

Signature 65SM

**Municipal Employers Insurance Trust
(MEIT)**

**Signature 65 with Major Medical
Effective January 1, 2009**

Produced March, 2009



A Retiree Program for Medicare Eligibles

*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 February 6, 2009, the following Professional Providers are included in the **Eligible Providers** section of your benefit booklet in accordance with Act 108 of 2008.

- Clinical social worker
- Marriage and family therapist
- Professional counselor

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This Booklet is not a Contract

This booklet does not constitute a contract of benefits and provisions. The complete set of terms of coverage are set forth in the Group Contract issued by Highmark Blue Cross Blue Shield, an Independent Licensee of the Blue Cross and Blue Shield Association. This booklet is merely a description of the principal features of your Signature 65 program.

Introduction to Your Signature 65sm Program

This booklet provides you with the information you need to understand Signature 65, a Medicare complement program from Highmark Blue Cross Blue Shield. We encourage you to take the time to review this information so you understand how your health care program works.

Medicare does not pay for all of your hospital and doctor expenses if you become sick or injured. But Signature 65 complements your Medicare benefits by paying for some or all of the deductibles or coinsurance that are not covered by Medicare alone. Signature 65 also provides additional benefits, which are not covered by Medicare.

Signature 65 Features

Reliable Health Coverage

Highmark's financial stability has earned the company a "strong" rating and helps assure your coverage will be with you now and in the future.

Freedom of Choice

We know how important your relationship is with your doctor. Signature 65 lets you go directly to the doctors and hospitals of your choice for treatment. You aren't restricted to a limited network of hospitals and doctors.

Automatic Claim Filing

When you receive treatment from Medicare-participating physicians, hospitals and other providers, just present your Medicare ID card and your Signature 65 ID card. As a Highmark customer, you benefit because your claims for deductibles and coinsurance for covered expenses are automatically processed for you. You save time and trouble because, in most cases, we do all the paperwork for you.

Peace of Mind

Not all Medicare complement programs offer you full protection when you travel outside a specific geographic location. As a Highmark member, you will enjoy the security of knowing that your identification card is recognized and accepted by Medicare-participating hospitals and physicians throughout the United States.

A Wide Range of Member Support

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[®]" to maintain or improve your health.

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

If you have any questions on your Signature 65 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 Major Medical coverage and how it works, here's an explanation of some benefit terms found in your Summary of Benefits and a description of how your benefits are applied. For specific amounts, refer to your Summary of Benefits.

Major Medical Cost-Sharing Provisions

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

Benefit Period

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

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.

Deductible

The deductible is a specified dollar amount you must pay for covered Major Medical 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.

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 deductibles, mental health/substance abuse expenses, or amounts in excess of the provider's reasonable charge.

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 plan 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.

Summary of Benefits - Signature 65

COVERED SERVICES	GROUP PAYS
Medicare Part A Covered Services	
Inpatient Hospital (Medicare inpatient mental health care coverage in a psychiatric facility is limited to 190 inpatient hospital days in a lifetime.)	
Days 1 – 60 Days 61 – 90 Days 91 – 150 For 60 Medicare lifetime reserve days that may be used only once Additional Inpatient Hospital Days	Medicare Part A deductible Medicare Part A coinsurance Medicare Part A coinsurance 100% of Medicare eligible expenses for 365 days per benefit period after the 60 Medicare inpatient lifetime reserve days are exhausted.
Inpatient Rehabilitation	100% of the provider's reasonable charge
Drug and Alcohol Abuse Rehabilitation	100% of the provider's reasonable charge for 365 additional inpatient hospital days per benefit period, after the Medicare inpatient hospital days have been exhausted
Skilled Nursing Facility Care	
Days 21 to 100 Day 101 and beyond	Medicare Part A coinsurance Not covered by this program
Blood	First three pints per calendar year
Medicare Part B Covered Services	
Deductible	Not covered by this program
Coinsurance	Medicare Part B coinsurance

