provision is used when you, your spouse or your covered dependents are eligible for payment under more than one health care plan. The object of coordination of benefits is to ensure that your covered expenses will be paid, while preventing duplicate benefit payments.

Here is how the coordination of benefits provision works:

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your plan.
- When the person who received care is covered as an employee under one contract, and as a dependent under another, then the employee coverage pays first.

- When a dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the calendar year pays first. But, if both parents have the same birthday, the plan which covered the parent longer will be the primary plan. If the dependent child's parents are separated or divorced, the following applies:
  - The parent with custody of the child pays first.
  - The coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody.
  - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.
- When none of the above circumstances applies, the coverage you have had for the longest time pays first, provided that:
  - the benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person and if
  - the other plan does not have this provision regarding laid-off or retired employees, and, as a result, plans do not agree on the order of benefits, then this rule is disregarded.

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

Subrogation

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

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

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

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

BlueCard® Program

When a member obtains covered services through BlueCard outside the geographic area Highmark serves, the amount a member pays for covered services is calculated on the **lower** of:

- The billed charges for a member's covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan (Host Blue) passes on to us.

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

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

A Recognized Identification Card

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

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

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

- Your name
- Identification number
- Group number
- Premier Pharmacy network logo (when applicable)
- Member Service toll-free number (on back of card)
- Precertification toll-free number (on back of card)

How to File a Claim

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

The procedure is simple. Just take the following steps:

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

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

- ***Copy Itemized Bills.*** You must submit originals, so you may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.
- ***Complete a Claim Form.*** Make sure all information is completed properly, and then sign and date the form. *Claim forms are available from your employee benefits department, through the member Web site at*

www.highmarkbcbs.com, or call the Member Service telephone number on the back of your ID card.

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

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

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

Your Explanation of Benefits Statement

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

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 Blue Cross Blue Shield reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

– ***Requests for Precertification and Other Pre-Service Claims***

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

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

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

Determinations on Benefit Claims

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

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

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

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

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

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

Appeal Procedure

Your benefit program maintains an appeal process involving three levels of review with the exception of urgent care claims (which are subject to 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 your appeal process, you may contact the Member Service Department at the toll-free telephone number listed on your ID card to inquire about the filing or status of your appeal.

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

With the exception of pre-service claims, the second level appeal is mandatory and must be exhausted before you can (i) seek a third level review or (ii) institute an action in law or in equity in a court of competent jurisdiction as may be appropriate.

Initial Review

If you receive notification that a claim has been denied by Highmark, in whole or in part, you may appeal the decision. Your appeal must be submitted not later than 180 days from the date you received notice from Highmark of the adverse benefit determination.

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

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

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

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

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

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

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

- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 30 days following receipt of the appeal.

In the event Highmark renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, the procedure for appealing the decision and, in the case of an adverse benefit determination involving a pre-service claim, a statement regarding your right to pursue a court action.

Your decision to proceed with a second level review of a pre-service claim (other than an urgent care claim, which involves one level of review) is voluntary. In other words, you are not required to pursue the second level review of a pre-service claim before pursuing a court action. Should you elect to pursue the second level review before filing a claim for benefits in court, your benefit program:

- Will not later assert in a court action under that you failed to exhaust administrative remedies (i.e. that you failed to proceed with a second level review) prior to the filing of the lawsuit;

- Agrees that any statute of limitations applicable to the court action will not commence (i.e. run) during the second level review; and

- Will not impose any additional fee or cost in connection with the second level review.

If you have further questions regarding second level reviews of pre-service claims, you should contact Member Service using the telephone number on your ID card.

Second Level Review

If you are dissatisfied with the decision following the initial review of your appeal (other than an urgent care claim), you may request to have the decision reviewed by Highmark. The request to have the decision reviewed must be submitted in writing (or communicated orally under special circumstances) within 45 days from the date an adverse benefit determination.

Upon request to Highmark, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall

have the right to submit any written comments, documents, records, information, data or other material in support of your appeal.

A representative from the Appeal Review Department will review the second level appeal. The representative will be an individual who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the matter under review.

In rendering a decision on the second level appeal, the Appeal Review Department will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Highmark. The Appeal Review Department will also afford no deference to any previous adverse benefit determination on the matter under review.

In rendering a decision on a second level appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and is in the same profession and in a similar specialty as any health care professional that was involved in any previous adverse benefit determination. Furthermore, the health care professional will be a person who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the matter under review.

