

PPOBlueSM

PPO PROGRAM

**Municipal Employers
Insurance Trust (MEIT)
PPOBlue Option 2
Effective January 1, 2008
Produced October, 2008**



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

Language Assistance Services Available for Multiple Languages

ENGLISH

Please Read This Important Message

It is important for you to understand all of the enclosed information about your health care coverage. This information includes rights you have and requirements you must meet to take full advantage of your health care benefits.

Language services are available to you, free of charge, upon request. Call the toll-free phone number on the back of your identification card for help.

SPANISH

Lea este importante mensaje

Es importante que comprenda toda la información adjunta sobre su cobertura de atención de salud. Esta información incluye los derechos con los que usted cuenta y los requisitos que debe cumplir para aprovechar al máximo los beneficios de atención de salud.

Si los solicita, se encuentran a su disposición servicios de idiomas gratuitos. Llame al número de teléfono gratuito en el reverso de su tarjeta de identificación.

VIETNAMESE

Xin Đọc Tin Nhấn Quan Trọng Đây

Điều quan trọng là quý vị hiểu rõ tất cả các thông tin đính kèm về bảo hiểm sức khỏe của quý vị. Thông tin này bao gồm quyền lợi mà quý vị được và các đòi hỏi mà quý vị cần đáp ứng để tận dụng toàn bộ các quyền lợi chăm sóc sức khỏe của mình.

Quý vị sẽ được dịch vụ về ngôn ngữ miễn phí khi yêu cầu. Xin gọi số điện thoại miễn phí ghi ở phía sau thẻ ID của quý vị để được giúp đỡ.

RUSSIAN

Пожалуйста, ознакомьтесь с этой важной информацией

Очень важно, чтобы Вы хорошо понимали всю информацию, которая изложена в приложении и описывает Вашу программу страхового медицинского покрытия. В этой информации представлены права, которые Вам предоставлены, а также условия, которым Вы должны соответствовать, чтобы получить полный доступ к страховому медицинскому покрытию.

Вы имеете возможность воспользоваться языковыми услугами, которые предоставляются бесплатно и по требованию. Позвоните по бесплатному номеру телефона, указанному на обороте Вашей идентификационной карты, чтобы получить эту помощь.

ITALIAN

Leggere attentamente il presente messaggio

E' molto importante che comprenda perfettamente le informazioni allegate relative alla sua copertura sanitaria. Tali informazioni includono i diritti in suo possesso e i requisiti da soddisfare per usufruire dei vantaggi offerti dalla sua copertura sanitaria.

Sono disponibili servizi linguistici gratuiti su richiesta. Chiami il numero verde gratuito sul retro della sua tessera identificativa per un'ulteriore assistenza.

CHINESE (MANDARIN/SIMPLIFIED)

请阅读以下重要信息

理解随附的所有有关您的健康护理保赔的信息十分重要。该信息包括您享有的权利以及充分利用您的健康护理福利必须符合的要求。

可应您的请求免费向您提供语言服务。请拨印在您的会员卡背面的免费电话号码，获取帮助。

NOTICE

THIS IS IMPORTANT TO YOU

Please keep this attached to your benefits booklet

Effective April 30, 2008, the definition of **Medically Necessary and Appropriate (Medical Necessity and Appropriateness)** in the **Terms You Should Know** section of your benefits booklet is clarified as follows:

Medically Necessary and Appropriate (Medical Necessity and

Appropriateness) - Services, supplies or covered medications that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (iii) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Highmark reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply or covered medication is medically necessary and appropriate. No benefits will be provided unless Highmark determines that the service, supply or covered medication is medically necessary and appropriate.

NOTICE

THIS IS IMPORTANT TO YOU

Please keep this attached to your benefits booklet

Effective April 30, 2008, the definition of **Medically Necessary Contact Lenses** in the **Terms You Should Know** section of your benefits booklet is clarified as follows:

Medically Necessary Contact Lenses - A contact lens considered eligible only after cataract surgery, corneal transplant surgery, or other conditions such as, but not limited to, keratoconus or when adequate visual acuity is not attainable with eyeglasses but can be achieved through the use of contact lenses.

Medically necessary contact lenses are contact lens that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Highmark reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether covered contact lenses are medically necessary. This benefit will not be provided unless Highmark determines that the covered contact lenses are medically necessary.

MNA

Table of Contents

Introduction to Your PPOBlue Program	1
How Your Benefits Are Applied	3
Benefit Period	3
Medical Cost-Sharing Provisions.....	3
Maximum	4
Lifetime Maximum	5
Prescription Drug Cost-Sharing Provisions.....	5
Summary of Benefits	6
Covered Services - Medical Program	10
Ambulance Service	10
Dental Services Related to Accidental Injury	10
Diabetes Treatment.....	10
Diagnostic Services.....	11
Dr. Dean Ornish Program (For Reversing Heart Disease).....	11
Durable Medical Equipment	12
Enteral Formulae.....	12
Home Health Care/Hospice Care Services.....	13
Home Infusion Therapy Services	14
Hospital Services	14
Emergency Care Services.....	15
Maternity Services.....	16
Medical Services	17
Mental Health Care Services.....	18
Orthotic Devices.....	19
Pediatric Extended Care Services	19
Private Duty Nursing Services.....	20
Prosthetic Appliances.....	20
Preventive Care Services	21
Skilled Nursing Facility Services.....	22
Spinal Manipulations	22
Substance Abuse Services	22
Surgical Services	23
Therapy and Rehabilitation Services	25
Transplant Services	26
Covered Services - Prescription Drug Program	27
Covered Drugs – Choice Formulary	27
What Is Not Covered.....	29
How PPOBlue Works	35
Network Care	35
Out-of-Network Care	35
Out-of-Area Care.....	35
The BlueCard Worldwide Program.....	36
Your Provider Network	36

How to Get Your Physicians' Professional Qualifications	37
Eligible Providers	37
Participating Pharmacies.....	39
Healthcare Management.....	40
Medical Management.....	40
Healthcare Management Services' Care Utilization Review Process.....	41
Prescription Drug Management.....	42
Precertification, Preauthorization and Pre-Service Claims Review Processes.....	42
General Information.....	45
Who is Eligible for Coverage	45
Changes in Membership Status	45
Medicare	46
Leave of Absence or Layoff.....	46
Continuation of Coverage.....	46
Conversion.....	47
Certificates of Creditable Coverage.....	47
Termination of Your Coverage Under the Employer Contract.....	47
Benefits After Termination of Coverage.....	48
Coordination of Benefits	49
Subrogation.....	50
BlueCard Program	50
A Recognized Identification Card	52
How to File a Claim	53
Your Explanation of Benefits Statement	54
Using the Mail Service Pharmacy Benefit.....	54
Additional Information on How to File a Claim	54
Determinations on Benefit Claims	55
Appeal Procedure	56
Member Service	58
Blues On Call	58
Member Service	58
Baby BluePrints.....	60
Member Rights and Responsibilities.....	62
Terms You Should Know.....	63
Introduction to Your Fashion Advantage Program.....	69
How Your Benefits Are Applied - Vision Program	70
Payment For Network Covered Expenses.....	70
Payment For Out-of-Network Covered Expenses.....	71
Summary of Vision Benefits - Fashion Advantage.....	72
Covered Services - Vision Program.....	74
Eye Examination and Refractive Services	74
Post-Refractive Products.....	74
Low Vision Care Services	76
Laser Vision Correction Services Discount Program	76

What Is Not Covered - Vision Program.....	77
How Your Program Works - Vision Program.....	79
Network Care	79
Out-of-Network Care	79
Eligible Providers	79
General Information - Vision Program.....	80
Who is Eligible for Coverage	80
Changes in Membership Status	80
Continuation of Coverage.....	81
Leave of Absence or Layoff.....	81
Termination of Your Coverage Under the Employer Contract.....	81
How to File a Claim - Vision Program.....	82
Your Explanation of Benefits Statement	82
Additional Information on How to File a Claim	82
Determinations on Benefit Claims	84
Appeal Procedure	84
Member Service - Vision Program	86
Member Services	86
Terms You Should Know - Vision Program.....	87
Notice of Privacy Practices	91

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 PPOBlue program.

Introduction to Your PPOBlueSM Program

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

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

- ***Your PPOBlue program gives you freedom of choice.*** You are not required to select a primary care physician to receive covered care. PPOBlue gives you access to the largest provider network of physicians, hospitals, and other providers in the Highmark service area, as well as providers across the country who are part of the local Blue Cross and Blue Shield PPO network. For a higher level of coverage, you need to receive care from one of these network providers. However, you can go outside the network and still receive care at the lower level of coverage. To locate a network provider near you, or to learn whether your current physician is in the network, log onto Highmark's Web site, www.highmarkbcbs.com.
- ***Your PPOBlue program gives you "stay healthy" care.*** You are covered for a range of preventive care, including physical examinations and selected diagnostic tests. Preventive care is a proactive approach to health management that can save you time and medical expenses down the road.

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

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

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

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

Information for Non-English-Speaking Members

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

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

How Your Benefits Are Applied

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

Benefit Period

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

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

Medical Cost-Sharing Provisions

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

Coinsurance

The coinsurance is the specific percentage of the provider's reasonable charge for covered services that is your responsibility. You may be required to pay any applicable coinsurance at the time you receive care from a provider. Refer to the Plan Payment Level in your Summary of Benefits for the percentage amounts paid by the program.

Copayment

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

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

Deductible

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

Family Deductible

For a family with several covered dependents, the deductible you pay for all covered family members, regardless of family size, is specified under family deductible. To reach

this total, you can count the expenses incurred by two or more covered family members. However, the deductible contributed towards the total by any one covered family member will not be more than the amount of the individual deductible. If one family member meets the individual deductible and needs to use benefits, the program would begin to pay for that person's covered services even if the deductible for the entire family has not been met.

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

If your group changes group health care expense coverage during your benefit period, the amount you paid toward your deductible during the last partial benefit period for services covered under the prior Highmark coverage will be applied to the network and out-of-network deductible of the initial benefit period under this 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, Highmark begins to pay 100% of all covered expenses. See your Summary of Benefits for the out-of-pocket limit. The out-of-pocket limit does not include copayments, deductibles, mental health/substance abuse expenses, prescription drug expenses or amounts in excess of the provider's reasonable charge.

Family Out-of-Pocket Limit

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

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

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

Maximum

The greatest amount of benefits that the program will provide for covered services within a prescribed period of time. This could be expressed in dollars, number of days or number of services.

Lifetime Maximum

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

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

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

Prescription Drug Cost-Sharing Provisions

Cost-sharing is a requirement that you pay part of your covered expenses. The following provision(s) describe the methods of such payment.

