

Duquesne University
Plan A
Group 81198-00,70
Effective July 1, 2005
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Dear Member:

Enclosed is your *Comprehensive* benefits program information.

We encourage you to take a few minutes to read your Comprehensive benefits program information. Reading this information will help put you in charge of your health care. And it will help you make the most of your coverage.

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

If you have any questions after reading the Comprehensive benefits program information, please call the toll-free Member Service number on your identification card.

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

Sincerely,

A handwritten signature in cursive script that reads "Deborah L. Rice".

Deborah L. Rice
Senior Vice President, Regional Markets

P.S. For all kinds of health and lifestyle information, we encourage you to log onto Highmark's Web site, www.highmarkbcbs.com. Our site provides access to a comprehensive library of health care information and even lets you create your own personal Web page.

comp/m/dh



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This Booklet Is Not A Contract

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



Terms You Should Know

Blues On CallSM - A health, education and support program that includes assistance in the self-management of certain health conditions.

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. Claim includes:

- **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.

Dr. Dean Ornish Participating Provider - a participating facility provider or participating professional provider who has entered into an agreement with Highmark Blue Cross Blue Shield to provide covered services to members through the Dr. Dean Ornish Program (For Reversing Heart Disease)[®].

Experimental/Investigative - The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by Highmark to be medically effective for the condition being treated. Highmark will consider an intervention to be experimental/investigative if: the intervention does not have FDA approval to be marketed for the specific relevant indication(s); or available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or the intervention is not proven to be as safe 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.

Medically Necessary and Appropriate - Services or supplies provided by a facility provider, professional provider or other professional provider that Highmark determines are: (i) appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury; and (ii) provided for the diagnosis or the direct care and treatment of your condition, illness, disease or injury; and (iii) provided in accordance with standards of good medical practice; and (iv) not primarily for your or your provider's convenience; and (v) the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered for your condition, and you cannot receive safe or adequate care as an outpatient. Highmark reserves the right to determine, in its sole judgment, whether a service is medically necessary and appropriate. No benefits will be provided unless Highmark determines that the service or supply is medically necessary and appropriate.

Precertification – The process through which Highmark determines the medical necessity and appropriateness of certain covered services.

Provider's Reasonable Charge - The provider's reasonable charge is the amount agreed to by Highmark and the provider or an amount that Highmark determines is reasonable for covered services provided to 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 charge.

Usual, Customary and Reasonable (UCR) Allowance

Highmark 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 determined by Highmark by applying one or more of the following criteria:

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

Customary – the allowed amount determined by Highmark by considering relevant professional, economic and market factors, including but not limited to: charges of professional providers of the same or similar specialty for the procedure performed, the degree of



professional involvement, the actual cost of equipment and facilities, or other factors which contribute to the cost of the procedure;

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

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



Summary of Benefits

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.

Cost-Sharing	
Benefit Period ¹	Contract Year
Deductible Individual	\$2,000 per benefit period
Family	\$4,000 per benefit period
Coinsurance	80% after deductible
Out-of-Pocket Limit Individual	\$10,000 per benefit period
Family	\$20,000 per benefit period
Maximum Lifetime	\$1,000,000
Benefits	
Allergy Extract/Injections	80%; deductible does not apply
Ambulance	80% after deductible
Assisted Fertilization Procedures	Not Covered
Dental Services Related to Accidental Injury	80% after deductible
Diabetes Treatment	80% after deductible
Diagnostic Services (Lab, X-ray and other tests)	80% after deductible
Dr. Dean Ornish Program (For Reversing Heart Disease) [®]	80% after deductible
	Maximum of one enrollment per lifetime per member
Durable Medical Equipment	80% after deductible
Enteral Formulae	80%; deductible does not apply
Home Health Care Services ²	80% after deductible
	Limit: 60 visits per benefit period