COVERED SERVICES	GROUP PAYS
Therapy Services	
Outpatient Physical Therapy	Medicare Part B coinsurance
Outpatient Occupational Therapy	Medicare Part B coinsurance
Outpatient Speech Therapy	Medicare Part B coinsurance
Durable Medical Equipment	Medicare Part B coinsurance
Outpatient Hospital Services (except Outpatient Psychiatric Treatment)	Medicare Part B coinsurance
Outpatient Psychiatric Treatment	Medicare Part B coinsurance
Blood	First 3 pints per calendar year
Outpatient Prescription Drugs used in Immunosuppressive Therapy	Medicare Part B coinsurance
Emergency Care	
Emergency Accident Care	Medicare Part B coinsurance
Emergency Medical Care	Medicare Part B coinsurance
Preventive Services	
Mammogram Screening	Medicare Part B coinsurance (not subject to Medicare Part B deductible)
Gynecological Services	Medicare Part B coinsurance (not subject to Medicare Part B deductible)
Colorectal Cancer Screening	Medicare Part B coinsurance
Diabetes Monitoring	Medicare Part B coinsurance
Bone Mass Measurements	Medicare Part B coinsurance
Prostate Cancer Screening	Medicare Part B coinsurance
Vaccinations	Medicare Part B coinsurance
Additional Medicare Part B Benefits	Medicare Part B coinsurance
Additional Benefits Not Covered By Medicare	

COVERED SERVICES	GROUP PAYS
Additional Inpatient Psychiatric Treatment	100% of Medicare Eligible Expenses for 365 additional Inpatient Hospital days per benefit period.
Chemotherapy*	80% of the provider's reasonable charge
Enteral Formulae*	80% of the provider's reasonable charge
Routine Gynecological Exams and Papanicolaou Smear*	80% of the provider's reasonable charge

*State mandate applies.

Summary of Benefits - Major Medical

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

Benefits	Major Medical
General Provisions	
Benefit Period	Calendar Year
Deductible (per benefit period)	\$250 Individual
Plan Payment Level -- Based on the provider's reasonable charge (PRC)	80% after deductible until out-of-pocket is met; then 100%
Out-of-Pocket Limit	\$2,000 Individual
Lifetime Maximum (per member)	\$500,000
Office Visits	
Clinic Visits/Outpatient Medical Visits	80% after deductible
Preventive Care Services	
Adult	
Routine physical exams	Not Covered
Routine gynecological exams, including a PAP Test	80%; deductible does not apply
Mammograms, annual routine and medically necessary	80%; deductible does not apply
Pediatric	
Routine physical exams	Not Covered
Immunizations	80%; deductible does not apply
Emergency Room Services	
Emergency Accident Care	80% after deductible
Emergency Medical Care	80% after deductible
Hospital Services	
Hospital Services - Inpatient	80% after deductible
Hospital Services - Outpatient	80% after deductible
Inpatient Medical Care (professional)	80% after deductible
Therapy and Rehabilitation Services	
Spinal Manipulations	80% after deductible Limited to 20 visits per benefit period
Physical Medicine	80% after deductible Limited to 20 visits per benefit period
Speech Therapy	80% after deductible Limited to 20 visits per benefit period
Occupational Therapy	80% after deductible Limited to 20 visits per benefit period
Radiation Therapy	80% after deductible
Therapy and Rehabilitation Services	80% after deductible

Benefits	Major Medical
Diagnostic Services	
Diagnostic Services	80% after deductible
Behavioral Health Services	
Mental Health - Inpatient	80% after deductible
Mental Health - Outpatient	50% after deductible
Substance Abuse -Inpatient Detoxification	80% after deductible
Substance Abuse - Inpatient Residential Treatment and Rehabilitation Services	80% after deductible
Substance Abuse - Outpatient	50% after deductible
Other Services	
Assisted Fertilization Treatment	Not Covered
Ambulance	80% after deductible
Anesthesia	80% after deductible
Dental Services Related to Accidental Injury	80% after deductible
Diabetes Treatment	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible
Enteral Formulae	80%; deductible does not apply
Home Health Care	80% after deductible
Hospice	Not Covered
Infertility Counseling, Testing and Treatment ¹	80% after deductible
Maternity (facility and professional services)	80% after deductible
Pediatric Extended Care Services	80% after deductible
Prescription Drugs	Not Covered
Private Duty Nursing	80% after deductible
Skilled Nursing Facility Services	80% after deductible
Surgical Services	80% after deductible
Assistant At Surgery	80% after deductible
Second Surgical Opinion	80% after deductible
Transplant Services	80% after deductible

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

Covered Services - Signature 65 Medical Program

MEDICARE PART A SERVICES

Hospital and Related Benefits

Benefits are provided for semi-private accommodations and all other services provided and billed for by the hospital. Coverage includes, but is not limited to, meals and special diets, general nursing care, drugs and medicines, use of operating, recovery and other specialty service rooms, anesthesia, laboratory tests, x-ray examinations, dressings, plaster casts and splints, oxygen, processing and administration of blood and blood plasma, physiotherapy and hydrotherapy, radiation therapy, EKG and EEG, basal metabolism testing, intravenous fluids and prosthetic devices surgically implanted.