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

Copayment

The copayment is the specific, upfront dollar amount you pay for covered medications which will be deducted from the provider's allowable price. Your copayment obligation is the amount specified in the Summary of Benefits, or the cost of the covered medication, whichever is lower.

Summary of Benefits

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

Benefits	Network	Out-of-Network
General Provisions		
Benefit Period	Calendar Year	
Deductible (per benefit period)		
Individual	None	\$250
Family	None	\$500
Plan Payment Level - Based on the provider's reasonable charge (PRC)	100%	80% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limits		
Individual	None	\$1,500
Family	None	\$3,000
Lifetime Maximum (per member)	Unlimited	\$1,000,000
Office Visits		
Primary Care Physician Office Visits ¹	100% after \$10 copayment	80% after deductible
Specialist Office Visits	100% after \$10 copayment	80% after deductible Limit: 15 primary care physician/specialist visits per benefit period
Preventive Care Services		
Adult		
Routine physical exams	100% after \$10 copayment	Not Covered
Adult Immunizations	100%	80% after deductible
Routine gynecological exams, including a PAP Test	100% after \$10 copayment	80%; deductible and maximum do not apply
Mammograms, annual routine and medically necessary	100%	80% after deductible
Pediatric		
Routine physical exams	100% after \$10 copayment	Not Covered
Pediatric immunizations	100%	80%; deductible and maximum do not apply
Emergency Room Services		
Emergency Room Services	100% after \$25 copayment (waived if admitted)	Same as network services
Hospital Services		
Hospital Services - Inpatient	100%	80% after deductible Limit: 90 inpatient days per benefit period
Hospital Services - Outpatient ²	100%	80% after deductible
Therapy and Rehabilitation Services		
Spinal Manipulations	100%	80% after deductible Combined Limit: 25 visits per benefit period
Physical Medicine	100%	80% after deductible
Speech Therapy	100%	100% after deductible
Occupational Therapy	100%	100% after deductible
Cardiac Rehabilitation, Chemotherapy, and Dialysis Treatment	100%	80% after deductible
Infusion Therapy	100%	80% after deductible
Radiation Therapy	100%	80% after deductible

Benefits	Network	Out-of-Network
Respiratory Therapy	100%	100% after deductible
Diagnostic Services		
Diagnostic Services (including routine and pre-admission testing) (Lab, x-ray, allergy testing and other diagnostic medical tests)	100%	80% after deductible
Behavioral Health Services		
Mental Health Care Services - Inpatient³	100%	80% after deductible
	Limit: 30 days per benefit period	Limit: 10 days per benefit period
Mental Health Care Services - Outpatient	100% after \$20 copayment	50% after deductible
	Limit: 45 visits per benefit period	Limit: 15 visits per benefit period
Substance Abuse Services - Inpatient Detoxification	100%	80% after deductible
	Combined Limit: 7 days per admission; 4 admissions per lifetime	
Substance Abuse Services - Inpatient Residential Treatment and Rehabilitation Services	100%	80% after deductible
	Combined Limit: 30 days per benefit period; 90 days per lifetime	
Substance Abuse Services - Outpatient^{4,5}	100% after \$10 copayment	80% after deductible
	Combined Limit: 60 visits per benefit period; 120 visits per lifetime	
Other Services		
Allergy Extracts and Injections	100%	80% after deductible
Assisted Fertilization Treatment	Not Covered	
Ambulance	100%	100%; deductible does not apply
Dental Services Related to Accidental Injury	100%	80% after deductible
Diabetes Treatment	100%	80% after deductible
Dr. Dean Ornish Program For Reversing Heart Disease⁶	100%	Same as network services
	Maximum of one enrollment per lifetime	
Durable Medical Equipment	100%	100% after deductible
Enteral Formulae	100%	80%; deductible does not apply
Home Infusion Therapy	100%	100% after deductible
Home Health Care⁷	100%	100%; deductible does not apply
	Combined Limit: 100 visits per benefit period	
Hospice	100%	100% after deductible
Infertility Counseling, Testing and Treatment⁸	100%	80% after deductible
Maternity (facility and professional services)	100%	80% after deductible
Orthotics	100%	100% after deductible
Pediatric Extended Care Services	100%	80% after deductible
	Combined Limit: 100 days per benefit period	
Private Duty Nursing	100%	100%; deductible does not apply
	Combined Limit: \$20,000 maximum per benefit period	
Prosthetics	100%	100% after deductible
Skilled Nursing Facility Care	100%	100%; deductible does not apply
	Combined Limit: 100 days per benefit period	
Medical/Surgical Expenses (except office visits)	100%	80% after deductible

Benefits	Network	Out-of-Network
Transplant Services	100%	80% after deductible
Precertification Requirements	Yes ⁹	

- ¹ A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics.
- ² Other cost sharing provisions and/or limits may apply to specific benefits, i.e., physical medicine, therapies, diagnostic services, mental health/substance abuse visits.
- ³ State-mandated benefits (30 inpatient days and 60 outpatient visits per benefit period, with the right to exchange inpatient days for outpatient visits on a one-for-two basis) apply to a diagnosis of serious mental illness. Serious mental illnesses include: schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa and delusional disorder. Once mental health limits are exhausted, both inpatient and outpatient serious mental illness services must be provided by a network provider (see Summary of Benefits for program limits).
- ⁴ First instance or course of treatment reimbursed at program coinsurance and/or copayment for network or out-of-network care.
- ⁵ Of the 60 outpatient visits or equivalent partial visits or partial hospitalization services per benefit period, a maximum of 30 of these visits may be exchanged on a two-for-one basis to secure up to 15 additional days per benefit period beyond the 30-day limit for inpatient non-hospital rehabilitation services.
- ⁶ The program may be subject to class size limits and is only offered at selected sites. Therefore, the availability of a Dr. Dean Ornish participating provider within a particular geographic area may be limited.
- ⁷ The maternity home health care visit for network care is not subject to the program copayment, coinsurance or deductible amounts, if applicable. See Maternity Home Health Care Visit in the Covered Services section.
- ⁸ If testing is required, cost sharing may apply as outlined under Diagnostic Services. Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- ⁹ Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

Prescription Drug Benefits	Benefits available through the Premier Pharmacy Network only. Mandatory Generic ¹
Retail Pharmacy	Up to 31-day supply
Copayment	\$5 generic \$15 brand/formulary ² \$30 brand/non-formulary ²
Maintenance Prescription Drugs through Mail Order	Up to 90-day supply
Copayment	\$10 generic \$30 brand/formulary ² \$60 brand/non-formulary ²

¹ You are responsible for the payment differential when a generic drug is authorized by the physician and the patient purchases a brand name drug. Your payment is the price difference between the brand drug and generic drug in addition to the brand drug copayment or coinsurance amounts which may apply.

² The Highmark formulary is an extensive list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above.

Covered Services - Medical Program

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

Ambulance Service

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

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

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

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

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

Dental Services Related to Accidental Injury

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

Diabetes Treatment

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

- Equipment and supplies: Blood glucose monitors, monitor supplies, and insulin infusion devices

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

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

Diagnostic Services

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

- Diagnostic x-ray consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine
- Diagnostic pathology consisting of laboratory and pathology tests
- Diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by 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 if you meet the specific benefit eligibility criteria and receive 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 only 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 can not exceed the total cost of purchase.

Enteral Formulae

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

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

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

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

- with modular components; or
- with standardized nutrients.

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

Additional coverage for enteral formulae 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, when provided orally
- Normal food products used in the dietary management of rare hereditary genetic metabolic disorders

Home Health Care/Hospice Care Services

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

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

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

- dietitian services;

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

Home Infusion Therapy Services

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

Hospital Services

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

Bed and Board

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

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

Ancillary Services

Hospital services and supplies including, but not restricted to:

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

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

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.

Emergency Care Services

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

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

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

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

Emergency Accident Care

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

Emergency Medical Care

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

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

- causing other serious medical consequences.

Maternity Services

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

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

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

Complications of Pregnancy

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

Normal Pregnancy

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

Nursery Care

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

Maternity Home Health Care Visit

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

Under state law, entities such as Highmark, which issue health insurance to your employer or union, are generally prohibited from restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, state law does not prohibit the mother's or newborn's attending provider from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable) if the mother and newborn meet the medical criteria for a safe discharge contained in guidelines which recognize treatment standards used to determine the appropriate length of stay; including those of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. In any case, health insurance issuers like Highmark can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

Medical Services

Inpatient Medical Services

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

Concurrent Care

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

Consultation

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

Inpatient Medical Care Visits

Intensive Medical Care

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

Routine Newborn Care

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

Outpatient Medical Care Services (Office 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 consultations for the examination, diagnosis and treatment of an injury or illness.

Therapeutic Injections

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

Mental Health Care Services

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

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

Inpatient Facility Services

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

Inpatient Medical Services

Covered inpatient medical services provided by a professional provider:

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

Partial Hospitalization Mental Health Care Services

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

Outpatient Mental Health Care Services

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

Serious Mental Illness Care Services

Coverage is provided for inpatient care for the treatment of serious mental illness for up to 30 days per benefit period. Each day of inpatient care for the treatment of serious mental illness or any other mental illness reduces the total number of inpatient care days available under the mental health care services benefit by one day.

Coverage is provided for outpatient care for the treatment of serious mental illness for up to 60 outpatient care visits per benefit period. Each outpatient care visit utilized for the treatment of serious mental illness or any other mental illness reduces the total number of outpatient care visits available under the mental health care services benefit by one visit. A serious mental illness service provided on a partial hospitalization basis will be deemed to be an outpatient care visit subject to any outpatient cost-sharing amounts.

In any event, no matter how many inpatient care days or outpatient care visits for the treatment of mental illness are utilized, coverage for 30 inpatient care days and 60 outpatient care visits for the treatment and care of serious mental illness as required under Act 150 of 1998 are always available per benefit period. Once you have exhausted your benefit period outpatient care visits, additional outpatient care visits may be obtained in exchange for each unused inpatient care day on a two-for-one basis.

When the inpatient care days and outpatient care visits specified in this mental health care services benefit have been exhausted, but additional inpatient care days and outpatient care visits for the treatment of serious mental illness are required in accordance with Act 150 of 1998, these additional benefits will only be available at the network level. No benefits will be available at the out-of-network level of benefits.

Orthotic Devices

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

Pediatric Extended Care Services

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

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

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

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

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.

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.

Preventive Care Services

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

Adult Care

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

Adult Immunizations

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

Routine Gynecological Examination and Pap Test

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

Mammographic Screening

Benefits are provided for the following:

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

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

Pediatric Care

Routine physical examinations, regardless of medical necessity and appropriateness.

Pediatric Immunizations

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

Allergy Extract/Injections

Benefits are provided for allergy extract and allergy injections.