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

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

- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 30) days following receipt of the appeal.

In the event Highmark renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, the procedure for appealing the decision and, in the case of an adverse benefit determination involving a post-service claim, a statement regarding your right to pursue a court action.

Your decision to proceed with a third level review of a claim is voluntary. In other words, you are not required to pursue the third level review of a claim before pursing a court action. Should you elect to pursue the third level review before filing a claim for benefits in court, your benefit program:

- Will not later assert in a court action that you failed to exhaust administrative remedies (i.e. that you failed to proceed with a third level review) prior to the filing of the lawsuit;

- Agrees that any statute of limitations applicable to the court action will not commence (i.e. run) during the third level review; and

- Will not impose any additional fee or cost in connection with the third level review.

If you have further questions regarding third level reviews of claims, you should contact Member Service using the telephone number on your ID card.

Third Level Review

If you are dissatisfied with the decision following the second level review of your appeal, you may request to have the decision reviewed by your Plan Sponsor in accordance with procedures established for your benefit program.

Member Service

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

For most of us, life is more hectic than ever. There just are not enough hours in the day. Therefore, we offer you the opportunity to get answers to your health care questions 24 hours a day, seven days a week.

Blues On Call℠

Blues On Call, our comprehensive health information and support program, provides you with up-to-date, easy to understand information about medical conditions and treatment options.

A registered nurse Health Coach is available online at your Highmark member Web site or at a toll-free telephone number -- 1-800-BLUE-428 -- 24 hours a day, seven days a week to help you make informed health care decisions, optimize your self-care capabilities, and follow your prescribed treatment plans to improve your health outcomes. Using the patient-centered approach, Shared Decision-Making, Blues On Call offers three levels of health coaching and support:

- General information and support regarding medical procedures, treatment decisions and questions following a doctor's visit, plus access to audiotapes on hundreds of health-related topics and targeted mailings of printed materials
- Treatment decision support for making medical and surgical decisions that reflect personal values and preferences, talking with physicians regarding treatment options, and receiving ongoing support and follow-up throughout treatment plans, plus links to information sources, free videotapes and Web-based education
- Chronic condition management for those at greater risk for hospitalization, complications or an increase in the severity of their disease, including needs assessments, information on effectively managing a chronic condition, and referrals to appropriate resources, such as case managers, home health services, community resources or Employee Assistance Programs. Blues On Call also provides targeted mailings relative to specific risks, free equipment or tools to support self-management goals and help to improve clinical and quality of life outcomes and reduce ongoing risks associated with chronic disease.

Member Services

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

Highmark's Web site

The Highmark Web site, www.highmarkbcbs.com, engages employees in their coverage, care and health. By logging onto the site, you can manage your coverage more efficiently and make more informed, appropriate and affordable health care decisions.

Online "self-service" tools let you:

- Locate network physicians and pharmacies
- Get prescription drug pricing information
- Review Preventive Care Guidelines
- Access Highmark's R_x formulary
- Refill mail order prescriptions
- Check eligibility information
- Order ID cards
- Order medical or drug claim forms

Online health tools let you:

- Learn your health status and identify goals for health improvement
- Refer to the comprehensive, full-color Health Encyclopedia
- Access the Healthwise Knowledgebase with information on every kind of medical condition
- Take Lifestyle Improvement courses on stress management, smoking cessation and nutrition
- Use Health Crossroads to access treatment options for conditions such as back pain, breast cancer and coronary artery disease
- Look up information on every type of health condition in Patient Guides
- Follow step-by-step Care Guides for a variety of conditions, including high cholesterol and high blood pressure
- E-mail Blues On Call for confidential health decision support from a specially-trained Health Coach

Online cost and quality tools help you:

- Look up typical medical expenses using Cost by Condition and Price by Procedure Guides

- Keep track of your care expenses conveniently through My Expense Summary
- Review claims and EOB information
- Access provider quality information, such as how well hospitals care for patients with certain medical conditions and how often providers perform certain care services

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's Member Service representatives are trained to make the connection.

Terms You Should Know

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

BlueCard Program - A program comprised of licensees of the Blue Cross and Blue Shield Association which allows a member to receive covered services from participating professional, contracting supplier and participating facility providers located out-of-area. The local licensee of the Blue Cross and Blue Shield Association that services that geographic area where the covered services are provided is referred to as the "on-site" licensee of the Blue Cross and Blue Shield Association.

