

Health

BENEFITS GUIDE 2025



CRETE CARRIER CORPORATION

GROUP HEALTH CARE PLAN



**CRETE
CARRIER**



**SHAFER
TRUCKING**

**HUNT
TRANSPORTATION**

2025

Discrimination is Against the Law

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

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

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

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyonang tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注: 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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Disclosure

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

Non-Assignment

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

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

Once covered services are rendered by a provider, Highmark will not honor your requests not to pay the claims submitted by the provider. Highmark will have no liability to any person because of its rejection of the request. In the event that payment has been made to you for any excluded services or supplies, either through inadvertence or error, you shall reimburse Highmark for such payment. However, in the event the home plan does not pay a claim related to health care services rendered under the BlueCard Program within sixty (60) days of its receipt, Highmark is required to pay the claim directly to the provider at one hundred percent (100%) of the allowed amount. You will be required to reimburse Highmark for any member cost sharing that would have been applicable to that particular claim.

Introduction to Your Health Care Program

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

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

Together, this document and the Crete Carrier Corporation Welfare Benefits Plan and Summary Plan Description form the Summary Plan Description ("SPD") for the Crete Carrier Corporation Group Health Care Plan ("Plan"). Please note, the information provided in the SPD is only a summary and is not intended to be a complete description of every detail for the Plan. The Plan is administered in accordance with the provisions set forth in other Plan documents. If there is a discrepancy or conflict between the SPD and the Plan documents, the Plan documents will govern.

The Plan may be amended and updated from time to time. The most up to date SPD can be found online at www.cretecarrierbenefits.com.

Should you have questions about the Plan, you may contact the Crete Carrier Corporation Benefits Department.

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

- ***Your health care program gives you freedom of choice.*** You are not required to select a primary care provider to receive covered care. You have access to a large provider network of physicians, hospitals, and other providers throughout the country. For a higher level of coverage, you need to receive care from one of these network providers. However, you can go outside the network and still receive care at the lower level of coverage. To locate a network provider near you, or to learn whether your current physician is in the network, call the members services number on the back of your ID card or log onto your Highmark member website, www.myhighmark.com.
- ***Your health care program gives you "stay healthy" care.*** You are covered for a range of preventive care, including physical examinations and selected

diagnostic tests. Preventive care is a proactive approach to health management that can help you stay on top of your health status and prevent more serious, costly care down the road.

You can review your Preventive Care Guidelines online at your member website. And, as a member of your health care program, you get important extras. Along with 24-hour assistance with any health care question via Blues On Call, your member website connects you to a range of self-service tools that can help you manage your coverage. You can also access programs and services designed to help you make and maintain healthy improvements. And you can access a wide range of care cost and care provider quality tools to assure you spend your health care dollars wisely.

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

Information for Non-English-Speaking Members

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

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

How Your Benefits Are Applied

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

Benefit Period

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

Medical Cost-Sharing Provisions

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

Coinsurance

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

Copayment

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

Deductible

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

Family Deductible

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

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

Out-of-Pocket Limit

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

Total Maximum Out-of-Pocket

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

Maximum

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

Covered Services - Medical Program

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

Network care is covered at a higher level of benefits than out-of-network care.

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

Ambulance Service

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

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

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

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

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

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

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

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

Autism Spectrum Disorders

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

Diagnostic Assessment of Autism Spectrum Disorders

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

Treatment of Autism Spectrum Disorders

Treatment may include the following medically necessary and appropriate services:

Pharmacy care

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

Psychiatric and psychological care

Direct or consultative services provided by a psychologist or by a physician who specializes in psychiatry.

Rehabilitative care

Professional services and treatment programs, including Applied Behavioral Analysis, provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of an attained skill or function.

Therapeutic care

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

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

Blue Distinction Specialty Care

The Blue Distinction Specialty Care Program is a nationwide quality designation program, awarded by the Blue Cross Blue Shield Association, recognizing health care providers that demonstrate expertise in delivering quality specialty care safely, effectively and cost-efficiently. The Blue Distinction Specialty Care Program offered by your group focuses on the following areas of specialty care provided at the designated health care providers.

Although these areas of specialty care (listed below) are covered when performed at a provider that does not have the Blue Distinction Specialty Care designation, having the services performed in a Blue Distinction center provides a higher level of coverage. Refer to the Summary of Benefits for your program's specific level of coverage.

Cardiac Care

Care includes comprehensive inpatient cardiac services including cardiac valve surgery, coronary artery bypass graft (CABG) and percutaneous coronary intervention (PCIs) which are procedures such as angioplasty, stenting and embolectomies.

Knee and Hip Replacement

Care includes comprehensive inpatient knee and hip replacement services, including total knee replacement and total hip replacement surgeries.

Spine Surgery

Care includes comprehensive inpatient spine surgery services, including discectomy, fusion and decompression procedures.

Transplants

Facilities may be designated for one or more of the following types of transplants: heart, lung, liver (deceased and living donor), kidney (deceased and living donor), pancreas (adult transplants only) and bone marrow/stem cell.

Dental Services Related to Accidental Injury

Dental services initially rendered by a physician which are required as a result of accidental injury to the jaws, sound natural teeth, mouth or face. Follow-up services, if any, that are provided after the initial treatment are not covered. Injury as a result of chewing or biting shall not be considered an accidental injury.

Diabetes Treatment

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

- Equipment and supplies: Blood glucose monitors, monitor supplies, injection aids, syringes and insulin infusion devices
- Diabetes Education Program*: When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through a diabetes education program:
 - Visits medically necessary and appropriate upon the diagnosis of diabetes

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

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

Diabetes Care Management Program (Digitally-Monitored) – a digitally-monitored care management program offered by Highmark if you have been diagnosed with type 1 or 2 diabetes and meet other program and clinical criteria. You will have access to a mobile application and telehealth consults with specific health care providers participating in the diabetes care management program. The telehealth consults may involve coaching and medication management and optimization. Additionally, you may receive a cellular-enabled blood glucose monitor and supplies, including testing strips upon request.

In addition, devices such as continuous glucose monitors may be available for members with type 2 diabetes. Continuous glucose monitors are typically utilized by providers to monitor the glucose levels of a patient in real time in order to determine appropriate medication and/or medication levels for that particular patient.

Diagnostic Services

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

Advanced Imaging Services

Include, but are not limited to, computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance

angiography (MRA), positron emission tomography (PET scan), positron emission tomography/computed tomography (PET/CT scan).

Basic Diagnostic Services

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

Durable Medical Equipment

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

Hearing Care Services

Benefits include coverage for diagnostic testing, and an audiometric examination, when prescribed by a professional provider.

Home Health Care/Hospice Care Services

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

- Skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN), excluding private duty nursing services
- Physical medicine, speech therapy and occupational therapy

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

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

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

Home Infusion and Suite Infusion Therapy Services

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

Hospital Services

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

Inpatient Services

Bed and Board

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

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

Ancillary Services

Hospital services and supplies including, but not restricted to:

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

Outpatient Services

Ancillary Services

Hospital services and supplies including, but not restricted to:

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

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

- medical and surgical dressings, supplies, casts and splints.

Emergency Care Services

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

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

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

- a. are unable to travel using non-medical transportation or non-emergency medical transportation to an available network provider located within a reasonable travel distance; or
- b. does not consent to be transferred

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

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

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

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

Pre-Admission Testing

Tests and studies, as indicated in the Basic Diagnostic Services subsection above, required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.

Surgery

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

Inpatient Medical Services

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

Concurrent Care

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

Consultation

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

Inpatient Medical Care Visits

Benefits are provided for inpatient medical care visits.

Intensive Medical Care

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

Routine Newborn Care

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

Maternity Services

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

Complications of Pregnancy

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

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

Normal Pregnancy

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

Nursery Care

Covered services provided to the newborn child from the moment of birth, including care which is necessary for the treatment of medically diagnosed congenital defects,

birth abnormalities, prematurity and routine nursery care. Routine nursery care includes inpatient medical visits by a professional provider.