Continued Stay Review

The medical progress of patients is reviewed to identify the continued medical necessity and appropriateness of the inpatient stay. If a member elects to continue to receive inpatient services after receipt of written notification by the plan, or its designated agent, that such level of care is no longer medically necessary and appropriate, the member will be financially responsible for the full amount of the professional providers' charges from the date appearing on the written notification.

Inpatient Rehabilitation

Coverage is provided for Medicare eligible expenses after the Medicare inpatient hospital days are exhausted.

Drug and Alcohol Abuse Rehabilitation

Coverage is provided for individual and group counseling and psychotherapy, psychological testing and family counseling for the treatment of alcohol abuse and drug abuse when rendered to a member by a hospital.

Skilled Nursing Facility Care

Coverage is provided for a semi-private room meals, skilled nursing and rehabilitative services, and other services and supplies when: the member needs daily skilled nursing or rehabilitation services; services as a practical matter can only be provided in an inpatient facility; and the care begins within 30 days of the member's discharge from a hospital stay of at least three days.

MEDICARE PART B SERVICES

Medical and Surgical Benefits

Coverage of Medicare Part B coinsurance is provided for physician services and inpatient and outpatient medical and surgical supplies.

Generally, Medicare Part B coverage includes, but is not limited to the following:

- X-ray, radium and radioactive isotope therapy
- Diagnostic x-ray, diagnostic laboratory and other diagnostic tests
- Rental or purchase of durable medical equipment for use in your home, when prescribed by a provider
- Splints, casts and surgical dressings
- Ambulance services where transportation by other means could endanger the patient's health, but only to the extent provided in the Medicare Part B regulations
- Surgical services performed by a professional provider, including services involving surgery of the jaw or related structures or setting of fractures of the jaw or facial bones
- Transplant services performed for a member including the services for the removal of an organ from a donor when the donor is not a member
- Medical services performed by a professional provider
- Services and supplies furnished as part of a professional provider's professional care and which are commonly included in the charge
- Obstetrical delivery including pre- and post-natal care for a female member
- Devices (other than dental) which replace all or part of an internal body organ, including replacement of the devices
- Leg, arm, back and neck braces and artificial legs, arms and eyes, including replacements, if required, because of a change in the member's physical condition

Therapy Services

Coverage is provided for the following services, when ordered by a physician:

- Outpatient physical therapy
- Outpatient occupational therapy
- Outpatient speech therapy

Outpatient Hospital Services

Coverage is provided for services for the diagnosis or treatment of an illness or injury.

Outpatient Psychiatric Treatment

Coverage is provided for the outpatient treatment of mental illness when services are rendered in a hospital or psychiatric facility.

Emergency Care

Coverage is provided for the following Medicare eligible expenses:

Emergency Accident

The initial treatment of bodily injuries resulting from an accident and any follow-up care.

Emergency Medical

The initial treatment after the sudden onset of a medical condition manifesting itself by acute symptoms that require immediate medical attention and any follow-up care.

Preventive Services

Coverage is provided for the following Medicare eligible expenses:

Mammogram Screening

Benefits are provided once every 12 months for all female members age 40 and over, and once for female members age 35-39.

Gynecological Services

Benefits are provided to all female members for pelvic exams to check for cervical and vaginal cancer once every two years. If the member is of child bearing age and has had an abnormal Pap smear within three years, or has a high risk for cervical or vaginal cancer, coverage is provided for a pelvic exam every year. In addition to the pelvic exam, a clinical breast exam is also covered to check for breast cancer. This benefit is not subject to the Medicare Part B deductible.

Colorectal Cancer Screening

Benefits are provided to members age 50 and older (no age limit for a colonoscopy) as follows:

- Flexible sigmoidoscopy once every four years
- Colonoscopy once every two years if the member is a high risk for colon cancer
- Barium enema (doctor can substitute for sigmoidoscopy or colonoscopy)

Diabetes Monitoring

Benefits are provided to all members with diabetes (insulin users and non-users) for glucose monitors, test strips, lancets and self-management training.

Bone Mass Measurements

Benefits are provided to certain members at risk for losing bone mass.

Prostate Cancer Screening

Benefits are provided to all male members age 50 and older once every 12 months.