Benefits	
Home Infusion Therapy Services	80% after deductible
Hospice Care Services	80% after deductible
Hospital Services	
Inpatient	80% after deductible
Outpatient	80% after deductible
Emergency Room Services	80% after deductible
Infertility counseling, testing and treatment³	80% after deductible
Maternity	80% after deductible
Inpatient Medical Services	80% after deductible
Outpatient Medical Care Services (Physician Visits)	80% after deductible
Mental Health Services⁴	
Inpatient	80% after deductible Limit: 30 days per benefit period
Outpatient	80% after deductible
	Limit: 45 visits per benefit period
Orthotic Devices	80% after deductible
Pediatric Extended Care	80% after deductible
	Limit: 100 days per benefit period
Prescription Drugs (Non-facility)	80% after deductible
Preventive Care Services	
Adult Care	100%; deductible does not apply
Adult Immunizations	100%; deductible does not apply
Routine Gynecological Exam and PAP Test	100%; deductible does not apply
Mammographic Screening	100%; deductible does not apply
Pediatric Care	100%; deductible does not apply



Benefits	
Pediatric Immunizations	100%; deductible does not apply
Private Duty Nursing Services	80% after deductible
	Limit: \$5,000 maximum per benefit period
Prosthetic Appliances	80% after deductible
Skilled Nursing Facility Services	80% after deductible
	Limit: 50 days per benefit period
Spinal Manipulations	80% after deductible
Substance Abuse Services	
Inpatient Care	80% after deductible
Detoxification	Limit: 7 days per admission Limit: 4 admissions per lifetime
Residential Treatment and Rehabilitation Therapy	Limit: 30 days per benefit period Limit: 90 days per lifetime
Outpatient Care	80% after deductible
	Limit: 60 visits per benefit period Limit: 120 visits per lifetime
Surgical Services	80% after deductible
Therapy and Rehabilitation Services	
Cardiac Rehabilitation	80% after deductible
Chemotherapy	80% after deductible
Dialysis Treatment	80% after deductible
Infusion Therapy	80% after deductible
Occupational Therapy	80% after deductible
Physical Medicine	80% after deductible
Radiation Therapy	80% after deductible
Respiration Therapy	80% after deductible
Speech Therapy	80% after deductible



Benefits	
Transplant Services	80% after deductible
Precertification Requirements	Performed by a Highmark Blue Cross Blue Shield participating provider

- ¹ Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on July 1.
- ² The maternity home health care visit is not subject to the program copayment, coinsurance or deductible amounts, if applicable. See Maternity Home Health Care Visit in the Covered Services section.
- ³ 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.
- ⁴ State-mandated benefits (30 inpatient days and 60 outpatient visits per calendar year, with the right to exchange inpatient days for outpatient visits on a one-for-two basis) apply to a diagnosis of serious mental illness. Serious mental illness includes: schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa and delusional disorder.



A Recognized Identification Card

“Passport” to Quality Care

The Blue Cross and Blue Shield symbols on your Highmark Blue Cross Blue Shield 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.

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

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

The following information will be displayed on your ID card:

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

Protect Your Card

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



Healthcare Management Services

Your benefits are subject to review by Healthcare Management Services (HMS), a division of Highmark Blue Cross Blue Shield, or its designated agent, as part of its health care management program. This program is to help ensure that you receive:

- care that is medically necessary and appropriate; and
- health care services in a setting which best meets your individual treatment needs.

IMPORTANT NOTICE REGARDING TREATMENT WHICH HIGHMARK DETERMINES IS NOT MEDICALLY NECESSARY OR APPROPRIATE:

Highmark only covers services which it or its designated agent(s) determine to be medically necessary and appropriate. Highmark participating providers will accept this determination. A non-participating facility provider is not obligated to accept this determination and may bill you for services determined not to be medically necessary and appropriate. You are solely responsible for payment of such services rendered by a non-participating facility provider, subject to the conditions and limitations of your benefit program. You will not be financially liable when covered services are received from a Highmark participating facility provider unless you elect to receive services which have been determined not to be medically necessary and appropriate and you have been notified of this determination prior to receiving the services. If you elect to receive services from a non-participating facility provider, you should contact HMS or its designated agent to confirm the medical necessity and appropriateness of the services. You are solely responsible for payment of services rendered by a non-participating facility provider that Highmark or its designated agent determine are not medically necessary or appropriate.

Refer to the Terms You Should Know section for a definition of medical necessity and appropriateness.

The health care management services provided by HMS or its designated agent depend on your benefit program. They may include:

- precertification;
- pre-admission certification;



- admission certification;
- pre-procedure certification;
- continued stay review;
- discharge planning; or
- case management.