Skilled Nursing Facility Services

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

No benefits are payable:

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

Spinal Manipulations

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

Substance Abuse Services

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

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

- Outpatient hospital or substance abuse treatment facility or outpatient substance abuse treatment facility services for rehabilitation therapy

For purposes of this benefit, a substance abuse service provided on a partial hospitalization basis shall be deemed an outpatient care visit and will accumulate against the outpatient substance abuse visit limit and is subject to any outpatient care cost-sharing amounts. Once you have exhausted your benefit period inpatient residential treatment and rehabilitation days, any unused full session, equivalent partial-session or partial hospitalization outpatient care visits may be exchanged on a two-for-one basis to secure additional residential treatment and rehabilitation service days beyond the residential treatment and rehabilitation service day maximum per benefit period as set forth herein. These additional residential treatment and rehabilitation service days may be deducted from the lifetime residential treatment and rehabilitation service day limit.

When you are admitted to an out-of-network facility, you are responsible for notifying HMS of your admission. However, when you are admitted to a PPO network facility, the provider will contact HMS for authorization of your care.

Surgical Services

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

Anesthesia

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

Assistant at Surgery

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

Second Surgical Opinion

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

Keep in mind that:

- the second opinion consultant must not be the physician who first recommended elective surgery;

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

Special Surgery

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

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

- Extraction of impacted third molars when partially or totally covered by bone
- Extraction of teeth in preparation for radiation therapy
- Mandibular staple implant, provided the procedure is not done to prepare the mouth for dentures
- Mandibular frenectomy
- Facility provider and anesthesia services rendered in conjunction with non-covered dental procedures when determined by Highmark to be medically necessary and appropriate due to your age and/or medical condition
- Accidental injury to the jaw or structures contiguous to the jaw
- The correction of a non-dental physiological condition which has resulted in a severe functional impairment
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth
- Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus

- **Mastectomy and Breast Cancer Reconstruction**

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

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

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

Surgery

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

Therapy and Rehabilitation Services

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

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

- Speech therapy

Transplant Services

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

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

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

Covered Services - Prescription Drug Program

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

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

Should you purchase a brand name drug when a generic is available and authorized by your doctor, you must pay the price difference between the brand and generic prices in addition to the applicable copayment or coinsurance amount.

Covered Drugs – Choice Formulary

Covered drugs include:

- those which, under Federal law, are required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription;"
- legend drugs under applicable state law and dispensed by a licensed pharmacist;
- prescription drugs listed in your program's prescription drug formulary; including compounded medications, consisting of the mixture of at least two ingredients other than water, one of which must be a legend drug (drug that requires a pharmacist dispenses it);
- prescribed injectable insulin;
- diabetic supplies, including needles and syringes; and
- certain drugs that may require prior authorization from Highmark Blue Cross Blue Shield.

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

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

- Oncology-related therapies
- Interferons
- Agents for multiple sclerosis and neurological related therapies
- Antiarthritic therapies
- Anticoagulants
- Hematinic agents
- Immunomodulators
- Growth hormones
- Fertility drugs

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

Your prescription drug program follows a select drug list which is referred to as a “formulary.” The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. Your program includes coverage for both formulary and non-formulary drugs.

To receive a copy of the formulary, call your toll-free Member Service number. You can also look up the formulary via Highmark's Web site, www.highmarkbcbs.com.

These listings are subject to periodic review and modification by Highmark or a designated committee of physicians and pharmacists.

What Is Not Covered

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

- Which are not medically necessary and appropriate as determined by Highmark Blue Cross Blue Shield.
- Which are not prescribed by or performed by or upon the direction of a professional provider.
- Rendered by other than facility providers, professional providers or suppliers.
- Which are experimental/investigative in nature.
- Rendered prior to your effective date of coverage.
- Incurred after the date of termination of your coverage except as provided herein.
- For loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.
- For which you would have no legal obligation to pay.
- Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.
- To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program and you elect this coverage as primary.
- For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.
- To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.
- For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law,

including medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.

- For prescription drugs which were paid or are payable under a freestanding prescription drug program.
- For nicotine cessation support programs and/or classes.
- For methadone hydrochloride treatment for which no additional functional progress is expected to occur.
- Which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same member.
- Rendered by a provider who is a member of your immediate family.
- Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
- For ambulance services, except as provided herein.
- For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise provided herein. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; b) surgery to correct a congenital birth defect; and c) surgery to correct a functional impairment which results from a covered disease or injury.
- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider.
- For inpatient admissions which are primarily for diagnostic studies.
- For inpatient admissions which are primarily for physical medicine services.
- For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care.
- For the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: dietitian services; homemaker services; maintenance therapy; dialysis treatment; custodial care; food or home-delivered meals.

- For skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness.
- For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate.
- For respite care.
- Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses otherwise covered because of accidental bodily injury to sound natural teeth and for orthodontic treatment for congenital cleft palates as provided herein.
- For oral surgery procedures, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, except as provided herein.
- For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
- For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
- For hearing aid devices 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.
- Related to treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law.
- For oral or injectable contraceptive medication, even if such medication is a prescription drug.

- For contraceptive devices and contraceptive implants, including services related to the provision of such devices or implants.
- For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury).
- For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.
- For nutritional counseling, except as provided herein.
- For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
- For treatment of obesity, except for medical and surgical treatment of morbid obesity or as provided herein.
- For the following services associated with the additional enteral formulae benefits provided under your program: blenderized food, baby food, or regular shelf food when used with an enteral system; milk or soy-based infant formulae with intact proteins; any formulae, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance; semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally; normal food products used in the dietary management of rare hereditary genetic metabolic disorders.
- For preventive care services, wellness services or programs, except as provided herein or as mandated by law.
- For well-baby care visits, except as provided herein.
- For allergy testing, except as provided herein or as mandated by law.
- For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein or as mandated by law.
- For immunizations required for foreign travel or employment.
- For treatment of sexual dysfunction that is not related to organic disease or injury.

- For any care that is related to conditions such as autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, or mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change. Care which extends beyond traditional medical management or for inpatient confinement for environmental change includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services provided for purposes of behavioral modification and/or training; d) services related to the treatment of learning disorders or learning disabilities; e) services provided primarily for social or environmental change or for respite care; f) developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the member has not yet attained; and g) services provided for which, based on medical standards, there is no established expectation of achieving measurable, sustainable improvement in a reasonable and predictable period of time.
- For any care, treatment or service which has been disallowed under the provisions of Healthcare Management program.
- For otherwise covered services ordered by a court or other tribunal as part of your or your dependent's sentence.
- For any illness or injury suffered during your commission of a felony.
- For any other medical or dental service or treatment except as provided herein or as mandated by law.

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

- Services of your attending physician, surgeon or other medical attendant.
- Prescription drugs dispensed for treatment of an illness or an injury for which the group is required by law to furnish hospital care in whole or in part—including, but not limited to—state or federal workers' compensation laws, occupational disease laws and other employer liability laws.
- Prescription drugs to which you are entitled, with or without charge, under a plan or program of any government or governmental body.
- Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances).
- Charges for administration of prescription drugs and/or injectable insulin, whether by a physician or other person.

- Any charges by any pharmacy provider or pharmacist except as provided herein.
- Any drug or medication except as provided herein.
- Any amounts you are required to pay directly to the pharmacy for each prescription or refill.
- Charges for a prescription drug when such drug or medication is used for unlabeled or unapproved indications and where such use has not been approved by the Food and Drug Administration (FDA).
- Drugs and supplies that are not medically necessary and appropriate or otherwise excluded herein.
- Any drug or medication which does not meet the definition of covered maintenance prescription drug.
- Hair growth stimulants.
- Food supplements.
- Immunizations/biologicals.
- Any drugs used to abort a pregnancy.
- Blood products.
- Antihemophilic drugs.
- Any drugs prescribed for cosmetic purposes only.
- Any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes.
- Any drugs which are experimental/investigative.
- Any drugs and supplies which can be purchased without a prescription order, unless specifically described as provided herein.
- Any prescription drugs or supplies purchased at a non-participating pharmacy provider, except in connection with emergency care described herein.
- Any selected diagnostic agents.

How PPOBlue Works

Your PPO program lets you get the care you want from the provider you select. When you or a covered family member needs medical care, you can choose between two levels of health care services: **network** or **out-of-network**.

Network Care

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

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

Out-of-Network Care

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

Even when you go outside the network, you will still be covered for eligible services. However, your benefits generally will be paid at the lower, out-of-network level. Additionally, you may need to obtain precertification from Highmark before services are received. For specific details, see your Summary of Benefits.

You may be responsible for paying any difference between the provider's actual charge and the Highmark payment.

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

Out-of-Area Care

Your program also provides coverage for you and your eligible dependents who are temporarily away from home, or those dependents who permanently reside away from home.

Services received from providers across the country who are part of the local Blue Cross and Blue Shield PPO network will be covered at the higher level of benefits. If you receive covered services from a provider who is not part of the local Blue Cross and Blue Shield PPO network, these services will be covered at the lower level of benefits.

If you are traveling and an urgent injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic:

- If the illness or injury is a true emergency, it will be covered at the higher benefit level, regardless of whether the provider is in the local Blue Cross and Blue Shield PPO network. If the treatment results in an admission, you need to obtain precertification from Highmark. If precertification is not obtained and the admission is not considered to be medically necessary and appropriate, you will be responsible for all costs associated with the stay. For specific details, see the Healthcare Management section of this booklet.
- If the illness or injury is not an emergency, you are required to use providers in the local Blue Cross and Blue Shield PPO network in order to be covered at the higher benefit level. If you receive care from an out-of-network provider, benefits for eligible services will be provided at the lower, out-of-network level of benefits.

The BlueCard Worldwide® Program

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

Services may include:

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

Your Provider Network

Your PPO provider network is your key to receiving the higher level of benefits. The network includes: thousands of primary care physicians; a wide range of specialists; a wide variety of mental health and substance abuse providers; community and specialty hospitals; and laboratories in the Plan service area.

This provider network is large, so chances are very good that your favorite doctor and your local hospital are in the network. To determine if your physician is in the network, call the Member Service toll-free telephone number on the back of your ID card, or log onto www.highmarkbcbs.com.

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

Please note that while you or a family member can use the services of any network physician or specialist and receive the maximum coverage under your benefit program, you are encouraged to select a personal or primary care physician. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal physician can help you select an appropriate specialist and work closely with that specialist when the need arises.

Remember:

If you want to enjoy the higher level of coverage, it is *your* responsibility to ensure that you receive network care. You may want to double-check any provider recommendations to make sure the doctor or facility is in the network.