Vaccinations

Benefits are provided to all members on an outpatient basis for the following:

- Hepatitis B vaccine immunization for individuals at a high or intermediate risk for Hepatitis B

- Flu shots every 12 months
- Pneumococcal (pneumonia) shot upon the recommendation of a professional provider

Additional Medicare Part B Benefits

Coverage is provided for the following Medicare eligible expenses:

- Limited chiropractic services
- One pair of eyeglasses after cataract surgery with an intraocular lens
- Kidney dialysis and kidney transplants
- Medical supplies for items such as ostomy bags and some diabetic supplies
- Prosthetic devices, including breast prosthesis after mastectomy and subsequent replacements of the removed breast or portions thereof, pursuant to an order of the member's physician, and replacements are also covered due to the normal growth of a child when medically necessary and appropriate
- Services of practitioners such as clinical psychologists, social workers and nurse practitioners
- Transplants, under certain conditions, for heart, lung and liver
- Nursery care for routine newborn care performed while the mother is confined in an accredited hospital

ADDITIONAL BENEFITS NOT COVERED BY MEDICARE

Additional Inpatient Psychiatric Treatment

Coverage is provided for additional inpatient days in a hospital or psychiatric facility after the member has exhausted 190 Medicare inpatient hospital lifetime days in a psychiatric facility.

Chemotherapy

Benefits are available for the treatment of malignant diseases regardless of the type of facility in which treatment is rendered.

Enteral Formulae

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

Routine Gynecological Examination and Papanicolaou Smear

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

Covered Services - Major Medical Program

MAJOR MEDICAL SERVICES

Major Medical coverage is designed to supplement your Basic Plan benefits by providing additional protection against the expenses incurred due to non-occupational illness or accidents only when such services are determined to be medically necessary and appropriate for the proper treatment of the patient's condition. Please refer to the section headed "Terms You Should Know" for specific details. Any benefit limits, deductibles and coinsurance amounts are described in the Summary of Benefits. Major Medical will reimburse you for certain covered medical expenses not covered by the Basic Plan.

Ambulance Services

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

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

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

Dental Services Related to Accidental Injury

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

Diabetes Treatment

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

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

changes in 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 ECG, EEG, and other electronic diagnostic medical procedures and physiological medical testing approved by Highmark
- Allergy testing, consisting of percutaneous, intracutaneous, and patch tests and in vitro tests

Durable Medical Equipment

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

Enteral Formulae

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

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

- When provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized, instead of regular shelf food or regular infant formulas; or

- When provided orally, and identified as one of the following types of defined formula:
 - With hydrolyzed (pre-digested) protein or amino acids; or
 - With specialized content for special metabolic needs; or
 - With modular components; or
 - With standardized nutrients.

These additional benefits are subject to the program deductible, copayments and maximums.

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
- The following formulae when provided orally: semisynthetic intact protein/protein isolates, natural intact protein/protein isolates; and intact protein/protein isolates
- Normal food products used in the dietary management of rare hereditary genetic metabolic disorders

Home Health Care Services

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

- Skilled nursing services of an RN or LPN, excluding private duty nursing services
- Physical medicine, speech therapy and occupational therapy
- Medical and surgical supplies and equipment provided by the home health care agency or hospital program for home health care
- Durable medical equipment
- Oxygen and its administration
- Medical social service consultations
- Health aide services to an individual who is receiving covered nursing services or therapy and rehabilitation services

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

No home health care benefits will be provided for:

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

Hospital Services

Bed and Board

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

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

Ancillary Services

Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms and equipment;
- drugs and medicines provided to you when you are an inpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives.
Expenses incurred for the first 2 one-pint units of whole blood or blood components are your responsibility.
- medical and surgical dressings, supplies, casts, and splints;
- oxygen and its administration.

Mastectomy and Breast Cancer Reconstruction

The program covers a mastectomy performed on an inpatient or outpatient basis, as well as surgery to reestablish symmetry or alleviate functional impairment. This includes, but is not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy. Also covered is the use of initial and subsequent prosthetic devices to replace the removed breast or portions thereof. Physical complications of all stages of mastectomy are also covered, including lymphedema. The program covers one home health care visit, as determined by your physician, within 48 hours after discharge if discharge occurred within 48 hours after your admission for a mastectomy.

Maternity Services

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

Normal Pregnancy

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

Complications of Pregnancy

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

Nursery Care

Ordinary nursery care of the newborn infant, including inpatient medical visits by a professional provider. Benefits will continue for a maximum of 31 days.

Maternity Home Health Care Visit

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

Under state law, entities like 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 and consultations by a professional provider for the diagnosis and treatment of an injury or illness to you when you are an inpatient.