Some portions of the program may affect your coverage. Please read the following information carefully.

Precertification

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

Precertification is required for the following inpatient services:

- Hospital admissions
- Rehabilitation admissions
- Substance abuse treatment
- Psychiatric treatment

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

- Skilled nursing facility admissions
- Home health services
- Hospice services
- Outpatient surgery

If you use a Highmark Participating Facility Provider or Participating Professional Provider:

A Highmark participating provider WILL CONTACT HMS or its designated agent FOR YOU in order to determine whether services are medically necessary and appropriate. You are not financially liable for services performed by a Highmark participating provider unless you



elect to receive services that have been determined by HMS or its designated agent to be not medically necessary and appropriate.

All Planned Admissions, Procedures and Services

When the Highmark participating provider contacts HMS or its designated agent, a review will determine whether an admission, procedure or requested service is medically necessary and appropriate and/or whether a specific number of days is required to adequately treat the condition. If a limited number of days are approved, the days which are not approved will be your financial responsibility. If HMS or its designated agent determines that an entire admission, procedure or requested service is not medically necessary and appropriate, you and your provider will be notified in writing that the service will not be paid under your benefits program. If you and your provider decide to proceed with a service that is not medically necessary and appropriate, you will be responsible for full payment of the service.

If the Highmark participating provider does not contact HMS or its designated agent prior to an admission, procedure or service when required, your care may be reviewed by HMS or its designated agent after your services are received, at which time it will be determined whether the admission, procedure or service was medically necessary and appropriate. If HMS or its designated agent determines that your admission, procedure or service was not medically necessary and appropriate, *you will not be financially liable for charges associated with those services.*

Emergency or Maternity-Related Admissions

For an emergency or maternity-related admission, a Highmark participating provider is responsible for contacting HMS or its designated agent following the admission, within 48 hours of admission or as soon as reasonably possible, at which time the admission will be reviewed to determine whether it was medically necessary and appropriate.

If the admission is found to be not medically necessary and appropriate, *you will not be financially liable for charges associated with those services.*

If You Use a Non-Participating Facility Provider or Non-Participating Professional Provider:

IMPORTANT: NON-PARTICIPATING FACILITY PROVIDERS OR NON-PARTICIPATING PROFESSIONAL PROVIDERS ARE NOT OBLIGATED TO CONTACT HMS OR ITS DESIGNATED AGENT OR TO ABIDE BY ANY DETERMINATION OF



MEDICAL NECESSITY AND APPROPRIATENESS RENDERED BY HMS OR ITS DESIGNATED AGENT. A non-participating facility provider or non-participating professional provider may, therefore, bill you, the member, for services that are not medically necessary and appropriate, as determined by HMS or its designated agent.

You may certify emergency admissions, maternity-related admissions, or any other service to a non-participating provider by calling the toll-free telephone number on your Highmark ID card. *If you do not call to certify your admission to or a service by a non-participating provider, your care may be reviewed by HMS or its designated agent after your services are received, at which time it will be determined whether such services were medically necessary and appropriate.*

- **For Emergency or Maternity-Related Admissions:**
YOU MUST CONTACT HMS or its designated agent to certify any emergency or maternity-related admission. For emergency or maternity-related admissions, you should call HMS or its designated agent within 48 hours of the admission, or as soon as reasonably possible.

- **All Planned Admissions, Procedures and Services:**
YOU MUST CONTACT HMS or its designated agent **PRIOR TO YOUR ADMISSION, PROCEDURE OR SERVICE**, if required. You should call HMS or its designated agent 7 to 14 days prior to your planned admission or service.
 - If an admission, procedure or service is found to be medically necessary and appropriate, your benefit program will pay up to the non-participating facility provider or non-participating professional provider allowance for covered services and your provider can bill you for any balance of the charges which are not covered under your benefit program.
 - If the entire admission/service is determined not to be medically necessary and appropriate, you will be responsible for full payment.
 - If a specific number of days or visits for an admission or service are approved and you continue to received services beyond the approved number of days or visits, you will be responsible for full payment of those days or visits which are not approved.