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

Mental Health Care Services

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

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

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

Inpatient Facility Services

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

Inpatient Medical Services

Covered inpatient medical services provided by a professional provider:

- Individual psychotherapy
- Group psychotherapy
- Psychological testing
- Family counseling

Counseling with family members to assist in your diagnosis and treatment

- Convulsive therapy treatment; and

Electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same professional provider

- Medication management

Partial Hospitalization Program

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

Outpatient Mental Health Care Services

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

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.

Outpatient Medical Care Services (Visits and Consultations)

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

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

specialist office visit benefit and subject to the cost sharing amount in your Summary of Benefits.

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

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

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

Professional providers may also request consultations from another professional provider for an advisory opinion regarding a diagnosis or management of your medical problem. These are called "provider-to-provider" consultations or "interprofessional consultations".

Interprofessional consultations do not include provider interaction with you.

Different types of providers, their services and their locations may require different payment amounts and result in different charges. You may be responsible for a facility fee, clinic charge or similar fee (in addition to any professional fees) if your office visit or service is provided at a hospital, facility provider, ancillary provider, retail clinic or urgent care center. You may also be responsible for a charge for an interprofessional consultation, which may occur during your office visit or at a different time.

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

Allergy Extract/Injections

Benefits are provided for allergy extract and allergy injections.

Therapeutic Injections

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

Pediatric Extended Care Services

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

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

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

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

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

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

Preventive Care Services

Benefits will be provided for preventive care services in accordance with a predefined

schedule*. Recommended annual services are based on a calendar year resetting January 1 of every year. Refer to the Summary of Benefits for your program's specific level of coverage.

Adult Care

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

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

Adult Immunizations

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

Colorectal Cancer Screenings

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

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

Colorectal cancer screenings are covered:

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

For all members 45 years of age or older as follows:

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

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

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

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

Diabetes Prevention Program

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

Breast Cancer Screenings

Benefits are provided for the following:

- An annual routine mammographic screening starting at 40 years of age or older pursuant to the 2002 recommendations by the United States Preventive Services Task Force.
- For members believed to be at an increased risk of breast cancer due to:
 - personal history of atypical breast histologies;
 - personal history or family history of breast cancer
 - genetic predisposition for breast cancer;

- prior therapeutic thoracic radiation therapy;

heterogeneously dense breast tissue based on breast composition categories with any one of the following risk factors:

- lifetime risk of breast cancer of greater than 20%, according to risk assessment tools based on family history;
- personal history of BRCA1 or BRCA2 gene mutations;
- a first-degree relative with a BRCA1 or BRCA2 gene mutation;
- prior therapeutic thoracic radiation therapy between 10 and 30 years of age; or
- personal history of Li-Fraumeni syndrome, Cowden syndrome or Bannayan-Riley-Ruvalcaba syndrome or a first-degree relative with one of these syndromes; or
- extremely dense breast tissue based on breast composition categories;
 - one (1) supplemental breast screening every year using standard or abbreviated magnetic resonance imaging (MRI) or, if such imaging is not possible, ultrasound if recommended by the treating physician to screen for breast cancer when there is no abnormality seen or suspected in the breast.
 - Mammographic screenings for all members regardless of age when such services are prescribed by a physician.

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

BRCA-Related Genetic Counseling and Genetic Testing

Benefits are provided for genetic counseling and, if indicated after genetic counseling, a genetic laboratory test of the BRCA1 and BRCA2 genes for members assessed to be at an increased risk, based on a clinical risk assessment tool, of potentially harmful mutations in the BRCA1 or BRCA2 genes due to a personal or family history of breast or ovarian cancer. Benefits for BRCA-related genetic counseling and genetic testing are payable only if provided by an individual licensed, certified or otherwise regulated to provide genetic counseling and genetic testing.

Pediatric Care

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

Pediatric Immunizations

Benefits are provided to members through 18 years of age and dependent children for those pediatric immunizations, including the immunizing agents, which conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services.

Routine Gynecological Examination and Pap Test

Benefits are provided for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine Papanicolaou smear (pap test) per calendar year.

Routine Screening Tests and Procedures

Benefits are provided for routine screening tests and procedures, regardless of medical necessity and appropriateness.

Tobacco Use, Counseling and Interventions

Benefits are provided for screenings for tobacco use and, for those who use tobacco products, two tobacco cessation attempts per year. A tobacco cessation attempt includes four tobacco cessation counseling sessions and covered medications.

Private Duty Nursing Services

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

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

Prosthetic Appliances

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

Skilled Nursing Facility Services

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

No benefits are payable:

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

Spinal Manipulations

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

Substance Abuse Services

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

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

- Substance abuse treatment facility services for non-hospital inpatient residential treatment and rehabilitation services. Residential treatment and rehabilitation services include medically monitored high intensity inpatient services with twenty-four hour nursing care and physician availability and medically managed intensive inpatient services with twenty-four hour nursing care and daily physician oversight; and
- Outpatient services rendered in a hospital, substance abuse treatment facility or through an Intensive Outpatient Program or Partial Hospitalization Program, and outpatient substance abuse treatment facility services for rehabilitation therapy

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

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

Surgical Services

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

Anesthesia

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

Assistant at Surgery

Services of a physician or of the physician's employed physician assistant (PA), or certified registered nurse practitioner (CRNP) or certified nurse midwife (CNM), who actively assists the operating surgeon in the performance of covered surgery. Benefits will be provided for an assistant at surgery only if a house staff

member, intern or resident is not available.

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

Mastectomy and Breast Cancer Reconstruction

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

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

Special Surgery

- Oral Surgery

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

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

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

Second Surgical Opinion

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

Keep in mind that:

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

Surgery

- Surgery performed by a professional provider. Separate payment will not be made for pre- and post-operative services.
- If more than one surgical procedure is performed by the same professional provider during the same operation, the total benefits payable will be the

amount payable for the highest paying procedure and no allowance shall be made for additional procedures except where Highmark deems that an additional allowance is warranted.

Therapy and Rehabilitation Services

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

- Cardiac rehabilitation
- Chemotherapy
- Dialysis treatment
- Infusion therapy when performed by a facility provider or ancillary provider and for self-administration if the components are furnished and billed by a facility provider or ancillary provider. Benefits for certain infusion therapy prescription drugs as identified by Highmark and which are appropriate for self-administration will be provided only when received from a participating pharmacy provider.
- Occupational therapy
- Physical medicine
- Radiation therapy
- Respiratory therapy
- Speech therapy

*Refer to the Summary of Benefits for therapy and rehabilitation services covered under your plan.

Transplant Services

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

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

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

What Is Not Covered

Except as specifically provided in this booklet or as is mandated or required to be covered based upon applicable law, no benefits will be provided for services, supplies or charges:

<u>Key Word</u>	<u>Exclusion</u>
Acupuncture	For acupuncture therapy services, except as otherwise set forth in the Covered Services – Medical Program section of this booklet.
Abortion	For elective abortions except those abortions necessary to avert the death of the mother or terminate pregnancies caused by rape or incest.
Allergy Testing	For allergy testing, except as provided herein.
Ambulance	For ambulance services, except as provided herein.
Assisted Fertilization	Related to treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization.
Comfort/Convenience Items	For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider.
Cosmetic Surgery	For a cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except: a) as otherwise provided herein, b) when required to correct a condition directly resulting from an accident; c) when necessary to correct a functional impairment which directly results from a covered disease or injury, or d) to correct a congenital birth defect.
Court Ordered Services	For otherwise covered services ordered by a court or other tribunal unless medically necessary and

	appropriate or if the reimbursement of such services is required by law.
Custodial Care	For custodial care, domiciliary care, protective and supportive care including educational services, rest cures and convalescent care.
Dental Care	Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses otherwise covered because of accidental bodily injury to sound natural teeth and for orthodontic treatment for congenital cleft palates as provided herein.
Diabetes Prevention Program	For a diabetes prevention program offered by other than a network diabetes prevention provider.
Effective Date	Rendered prior to your effective date of coverage.
Enteral Foods	For the following services associated with the additional enteral foods benefits provided under your program: blenderized food, baby food, or regular shelf food; milk or soy-based infant formulae with intact proteins; any formulae, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance; semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally; normal food products used in the dietary management of the disorders provided herein.
Experimental/ Investigative	Which are experimental/investigative in nature, except as provided herein for Routine Patient Costs incurred in connection with an Approved Clinical Trial.