How to Get Your Physicians' Professional Qualifications

To view board certification information, hospital affiliation or other professional qualifications of your PCP or network specialist, visit our Web site at www.highmarkbcbs.com. and click on "Find Providers". Type in your zip code and choose the type of professional. Click on the physician's name to view credentials and hospital affiliation. Or call a Member Service Representative at the telephone number printed on your ID card.

Eligible Providers

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

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 substance abuse treatment facility
- Outpatient physical rehabilitation facility
- Outpatient psychiatric facility
- Pediatric extended care facility
- Pharmacy provider
- Skilled nursing facility
- Substance abuse treatment facility

Professional Providers

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

Contracting Suppliers (for the sale or lease of):

- Durable medical equipment
- Supplies
- Orthotics
- Prosthetics

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

Participating Pharmacies

Participating Pharmacies

You must purchase drugs from a Premier Pharmacy to be eligible for benefits under this program. *No benefits are available if drugs are purchased from a Non-Premier Pharmacy.*

- **Premier Pharmacy:** Premier pharmacies have an arrangement with Highmark to provide prescription drugs to you at an agreed upon price. When you purchase covered drugs from a pharmacy in the Premier network applicable to your program, present your prescription and ID card to the pharmacist. (Prescriptions that the pharmacy receives by phone from your physician or dentist may also be covered.) You should request and retain a receipt for any amounts you have paid if needed for income tax or any other purpose.
- **Mail Suppliers:** Premier pharmacies also include Mail Service suppliers designated by Highmark. Prescriptions that you take on an ongoing basis may be ordered through our mail service pharmacy for added savings and convenience. To order your prescription through our mail service pharmacy, ask your doctor to prescribe your medication for up to the maximum days allowed under your program, plus refills if appropriate. For a description on how to obtain your medication, see the How to File a Claim section of this benefit booklet.
- **Exclusive Pharmacy Provider:** The exclusive pharmacy provider has an agreement with Highmark pertaining to the payment and exclusive dispensing of selected prescription drugs provided to you. Please refer to the Covered Services - Prescription Drug Program section for a list of the selected prescription drug categories.

Healthcare Management

Medical Management

For your benefits to be paid under your program, at either the network or out-of-network level, services and supplies must be considered medically necessary and appropriate.

Healthcare Management Services (HMS), a division of Highmark Blue Cross Blue Shield, or its designated agent, is responsible for determining whether care is medically necessary and provided in the appropriate setting.

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

Network Care

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

Out-of-Network Care or Out-of-Area Care

When you are admitted to an out-of-network or out-of-area facility provider, ***you are responsible*** for notifying HMS of your admission. However, some facility providers will contact HMS and obtain preauthorization of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for preauthorization. If not, you are responsible for contacting HMS.

You should call 7 to 10 days prior to your planned admission. For emergency or maternity-related admissions, call HMS within 48 hours of the admission, or as soon as reasonably possible. You can contact HMS via the toll-free Member Service telephone number located on the back of your ID card.

If you do not notify HMS of your admission to an out-of-network facility provider, HMS may review your care after services are received to determine if it was medically necessary and appropriate. If your admission is determined not to be medically necessary and appropriate, **you will be responsible for all costs not covered by your program.**

Remember:

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

Healthcare Management Services' Care Utilization Review Process

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

Prospective Review

Prospective review, also known as precertification or pre-service review, begins upon receipt of treatment information.

After receiving the request for care, HMS:

- verifies your eligibility for coverage and availability of benefits;
- reviews diagnosis and plan of treatment;
- assesses whether care is medically necessary and appropriate;
- authorizes care and assigns an appropriate length of stay for inpatient admissions

Concurrent Review

Concurrent review may occur during the course of ongoing treatment and is used to assess the medical necessity and appropriateness of the length of stay and level of care.

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 will help plan for and coordinate your discharge to assure that you receive safe and uninterrupted care when needed at the time of discharge.

Procedure or Covered Service Precertification

Precertification may be required to determine the medical necessity and appropriateness of certain procedures or covered services as determined by Highmark. Network providers in the Highmark Blue Shield service area and the Plan Service area are responsible for the precertification of such procedures or covered services and you will be held harmless whenever certification for such procedures or covered services is not obtained. If the procedure or covered service is deemed not to be medically necessary and appropriate, you will be held harmless, except when Highmark provides prior written notice to you

that charges for the procedure or covered service will not be covered. In such case, you will be financially responsible for such procedure or covered service.

Retrospective Review

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

Case Management Services

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

Highmark case managers are a free resource to all Highmark members. If you have an inpatient hospital admission, you may be contacted as part of our Outreach program. If your claims history indicates that your needs appear to be more complex, you may be contacted by a case manager from our Complex program. In either case, you are always free to call and request case management if you feel you need it by contacting Member Services at the telephone number listed on the back of your ID card.

Prescription Drug Management

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

Preauthorization

The prescribing physician must obtain authorization from Highmark prior to prescribing certain prescription drugs. The specific drugs or drug classifications which require preauthorization may be obtained by calling the toll-free Member Service telephone number appearing on your ID card.

Precertification, Preauthorization and Pre-Service Claims Review Processes

The precertification, preauthorization and pre-service claims review processes information described below applies to both medical and prescription drug management.

– ***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 your claim. However, this 15-day period of time may be extended one time by Highmark for an additional 15 days, provided that Highmark determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 15-day pre-service claim determination period. If an extension of time is necessary because you failed to submit information necessary for Highmark to make a decision on your pre-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your pre-service claim.

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

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

In addition, the 72-hour time frame may be shortened in those cases where your urgent care claim seeks to extend a previously approved course of treatment and that request

is made at least 24 hours prior to the expiration of the previously approved course of treatment. In that situation, Highmark will notify you of its decision concerning your urgent care claim seeking to extend that course of treatment not later than 24 hours following receipt of your claim.

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

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

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

General Information

Who is Eligible for Coverage

You may enroll your:

- Spouse
- Unmarried children under 19 years of age, including:
 - Newborn children
 - Stepchildren
 - Children legally placed for adoption
 - Legally adopted children or children for whom the employee or the employee's spouse is the child's legal guardian
 - Children awarded coverage pursuant to an order of court
- Unmarried children up to the age of 25, provided they are enrolled in and regularly attending a full-time accredited school, college or university or a licensed technical or specialized school and are dependent solely upon you for support. Coverage automatically terminates at the end of the month in which the student ceases to be eligible, whether or not notice to terminate is received by Highmark Blue Cross Blue Shield
- Unmarried children over age 19 who are not able to support themselves due to mental retardation, physical disability, mental illness or developmental disability. Highmark Blue Cross Blue Shield may require proof of such disability from time to time.

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

Changes in Membership Status

For Highmark to administer consistent coverage for you and your dependents, you must keep your Employee Benefit Department informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage.

Your newborn child may be covered under your program for a maximum of 31 days from the moment of birth. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within such period.

Medicare

Covered Active Employees Age 65 or Over

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

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

- or -

Non-Covered Active Employees Age 65 or Over

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

Spouses Age 65 or Over of Active Employees

If you are actively employed in a group with 20 or more employees, 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 elect to be covered under the program, you may wait to enroll for Medicare Part B. You will be able to enroll for Part B later during special enrollment periods without penalty.

Leave of Absence or Layoff

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

Continuation of Coverage

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 temporarily extend their health care coverage to certain categories of employees and their covered dependents when, due to certain "qualifying events," they are no longer eligible for group coverage.

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

Conversion

If your employer does not offer continuation of coverage, or if you do not wish to continue coverage through your employer's program, you may be able to enroll in an individual conversion program available from Highmark. Also, conversion is available to anyone who has elected continued coverage through your employer's program and the term of that coverage has expired.

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

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

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

Certificates of Creditable Coverage

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

Upon termination from a group health 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 can be terminated in the following instances:

- When you cease to be an employee, your coverage will terminate at the end of the last month for which payment was made.
- When you fail to pay the required contribution, your coverage will terminate at the end of the last month for which payment was made.

- Termination of the employer contract automatically terminates the coverage of all the members. It is the responsibility of the employer to notify you of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given to you by the employer.
- If it is proven that you obtained or attempted to obtain benefits or payment for benefits through fraud or intentional misrepresentation of a material fact, Highmark may, upon notice to you, terminate your coverage under the program.

Benefits After Termination of Coverage

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

- Until the maximum amount of benefits has been paid; or
- Until the inpatient stay ends; or
- Until you become covered, without limitation as to the condition for which you are receiving inpatient care, under another group program; whichever occurs first.

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

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

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

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

Coordination of Benefits

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

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

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

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

Subrogation

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

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

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

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

BlueCard[®] Program

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

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

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

underestimation of past prices. However, the amount a member pays is considered a final price.

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

A Recognized Identification Card

The Blue Cross and Blue Shield symbols on your 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.

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

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

- Your name and your dependent's name, if applicable
- Identification number
- Group number
- Copayment for physician office visits and emergency room visits
- Premier Pharmacy network logo (when applicable)
- Member Service toll-free number (on back of card)
- Toll-free telephone number for out-of-network facility admissions (on back of card)
- "PPO in Suitcase" symbol

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

How to File a Claim

If you receive services from a network provider, you will not have to file a claim. If you receive services from an out-of-network provider, you may be required to file the claim yourself.

If you receive medications from a Premier pharmacy and present your ID card, you will not have to file a claim. If you forget your ID card when you go to a Premier pharmacy, the pharmacy may ask you to pay in full for the prescription.

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 or pharmacy provider;
 - The patient's full name;
 - The date of service or supply or purchase;
 - A description of the service or medication/supply;
 - The amount charged;
 - For a medical service, the diagnosis or nature of illness;
 - For durable medical equipment, the doctor's certification;
 - For private duty nursing, the nurse's license number, charge per day and shift worked, and signature of provider prescribing the service;
 - For ambulance services, the total mileage;
 - Drug and medicine bills must show the prescription name and number and the prescribing provider's name.

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

- **Copy Itemized Bills.** You must submit originals, so you may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.

- ***Complete a Claim Form.*** Make sure all information is completed properly, and then sign and date the form. *Claim forms are available from your employee benefits department, or call the Member Service telephone number on the back of your ID card.*
- ***Attach Itemized Bills to the Claim Form and Mail.*** After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the form.

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

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

Your Explanation of Benefits Statement

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

Using the Mail Service Pharmacy Benefit

To order your prescription through our mail service pharmacy, visit our Web site or call Member Service using the telephone number on the back of your ID card to obtain a Mail Service Pharmacy Order Form and envelope. Mail your prescription and required copayment or coinsurance, along with the Mail Service Pharmacy Order Form to the address listed on the form. Your order will be processed promptly and your medication will be sent to you via U.S. mail or UPS. Included with your order will be instructions for ordering refills. Refills can be ordered by phone, mail or online.