Depending on your benefit program, other components of the HMS healthcare management program available to you as a Highmark customer include the following: **(These components apply regardless of whether or not you use a Highmark participating provider or a non-participating provider.)**

Continued Stay Review

While you or your covered dependent are receiving inpatient services that require ongoing review, HMS or its designated agent will be in contact with medical personnel familiar with your case to make certain that continued inpatient services are medically necessary and appropriate. Determination of the need for continued inpatient service will be made in consultation with your physician(s). HMS or its designated agent, the facility or the provider will notify you if continued service is determined to be no longer medically necessary and appropriate. If you or your covered dependent elect to receive inpatient services after such notification, no further benefits will be provided for the remainder of the inpatient stay.

Discharge Planning

Discharge planning is a process that begins prior to your scheduled hospital admission. Working with you, your family, your attending physician(s) and hospital staff, HMS or its designated agent will help plan for and assist in coordinating your discharge to ensure that you receive safe and uninterrupted care when needed at the time of discharge.

Case Management

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

Additional Utilization Review Process Information

– *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. You will have at least 45 days in which to submit the information.

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

If your request involves an urgent care claim, Highmark will make a decision on your request as soon as possible, taking into account the medical exigencies involved. You will receive notice of the decision that has been made on your urgent care claim no later than 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 request 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 to extend that course of treatment not later than 24 hours following receipt of your request.



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

Any time your request for precertification or any other pre-service claim is approved, you will be notified in writing 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 benefit determination of a request for precertification or any other pre-service claim, see the Appeal Procedure section of this benefit booklet.



Your Guides to Good Care

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
- Pharmacy provider
- Skilled nursing facility
- Substance abuse treatment facility

Professional Providers

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



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

Other Professional Providers

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

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



How Your Benefits Are Applied

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

Benefit Period

The period of time in which you can receive services without incurring a new deductible or out-of-pocket limit. Your benefit period is 12-consecutive months beginning on July 1.

Cost-Sharing Provisions

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

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 your *Summary of Benefits* for the deductible amount.

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

If your group changes group health care expense coverage during your benefit period, the amount paid to you or on your behalf during the last partial benefit period for services covered under the prior group coverage will be applied to the deductible 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 Services section.

Coinsurance

The coinsurance is the specific percentage of the provider's reasonable charge for eligible expenses that Highmark pays; the remaining percentage



is the percentage that you pay. Refer to your *Summary of Benefits* for the percentage amounts paid by the program.

Out-of-Pocket Limit

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

The family out-of-pocket limit refers to the amount you have paid out of your own pocket for total covered services your family received during the benefit period.

If your group changes group health care expense coverage during your benefit period, the amount paid to you or on your behalf during the last partial benefit period for services covered under the prior Highmark 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 Services section.

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 program between the group and Highmark, for the purpose of calculating the benefit period or lifetime maximum applicable to each member.



Covered Services

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

This program covers services for 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
- from a skilled nursing facility to your home.

Dental Services Related to Accidental Injury

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



Diabetes Treatment

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

- Equipment and supplies: Blood glucose monitors, monitor supplies, injection aids, syringes and insulin infusion devices; and
- Outpatient Diabetes Education*: When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through an outpatient diabetes education program:
 - Visits that are 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 self-management, or b) identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to the treatment and/or management of diabetes

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

Diagnostic Services

The program covers the following services when ordered by a professional provider:

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



Dr. Dean Ornish Program(For Reversing Heart Disease)

- The Dr. Dean Ornish Program (For Reversing Heart Disease) is a comprehensive lifestyle modification program which emphasizes nutritional counseling, therapeutic exercise, stress management techniques, and regular participation in a professionally supervised support group, on an outpatient basis. It is designed to assist you in the management of coronary artery disease and/or to address key risk factors associated with the onset and progression of coronary artery disease.
- The program requires a minimum one year participation commitment and must be provided by a Dr. Dean Ornish participating provider.
- Coverage will be provided subject to your meeting specific benefit eligibility criteria and the approval of your attending physician.
- Coverage is limited to a one time enrollment in the program per lifetime, regardless of whether you complete the program.
- The program may be subject to class size limits and is offered at selected sites. Therefore, the availability of a Dr. Dean Ornish participating provider within a particular geographic area may be limited.