Eyeglasses/Contact Lenses	• For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury).
Felonies	• For any illness or injury you suffer during your commission of a felony, as long as such illness or injuries are not the result of a medical condition or an act of domestic violence.
Foot Care	• For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
Health Care Management program	• For any care, treatment, prescription drug or service which has been disallowed under the provisions of Health Care Management program.
Home Health Care	• For the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: dietitian services; homemaker services; maintenance therapy; dialysis treatment; custodial care; food or home-delivered meals.
Immunizations	• For immunizations required for foreign travel or employment, except as provided herein.
Inpatient Admissions	• For inpatient admissions which are primarily for diagnostic studies. • For inpatient admissions which are primarily for physical medicine services.

Learning Disabilities

- For any care that is related to conditions such as learning disabilities, behavioral problems, or intellectual disabilities, but not including care related to autism spectrum disorders, which extends beyond traditional medical management or medically necessary and appropriate inpatient confinement. For any care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services related to the treatment of learning disorders or learning disabilities; and d) services provided primarily for social or environmental change or for respite care.
- For any care that is related to autism spectrum disorders which extends beyond traditional medical management, except as otherwise provided herein. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement, and aptitude testing); except for specific evaluation purposes directly related to medical treatment; and c) services provided primarily for respite care.

Legal Obligation

- For which you would have no legal obligation to pay.

Medically Necessary and Appropriate

- Which are not medically necessary and appropriate as determined by Highmark.

Medicare

- To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program.

- For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage.
- Military Service
- To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.
- Miscellaneous
- Services for which coverage or reimbursement is determined to be illegal by your state of residence regardless of whether you travel to a state where the service can be legally performed.
 - For telephone consultations which do not involve telemedicine services, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
 - For any other medical or dental service or treatment or prescription drug except as provided herein.
 - For any tests, screenings, examinations or any other services required by: (a) an employer or governmental body or agency in order to begin or to continue working or as a condition to performing the functions of any employment in a particular setting; (b) a school, college or university in order to enter onto school property or a particular location regardless of purpose, or; (c) a governmental body or agency for public surveillance purposes; and that does not relate to the furnishing or administration of an individualized test, screening or evaluation determined by the member's attending professional provider as being medically appropriate.
 - Services for which coverage or reimbursement is determined to be illegal by your state of residence regardless of whether you travel to a state where the service can be legally performed.

Motor Vehicle Accident	• For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law.
Nutritional Counseling	• For nutritional counseling, except as provided herein or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
Obesity	• For treatment of obesity, except for medical and surgical treatment of morbid obesity or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
Oral Surgery	• For oral surgery procedures, except as provided herein.
Physical Examinations	• For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein.
Prescription Drugs (Medical Program)	• For prescription drugs and medications, except those which are administered in a facility provider or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
Preventive Care Services	• For preventive care services, wellness services or programs, except as provided herein.
Provider of Service	• Which are not prescribed by or performed by or upon the direction of a professional provider. • Rendered by other than providers.

	- Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group. - Which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same member. - Rendered by a provider who is a member of your immediate family. - Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
Respite Care	For respite care.
Sexual Dysfunction	For treatment of sexual dysfunction that is not related to organic disease or injury.
Skilled Nursing	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.
Smoking (nicotine) Cessation	For nicotine cessation support programs and/or classes, except as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
Sterilization	For reversal of sterilization.
Termination Date	Incurred after the date of termination of your coverage except as provided herein.
Therapy	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.

- | | |
|---------------------------|--|
| Vision Correction Surgery | <ul style="list-style-type: none">• For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services. |
| War | <ul style="list-style-type: none">• For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared. |
| Weight Reduction | <ul style="list-style-type: none">• For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate. |
| Well-Baby Care | <ul style="list-style-type: none">• For well-baby care visits, except as provided herein. |
| Workers' Compensation | <ul style="list-style-type: none">• 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. |

How Your Health Care Program Works

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

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

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

Network Care

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

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

Out-of-Network Care

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

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

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

Even though a hospital may be in our network, not every doctor providing services in that hospital is in the network. For example: If you are having surgery, make sure that all of your providers, including surgeons, anesthesiologists and radiologists, are in the network.

Provider Reimbursement and Member Liability

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

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

When you receive covered services from an out-of-network provider, in addition to your cost-share liability described above, you will be responsible for the difference between your plan's payment and the provider's billed charge. If you receive services which are not covered under your plan, you are responsible for all charges associated with those services.

However, the following covered services when received from an out-of-network provider will be provided at the network services level of benefits and you will not be responsible for such difference:

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

Additionally, in very limited circumstances, you may not be liable for charges for non-emergency covered services received from certain professional providers or ancillary providers who are not part of the network. A network facility provider may have an arrangement with a professional provider or ancillary provider who is not part of the network to render certain items and professional services (such as, but not limited to,

equipment, devices, anesthesiology, radiology or pathology services) to patients of the network facility provider. The selection of such professional providers or ancillary providers may be beyond your control. In that situation, you will not be liable, except for applicable network deductible, copayment, or coinsurance obligations, for the charges of the professional provider or ancillary provider.

No Prior Approval Requirement or Pre-Certification Requirement applies when members receive Emergency Care services.

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

Out-of-Area Care

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

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

Inter-Plan Arrangements

Out-of-Area Services

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

Typically, when accessing care outside of Pennsylvania, members obtain care from providers that have a contractual agreement ("participating providers") with the local

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

BlueCard® Program

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

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

Liability Calculation Method per Claim

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

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

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

price.

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

Special Cases: Value-Based Programs

Highmark has included a factor for bulk distributions from Host Blues in your premium for Value-Based Programs when applicable under your program. Additional information is available upon request.

Return of Overpayments

Recoveries of overpayments from a Host Blue or its participating and non-participating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to Highmark, they will be credited to your account. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to you as a percentage of the recovery.

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

In some instances, federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts.

Non-Participating Providers Outside of Pennsylvania

Member Liability Calculation

When covered services are provided outside of Pennsylvania by non-participating providers, the amount(s) a member pays for such services will generally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable law. In these situations, the member may be

responsible for the difference between the amount that the non-participating provider bills and the payment Highmark will make for the covered services as set forth in this paragraph. Payments for emergency services rendered by non-participating providers will be governed by applicable federal and state law.

Exceptions

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

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

Blue Cross Blue Shield Global Core Program

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

Inpatient Services

In most cases, if members contact the Blue Cross Blue Shield Global Core service center ("service center") for assistance, hospitals will not require members to pay for inpatient covered services, except for their cost-sharing amounts. In such cases, a Blue

Cross Blue Shield Global Core contracting hospital will submit member claims to the service center to initiate claims processing. However, if the member paid in full at the time of service, the member must submit a claim to obtain reimbursement for covered services. **Members must contact Highmark to obtain precertification or preauthorization for non-emergency inpatient services.**

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

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

Your Provider Network

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

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

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

Please note that while you or a family member can use the services, including behavioral health and well-woman care, of any network physician or specialist without a referral and receive the maximum coverage under your benefit program, you are

encouraged to select a personal or primary care provider. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal provider can help you select an appropriate specialist and work closely with that specialist when the need arises. In addition, primary care providers or their covering physicians are on call 24/7.

Remember:

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

How to Obtain Information Regarding Your Physician

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

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

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

Eligible Providers

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

Facility Providers

- Hospital
- Psychiatric hospital
- Rehabilitation hospital

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

Professional Providers

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

Ancillary Providers:

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

Contracting Suppliers (for the sale or lease of):

- Durable medical equipment
- Supplies
- Orthotics
- Prosthetics

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

Health Care Management

Medical Management

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

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

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

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

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

Benefits after Provider Termination from the Network

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

If, however, the network provider is terminated for cause and you continue to seek treatment from that provider, then your plan will not cover payment for health care services provided to you following the date of termination.