Additional Information on How to File a Claim

Member Inquiries

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

Filing Benefit Claims

- ***Authorized Representatives***

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

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

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

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

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

Determinations on Benefit Claims

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

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

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

Highmark will notify you in writing of its determination on your request for reimbursement or other post-service claim within a reasonable period of time following receipt of your claim. That period of time will not exceed 30 days from the

date your claim was received. However, this 30-day period of time may be extended one time by Highmark for an additional 15 days, provided that Highmark determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day post-service claim determination period. If an extension of time is necessary because you failed to submit information necessary for Highmark to make a decision on your post-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your post-service claim.

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

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

Appeal Procedure

Highmark maintains an appeal process involving one level of review. This appeal process is mandatory and must be exhausted before you are permitted to institute such action at law or in equity in a court of competent jurisdiction as may be appropriate.

At any time during the appeal process, you may choose to designate an authorized representative to participate in the appeal process on your behalf. You or your authorized representative shall notify Highmark in writing of the designation. For purposes of the appeal process described below, “you” includes designees, legal representatives and, in the case of a minor, parents 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 a physician or other health care provider with knowledge of your medical condition to act as your authorized representative.

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

If you receive notification that a claim has been denied by Highmark, in whole or in part, you may appeal the decision. Your appeal must be submitted within 180 days from the date of your receipt of notification of the adverse decision.

Upon request to Highmark, you may review all documents, records and other information relevant to your appeal and shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal. Your appeal will be reviewed by a representative from the Member Grievance and Appeals Department. The representative shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the claim which is the subject of your appeal. In rendering a decision on your appeal, the Member Grievance and Appeals 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 Member Grievance and Appeals Department will afford no deference to any prior adverse decision on the claim which is the subject of your appeal.

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Member Grievance and Appeals Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is different from and not the subordinate to any individual who was consulted in a prior review.

Each appeal will be promptly investigated and Highmark will provide 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 decision on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding your right to pursue legal action.

Member Service

As a Highmark Blue Cross Blue Shield member, you have access to a wide range of readily available health education tools and support services, all geared to help you "Have A Greater Hand in Your Health."

Blues On Call

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

A Health Coach is available at the toll-free telephone number -- 1-888-BLUE-428 -- 24 hours a day, seven days a week to help you make informed health care decisions, optimize your self-care capabilities, and follow your prescribed treatment plans. Blues On Call offers three levels of health coaching and support:

- Information and support regarding medical procedures and treatment decisions following a doctor's visit, plus access to audiotapes on hundreds of health-related topics
- Support for making medical and surgical decisions that reflect personal preferences, information regarding treatment options, and ongoing support and follow-up throughout treatment, plus links to health information sources
- Condition management for those at risk for hospitalization, including needs assessments, information on effectively managing a chronic condition, and referrals to appropriate resources

Member Service

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

Highmark Web site

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

Go to www.highmarkbcbs.com. Then click on the "Members" tab and log in to your homepage to take advantage of all these health tools:

- **At "Your Coverage" you can:** research plan options, review your member information and benefits, get coverage information and request replacement identification cards.
- **At "Your Spending" you can:** view your claims, track your health care costs, get information about the costs of medical services and access information on your spending account if you have one.
- **At "Your Health" you can:** assess your wellness, link to health care decision support, explore treatment options, and get information on lifestyle improvement and preventive health care recommendations. For example, this tool offers the following programs to you if you are interested in tobacco cessation:
 - **Telephonic Smokeless®** offers two options for smoking cessation. This telephone-based program can be self-guided at your own pace or coordinated by a professional tobacco cessation specialist. Helpful topics include behavior modification, coping with withdrawal, stress reduction and weight management. Participants have unlimited toll-free access to a qualified tobacco cessation specialist to address additional concerns. Discounted nicotine replacement products are available to enrolled participants. Members can participate in one Smokeless program per year, determined from day of enrollment. For more information or to enroll, call Telephonic Smokeless at 1-800-345-2476.
 - **HealthMedia® Breathe™** is an online smoking cessation program that provides a customized, four-part action plan. The program length is based on your chosen quit date. Participants receive one initial and three follow-up tailored action plans. The follow-up plans promote confidence and motivation, increase active participation in the change process and help prevent relapse.

Other lifestyle improvement programs include:

- **HealthMedia® Succeed™** is an online health risk assessment that identifies individual risk, readiness and confidence to make lifestyle changes. Each participant receives a personalized wellness plan with recommendations to improve or maintain their health.
- **HealthMedia® Nourish™** is an eight-week nutrition program, including a tailored action plan.
- **HealthMedia® Balance™** is a six-week weight management and physical activity program that offers a personally tailored action plan.
- **HealthMedia® Relax™** is a five-week stress management program, including a tailored action plan that helps adults effectively cope with stress.
- **HealthMedia® Care™ For Your Health** is a self-management program designed to help individuals take charge of their chronic conditions such as diabetes, asthma, migraines, high blood pressure and high cholesterol.
- **HealthMedia® Care™ For Your Back** is a self-management program designed to help participants with preventing back pain or managing existing back pain.

- **HealthMedia® Care™ For Diabetes** is a program that simulates a one-on-one session with a nurse counselor, providing a high-quality behavior change intervention addressing various diabetes management factors.
- **HealthMedia® Overcoming™ Depression** is a clinically sophisticated self-help online program providing 24/7 access to coping strategies and skills for a wide range of symptoms associated with depression.
- **HealthMedia® Overcoming™ Insomnia** is a six-week online program that uses proven techniques based on sound clinical evidence to help individuals recover from insomnia.
- **At "Choose Providers" you can:** access our provider directory which includes a wide range of information on doctors, hospitals and other providers; you can also take advantage of a Wellness Discount Program which offers discounts on complementary and alternative medicine, products and services such as fitness centers and spas, nutrition counseling, yoga and pilates, tai chi, massage and body work, health magazines, mind-body therapies, holistic practitioners, acupuncture, personal trainers, vitamins and chiropractic.
- **At "Health Topics" you can:** read articles, get information in the Health Encyclopedia, go "Inside the Human Body," and find the latest information on surgeries and procedures.

Highmark realizes the importance of a healthy lifestyle. Our goal is to help you reach your healthiest potential. That's why, in addition to your Web site wellness tools, we keep you informed via your quarterly member newsletter, *Looking Healthward*. This newsletter contains new product updates, as well as a wide variety of health and preventive care articles and "stay healthy" tips. Watch for your copy in the mail!

Baby BluePrints

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

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

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

By enrolling in this free program you will have access to printed and online information on all aspects of pregnancy and childbirth. Baby BluePrints will also provide you with personal support from a nurse Health Coach available to you throughout your pregnancy. And you'll be sent valuable gifts for participating!

Easy Enrollment

Just call toll-free at 1-866-918-5267. You can enroll at any time during your pregnancy. Once you enroll, you will receive a Welcome Package that includes:

- a comprehensive Maternity Guide with important health information;

- a guide to educational resources found on your member Web site;
- flyers on available discount programs/services;
- a Childbirth Education Class Reimbursement form;
- a Child Immunization and Preventive Care pamphlet; and
- vouchers for the three free gifts:
 - gift at initial enrollment -- choice of book on pregnancy/childcare;
 - gift at the end of the second trimester -- baby photo album; and
 - gift after delivery -- child's dish set and book on child emergency and first aid care.

For More Information

If you have any questions about Baby BluePrints, please call Member Service at the number on your ID card. We encourage you to enroll early in your pregnancy to take full advantage of this exciting program.

Member Rights and Responsibilities

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

You have the right to:

1. Receive information about Highmark, its products and its services, its practitioners and providers, and your rights and responsibilities.
2. Be treated with respect and recognition of your dignity and right to privacy.
3. Participate with practitioners in decision-making regarding your health care. This includes the right to be informed of your diagnosis and treatment plan in terms that you understand and participate in decisions about your care.
4. Have a candid discussion of appropriate and/or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Highmark does not restrict the information shared between practitioners and patients and has policies in place, directing practitioners to openly communicate information with their patients regarding all treatment options regardless of benefit coverage.
5. Voice a complaint or file an appeal about Highmark or the care provided and receive a reply within a reasonable period of time.
6. Make recommendations regarding the Highmark Members' Rights and Responsibilities policies.

You have a responsibility to:

1. Supply to the extent possible, information that the organization needs in order to make care available to you, and that its practitioners and providers need in order to care for you.
2. Follow the plans and instructions for care that you have agreed on with your practitioners.
3. Communicate openly with the physician you choose. Ask questions and make sure you understand the explanations and instructions you are given, and participate in developing mutually agreed upon treatment goals. Develop a relationship with your doctor based on trust and cooperation.

Terms You Should Know

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

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

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

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

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

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

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

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

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

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

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

Medical Researchers constantly experiment with new medical equipment, drugs and other technologies. In turn, health care plans must evaluate these technologies.

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

considered "experimental/investigative" and is not generally covered. However, it may be re-evaluated in the future.

A similar process is followed for evaluating new pharmaceuticals. The Pharmacy and Therapeutics (P & T) Committee assesses new pharmaceuticals based on national and international data, research that is currently underway and expert opinion from leading clinicians. The P & T Committee consists of at least one Highmark-employed pharmacist and/or medical director, five board-certified, actively practicing network physicians and two Doctors of Pharmacy currently providing clinical pharmacy services within the Highmark service area. At the committee's discretion, advice, support and consultation may also be sought from physician subcommittees in the following specialties: cardiology, dermatology, endocrinology, hematology/oncology, obstetrics/gynecology, ophthalmology, psychiatry, infectious disease, neurology, gastroenterology and urology. Issues that are addressed during the review process include clinical efficacy, unique value, safety, patient compliance, local physician and specialist input and pharmacoeconomic impact. After the review is complete, the P & T Committee makes recommendations.

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

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

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

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

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

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

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

Medically Necessary and Appropriate - Services or supplies provided by a facility provider or professional provider that Highmark or its designated agent 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.

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

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

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

Plan Service Area - The geographic area consisting of the following counties in Pennsylvania:

Allegheny	Centre (part)	Forest	Mercer
Armstrong	Clarion	Greene	Potter
Beaver	Clearfield	Huntingdon	Somerset
Bedford	Crawford	Indiana	Venango
Blair	Elk	Jefferson	Warren
Butler	Erie	Lawrence	Washington
Cambria	Fayette	McKean	Westmoreland
Cameron			

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

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

Primary Care Physician (PCP) - A physician who limits his or her practice to family practice, general practice, internal medicine or pediatrics and who may supervise, coordinate and provide specific basic medical services and maintain continuity of patient care.

Provider's Allowable Price - The amount at which a participating pharmacy provider has agreed with Highmark to provide covered medications to you under this program.