Durable Medical Equipment

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

Enteral Formulae

Enteral formulae is a liquid source of nutrition administered under the direction of a physician 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 the sole source of nutrition and:

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

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

Additional coverage for enteral formulae excludes the following:

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



Home Health Care

The program covers the following services you receive from 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, occupational therapy and speech therapy
- Medical and surgical supplies provided by the home health care agency or hospital program for home health care
- Oxygen and its administration
- Medical social service consultations
- Health aide services when you are also receiving covered nursing 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 you receive from 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, occupational therapy and speech therapy
- Medical and surgical supplies provided by the home health care agency or hospital program for hospice care



- Oxygen and its administration
- Medical social service consultations
- Health aide services when you are also receiving covered nursing 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

The 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 plus \$10 per day.



- 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.

Other Services

- 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
- 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.

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, professional provider or other 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.

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. The visit is subject to all the terms of this plan and is exempt from any copayment, coinsurance or deductible amounts.

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).

Inpatient Medical Services

Medical Care Visits

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.

Intensive Medical Care

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

Concurrent Care

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

Consultation

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

Routine Newborn Care

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

Mental Health 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 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, professional provider and other professional provider. Such programs are subject to periodic review by Highmark.

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, professional provider or other professional provider when you are an outpatient.

Serious Mental Illness Care Services

You are covered for inpatient services for the treatment of serious mental illness for up to 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 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.

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.



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

The program covers basic non-residential services in a facility provider 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, occupational therapy and speech therapy
- Respiratory therapy
- Medical and surgical supplies provided by the pediatric extended care facility
- Acute health care support
- Ongoing assessments of health status, growth and development

Pediatric extended care services will be covered for children 8 years of age or under, pursuant to the attending physician's treatment plan only when provided in a pediatric extended care facility and when approved by Highmark.

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

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



Prescription Drugs

Benefits include injectable insulin and drugs that under Federal law may only be dispensed by written prescription and are approved for general use by the Food and Drug Administration. The drugs must be dispensed for outpatient use by a pharmacy provider on or after your effective date.

Preventive Care Services

The following services are eligible for payment within certain age categories and for specified frequencies. Highmark periodically reviews the schedule of covered services based on recommendations from organizations 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.

Adult Care

Includes routine physical examinations and diagnostic services limited to members 18 years of age and older.

Adult Immunizations

Immunizations for members 18 years of age and older.

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 examinations, 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 by the Pennsylvania Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

Pediatric Care

Routine physical examinations and diagnostic services limited to members 17 years of age or younger.



Pediatric Immunizations

Benefits are provided to members under 21 years of age for those pediatric immunizations, including the immunizing agents, which, as determined by the Pennsylvania Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services. Benefits are not subject to the program deductibles or dollar limits.

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

Covered services include individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance abuse.

This program covers the following services rendered by a facility provider or a professional provider:

- 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 Services 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 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 opinion and directly related diagnostic services to confirm the need for elective surgery recommended by your first physician.

Keep in mind that:

- the second opinion consultant must not be the physician who first recommended elective surgery;
- elective surgery is covered services that may be deferred and is not an emergency;
- getting a second surgical opinion is your choice;
- if the first opinion for elective surgery and the second opinion conflict, then a third opinion and directly related diagnostic services are covered; 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.

Surgical Services

- 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.
- 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

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

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

The program covers 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.

Therapy and Rehabilitation Services

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



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

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 or tissue 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.
- Which are not prescribed by or performed by or upon the direction of a professional provider.
- Rendered by other than facility providers, professional providers, other professional providers or suppliers.
- Which are experimental/investigative in nature.
- Rendered prior to your effective date of coverage.
- 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 or other 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 or other 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 or other professional provider.
- For inpatient admissions primarily for physical medicine services.
- For inpatient admissions which are primarily for diagnostic studies.



- For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care.
- 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 unless specifically provided, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, except as provided herein.
- For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
- For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
- For hearing aids and 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 treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used



in conjunction with assisted fertilization, unless mandated or required by law.