Any services authorized under this section will be covered in accordance with the same terms and conditions as applicable to a network provider. Nothing in this section shall require payment of benefits for health care services that are not otherwise provided under the terms and conditions of your plan.

Pre-Admission Certification

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

In-Area Network Care

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

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

Out-of-Area Network Care

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

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

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

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

Out-of-Network Care

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

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

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

Care Utilization Review Process

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

Prospective Review

Prospective review, also known as precertification or pre-service review, begins upon

receipt of treatment information. Upon receipt and review of a precertification request from a provider, if Highmark determines that information is missing that is needed in order to make a decision, Highmark will notify the requesting provider that the information is missing. Highmark will identify the missing information with enough specificity so that the provider can submit the information needed to Highmark.

After receiving the request for care, Highmark:

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

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

Concurrent Review

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

Discharge Planning

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

Outpatient Procedure or Covered Service Precertification

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

In-Area Pennsylvania Network Care

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

Out-of-Area Care

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

Out-of-Network Care

Whenever you utilize an out-of-network provider, it is your responsibility to first contact Highmark to confirm the medical necessity and appropriateness and/or obtain precertification of such procedure or covered service. If you do not contact

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

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

Retrospective Review

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

Case Management Services

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

Individual Case Management

Highmark shall provide such alternative benefits, in its sole discretion, only when, and for so long as, it determines that the services are medically necessary and appropriate, cost effective, and that the total benefits paid for such procedures/services do not exceed the total benefits to which you would otherwise be entitled to.

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

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

Health Improvement Services and Support

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

Selection of Providers

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

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

Precertification, Preauthorization and Pre-Service Claims Review Processes

The precertification, preauthorization and pre-service claims review processes

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

Authorized Representatives

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

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

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

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

Decisions Involving Urgent Care Claims

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

If Highmark determines in connection with an urgent care claim that you have not provided sufficient information to determine whether or to what extent benefits are

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

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

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

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

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

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

General Information

Who is Eligible for Coverage

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

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

You may enroll your:

- Spouse under a legally valid existing marriage, unless ended by a legal, effective decree of dissolution, divorce, or separation
- Children under 26 years of age, unless otherwise extended pursuant to applicable state or federal law, including:
 - Biological children
 - Stepchildren (the son or daughter of the employee's/associate's current spouse)
 - Legally adopted children and children for whom the employee/associate is the child's legal guardian, but does not include foster children
 - Otherwise eligible children awarded coverage pursuant to a Qualified Medical Child Support Order

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

- Unmarried children age 26 or over who are not able to support themselves due to intellectual disability, physical disability, mental illness or developmental disability that started before age 26, and who depend on the employee/associate for support and maintenance. Proof of disability must be received from the employee/associate within 31 days of the child's reaching age 26 and after that, as required. Coverage automatically terminates and all benefits hereunder cease,

except as otherwise indicated, on the last day of the month following the date on which the disability ceases, whether or not notice to terminate is received.

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

Changes in Membership Status

In order for there to be consistent coverage for you and your dependents, you must keep your Benefits Department informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage.

Medicare

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

Covered Active Employees/Associates Age 65 or Over

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

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

- or -

Non-Covered Active Employees/Associates Age 65 or Over

If you are age 65 or over and actively employed in/associated with a group with 20 or more employees/associates, you may elect not to be covered under your program. In such a case, Medicare will be your only coverage. If you choose this option, you will not be eligible for any benefits under the program. Contact your plan administrator for specific details.

Spouses Age 65 or Over of Active Employees/Associates

If you are actively employed in/associated with a group with 20 or more employees/associates, your spouse has the same choices for benefit coverage as indicated above for the employee age 65 and over. If your spouse is covered under this program as your dependent and is also entitled to Medicare benefits:

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

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

Leave of Absence or Layoff

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

Continuation of Coverage

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

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

Termination of Your Coverage Under the Employer/Plan Sponsor Contract

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

Coordination of Benefits

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

Here is how the coordination of benefits provision works:

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your program.
- When the person who received care is covered as an employee/associate under one program, and as a dependent under another, then the employee/associate coverage pays first.
- Unless a court decree requires otherwise, when a dependent child whose parents are married or are living together, whether or not they have ever been married, is covered under two programs, the program which covers the person as a dependent of the parent whose birthday (month and day) falls earliest in the calendar year will be primary. But, if both parents have the same birthday, the program which covered the parent longer will be the primary program. (Birthday rule)
- If the dependent child's parents are divorced or separated or not living together, whether or not they have ever been married, the following applies:
 - if a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage, and the program covering that parent has actual knowledge of those terms, that program is the primary program;

- If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, the program of that parent's spouse is primary. This rule applies to program years beginning after the program is given notice of the court decree.
- if a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provision for parents who are married or living together above shall determine the order of benefits;
- if a court decree states the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provision for parents who are married or living together above shall determine the order of benefits; or
- if there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - i. the program covering the custodial parent;
 - ii. the program covering the spouse of custodial parent;
 - iii. the program covering the non-custodial parent; and then
 - iv. the program covering the spouse of the non-custodial parent
- For a dependent child covered under more than one program of individuals who are not parents of the child, the above provisions shall apply as if those individuals were the parents.
- For a dependent child covered under either or both parents' program and also has his or her own coverage as a dependent under a spouse's plan, the rule below for longest time applies. In the event the dependent child's coverage under the spouse's program began on the same date as his or her coverage under the parents' program(s), the order of benefits shall be determined by applying the "birthday rule" above, to the child's parent(s) and to his or her spouse.
- If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another program, the program covering the person as an employee/associate or covering the person as a dependent of an employee/associate is the primary program. If the other program does not have this rule, and as a result, the programs do not

agree on the order of benefits, this rule is ignored. This rule does not apply if the another rule can determine the order of benefits.

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

If the above rules do not determine the order of benefits, the allowable expenses shall be shared equally between the programs. In addition, this program will not pay more than it would have paid had it been the primary program.

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

Administration of Coordination of Benefits (Prescription Drugs)

Please refer to the Prescription Drug Benefits Summary for information regarding coordination of benefits for prescription drugs.

Force Majeure

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

outbreaks, National Emergency, quarantines, disruption of the labor force and/or any other cause which is beyond the reasonable control of Highmark (hereinafter a "Force Majeure Event"), that makes it impossible, illegal or commercially impracticable for Highmark to perform its obligations in whole or in part.

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

Subrogation

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

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

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

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

The Plan will provide eligible benefits when needed, but you may be asked to show, execute and/or deliver documents, or take other necessary actions to support the Plan in any subrogation efforts. Neither you nor any of your dependents shall do

anything to prejudice the right given to the Plan by this Subrogation section without the Plan's consent.

A Recognized Identification Card

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

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

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

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

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

How to File a Claim

In most instances, hospitals and physicians will submit a claim on your behalf. If your claim is not submitted directly by the provider, you may be required to file the claim yourself.

If you have to file a claim, the procedure is simple. Just take the following steps:

- **Know Your Benefits.** Review this information to see if the services you received are eligible under your medical program.
- **Get an Itemized Bill.** Itemized bills must include:
 - The name and address of the service provider
 - The patient's full name
 - The date of service or supply or purchase
 - A description of the service or supply
 - The amount charged
 - For a medical service, the diagnosis or nature of illness
 - For durable medical equipment, the doctor's certification
 - For ambulance services, the total mileage

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

- **Copy Itemized Bills.** You must submit originals, so you may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.
- **Complete a Claim Form.** Make sure all information is completed properly, and then sign and date the form. *Claim forms can be downloaded from the member website by entering "forms" in the search box or call the Member Service telephone number on the back of your ID card.*
- **Attach Itemized Bills to the Claim Form and Mail.** After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the back of your ID card.