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

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

- **Pre-Service Claim** – A request for precertification or prior approval of a covered service which under the terms of your coverage must be approved before you receive the covered service.

- **Urgent Care Claim** – A pre-service claim which, if decided within the time periods established for making non-urgent care pre-service claim decisions, could seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service.

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

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

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

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.

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

Situations may occur when you elect to pursue experimental/investigative treatment. If you have a concern that a service you will receive may be experimental/investigational, you or the hospital and/or professional provider may contact Highmark's Member Service to determine coverage.

Highmark Blue Shield Service Area - The geographic area, within Pennsylvania, in which Highmark Blue Shield operates as a hospital plan corporation consisting of the following counties in Pennsylvania:

Adams	Franklin	Lehigh	Perry

Berks	Fulton	Mifflin	Schuylkill
Centre (part)	Juniata	Montour	Snyder
Columbia	Lancaster	Northampton	Union
Cumberland	Lebanon	Northumberland	York
Dauphin			

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

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

Medically Necessary and Appropriate - Services or supplies provided by a facility provider or professional provider that are determined to be: (i) appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury; and (ii) provided for the diagnosis or the direct care and treatment of your condition, illness, disease or injury; and (iii) provided in accordance with standards of good medical practice; and (iv) not primarily for your or your provider's convenience; and (v) the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered for your condition, and you cannot receive safe or adequate care as an outpatient.

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

Participating Provider - A health care provider who has signed an agreement with Highmark regarding payment of benefits for covered services.

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

Plan Service Area - The geographic area 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			

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

Provider's Reasonable Charge - The provider's reasonable charge is the amount agreed to by your program and the provider or an amount that is determined to be reasonable for covered services provided to you. In the case of professional providers, the provider's reasonable charge will be the lesser of the usual, customary and reasonable allowance or the billed charge.

Usual, Customary and Reasonable (UCR) Allowance

Your program reimbursement amounts are often referred to as UCR allowances. UCR is an abbreviation for usual, customary and reasonable. A UCR allowance is an amount for payment of covered services that is determined by applying one or more of the following criteria:

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

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

Reasonable – the allowed amount (which may differ from the usual or customary allowed amounts) that is determined by considering unusual clinical circumstances.

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

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

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

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

HIGHMARK INC.
NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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

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

Our Legal Duties

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

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

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

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

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

I. Uses and Disclosures of Protected Health Information

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

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

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

Payment

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

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

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

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

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

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

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

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

II. Other Possible Uses and Disclosures of Protected Health Information

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

A. **To Plan Sponsors**

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

B. **Required by Law**

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

C. **Public Health Activities**

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

D. **Health Oversight Activities**

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

E. **Abuse or Neglect**

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

F. **Legal Proceedings**

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

G. **Law Enforcement**

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

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

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

I. **Research**

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

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

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

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

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

L. **Inmates**

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

M. **Workers' Compensation**

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

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

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

III. Required Disclosures of Your Protected Health Information

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

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

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

B. Disclosures to You

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

IV. Other Uses and Disclosures of Your Protected Health Information

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

V. Your Individual Rights

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

A. Right to Access

You have the right to look at or get copies of your protected health information in a designated record set. Generally, a "designated record

set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

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

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

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

B. Right to an Accounting

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

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

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or submitting your request in writing to the Highmark Privacy Department, 1800 Center

Street, Camp Hill, PA 17089. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

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

C. Right to Request a Restriction

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

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

D. Right to Request Confidential Communications

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

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

E. Right to Request Amendment

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

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

F. Right to a Paper Copy of this Notice

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

VI. Questions and Complaints

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

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

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

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

Contact Office: Highmark Privacy Department
Telephone: 1-866-228-9424 (toll free)
Fax: 1-717-302-3601
Address: 1800 Center Street
Camp Hill, PA 17089

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

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

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

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

- We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.

- We collect and create information about our members' transactions with Highmark, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

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

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

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

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

For questions about this Privacy Notice, please contact:

Contact Office: Highmark Privacy Department
Telephone: 1-866-228-9424 (toll free)
Fax: 1-717-302-3601
Address: 1800 Center Street
Camp Hill, PA 17089

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

HIGHMARK®
Blue Cross Blue Shield

An Independent Licensee of the Blue Cross and Blue Shield Association