- For sterilization and 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, LASIX and all related services.
- For nutritional counseling, except as provided herein.
- For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
- For treatment of obesity, except for medical and surgical treatment of morbid obesity.
- For preventive care services, wellness services or programs, except as provided herein or as mandated by law.
- For well-baby care visits, except as provided herein.
- For 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. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services provided for purposes of behavioral modification and/or training; d) services related to learning disorders or learning disabilities; e) services provided primarily for social or environmental change unrelated to medical treatment; f) developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the member has not yet attained; and g) services provided for which, based on medical standards, there is no established expectation of achieving measurable improvement in a reasonable and predictable period of time.
- For any conditions, treatment or service which has been disallowed under the provisions of the Healthcare Management Services section.
- For any other medical or dental service or treatment, except as provided herein or as mandated by law.
- 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.



Care Away From Home

The BlueCard[®] Worldwide Program

This program provides assistance with medical problems you may incur while traveling outside of the United States. Services 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.

BlueCard Program

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

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

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

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price of expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care provider or with a specified group of providers. The price that reflects average savings



may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

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



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, and are dependent solely upon you for support.
- Unmarried children over age 19 who are not able to support themselves due to a physical disability, mental retardation, mental illness or developmental disability. Highmark may require proof of such disability from time to time.

Changes in Membership Status

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

Medicare

Active Employees Age 65 or Over

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

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



- or -

- You may elect Medicare as your primary coverage. If you choose this option, you will not be eligible for any benefits under the employer-sponsored program. Contact your Personnel Department for specific details.

Spouses Age 65 or Over of Active Employees

If you are actively employed, your spouse has the same choices for benefit coverage as indicated above for the employee age 65 and over.

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

Leave of Absence or Layoff

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

Continuation of Coverage

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

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

Upon termination from a group health program or health insurance policy, such as this program, you and your covered dependents will automatically



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

Termination of Your Coverage Under the Employer Contract

Your coverage will be terminated when the member ceases to be eligible to participate under the Plan in accordance with its terms and conditions for eligibility.

Benefits after Termination of Coverage

If you are an inpatient on the day your coverage terminates, facility 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 on the day your coverage terminates due to termination of active employment, benefits will be continued for services directly related to the condition causing such total disability, and for no other condition, illness, disease or injury, provided such termination is not due to fraud or intentional misrepresentation of a material fact. Benefits for covered services, as provided herein, will be provided as long as you remain so disabled.

Benefits for total disability shall be provided as follows:

- up to a maximum period of 12 consecutive months; or
- until the total disability ends; or
- until the maximum amount of benefits has been paid; or



- until you become covered without limitation as to the disabling condition under another group program; 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 your program, contain a coordination of benefits provision. This provision is used when you, your spouse or your covered dependents are eligible for payment under more than one health care program. The object of coordination of benefits is to assure you that your covered expenses will be paid, while preventing duplicate benefit payments.

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

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your program.
- When the person who received care is covered as an employee under one contract, and as a dependent under another, then the employee coverage pays first.
- When a dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the calendar year pays first. But, if both parents have the same birthday, the program which covered the parent longer will be the primary program. If the dependent child's parents are separated or divorced, the following applies.
 - The parent with custody of the child pays first.
 - The coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody.
 - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.
 - The benefits of a program covering the person as an employee other than a laid-off or retired employee or as the dependent of



such person shall be determined before the benefits of a program covering the person as a laid-off or retired employee or as a dependent of such person; and if the other program does not have this provision regarding laid-off or retired employees and, as a result, the plans do not agree on the order of benefits, then this rule is disregarded.

- When none of the above circumstances applies, the coverage you have had for the longest time pays first.

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

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

Subrogation

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

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

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

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



How to File a Claim

In most instances, hospitals and physicians will submit a claim on your behalf directly to Highmark Blue 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;
 - For ambulance services, the total mileage.
 - For prescription drugs, the prescription name and number and prescribing physician'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 doctor) with your claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

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



from your employee benefits department or Highmark's Member Service Department.

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

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

Your claims must be submitted no later than within one year from the date of service.

Your Explanation of Benefits Statement

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

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 identification 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 Additional Utilization Review Process Information subsection in the Healthcare Management Services 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 Blue Cross or Blue Shield Plan 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 Explanation of Benefits (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 identification card.

To be eligible for benefits, you must submit all requests for reimbursement and other post-service claims within one year from the date of service.

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 Healthcare Management Services 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 section of this benefit booklet.