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

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

Your Explanation of Benefits Statement

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

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

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

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

How to Voice a Complaint

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

Highmark Blue Cross Blue Shield

P.O. Box 226
Pittsburgh, PA 15222

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

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

Fraud or Provider Abuse

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

Additional Information on How to File a Claim

Member Inquiries

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

Filing Benefit Claims

– *Authorized Representatives*

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

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

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

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

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

Determinations on Benefit Claims

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

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

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

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

you will have at least 45 days in which to submit the information before a decision is made on your post-service claim.

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

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

Appeal Procedure

Your benefit program maintains an appeal process involving two levels of review with the exception of urgent care claims (which involve a single level of review). At any time during the appeal process, you may choose to designate a representative to participate in the appeal process on your behalf. You or your representative shall notify Highmark in writing of the designation. Please refer to the Notice of Appeal Rights section of the Prescription Drug Benefits Summary for information about how to appeal denials relating to prescription benefits.

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

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

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

Initial Review

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

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

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

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

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

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

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

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

In the event Highmark renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, the procedure for appealing the decision and, in the case of an adverse benefit determination involving a pre-service claim, a statement regarding your right to request an external review or pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Your decision to proceed with a second level review of a pre-service claim (other than an urgent care claim, which involves one level of review) is voluntary. In other words, you are not required to pursue the second level review of a pre-service claim before pursuing a claim for benefits in court under § 502 of ERISA. Should you elect to pursue the second level review before filing a claim for benefits in court, your benefit program:

- Will not later assert in a court action under § 502 of ERISA that you failed to exhaust administrative remedies (i.e. that you failed to proceed with a second level review) prior to the filing of the lawsuit;
- Agrees that any statute of limitations applicable to the claim for benefits under § 502 of ERISA will not commence (i.e. run) during the second level review; and
- Will not impose any additional fee or cost in connection with the second level review.

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

Second Level Review

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

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

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

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

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

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

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

In the event Highmark renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination and, in the case of an adverse benefit determination involving a post-service claim, a statement regarding your right to request an external review or pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

External Review

You have four months from the date you receive notice of a final Highmark adverse benefit determination to file a request for an external review with Highmark. Note that for pre-service claims, the four month period begins to run from the date you received Highmark's first-level adverse benefit determination.

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

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

Preliminary Review

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

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

Highmark will notify you of the results of its preliminary review within one business day following its completion of the review. This will include our reasons regarding the ineligibility of your request, if applicable, and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not complete, Highmark's notification will describe the information or materials needed to make the request complete. You will then have the balance of the four month filing period or, if later, 48 hours from receipt of the notice, to perfect your request for external review; whichever is later.

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

Referral to an Independent Review Organization (IRO)

Highmark will, randomly or by rotation, select an IRO to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Within five business days thereafter, Highmark will provide the IRO with documents and information we considered when making our final adverse benefit determination. The IRO may reverse Highmark's final adverse benefit determination if the documents and information are not provided to the IRO within the five-day time frame.

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

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim *de novo*. In other words, the IRO

will not be bound by any decisions or conclusions reached during the above-described appeal process.

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

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

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

Expedited External Review (Applies to Urgent Care Claims Only)

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

- If the final adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or your health or would jeopardize your ability to regain maximum function and you filed a request for an expedited internal appeal; or
- Following a final internal adverse benefit determination, if you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or the final internal adverse benefit determination

concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from the facility rendering the emergency services.

In the above circumstances, Highmark will immediately conduct a preliminary review and will immediately notify you of our reasons regarding the ineligibility of your request, if applicable, and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not complete, Highmark's notification will describe the information or materials needed to make the request complete. You will then have 48 hours from receipt of the notice, to perfect your request for external review.

Referral to an Independent Review Organization (IRO)

Highmark will, randomly or by rotation, select an IRO to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Thereafter, Highmark will immediately provide the IRO with documents and information we considered when making our final adverse benefit determination via the most expeditious method (e.g., electronic, facsimile, etc.).

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

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

- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

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

Member Service

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

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

Blues On Callsm - 24/7 Health Decision Support

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

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

Help with common illnesses, injuries and questions

Health Coaches can address any health topic that concerns you:

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

You don't have to be ill to talk to a Health Coach. Call to learn about programs and other resources available to help you manage:

- Stress
- Personal nutrition
- Weight management

- Physical activities
- Insomnia
- Depression

Help with chronic conditions

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

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

myCare Navigatorsm - 24/7 Health Advocate Support

Getting the right care and finding the right doctor and wellness services for you and your family is now as quick and easy as calling myCare Navigator at **1-888-BLUE-428**.

Your dedicated health advocate can help you and your family members:

- locate a primary care provider or get an appointment with a hard-to-reach specialist;
- get your medical records transferred;
- get a second opinion;
- understand your health care options;
- locate wellness resources, such as services for your special needs child or quality elder care for a parent; or
- handle billing questions and make the most of your care dollars.

Get the help you need to navigate the health care system easily and effectively. The same number that connects you to Blues On Call now connects you to your health advocate, myCare Navigator. So call **1-888-BLUE-428** for *total* care support!

Highmark Website

As a Highmark member, you have a wealth of health information at your fingertips. It's easy to access all your online offerings. Whether you are looking for a health care provider or managing your claims...want to make informed health care decisions on

treatment options, or lead a healthier lifestyle, Highmark can help with online tools and resources.

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

Baby Blueprints®

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

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

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

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

Easy Enrollment

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

Member Rights and Responsibilities

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

You have the right to:

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

You have a responsibility to:

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

How We Protect Your Right to Confidentiality

We have established policies and procedures to protect the privacy of our members' protected health information ("PHI") in all forms, including PHI given verbally, from

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

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

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

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

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

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

Terms You Should Know

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

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

- a. The National Institutes of Health (NIH), including the National Cancer Institute (NCI);
- b. The United States Food and Drug Administration (FDA) in the form of an investigational new drug (IND) exemption;
- c. The United States Department of Defense (DOD);
- d. The United States Department of Veterans Affairs (VA);
- e. The Centers for Disease Control and Prevention (CDC);
- f. The Agency for Healthcare Research and Quality (AHRQ);
- g. The Centers for Medicare and Medicaid Services (CMS)
- h. The Department of Energy; or
- i. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support.

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

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

Blue Distinction Center - A provider designated by the Blue Cross Blue Shield Association for meeting certain quality focused criteria in a particular area of specialized care. The provider may be recognized as a Blue Distinction Center in one

or more areas of specialized care. The provider may be recognized as a Blue Distinction Center in one or more areas of specialized care.

Blue Distinction Center+ - A provider designated by the Blue Cross Blue Shield Association for meeting certain quality focused criteria as well as cost of care measures in a particular area of specialized care. The provider may be recognized as a Blue Distinction Center+ in one or more areas of specialized care.

Blue Distinction Specialty Care Program - A national designation program identifying providers that demonstrate expertise in delivering quality specialty care safely, effectively and cost efficiently relative to specific services. Providers that choose to participate in the Blue Distinction Specialty Care Program may be recognized as either Blue Distinction Centers or Blue Distinction Centers+.

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

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

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

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

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

Closely Related Service – a service subject to precertification/certification that is closely related in purpose, diagnostic utility or designated health care billing code, and provided on the same date of a service for which precertification/certification was obtained, such that a prudent provider, acting within the scope of the provider's license and expertise, may reasonably be expected to perform the service in conjunction with or instead of the original service for which precertification was obtained as a result of minor differences in observed characteristics of the member or needs for diagnostic information not readily identifiable until the provider was performing the service for which precertification was obtained. The term does not include an order for or administration of a prescription drug or any part of a series or course of treatments.

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

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

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

Detoxification Services (Withdrawal Management Services) - Inpatient and outpatient services for the treatment of withdrawal from alcohol or drugs.

Inpatient services must include twenty-four hour nursing care and physician oversight.

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

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

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

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

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

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

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

Experimental/Investigative - The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined to be medically effective for the condition being treated. An intervention is considered

to be experimental/investigative if: the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or, available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or, the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or, the intervention does not improve health outcomes; or, the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date.