Outpatient Medical Care Services

Medical care and consultations rendered by a professional provider for the diagnosis and treatment of an injury or illness when you are an outpatient for a condition not related to surgery.

Orthotic Devices

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

Pediatric Extended Care Services

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

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

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

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

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

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

Prescription Drugs

Benefits will be provided for drugs and medicines requiring a professional provider's prescription and dispensed by a licensed pharmacist.

Highmark has made arrangements with a network of pharmacies to offer you discounted prices for many prescription drugs. When you have prescriptions filled at a pharmacy in this network, you benefit from these negotiated prices. Your ID card has a special symbol printed on it that tells the pharmacist to give you a discount on most prescription drugs.

To receive your discount, you must show your card to the pharmacist when you have your prescription filled. The amount of your discount varies depending on the specific drug you buy. The amount you pay for most prescription drugs will reflect this discount. To locate a network pharmacy, call the toll-free Member Service telephone number printed on the back of your ID card or visit the Highmark Web site at www.highmarkbcbs.com.

Preventive Care

Mammographic Screening

Benefits will be provided for:

- an annual routine mammographic screening for all female members 40 years of age or older;
- mammographic examination for all female members regardless of age when prescribed by a physician;
- benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified by the Pennsylvania Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

Pediatric Immunizations

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

Routine Gynecological Examination and Papanicolaou Smear

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

Private Duty Nursing Services

Private duty nursing services of an actively practicing Registered Nurse (RN) or a 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.

- When 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.
- When you are at home, only when Highmark determines that the nursing services require the skills of a RN or of 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 (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses).

Psychiatric Care Services/Substance Abuse Treatment Services

The following services are provided for the inpatient and outpatient treatment of mental illness and the treatment of alcoholism and drug abuse by a facility or professional provider:

- Inpatient and outpatient medical care visits
- Individual psychotherapy
- Group psychotherapy
- Psychological testing
- Counseling with family members to assist in the patient's diagnosis and treatment
- Services in a planned therapeutic treatment program on a day or night only basis

For purposes of this benefit, an alcohol and drug abuse service provided on a partial hospitalization basis for rehabilitation therapy shall be deemed to be an outpatient care visit subject to outpatient care cost-sharing amounts.

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.

Coverage is provided for outpatient care for the treatment of serious mental illness for up to 60 outpatient care visits per benefit period. 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 of serious mental illness as required under Act 150 of 1998 are always available per benefit period.

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 requires definitive treatment other than routine supportive care;

- when confinement in a skilled nursing facility is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience;
- for the treatment of alcohol abuse, drug abuse or mental illness.

Spinal Manipulations

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

Surgical Services

Surgery

Surgery performed by a professional provider. Separate payment will not be made for pre- and post-operative services.

Also covered is the 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.

Assistant At Surgery

Services of a physician who actively assists the operating surgeon in performing a covered surgery if a house staff member, intern or resident is not available.

Anesthesia

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

Therapy and Rehabilitation Services

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

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

Transplant Services

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

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

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

What Is Not Covered

Your Signature 65 program will not provide benefits for services, supplies or charges:

- such as the Medicare Part B deductible;
- not covered by Medicare and not specifically referenced in this booklet;
- not covered by Medicare but covered under this program, and not medically necessary and appropriate as determined by the plan, or its designated agent;
- not covered by Medicare and incurred due to confinement in a freestanding psychiatric facility;
- not prescribed or performed by or upon the direction of a professional provider;
- rendered by other than hospitals, facility providers or professional providers;
- 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 an illness or injury suffered after your effective date as a result of any act of war;
- for which you would have no legal obligation to pay;
- received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
- 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 and the National Health Service or to patients in Veteran's Administration facilities for service-connected illness or injury unless you have a legal obligation to pay;
- for treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a program or policy of motor vehicle insurance, including a certified or qualified program 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 outpatient prescription drugs, except as provided for under Medicare Part B;
- which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same patient;

- rendered by a professional 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 to the extent covered by Medicare Part B or otherwise provided herein;
- for operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise required by law. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; and b) surgery to correct functional impairment that results from a covered disease, injury or congenital birth defect;
- 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 that are primarily for diagnostic studies;
- for inpatient admissions that are primarily for physical therapy;
- for custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care;
- 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;
- for oral surgery procedures unless specifically provided, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, unless specifically provided for 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, 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, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;
- for any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery;
- for artificial insemination;
- 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 in vitro fertilization;
- for sterilization and reversal of sterilization;
- for impotency treatment drugs;
- 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 or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;
- for nutritional counseling and services intended to produce weight loss;
- for the following services associated with the enteral formulae benefits provided under your program: normal food products used in the dietary management of rare hereditary genetic metabolic disorder;
- for well-baby care visits, except as provided herein;
- for allergy testing;
- for routine or periodic physical examinations, the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate;
- for immunizations required for foreign travel or employment;
- for treatment of sexual dysfunction not related to organic disease or injury;
- for therapy services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate;
- for private duty nursing services;
- for services or supplies provided by a home health care agency;

- for conditions related to autistic disease of childhood, learning disabilities, and mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change;
- for any other medical or dental service or treatment, except as provided herein or as mandated by law.