Appeal Procedure

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

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

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

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

If you receive notification that a claim has been denied by Highmark, in whole or in part, 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 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 prior 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 determinations of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal.

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

- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of the appeal;
- When the appeal involves an urgent care claim, as soon as possible taking into account the medical exigencies involved but not later than 72 hours following receipt of the appeal; or



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

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



Member Services Support Your Care

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

Member Service

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

Blues On CallSM

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

Personal Health Care Assistance

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

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

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

Immediate Health Care Assessment

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

Educational Audiotapes & Videotapes

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



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

Chronic Care Support

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

Service is Provided Where You Want It

Highmark's Web site

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

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

Utilize Online Self-Service Capabilities

Access a variety of services related to your coverage—find a physician, review claim status, order an ID card or claim form, check your prescription drug benefits or locate a network pharmacy. Have questions for Member Service? Send a secure message—just use your My BlueLink Message Center to send the message and check for a response from Member Service.

Access Health and Wellness Content and Tools

Customize your content to include the latest in breaking health news, diet and exercise tips, or articles specific to your health-related interests.



Access valuable online health resources: you can contact a Blues On Call Health Coach, or look up any medical topic in the Healthwise Knowledgebase[®] and the illustrated Health Encyclopedia, two comprehensive health information resources.

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

Servicenter

You may receive one-on-one guidance with any claims or coverage questions at your nearest Servicenter. Your Member Service representative will take the time to personally assist you and help you understand your coverage.

We Work Hard to Keep You Healthy and Informed

Highmark realizes the importance of a healthy lifestyle. Our goal is to help you reach yours! Lifestyle improvement courses are designed to help you make and maintain healthy improvements. Some of the courses offered throughout the year include “Osteoporosis Prevention and Education Program,” “Yoga,” “Stress Management,” “Nutrition and Weight Management,” “Diabetes Management,” and smoking cessation and maternity classes.

Information for Non-English-Speaking Members

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

Highmark is a registered mark of Highmark Inc.

Blues On Call and My BlueLink are service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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

BlueCard is a registered mark of the Blue Cross and Blue Shield Association.



The Dr. Dean Ornish Program for Reversing Heart Disease is a registered trademark of Dr. Dean Ornish.

Healthwise Knowledgebase is a registered trademark of Healthwise, Incorporated.

HIGHMARK INC. NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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

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

Our Legal Duties

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

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

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

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

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

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

I. Uses and Disclosures of Protected Health Information

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

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

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

Payment

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

For example:

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

Health Care Operations

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

For example:

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

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

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

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

(i) Business Associates.

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

(ii) Other Covered Entities.

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

II. Other Possible Uses and Disclosures of Protected Health Information

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

A. To Plan Sponsors

We may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to

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

B. Required by Law

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

C. Public Health Activities

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

D. Health Oversight Activities

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

E. Abuse or Neglect

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

F. Legal Proceedings

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

Rule. For example, we may disclose your protected health information in response to a subpoena for such information.

G. Law Enforcement

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

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

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

I. Research

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

J. To Prevent a Serious Threat to Health or Safety

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

K. Military Activity and National Security, Protective Services

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

L. Inmates

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

M. Workers' Compensation

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

N. Others Involved in Your Health Care

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

III. Required Disclosures of Your Protected Health Information

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

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

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

B. Disclosures to You

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

IV. Other Uses and Disclosures of Your Protected Health Information

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

V. Your Individual Rights

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

A. Right to Access

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

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

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

will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

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

B. Right to an Accounting

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

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

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

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

C. Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we may make to a request for

additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

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

D. Right to Request Confidential Communications

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

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

E. Right to Request Amendment

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

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

F. Right to a Paper Copy of this Notice

If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Please contact us using the information listed at the end of this Notice to obtain this Notice in written form.

VI. Questions and Complaints

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

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

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

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

Contact Office: Highmark Privacy Department

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

Fax: 1-717-302-3601

Address: 1800 Center Street

Camp Hill, PA 17089

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

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

be required, we will notify all affected customers in writing in advance of the change.

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

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

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

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

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

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

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

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

For questions about this Privacy Notice, please contact:

Contact Office: Highmark Privacy Department

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

Fax: 1-717-302-3601

Address: 1800 Center Street

Camp Hill, PA 17089