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.

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

In-Area – Means the state of Pennsylvania.

Infertility - The medically documented inability to conceive with unprotected sexual intercourse between partners of the opposite biological sex for a period of at least 12 months. The inability to conceive may be due to either partner.

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

Intensive Outpatient Program - A time-limited, separate and distinct outpatient program that includes individual therapy, family therapy, group therapy and medication management following an individualized treatment plan. Participation in an Intensive Outpatient Program may involve two (2) or more hours of programming a week. The program may be offered during the day or evening hours and can be a step-down from a higher level of care or a step-up to prevent the need for a higher level of care. The goals of an Intensive Outpatient Program are to prevent or reduce the need for inpatient hospitalization and to reduce or stabilize

symptoms and functional impairment of a psychiatric or co-occurring substance use disorder. Medically necessary treatment is provided within a structured therapeutic milieu.

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

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

Medicare Eligible Expenses - Expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary and appropriate by Medicare. If this program provides for benefits not covered by Medicare, Highmark reserves the right to determine whether such benefits are medically necessary and appropriate.

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

- **Keystone Health Plan West Network** - all Keystone Health Plan West facility providers and Keystone Health Plan West professional providers that have entered into a network agreement, either directly or indirectly, with Highmark.
- **Highmark Blue Shield Participating Facility Provider Network** - all Highmark Blue Shield participating facility providers that have entered into an agreement, either directly or indirectly, with Highmark Blue Shield.
- **PremierBlue Shield Preferred Professional Provider Network** - all PremierBlue Shield Preferred Professional providers who have an agreement, either directly or indirectly, with Highmark.

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

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

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

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

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

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

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

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

In-Network Benefits

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

Out-of-Network Benefits

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

Non-Emergency Services Received at Certain In-Network Facilities from Out-of-Network Physicians

For non-emergency covered medical services received at certain in-network facilities from out-of-network physicians when such services are either ancillary, or non-ancillary that have not satisfied the notice and consent criteria required by federal

law, the plan allowance may be based on the (i) the reference price (as defined below) if outside of Pennsylvania; (iii) the recognized amount (as defined below); (iii) the amount agreed to by the out-of-network provider and Highmark; or (iv) the amount determined by Independent Dispute Resolution (IDR).

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

Emergency Services Provided by an Out-of-Network Provider

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

Air Ambulance Transportation Provided by an Out-of-Network Provider

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

Your cost-sharing for each of the above out-of-network providers will be based on the recognized amount.

In All Other Cases

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

The plan allowance for an outside of Pennsylvania state-owned psychiatric hospital is what is required by law.

When covered medical services are received from an out-of-network provider outside of Pennsylvania, the plan allowance may be determined on the basis of the reference

price (as defined below) or on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your health care program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

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

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

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

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

Preferred Provider Organization (PPO) Program - A program that does not require the selection of a primary care provider, but is based on a provider

network made up of physicians, hospitals and other health care facilities. Using this provider network helps assure that you receive maximum coverage for eligible services.

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

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

A residential treatment program must provide the following:

- a. Awake adult supervision twenty-four hours per day;
- b. Clinical assessment at least once a day;
- c. Individual, group, or family therapy at least three times per week;
- d. Medical history and physical examination of patient within six months prior to admission or within thirty days after admission;
- e. Review of patient's current medication(s) initiated within twenty-four hours;
- f. Initiation of a multidisciplinary treatment plan within one week;
- g. Nursing staff on-site or on-call twenty-four hours per day;
- h. Parent training for patient's/guardians or family if return to family is expected;
- i. Discharge planning initiated within twenty-four hours;
- j. Psychiatric evaluation/updated (initial within one business day, updates at least once a week);
- k. Psychosocial assessment and substance evaluation within forty-eight hours;
- l. School or vocational program as per the clinical needs and/or age of the patient; and
- m. Toxicology screen, quantitative drug analysis, self-help, 12-step, or education group as needed.

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

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

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

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

Telemedicine Service - A real time interaction between you and a designated telemedicine provider conducted by means of telephonic or audio and video telecommunications system, for the purpose of providing specific outpatient medical care services.

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

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

Highmark is a registered mark of Highmark Inc.

Blues On Call and myCare Navigator are service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield companies.

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

The Blue Cross Blue Shield Association is an independent company that does not provide Highmark Blue Cross Blue Shield products and services.

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

Summary of Benefits

This Summary of Benefits outlines your covered services. More details can be found in the Covered Services section.

Benefit	In Network	Out of Network
General Provisions		
Effective Date	January 1	
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) (All services are credited to both in-network and out-of-network deductibles.)		
Individual	\$1,350	\$2,700
Family	\$2,700	\$5,400
Plan Pays – payment based on the plan allowance	80% after deductible	70% after deductible
Out-of-Pocket Limit (Includes coinsurance, copays and deductible. Once met, plan pays 100% coinsurance for the rest of the benefit period) (All services are credited to both in-network and out-of-network out-of-pocket limits.)		
Individual	\$3,800	\$6,500
Family	\$7,600	\$13,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$3,800	Not Applicable
Family	\$7,600	Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	80% after deductible	70% after deductible
Primary Care Provider Office Visits & Virtual Visits	80% after deductible	70% after deductible
Specialist Office Visits & Virtual Visits	80% after deductible	70% after deductible
Virtual Visit Provider Originating Site Fee	80% after deductible	70% after deductible
Urgent Care Center Visits	80% after deductible	70% after deductible
Telemedicine Services (3)	80% after deductible	not covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	70% after deductible
Adult Immunizations	100% (deductible does not apply)	100% (deductible does not apply)
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	70% after deductible
Mammograms, Annual Routine	100% (deductible does not apply)	70% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	70% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	70% after deductible
Pediatric Immunizations	100% (deductible does not apply)	100% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Emergency Services		
Emergency Room Services	\$250 copay (waived if admitted) after deductible, 80% thereafter	\$250 copay (waived if admitted) after in-network deductible, 80% thereafter
Ambulance - Emergency and Non-Emergency (5)	80% after deductible	80% after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	80% after deductible	70% after deductible
Hospital Outpatient (Non-Surgical)	80% after deductible	70% after deductible
Outpatient Surgery	80% after deductible	70% after deductible

Benefit	In Network	Out of Network
Blue Distinction Centers Blue Distinction Specialty Care Knee & Hip Replacements, Cardiac Care, Spine Surgery, and Transplants.	BDC/BDC+ facility 100% (deductible does not apply) Non-Blue Distinction Centers 80% after deductible	70% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	80% after deductible	70% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	80% after deductible	70% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	80% after deductible	70% after deductible
	limit: 60 visits/benefit period aggregate with speech therapy and occupational therapy	
Respiratory Therapy	80% after deductible	70% after deductible
	Limit: 60 visits per benefit period	
Speech Therapy	80% after deductible	70% after deductible
	limit: 60 visits/benefit period aggregate with occupational therapy and physical medicine	
Occupational Therapy	80% after deductible	70% after deductible
	limit: 60 visits/benefit period aggregate with speech therapy and physical medicine	
Spinal Manipulations	80% after deductible	70% after deductible
	limit: 30 visits/benefit period	
Cardiac Rehabilitation Therapy	80% after deductible	70% after deductible
Infusion Therapy	80% after deductible	70% after deductible
Chemotherapy	80% after deductible	70% after deductible
Radiation Therapy	80% after deductible	70% after deductible
Dialysis	80% after deductible	70% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	80% after deductible	70% after deductible
Inpatient Detoxification / Rehabilitation	80% after deductible	70% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	80% after deductible	70% after deductible
Outpatient Substance Abuse Services	80% after deductible	70% after deductible
Other Services		
Allergy Extracts and Injections	80% after deductible	70% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	80% after deductible	70% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	70% after deductible
Home Health Care	80% after deductible	70% after deductible
	limit: 60 visits/benefit period aggregate with visiting nurse	
Hospice	80% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment (6)	80% after deductible	70% after deductible
Private Duty Nursing	not covered	not covered
Skilled Nursing Facility Care	80% after deductible	70% after deductible
	limit: 60 days/benefit period	
Transplant Services	80% after deductible	70% after deductible
Precertification/Authorization Requirements (7)	Yes	Yes

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

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays and any qualified medical expense. Prescription drug expenses are subject to a separate prescription drug TMOOP.