You are not covered for the following Major Medical services, supplies or charges:

- Which are not medically necessary or medically appropriate as determined by Highmark Blue Cross Blue Shield;
- Which are not prescribed by, performed by or upon the direction of a professional provider;
- Which are experimental/investigative in nature;
- Incurred after the date of termination of your coverage except as provided herein;
- Rendered by a provider not specifically listed in this booklet;
- For which you 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 any similar person or group;
- Incurred prior to your effective date;
- For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage;
- For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act;
- 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 operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise required by law. 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 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 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 hearing aid devices, tinnitus maskers or examinations for the prescription or fitting of hearing aids;
- 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 elective abortions, except those abortions necessary to avert the death of the member or to terminate pregnancies caused by rape or incest;
- 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 or as mandated by law;
- For allergy testing, except as provided herein or as mandated by law;
- For any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery;
- For treatment of sexual dysfunction that is not related to organic disease or injury;
- 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 any other medical or dental service or treatment except as provided in this booklet or as mandated by law.
- Rendered prior to your effective date or during an inpatient admission that commenced prior to your effective date; except covered services will be provided for an eligible condition that commenced after your effective date during that inpatient admission;
- For any illness or injury to the extent that payment has been made by Medicare or any Medicare supplemental insurance program, when Medicare is primary;

- For charges for services, other than emergency and urgent care services when a private contract has not been executed by the Medicare beneficiary, which are payable under Medicare rendered by a Medicare opt-out provider when Medicare is primary;
- For charges for any services payable under Medicare and rendered by a Medicare non-participating provider in excess of the Medicare reasonable charge, when Medicare is primary;
- For any illness or bodily injury for or covered by any federal, state or local government's Worker's Compensation Act or Occupational Disease Law;
- To the extent benefits are provided to members of the armed forces and National Health Service or to patients in Veteran's Administration facilities for service-connected illness or injury unless you have a legal obligation to pay;
- For any illness or injury suffered after your effective date as a result of an act of war;
- For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomeleusis, keratophakia, and radial keratotomy and all related services;
- For custodial care, domiciliary care or rest cures;
- For respite care;
- For palliative or cosmetic foot care, including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
- For care received in a non-participating hospital or facility;
- For any amounts the patient is required to pay for under any deductible and/or coinsurance provisions of the basic program;
- For contraceptive services, including contraceptive devices, implants and injections, and all related services;
- For inpatient admissions which are primarily for diagnostic study;
- For inpatient admissions which are primarily for physical medicine services;
- For nutritional counseling and services intended to produce weight loss;
- 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;

- The following services you receive from a home health care agency or a hospital program for home health care: dietitian services; homemaker services; maintenance therapy; custodial care; food or home-delivered meals; drugs and medications;
- Performed on high cost technological equipment such as, but not limited to, computed tomography scanners (CT scanners), lithotriptors, and magnetic resonance imaging (MRI) scanners, as defined by Highmark, which is not approved through the certificate of need process if applicable and/or is not approved by Highmark;
- For routine or periodic physical examinations, except as provided herein or as mandated by law;
- For sterilization and reversal of sterilization;
- For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses and contact lenses (except for aphakic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury);
- For oral surgery procedures unless specifically provided, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face;
- Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates as provided herein;
- For any care related to autistic disease of childhood, learning disabilities, or mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change.

Out-of-Area Care

The BlueCard Worldwide® Program

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

Services may include:

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

Eligible Providers

Facility Providers

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

Professional Providers

- Audiologist
- Certified Clinical Nurse Specialist*
- Certified Community Health Nurse*
- Certified Enterostomal Therapy Nurse*
- Certified Psychiatric Mental Health Nurse*
- Certified Registered Nurse Anesthetist*
- Certified Registered Nurse Practitioner*
- Chiropractor
- Clinical laboratory
- Dentist
- Licensed practical nurse
- Nurse-midwife
- Occupational therapist
- Optometrist
- Osteopath
- Physical therapist

- Physician
- Podiatrist
- Psychologist
- Registered nurse
- Respiratory therapist
- Speech pathologist
- Speech therapist
- Speech-language pathologist
- Suppliers
- Teacher of hearing impaired

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

Providers Who Accept Assignment

Under the terms of assignment, you transfer to the provider the right to both the Medicare Part B and Highmark Blue Cross Blue Shield payment based on covered services specified on the claim. The provider, in turn, agrees to accept the reasonable charge set by the Medicare Part B carrier as his total charge for covered service.