Provider's Reasonable Charge (also called "Allowable Charge") - The allowance or payment that Highmark has determined is reasonable for covered services based on the provider who renders such services. The PRC is the portion of the provider's billed charge that is used by Highmark to calculate Highmark's payment to that provider and your liability.

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

Totally Disabled (or Total Disability) - A condition resulting from illness or injury as a result of which, and as certified by a physician, for an initial period of 24 months, you are continuously unable to perform all of the substantial and material duties of your regular occupation. However: (i) after 24 months of continuous disability, "totally disabled" (or total disability) means your inability to perform all of the substantial and

material duties of any occupation for which you are reasonably suited by education, training or experience; (ii) during the entire period of total disability, you may not be engaged in any activity whatsoever for wage or profit and must be under the regular care and attendance of a physician, other than your immediate family. If you do not usually engage in any occupation for wages or profits, "totally disabled" (or total disability) means you are substantially unable to engage in the normal activities of an individual of the same age and sex.

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

Highmark and Have A Greater Hand in Your Health are registered marks of Highmark Inc.

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

Baby BluePrints, BlueCard, BlueCard Worldwide, Blue Cross, Blue Shield and the Cross and Shield symbols are registered service marks 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.

Health Crossroads is a registered mark of Health Dialog.

Telephonic Smokeless is a registered trademark of the American Institute for Preventive Medicine.

HealthMedia, Breathe, Succeed, Nourish, Balance and Relax are registered trademarks of HealthMedia, Inc. Care and Overcoming are trademarks of HealthMedia, Inc.

The Blue Cross and Blue Shield Association, Dr. Dean Ornish, Healthwise, Incorporated, Health Dialog, American Institute for Preventive Medicine and HealthMedia, Inc., are independent companies that do not provide Highmark Blue Cross Blue Shield products and services. They are solely responsible for the services described in this booklet.

Introduction to Your Fashion Advantage Program

The following benefits apply to those members who selected vision coverage. If you have any questions, contact your benefits administrator.

Highmark Blue Cross Blue Shield is very pleased to provide this information about your vision care program administered by Davis Vision, Inc., a leading national administrator of vision care programs.

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. Should the information in this booklet differ from the information contained in the group contract, the terms of the group contract shall govern. This booklet is merely a description of the principal features of your Fashion Advantage program.

How Your Benefits Are Applied - Vision Program

Payment For Network Covered Expenses

Professional Services

Eye Examination and Refractive Services

When a network provider is used, payment for eye examinations and refractive services is based on the provider's reasonable charge.

Payment for the eye examination is made directly to the provider and is accepted as payment in full. If the eye examination is subject to a copayment, as indicated in the Summary of Benefits, you are responsible for paying that copayment amount to the provider.

Low Vision Care Services

When a network provider is used, payment for low vision care services is based on the amount of the provider's charge up to the program allowance.

Payment for low vision care services is also made directly to the provider. However, you are responsible for the difference between the program allowance and the provider's charge.

Laser Vision Correction Services

When a network provider is used, benefits for laser vision correction services are made available in the form of a percentage discount of the provider's charge. You are responsible for paying the entire discounted price to the provider.

Post-Refractive Products

When a network provider is used, payment for post-refractive products is based on the provider's reasonable charge, the amount of the provider's charge up to the program allowance or the discounted price which the provider has agreed to accept in satisfaction of its charge.

Payment of the provider's reasonable charge is made directly to the provider and is accepted as payment-in-full. If the covered post-refractive product is subject to a copayment, as indicated in the Summary of Benefits, you are responsible for paying that copayment amount to the provider.

If payment for the covered post-refractive product is made up to the program allowance, as indicated in the Summary of Benefits, you are responsible for any difference between that amount and the provider's charge.

For those post-refractive products that are provided in the form of a discounted price, as indicated in the Summary of Benefits, you are responsible for paying the entire discounted price to the network provider.

Payment For Out-of-Network Covered Expenses

When an out-of-network provider is used, payment for covered expenses is based on the amount of the provider's charge up to the program allowance, as indicated in the Summary of Benefits. You are responsible for the difference between the program allowance and the provider's charge.

You may "split" your benefits by receiving your eye examination and eyeglasses (or contact lenses) on different dates or through different provider locations, if desired. However, complete eyeglasses must be obtained at one time and from one provider. Continuity of care will best be maintained when all available services are obtained at one time from either a network or out-of-network provider.

Summary of Vision Benefits - Fashion Advantage

The following benefits apply to those members who selected vision coverage. If you have any questions, contact your benefits administrator.

Benefits	Network	Out-of-Network ¹ Reimbursement
FREQUENCY <ul style="list-style-type: none"> • Eye examination (including dilation as professionally indicated) • Eyeglass lenses • Frames • Contact lenses (in lieu of eyeglass lenses) <ul style="list-style-type: none"> • Formulary • Non-Formulary 	One visit every 12 months for members under age 19 and one visit every 24 months for members age 19 and over ² One pair every 12 months for members under age 19 and one pair every 24 months for members age 19 and over ² One frame every 24 months ² One pair of standard daily wear or an initial supply of disposable (4 multi-packs) or planned replacement (2 multi-packs) contact lenses every 12 months for members under age 19 and one pair of standard daily wear or an initial supply of disposable or planned replacement contact lenses every 24 months for members age 19 and over ² Payment of the program allowance ²	
EYE EXAMINATION (including dilation as professionally indicated)	Covered in full	Up to \$32 allowance
FRAMES <ul style="list-style-type: none"> • Fashion level frames from "The Collection" • Designer level frames from "The Collection" • Premier level frames from "The Collection" • Retail allowance toward a provider's frame 	Covered in full \$20 copayment \$40 copayment Up to \$60 allowance	Up to \$30 allowance
STANDARD EYEGLASS LENSES (per pair) ³ <ul style="list-style-type: none"> • Single vision lenses • Bifocal vision lenses • Trifocal vision lenses • Lenticular vision lenses 	Covered in full Covered in full Covered in full Covered in full	Up to \$25 allowance Up to \$36 allowance Up to \$46 allowance Up to \$72 allowance
OPTIONAL EYEGLASS LENSES (per pair) <ul style="list-style-type: none"> • Standard progressive lenses⁴ • Premium progressive lenses⁴ • Glass-Grey #3 prescription sunglasses • Polycarbonate lenses <ul style="list-style-type: none"> • Adult⁵ • Dependent children <ul style="list-style-type: none"> • Single vision Polycarbonate lenses (in lieu of single vision eyeglass lenses) • Bifocal Polycarbonate lenses (in lieu of bifocal eyeglass lenses) • Trifocal Polycarbonate lenses (in lieu of trifocal eyeglass lenses) • Blended segment lenses • Intermediate vision lenses • Glass photochromic lenses • Plastic photosensitive lenses 	\$50 discounted price \$90 discounted price \$11 discounted price \$30 discounted price Covered in full Covered in full Covered in full \$20 discounted price \$30 discounted price \$20 discounted price \$65 discounted price	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered

Benefits	Network	Out-of-Network ¹ Reimbursement
<ul style="list-style-type: none"> High-index (thinner and lighter) lenses Polarized lenses 	\$55 discounted price \$75 discounted price	Not Covered Not Covered
OPTIONAL EYEGLASS LENS COATINGS/TREATMENTS <ul style="list-style-type: none"> Fashion, sun or gradient tinted plastic lenses Ultraviolet coating Scratch-resistant coating Standard ARC (anti-reflective coating) Premium ARC (anti-reflective coating) Ultra ARC (anti-reflective coating) 	\$11 discounted price \$12 discounted price \$20 discounted price \$35 discounted price \$48 discounted price \$60 discounted price	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered
CONTACT LENSES (in lieu of eyeglass lenses - per pair or initial supply of disposable contact lenses) ⁶ <ul style="list-style-type: none"> Contact lens evaluation and fitting <ul style="list-style-type: none"> Daily wear Extended wear Standard daily wear contact lenses Specialty contact lenses Disposable contact lenses Medically necessary contact lenses (<i>prior approval required</i>) 	Covered in full when formulary contact lenses are prescribed Covered in full when formulary contact lenses are prescribed Formulary⁷/Non-Formulary Covered in full / Up to \$85 allowance ⁸ Covered in full / Up to \$85 allowance ⁸ Covered in full / Up to \$85 allowance ⁸ Covered in full	Not Covered Not Covered Up to \$85 allowance Up to \$85 allowance Up to \$85 allowance Up to \$225 allowance
LASER VISION CORRECTION SERVICES DISCOUNT PROGRAM	Up to 25% off provider's charge or 5% off any advertised special price	Not Covered
LOW VISION SERVICES⁹ <ul style="list-style-type: none"> Initial evaluation (<i>prior approval required</i>) Follow-up visits Low vision aids 		Up to \$300 allowance Up to \$100 allowance (per visit) Up to \$600 allowance (per aid) Up to \$1,200 lifetime maximum (for all aids)

1 If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement.

2 Eligibility will be determined from the date of the last similar service paid under this program or any other Highmark Blue Cross Blue Shield vision program for this group.

3 Includes glass, plastic or oversized lenses.

4 Progressive multifocals can be worn by most people. Conventional bifocals will be supplied at no additional charge for anyone who is unable to adapt to progressive lenses; however, the discounted price will not be refunded.

5 Discounted member price waived for monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

6 Contact lenses can be worn by most people. Once the contact lens option is selected and the lenses fitted, they may not be exchanged for eyeglasses.

7 Disposable contact lens wearers will receive four multi-packs of lenses. Planned replacement contact lens wearers will receive two multi-packs of lenses.

8 Reimbursement amount is applied toward the cost of contact lenses. The allowance may or may not apply to the evaluation/fitting.

9 One initial low vision evaluation is eligible every five years. Up to four follow-up care visits will be covered during the five-year period.

Covered Services - Vision Program

Eye Examination and Refractive Services

A comprehensive examination and evaluation of the eyes performed by a professional provider which shall include the following:

- Case history
- Assessment of current visual acuities, distance and near, using your present corrective lenses, if applicable
- External ocular examination including slit lamp examination
- Internal ocular examination including, where professionally indicated, a dilated fundus examination
- Tonometry
- Distance refraction, objective and subjective
- Binocular coordination and ocular motility evaluation
- Evaluation of pupillary function
- Biomicroscopy
- Gross visual fields

Post-Refractive Products

Services and supplies consisting of, but not necessarily limited to: ordering lenses and frames (facial measurement, lens formula and other specifications), the cost of materials, where applicable, verification of the completed prescription upon return from the laboratory, and adjustment of the completed glasses to the patient's face and the subsequent servicing, (ie, refitting, realigning, readjusting and tightening for a period not to exceed 90 days), tints and special lens treatments.