- (3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.
- (4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
- (5) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
- (6) 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.
- (7) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.

Health benefits or health benefit administration may be provided by or through Highmark Blue Cross Blue Shield or Highmark Choice Company, which are independent licensees of the Blue Cross Blue Shield Association.

2025 PRESCRIPTION DRUG BENEFITS SUMMARY

Prescription Drugs are covered under Crete Carrier Corporation's Group Health Care Plan (the "Plan") and are administered by MaxCare, LLC ("MaxCare"), the Plan's Pharmacy Benefits Manager. As a part of your pharmacy benefit, you have access to the MaxCare nationwide network of more than 66,000 chain and independent pharmacies, and you can enjoy the convenience of prescription home delivery through MaxCare's mail service program. Drugs covered under the Plan include FDA-approved drugs dispensed by a registered pharmacist requiring a doctor's written prescription, subject to the medication management programs and other limitations and exclusions generally set forth herein.

This Prescription Drug Benefits Summary ("Summary") explains the basic features of the prescription drug coverage offered under the Plan; however, it is only a summary. If anything between this Summary is different than the actual terms of the Plan, the terms of the Plan control. The Plan may be amended and updated from time to time. The most up to date Summary can be found online at www.cretecarrierbenefits.com.

DRUG TIERS & CO-PAYMENTS/OUT-OF-POCKET MAXIMUMS

Drug-Tiers

In order to review which drug tier your medications fall into, you can contact MaxCare's Member Services department **at the number on the back of your benefits card** or visit MaxCare's member portal at <https://my.maxcarerx.com>.

The member portal contains helpful information to keep you informed and involved in your prescription benefits plan. Among other information, the member portal contains the following: MaxCare's preferred drug list, a pharmacy locator to help you find in-network pharmacies in your area, access to view and print prior authorization and reimbursement forms, and news and wellness information.

The Plan has the following four tiers of drugs:

1. **Generic Drugs** - A generic drug is a drug which is identical to a brand name drug in dosage form, strength, safety, route of administration, quality, performance characteristics and intended use and is almost always less expensive than a brand name drug.
2. **Brand Name Preferred Drug** - A brand name preferred drug is a drug which can only be produced and sold by the company that holds the patent for the drug. They cost more than generics, but less than non-preferred brand-name drugs. If a physician prescribes a brand-name drug when a generic equivalent is available and you obtain the brand-name drug and do not switch to the generic drug, in addition to a co-payment, you may also pay a penalty, which is the difference in cost between the brand-name and generic drug. This penalty will not count towards your annual maximum out-of-pocket maximum amount.
3. **Brand Name Non-Preferred Drug** - Generally these are higher cost medications that have recently come on the market. In most cases, an alternative preferred medication is available. If a physician prescribes a brand-name drug when a generic equivalent is available and you obtain the brand-name drug and do not switch to the generic drug, in addition to a co-payment, you

may also pay a penalty, which is the difference in cost between the brand-name and generic drug. This penalty will not count towards your annual maximum out-of-pocket amount.

4. **Specialty Drug** - Specialty drugs are drugs that require special handling, administration, or monitoring. Specialty drugs are used to treat complex, chronic and often costly conditions and are usually available up to 30-day supplies. Specialty medications are available through a limited pharmacy network of providers. Please contact MaxCare's Member Services for assistance in locating a participating specialty pharmacy.

Co-Payments & Out-of-Pocket Maximums

Your prescription card co-payments and out-of-pocket maximums are as follows:

CO-PAYMENTS - PREFERRED NETWORK:

Retail (1-30 Days)

Generic Drugs:

Preferred Brand Drugs:

Non-Preferred Brand Drugs:

Co-payment

up to \$19 or 20%, whichever is greater

up to \$49 or 20%, whichever is greater

up to \$86 or 20%, whichever is greater

Specialty (1-30 Days)

Specialty Generic Drugs:

20% with a \$50 cap

Specialty Preferred Brand Drugs:

20% with a \$80 cap

Specialty Non-Preferred Brand Drugs:

20% with a \$150 cap

Oral Oncology Drugs, Split Fill, you pay ½ co-payment per split

Note: Reduced co-payments may apply when participating in the Specialty Assistance program. See details below.

Retail 90 and Mail Service (84-90 Days)

Generic Drugs:

\$ 40

Preferred Brand Drugs:

\$ 138

Non-Preferred Brand Drugs:

\$ 235

You have access to MaxCare's Retail 90 program. By participating in this program, you can receive a 90-day supply of your maintenance medications through select participating retail pharmacies as well as your mail service pharmacy. Retail 90 offers you choice and savings when you fill your prescription at any of MaxCare's network pharmacies.

CO-PAYMENTS - NON-PREFERRED NETWORK (WALGREENS, CVS, & ALBERTSON PHARMACIES ONLY):

Retail (1-30 Days)

Generic Drugs:

Co-payment

up to \$34 or 30%, whichever is greater

Preferred Brand Drugs:

up to \$59 or 30%, whichever is greater

Non-Preferred Brand Drugs:

up to \$96 or 30%, whichever is greater

Retail 90 and Mail Service (84-90 Days)

Generic Drugs:

\$ 55

Preferred Brand Drugs:	\$ 153
Non-Preferred Brand Drugs:	\$ 250

You have access to MaxCare's Retail 90 program. By participating in this program, you can receive a 90-day supply of your maintenance medications through select participating retail pharmacies as well as your mail service pharmacy. Retail 90 offers you choice and savings when you fill your prescription at any of MaxCare's network pharmacies.

CO-PAYMENTS - AFFORDABLE CARE ACT PREVENTIVE CARE \$0
(See Coverage Summary below)

OUT-OF POCKET-MAXIMUM (EMBEDDED) - RX ONLY

Individual	\$1,500 per calendar year
Family	\$3,000 per calendar year

Member Penalty on Brand-Name Drugs with Generic Available

When a generic drug is available, and you choose a brand-name drug, you will pay the standard co-payment amount plus a penalty, which is the cost difference between the generic and brand name drug. This penalty will not count towards your annual maximum out-of-pocket amount.

MEDICATION MANAGEMENT PROGRAMS

The following generally describes the Medication Management Programs managed by MaxCare.

MaxCare Medication Management Programs

MaxCare applies the following medication management initiatives:

- **Prior Authorization and/or Step Therapy:** MaxCare administers a Prior Authorization and/or Step Therapy program for certain drugs. These initiatives target high-cost therapies that have lower cost alternatives, as well as specific products or therapeutic categories that have safety concerns or require more complex management to ensure appropriate utilization. If a high-cost drug is prescribed as first-line therapy, you will be asked to try the less expensive drugs first. If use of the lower-cost products do not achieve the desired results, the higher-cost drug may be approved. Under these initiatives, you must obtain approval from MaxCare before certain drugs will be covered. To find out if the MaxCare Prior Authorization and/or Step Therapy initiatives apply to you, call Member Services toll free at 855-537-5843, Option 1. It's open Monday through Friday, 8:30 a.m. to 5:30 p.m. Central time. When you call, have this information with you: your member ID number; the name of your medicine; your doctor's name, phone number, and fax number (if available).

If you need a Prior Authorization approval for the drug your doctor prescribes for you, your doctor, your pharmacist, or you can ask for a prior authorization. Follow these easy steps:

1. Call 855-537-5843 toll free. MaxCare will send a fax form to your doctor to obtain more information about your health and why the doctor wants you to have the drug.
2. MaxCare's prior authorization pharmacists and/or nurses review the information submitted by your physician and will communicate a response back to your doctor within 48 hours.

If you have not been contacted regarding your prior authorization within 48 hours, you may need to call your doctor or pharmacist for an update.