The sum of the reasonable charge payments, 80% by Medicare Part B and 20% by Highmark, constitute payment in full, except where maximums or deductibles are specified. The plan reserves the right to make payment directly to the provider.

Providers Who Do Not Accept Assignment

You are responsible to pay any difference between the provider's charge and the combined Medicare Part B/Highmark payment if the provider does not accept assignment.

The plan reserves the right to make payment directly to you.

General Information

Who is Eligible for Coverage

Eligible Dependents

You may enroll your spouse if they are covered under Medicare by reason of age or disability. Unmarried children of a member are eligible; including newborn children, stepchildren, children legally placed for adoption, children awarded coverage pursuant to an order of court, and legally adopted children who are covered under Medicare.

Changes in Membership Status

For Highmark to administer consistent coverage for you, you must keep your Employee Benefit Department informed about any address changes or changes that may affect your coverage.

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 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 to temporarily extend health care coverage.

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, 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.

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 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 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.

Other Types of Coverage

If you are also covered by another group benefit program or under any governmental program for which any periodic payment is made by or for you, it must be determined which coverage has primary liability – that is, which coverage will pay first for eligible medical services – and which coverage has secondary liability or pays second. Highmark makes this determination to prevent members from receiving more in benefits than the actual cost of care and to ultimately conserve funds allocated for health care.

If the other plan does not have a policy to determine primary or secondary liability, then it has primary liability; if it does have a policy, then it has primary liability if you are the contract holder for both plans. If primary liability cannot be determined by looking at the contract holder for both plans, then the plan that has covered the patient the longest has primary liability. Except when prohibited by law, or when you have elected Medicare secondary, services provided under any governmental program for which any periodic payment is made by or for you, will always have primary liability.

Subrogation

If you need medical care as a result of an injury caused by someone else, Highmark has the right to seek repayment from the responsible party or his or her insurance company through a process called “subrogation”. Highmark will provide benefits at the time of need, but you may be asked to execute and deliver documents or take other action as necessary to assure the rights of Highmark. Subrogation helps to conserve funds allocated for health care.

A Recognized Identification Card

Your card is your “passport” to quality care. The Blue Cross and Blue Shield symbols on your card are recognized throughout the country and around the world. Carry your identification card with you at all times and show this card along with your Medicare card to the hospital, doctor, or other health care professional whenever you need medical care.

Protect your card: If your card is lost or stolen, please contact Member Service immediately. It is illegal to loan your card to persons who are not eligible to use your Signature 65 benefits.

To request additional ID cards, contact Member Service or log onto www.highmarkbcbs.com.

How to File a Claim

In most instances, health care providers will submit a claim on your behalf directly to Medicare and/or Highmark Blue Cross Blue Shield. **Most of the time, you will not have to take any action.**

If your claim is not submitted directly by your provider, you may need to file the claim yourself. 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.

- ***For benefits covered by Medicare (see the ‘Medicare Covered Services’ section of your Summary of Benefits):***
 - You must submit a copy of the Explanation of Medicare Benefits (EOMB) that states the Medicare portion of the claim has been paid.
 - If you receive a Medicare EOMB and no Explanation of Benefits (EOB) from Highmark within 30 days, submit the Medicare EOMB.
 - Write your ID number on the top right corner of the EOMB. Your ID number can be found on your ID card.

- ***For benefits that are not covered by Medicare (see the ‘Additional Benefits Not Covered By Medicare’ section of your Summary of Benefits):*** Mail the itemized bill to Highmark. Itemized bills must include:
 - The name and address of the service provider;
 - The patient’s full name;
 - The date of service or supply;
 - A description of the service/supply;
 - The amount charged;
 - The diagnosis or nature of illness;
 - Write your ID number on the top right corner of the bill.