Eyeglasses and Frames

Services and supplies prescribed by a professional provider, and received from a provider. Standard eyeglass lenses include prescription lenses of all sizes and diopter powers, glass or plastic and oversized, and may include any of the following:

- Single vision
- Bifocal vision
- Trifocal vision
- Lenticular vision

Optional eyeglass lenses benefits provided under this program include coverage for polycarbonate lenses. Eligibility for polycarbonate lenses benefits is limited to dependent children and members who are monocular patients or patients with prescription 6.00 diopters or greater.

Benefits also include discounted prices in connection with the following:

- Standard progressive lenses
- Premium progressive lenses
- Glass-Grey #3 prescription sunglasses
- Polycarbonate lenses, limited to adults who are non-monocular patients with prescription less than 6.00 diopters
- Blended segment lenses
- Intermediate vision lenses
- Photochromic glass lenses
- Plastic photosensitive lenses
- High-index lenses
- Polarized lenses

Optional lens coatings and treatment benefits provided under this program include discounted prices for the following:

- Tinted plastic lenses
- Ultraviolet coating
- Scratch-resistant coating
- Standard anti-reflective coating (ARC)
- Premium anti-reflective coating (ARC)
- Ultra anti-reflective coating (ARC)

Contact Lenses

Products and services prescribed by a professional provider which may include the following:

- Contact lens evaluation and fitting
- Ordering of lenses according to specifications
- Cost of the materials
- Verification of the completed prescription
- Fitting
- Dispensing

The contact lenses covered under this program include the following:

- Standard daily wear contact lenses - Contact lenses that are placed in the eye at the beginning of the day and removed at the end of the day.
- Specialty contact lenses - Includes standard daily wear, disposable or planned replacement types of contact lenses.

- Disposable contact lenses/planned replacement contact lenses - Soft contact lenses that are worn for a prescribed length of time and then are discarded. Compared to conventional soft contact lenses, these lenses are intended to offer you better eye health, clearer vision, increased comfort and a "fresh lens feeling" on a continuous basis. There is very little to no maintenance involved with these lenses.
- Medically necessary contact lenses - A contact lens considered eligible only after cataract surgery, corneal transplant surgery or other conditions such as, but not limited to, keratoconus or when adequate visual acuity is not attainable with eyeglasses but can be achieved through the use of contact lenses.

Medically necessary contact lenses are subject to preauthorization. If the required preauthorization is not obtained, no benefits will be paid for such lenses and the entire charge will be your responsibility.

Low Vision Care Services

Services performed by a professional provider who qualifies in evaluating the needs of individuals with low vision. Services include evaluating low vision problems, prescribing optical devices and providing training and instruction to individuals with low vision in order to maximize their remaining usable vision.

Low vision care services are subject to preauthorization. If the required preauthorization is not obtained, no benefits will be paid for low vision care services and the entire charge will be your responsibility.

Laser Vision Correction Services Discount Program

Discounts on services for refractive surgery to eliminate myopia by flattening the central portion of the cornea with a PRK or conventional LASIK laser vision correction rendered by a network professional provider who has specifically contracted with Davis Vision to provide such services.

What Is Not Covered - Vision Program

Except as specifically provided in this booklet, covered services will not include charges:

- for examinations, materials or products which are not listed herein as a covered service;
- for medical or surgical treatment of eye disease or injury;
- for visual therapy;
- for diagnostic services, such as diagnostic x-rays, cardiographic and encephalographic examinations and pathological or laboratory tests;
- for drugs or any other medications;
- for procedures determined by Highmark to be special or unusual, such as but not limited to, orthoptics, vision training and tonography;
- for eye examinations or materials necessitated by your employment or furnished as a condition of employment;
- for any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any legislation of any governmental unit. This exclusion applies whether or not you file a claim for said benefits or compensation;
- to the extent benefits are provided by any governmental unit, unless payment is required by law;
- for which you would have no legal obligation to pay in the absence of this or any similar coverage;
- received from a medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
- performed prior to your effective date;
- for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
- for temporary devices, appliances and services;
- for which you incur no charge;
- the cost of which has been or is later recovered in any action at law or in compromise or settlement of any claim except where prohibited by law;
- in a facility performed by a professional provider who is compensated by the facility for similar covered services performed for you;
- to the extent payment has been made under Medicare when Medicare is primary or would have been made if you had applied for Medicare and claimed Medicare

- benefits; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program and you so elect this coverage as primary;
- 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 self-insured plan, or payable in any manner under any state law governing liability for injuries arising from the maintenance or use of a motor vehicle;
 - for professional services not performed by licensed personnel;
 - for the cost of any insurance premiums indemnifying you against losses for lenses or frames;
 - for non-prescription industrial safety glasses and safety goggles;
 - for sports glasses;
 - incurred after the date of termination of your coverage except for lenses and frames prescribed prior to such termination and delivered within 31 days from such date;
 - for duplicate devices, appliances and services;
 - for any lenses which do not require a prescription;
 - for prosthetic devices and services;
 - for low vision aids and services not otherwise specified herein;
 - for non-prescription (Plano) lenses;
 - for special lens designs or coatings not otherwise specified herein;
 - for replacement of lost or stolen eyeglass lenses or frames or lost, stolen or damaged contact lenses and safety eyeglasses;
 - for replacement of broken frames and eyeglass lenses that are not supplied by Davis Vision's ophthalmic laboratories;
 - for replacement of lost, damaged or broken safety eyeglasses supplied by Davis Vision's ophthalmic laboratories or any other manufacturer;
 - for additives for glass lenses or contact lenses not otherwise specified herein; and
 - for sales tax and shipping charges that may be associated with purchases of post-refractive products covered herein.

How Your Program Works - Vision Program

Network Care

To receive services from a provider in the network, call the network provider of your choice and schedule an appointment. Identify yourself as a Highmark Blue Cross Blue Shield member in a vision program administered by Davis Vision, and provide the office with your ID number (located on your Highmark ID card), and the name and date of birth of any covered dependent receiving services. The provider's office will verify your eligibility for services, and no claims forms are required.

The Davis Vision provider network is being used for this vision product through a contractual arrangement between Davis Vision and Highmark. Davis Vision is an independent company that manages a network of licensed vision providers in both private practice and retail locations. Network providers are reviewed and credentialed to ensure that standards for quality and service are maintained. To find a network provider, go to www.highmarkbcbs.com and click on "find a vision network provider." Click "OK" to be redirected to the Davis Vision, Inc., Web site. Enter your zip code and mile radius then click on "Search" to see the most current listing of providers that will accept your vision program. Or, you can call Member Service toll-free at 1-800-223-4795.

In order to provide you with the greatest amount of flexibility and convenience, the network includes a number of retail establishments. Benefits at the retail locations may vary slightly from other locations. However, your value is comparable.

Out-of-Network Care

You and your covered dependents may use an out-of-network provider for certain covered services, although you can receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement. For specific details, see the "How To File A Claim" section of the benefit book.

Eligible Providers

- Ophthalmologist
- Optician
- Optometrist
- Physician
- Retail optical dispensing firm
- Supplier

General Information - Vision Program

Who is Eligible for Coverage

You may enroll your:

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

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

Changes in Membership Status

For Highmark to administer consistent coverage for you and your dependents, you must keep your Employee Benefit Department informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage.

Your newborn child may be covered under your program for a maximum of 31 days from the moment of birth. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within such period.

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 temporarily extend their vision coverage to certain categories of employees and their covered dependents when, due to certain "qualifying events," they are no longer eligible for group coverage.

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

Leave of Absence or Layoff

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

Termination of Your Coverage Under the Employer Contract

Your coverage can be terminated in the following instances:

- When you cease to be an employee, your coverage will terminate at the end of the last month for which payment was made.
- When you fail to pay the required contribution, your coverage will terminate at the end of the last month for which payment was made.
- Termination of the employer contract automatically terminates the coverage of all the members. It is the responsibility of the employer to notify you of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given to you by the employer.
- If it is proven that you obtained or attempted to obtain benefits or payment for benefits through fraud or intentional misrepresentation of a material fact, Highmark may, upon notice to you, terminate your coverage under the program.

How to File a Claim - Vision Program

If you receive services from a network provider, you will not have to file a claim. If you receive services from an out-of-network provider, you must file the claim for reimbursement to:

Vision Care
P.O. Box 1525
Latham, NY 12110-1525

Your claims must be submitted to Davis Vision within 20 days after the date of service or as soon thereafter as reasonably possible, but not later than within two years of the date of service.

Only one claim per service may be submitted for reimbursement each benefit cycle. To file a claim, take the following steps:

- Request an itemized bill which shows:
 - the patient's name and address;
 - the date of service;
 - the type of service and diagnosis;
 - itemized charges; and
 - the provider's complete name and address.
- Make a copy of your itemized bill for your records.
- Complete a claim form. To request claim forms, please visit the Highmark Web site at www.highmarkbcbs.com or call 1-800-223-4795.

Your Explanation of Benefits Statement

For out-of-network services, once your claim is processed, you will receive an Explanation of Benefits (EOB) statement. This statement lists the provider's charge and total benefits payable.

Additional Information on How to File a Claim

Member Inquiries

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

Filing Benefit Claims

- ***Authorized Representatives***

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

- ***Requests for Preauthorization and Other Pre-Service Claims***

When preauthorization is required under this program prior to receiving covered services from a network provider, the network provider will contact Davis Vision, complete any required prior approval form and submit any information necessary to request that services be preauthorized. If preauthorization is denied, your network provider will inform you, and you have the right to file an appeal. The appeal process is described in the Appeal Procedure section below.

If services requiring preauthorization are to be received from an out-of-network provider, the out-of-network provider will not initiate the preauthorization process on your behalf. In that case, you should ask the doctor to provide you with a letter explaining why the services you received were medically necessary (letter of medical necessity). Attach the letter of medical necessity and copies of the bill that you paid to your completed claim form and file that with Highmark in order to be reimbursed. You will receive written notice of any decision on a request for preauthorization or other pre-service claim within 15 days from the date Davis Vision receives your claim. However, this 15-day period of time may be extended one time by Davis Vision for an additional 15 days if 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 Davis to make a decision on your pre-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your pre-service claim.

If your request for preauthorization or approval of any other pre-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 determination and a statement describing your right to file an appeal.

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

When you receive services from a network provider, the provider will report the services to Davis Vision and payment will be made directly to the provider. Davis Vision will also notify the provider of any amounts that you are required to pay in the

form of a copayment. If you believe that the copayment amount is not correct or that any portion of those amounts are covered under your benefit program, you may file an appeal.