- ***For Major Medical benefits (see the Major Medical section of your Summary of Benefits):*** 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;

- ***Complete a Major Medical 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, your EOMB and/or EOB, if applicable, to the Major Medical claim form and mail everything to the address on the form.***

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

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

Time Limit To File A Claim

- Claims should be submitted as soon as reasonably possible after you receive a covered service.
- Claims for services covered by Medicare should be submitted within one year from the date that the Medicare claim was finalized.
- Claims for services not covered by Medicare must be submitted no later than the end of the benefit period following the benefit period for which benefits are payable.
- Major Medical claims must be submitted no later than the end of the benefit period following the benefit period for which benefits are payable.

Mailing Address For Claims

Mail Signature 65 claims for hospital expenses (benefits which complement Medicare Part A) to:

Highmark Blue Cross Blue Shield
P.O. Box 355
Pittsburgh, PA 15230

Mail all other Signature 65 claims to:

Medigap
P.O. Box 898845
Camp Hill, PA 17089-8845

Mail Major Medical claims to the address on your Major Medical claim form.

Your Explanation of Benefits Statement

Once your claim is processed, an Explanation of Benefits (EOB) statement will be issued within 30 days of receipt of the claim, unless extended for reasons outside our control. Highmark reserves the right to require additional information and documents as needed to support a claim.

Designation of an Authorized Representative

You may authorize someone else to file and pursue a claim on your behalf. If you do so, you must notify Highmark in writing of your choice of an authorized representative by completing a “Designation of an Authorized Representative” form. This form may be requested from a member service representative and must also be included in the letter you receive from Highmark that acknowledges receipt of your appeal.

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 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 Reimbursement and Other 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 Adverse Benefit Determinations Involving Requests for Reimbursement and Other Claims*

Highmark will notify you in writing of its determination on your request for reimbursement or other 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 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 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 claim.

If your request for reimbursement or other 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 claim, see the Appeal Procedure subsection below.

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!

Member Rights and Responsibilities

Your participation in the Signature 65 program is vital to maintaining quality in your program and services. Your importance to this process is reflected in the following statement of principles.

You have the right to:

1. Receive information about 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

Assignment - An agreement between the professional provider and the Medicare beneficiary. It is a process through which a professional provider or supplier agrees to accept the amount Medicare approves as payment in full. You pay any coinsurance amount.

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.

Basic Plan - The regular hospitalization and medical-surgical benefits made available to you through your group. The term "Basic Plan" as used herein is meant to include the following: Medicare Parts A and B, and Highmark Blue Cross Blue Shield Signature 65 program.

Benefit Period - That period which begins on the first day (which is not part of a prior benefit period) in which you are an inpatient in a hospital or skilled nursing facility. The benefit period ends when you have not been an inpatient of a hospital or skilled nursing facility for 60 consecutive days. Most Medicare Part A and Part B benefits are renewed when a new benefit period begins. There is no limit to the number of benefit periods you may have. See the section How Your Benefits Are Applied for the benefit period applicable to your Major Medical program.

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

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.

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.

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

Explanation of Medicare Benefits (EOMB) - This is the statement you'll receive after your Medicare claim is processed. It explains how much Medicare paid and how much you are responsible for. In most cases, amounts Medicare didn't pay will be filed automatically with Highmark for consideration under your Signature 65 coverage.

Immediate Family - Your spouse, child, parent, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, daughter-in-law or son-in-law.

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

Maximum - The greatest amount payable by the program for covered services. This could be expressed in dollars, number of days, or number of services for a specified period of time. There are two types of maximums:

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

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

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.

Medicare Non-Participating Provider - A professional provider eligible to provide services or supplies under Medicare Part B but who does not sign a participating agreement with Medicare, and may or may not elect to accept assignment on each Medicare claim that is filed. A Medicare non-participating provider who does not accept assignment does not accept the Medicare reasonable charge for a certain service or

supply as payment in full and may charge the patient more than the Medicare reasonable charge, unless otherwise prohibited by law.

Medicare Opt-Out Provider - A professional provider eligible to provide services or supplies under Medicare Part B but who has "opted out" of Medicare such that he or she forgoes any payments from Medicare to his or her patients or themselves, and enters into private contracts with Medicare beneficiaries to provide eligible services, and bills Medicare beneficiaries directly for services provided.

Medicare Reasonable Charge - The approved amount for services and supplies, as determined by Medicare.

Member - A contract holder or dependent enrolled for health care coverage.

Outpatient - A member who receives services or supplies while not a registered bed patient in a hospital or skilled nursing facility.

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.

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

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

Usual, Customary and Reasonable (UCR) Allowance

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

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

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

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

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

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

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.

Signature 65 is a service mark of Highmark Inc.

Blues On Call is a service mark of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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

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, 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.

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