Determinations on Benefit Claims

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

If you have submitted a post-service claim for services of an out-of-network provider, Davis Vision 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 for an additional 15 days, provided that Davis Vision 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 Davis Vision to make a decision on your post-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your post-service claim.

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

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

Appeal Procedure

If you receive notification that a claim has been denied, in whole or in part, you may appeal the decision. Your appeal must be submitted within 180 days from the date of your receipt of notification of the adverse decision.

Davis Vision handles all appeal decisions under the Highmark vision programs. The process involves one level of review. This appeal process is mandatory and must be exhausted before you are permitted to institute such action at law or in equity in a court of competent jurisdiction as may be appropriate.

At any time during the appeal process, you may choose to designate an authorized representative to participate in the appeal process on your behalf. You or your authorized representative shall notify Davis Vision in writing of the designation. For purposes of the

appeal process described below, “you” includes designees, legal representatives and, in the case of a minor, parents entitled or authorized to act on your behalf. Davis Vision reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

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

Upon request, you may review all documents, records and other information relevant to your appeal and shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal. Your appeal will be reviewed by a representative from the Quality Assurance Department. The representative shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the claim which is the subject of your appeal. In rendering a decision on your appeal, the Quality Assurance 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 Davis Vision. The Quality Assurance Department will afford no deference to any prior adverse decision on the claim which is the subject of your appeal.

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, the Quality Assurance Department will consult with a vision care professional who has appropriate training and experience and who is different from and not the subordinate to any individual who was consulted in a prior review.

Each appeal will be promptly investigated and Davis Vision will provide written notification of its decision within the following time frames:

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

In the event Davis Vision renders an adverse decision on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding your right to pursue legal action.

Member Service - Vision Program

We all have questions about our vision care coverage from time to time. To help you get accurate answers to questions and up-to-date information about your vision program, please visit Highmark's Web site at www.highmarkbcbs.com or call Highmark at 1-800-223-4795. You can get the following information:

- Learn about the Davis Vision company
- Find network providers and where to access the Davis Vision Frame Collection
- Verify eligibility for yourself or your dependents
- Print an enrollment confirmation from our Web site
- Request an out-of-network provider reimbursement form
- Speak with a Member Service representative
- Initiate an appeal of a benefit denial
- Ask any questions about your vision care benefits

Member Service representatives are available Monday through Friday, 8:00 a.m. to 5:00 p.m. Eastern Time.

Members who use a TTY (teletypewriter) because of a hearing or speech disability may access TTY services by calling 1-800-523-2847.

Member Services

Replacement Contact Lenses by Mail

As a member of this Highmark program, you are also eligible for free membership and access to a mail order replacement contact lens service, Lens 1-2-3[®], which allows you to enjoy the guaranteed lowest prices on contact lens replacement materials. For more information, please call 1-800-LENS-123 (1-800-536-7123) or visit the Lens 1-2-3 Web site at www.Lens123.com.

Warranty Information

A one-year unconditional breakage warranty is provided for all eyeglasses completely supplied through the Davis Vision collection.

Terms You Should Know - Vision Program

Blended Segment Lenses - Eyeglass lenses containing two different prescriptions, one prescribed for distance and one for near. Segment with near prescription is buffed out so as not to be noticeable to the eye.

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

- **Pre-Service Claim** - A request for preauthorization or prior approval of a covered service which under the terms of your coverage must be approved before you receive the covered service.
- **Post-Service Claim** - A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

Copayment - A specified dollar amount of eligible expenses which you are required to pay for a specified covered service.

Designated Agent - An entity that has contracted with Highmark to perform a function and/or service in the administration of this program.

Discounted Price - The reduced amount that network providers, regardless of their actual or usual charge, have agreed to bill you and accept as payment in full for a specific service.

Formulary Contact Lenses - Approved contact lenses as specified by Highmark.

Glass-Grey #3 Prescription Sunglasses - A glass material eyeglass lens that is colored all the way through the lens that is not dyed, dipped or coated.

High Index Lenses - Eyeglass lenses made with material that results in thinner and lighter lenses than normal plastic eyeglass lenses.

Intermediate Vision Lenses - Eyeglass lenses that are designed to correct vision at ranges intermediate to distant and near objects as typically used for occupational or computer use purposes.

Low Vision - A significant loss of vision but not total blindness.

Medically Necessary Contact Lenses - A contact lens considered eligible only after cataract surgery, corneal transplant surgery or other conditions such as, but not limited to, keratoconus or when adequate visual acuity is not attainable with eyeglasses but can be achieved through the use of contact lenses.

Network Provider - A provider who has entered into a participation agreement with Davis Vision pertaining to payment of covered services.

Non-Formulary Contact Lenses - Contact lenses that have not been approved by Highmark.

Non-Network (Out-of-Network) Provider - A provider who has not entered into a participation agreement with Davis Vision pertaining to payment for covered services.

Ophthalmologist - A physician who specializes in the diagnosis, treatment and prescription of medications and lenses related to conditions of the eye, and who may perform eye examination and refractive services.

Optician - A technician who makes, verifies and delivers lenses, frames and other specially fabricated optical devices and/or contact lenses upon prescription to the intended wearer.

Optometrist - A professional provider, licensed where required, who examines, diagnoses, treats and manages diseases, injuries and disorders of the visual system, the eye and associated structures as well as identifies related systemic conditions affecting the eye.

Photochromic Glass Lenses - Eyeglass lenses that darken when exposed to intense illumination, ie, sunlight, and which lighten in color when illumination is reduced.

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

Plastic Photosensitive Lenses - Plastic eyeglass lenses that turn dark when exposed to the ultraviolet rays of the sun.

Polarized Lenses - Eyeglass lenses that are either green, gray or brown and that redirect the way light enters the lens.

Polycarbonate Lenses - Impact resistant and lightweight eyeglass lenses.

Preauthorization - The process through which selected covered services or post-refractive products are pre-approved by Highmark for medical necessity or other benefit eligibility criteria.

Premium Anti-Reflective Coating (ARC) - A clear coating placed on eyeglass lenses that limits light reflection by allowing the maximum amount of light to pass through the lens (i.e. Essilor Crizal™, Carl Zeiss Carat Gold™, etc.)

Premium Progressive Lenses - All-distance lenses that have no line but progress from distance to intermediate, to near (i.e. Varilux™, etc.)

Professional Provider - A person or practitioner licensed where required and performing services within the scope of such licensure. The professional providers are: doctor of medicine, doctor of osteopathy, doctor of ophthalmology or doctor of optometry.

Program Allowance - A schedule of allowances as established by Highmark, subject to any regulatory approvals.

Provider's Reasonable Charge - The negotiated fee or contracted fee schedule amount that a network provider has agreed with Davis Vision to accept as payment for a covered service.

Retail Optical Dispensing Firm - An enterprise engaged in the performance of optical dispensing services and the sale of ophthalmic products to the public at large.

Safety Eyeglasses - Prescription eyeglasses conforming to applicable American National Standards Institute (ANSI) standards for protective eye devices as determined by the U.S. Department of Labor, Occupational Safety & Health Administration.

Scratch-Resistant Coating - Coating applied to eyeglass lenses to increase the scratch resistance of the lens surface.

Standard Anti-Reflective Coating (ARC) - A clear coating placed on eyeglass lenses that limits light reflection by allowing the maximum amount of light to pass through the lens (i.e. Essilor Reflection Free™, Carl Zeiss Gold ET™, etc.)

Standard Progressive Lenses - All-distance eyeglass lenses that have no line but progress from distance to intermediate, to near (i.e. AO Compact™, Sola VIP™, etc.)

Supplier - An individual or entity that is in the business of providing or dispensing post-refractive products as provided herein. Suppliers include but are not limited to retail optical dispensing firms and opticians.

Tinted Plastic Lenses -

- a) Fashion tinting - Eyeglass lenses dyed or coated with pigment of uniform color and density throughout the entire lens.
- b) Gradient tinting - Eyeglass lens coating that is darker at the top of the lens, fading to light at the bottom of the lens.

Ultra Anti-Reflective Coating (ARC) - A clear coating placed on eyeglass lenses that limits light reflection by allowing the maximum amount of light to pass through the lens (i.e. Essilor Alize™ with Clear Guard, Carl Zeiss Carat Advantage Gold™, etc.)

Ultraviolet Coating - A coating on plastic or glass eyeglass lenses that blocks ultraviolet rays.

Highmark is a registered mark of Highmark Inc.

HIGHMARK INC. NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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

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

Our Legal Duties

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

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

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

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

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

I. Uses and Disclosures of Protected Health Information

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

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

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

Payment

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

For example:

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

Health Care Operations

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

For example:

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

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

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

(i) Business Associates.

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

(ii) Other Covered Entities.

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

II. Other Possible Uses and Disclosures of Protected Health Information

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

A. To Plan Sponsors

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

B. Required by Law

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

C. Public Health Activities

We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or

disclose information for the purpose of preventing or controlling disease, injury, or disability.

D. Health Oversight Activities

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

E. Abuse or Neglect

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

F. Legal Proceedings

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

G. Law Enforcement

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

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

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

I. Research

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

J. To Prevent a Serious Threat to Health or Safety

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

K. Military Activity and National Security, Protective Services

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

L. Inmates

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

M. Workers' Compensation

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

N. Others Involved in Your Health Care

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

III. Required Disclosures of Your Protected Health Information

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

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

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

B. Disclosures to You

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

IV. Other Uses and Disclosures of Your Protected Health Information

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

V. Your Individual Rights

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

A. Right to Access

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

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

To inspect and/or copy your protected health information, you may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. The first request within a 12-month period will be free. If you request access to your designated record set more than once in a 12-month period, we

may charge you a reasonable, cost-based fee for responding to these additional requests. If you request an alternative format, we will charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

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

B. Right to an Accounting

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

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

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

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

C. Right to Request a Restriction

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

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

D. Right to Request Confidential Communications

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

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

E. Right to Request Amendment

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

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

F. Right to a Paper Copy of this Notice

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

VI. Questions and Complaints

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

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

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

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

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

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

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

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

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

- We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided

on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.

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

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

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

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

guard non-public personal financial information from unauthorized access, use and disclosure.

For questions about this Privacy Notice, please contact:

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

You are hereby notified, your health care benefit program is between the Group, on behalf of itself and its employees and Highmark Blue Cross Blue Shield. Highmark Blue Cross Blue Shield is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield Plans throughout the United States. Although all of these independent Blue Cross and Blue Shield Plans operate from a license with the Association, each of them is a separate and distinct operation. The Association allows Highmark Blue Cross Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Highmark Blue Cross Blue Shield shall be liable to the Group, on behalf of itself and its employees, for any Highmark Blue Cross Blue Shield obligations under your health care benefit program.



An Independent Licensee of the Blue Cross and Blue Shield Association