- **Specialty Drugs:** All specialty drugs require prior authorization by MaxCare. If prior authorization is granted, the Specialty Drug must be obtained through the Specialty Drug Program in order for benefits to be paid. A specialty drug will be excluded from coverage if prior authorization is not granted by MaxCare. Please call 855-537-5843 for more information on the Specialty Drug Program.
 - **Specialty Assistance Program:** Pharmaceutical manufacturers, either directly or through third party intermediaries or foundations, may sponsor Patient Assistance Programs (PAPs) and/or Co-payment Assistance Programs that provide you with financial or medication assistance in addition to the Plan's existing Prescription Drug Coverage.

Not all covered medications will have financial assistance available, however any financial assistance provided on your behalf and for which you do not pay, will not count towards your annual maximum out-of-pocket amount.

Any covered prescription claim where you are eligible for financial assistance will have a variable co-payment that is subject to change at any time and subject to the program benefit allowance. For medications where you are not eligible for assistance or if the covered medication does not have an assistance program available, the standard co-payment will apply.

- **Quantity Limits:** Certain drugs may be subject to Quantity Limits.
- **Exclusions:** Certain drugs may be excluded from coverage.
- **Reference Based Pricing:** This initiative is used when there is one or more similarly effective, safe, and lower cost drugs in a drug category. When this occurs, the Plan will only pay the amount it would pay for the lower-cost drugs, and you will pay the difference in cost between the higher-cost drug and the lower-cost alternatives in the form of a penalty. This penalty will not count towards your annual maximum out-of-pocket amount. Many times, you have an opportunity to reduce your co-payment expenses by switching to an alternative drug product.

A more detailed summary of your coverage is provided in the Coverage Summary section below.

Administration of Coordination of Benefits (COB)

The Coordination of Benefits section of the summary of medical coverage is incorporated herein. The rules described in that section govern the order in which each Plan will pay a Claim for benefits. The Plan that pays first is called the Primary Plan. The Plan that pays after the Primary Plan is called the Secondary Plan.

If this Plan is the Primary Plan, there shall be no reduction in your benefits. Benefits will be paid without regard to the benefits of any other Plan.

If this Plan is the Secondary Plan, your prescription drug claim will be denied by MaxCare until first processed by the Primary Plan. If your other health Plan is considered to be the Primary Plan and the prescription drug claim is not covered by the Primary Plan, MaxCare will process the claim based on their contracted price and you will pay the appropriate co-payment set by this Plan plus any amount in excess of the contracted price. If your other health Plan is considered to be the Primary Plan and the prescription drug claim is covered by the Primary Plan, this Plan, considered the Secondary Plan, will pay up to the allowed amount towards the co-payment charged by the Primary Plan.

To properly administer these COB rules, certain facts are needed. This Plan may obtain or release information to any insurance company, organization or person. Any person who claims benefits under this Plan agrees to furnish the information that may be necessary to apply COB rules and determine benefits.

If another Plan pays benefits that should have been paid under this Plan, this Plan may reimburse the other Plan amounts determined to be necessary. Amounts paid to other Plans in this manner will be considered benefits paid under this Plan and this Plan is released from liability for any such amounts.

If the amount of the benefits paid by this Plan exceeds the amount it should have paid, this Plan has the right to recover any excess from any other insurer, any other organization, or any person to or for whom such amounts were paid, including members under this Plan.

COVERAGE SUMMARY

This coverage summary explains the basic features of the prescription drug coverage offered under the Plan; however, it is only a summary. If anything between this coverage summary is different than the actual terms of the Plan, the terms of the Plan control. The Plan may be amended and updated from time to time. The most up to date coverage summary can be found online at www.cretocarrierbenefits.com.

AFFORDABLE CARE ACT PREVENTIVE CARE COVERAGE (\$0.00 Co-payment)

(Prescription is required and may be subject to limitations below)

- Aspirin 81mg only (adults 40 to 59 years of age)
- Bowel Preps (adults 45 to 75 years of age; limited to 2 scripts per 365 days)
- Breast Cancer Prevention Medications (adult women older than 35 years of age) - Tamoxifen & Raloxifene
- Contraceptives (to include FDA approved OTC items)
- Fluoride Supplements for children (children younger than 6 years of age)
- Folic Acid Supplements (adults younger than 51 years of age)
- HIV Preventive Care: Pre-Exposure Prophylaxis (PrEP) Medications (Prior Auth required)
- Iron supplements for children (children younger than 6 years of age)
- Prenatal Vitamins (adults younger than 51 years of age)
- Statin Medications – lovastatin & pravastatin only (ages 40-75)
- Tobacco Cessation - (adults older than 18 years of age; 2 quit attempts per year for 90 days per attempt)
- Vaccines (all preventive vaccines required by ACA are covered; shingles vaccines are only covered for adults age 50 and over)

COVERED DRUGS

Subject to certain management programs, limitations, and exclusions, eligible Brand and Generic drugs are covered up to a 30-day supply and eligible Maintenance Brand and Generic Drugs are covered up to a 90-day supply. In addition, certain medical supplies, such as diabetic supplies, are also covered with prescription, subject to management programs, limitations and exclusions.

QUANTITY LIMITS

Certain drugs are subject to Quantity Limits. The MaxCare Quantity Limit program ensures dosage optimization and appropriate billing of medications according to FDA approved recommended dosing. Prescriptions exceeding the established quantity limits set in the MaxCare Quantity Limit Program will require prior authorization.

PRIOR AUTHORIZATION &/OR STEP THERAPY

The MaxCare Prior Authorization & Step Therapy programs target high-cost therapies that have lower cost alternatives, as well as specific products or therapeutic categories that have safety concerns or require more complex management to ensure appropriate utilization. If a high-cost drug is prescribed as first-line therapy, the patient is asked to try the less expensive drugs first. If use of the lower-cost products do not achieve the desired results, the higher-cost drug may be approved. High-cost products in the following drug categories will be subject to the Prior Authorization &/or Step Therapy review process:

- Any request for a non-maintenance script to be filled for 90-day supply must have a clinical Prior Authorization
- Acthar Gel (only covered for pediatric patients between the ages of 0-18 who have the diagnosis for infantile spasms and meet established clinical criteria)
- Allergy - Oral, Ophthalmic, Intranasal
- Analgesics - Opioid
- Androgens (Anabolic Steroids and Testosterone Replacement; including injectables)
- Antibiotics/Anti-infectives
- Anticonvulsants
- Antidepressants / Antipsychotics
- Antidiabetics – Including tubeless insulin pumps (Omnipod 5, Omnipod DASH & V-GO)
- Antiemetics
- Anti-Fungals - Oral & Topical
- Antihypertensives/Cardiovascular
- Asthma/COPD
- Atopic Dermatitis medications that are FDA approved for this indication
- Bladder Control
- BPH (Benign Prostatic Hypertrophy)
- Cholesterol
- Compounded medications over \$500
- Continuous Glucose Monitors (CGMs) & Supplies – Dexcom Products Only
- Dermatologicals – Corticosteroids, Psoriasis, etc.
- Drugs used for off-label or non-FDA approved indications may require clinical review
- Gastro-Intestinal (except proton pump inhibitors, which are excluded)
- Hypnotics
- Migraine
- NSAIDS
- PCSK9 (only covered for select conditions based on established clinical criteria)
- Prescriptions exceeding the established quantity limit will require prior authorization
- Prescriptions greater than \$2,000
- Specialty Drugs
- Substance Abuse Treatment Agents, including methadone hydrochloride
- Miscellaneous High-Cost Products

EXCLUSIONS

Items included in the exclusions section are not covered and not eligible for prior authorization unless specifically listed under Plan terms as covered.

- Any prescription refills in excess of the number of refills specified by the physician or more than one year after the date of the physician's prescription
- Alcohol sheets (12x12 wipes) & alcohol swabs (glove contoured wipe)
- Allergy Serums
- Anorexiant/Anti-Obesity Drugs
- Azmiro
- Botulinum Toxins
- Blood Components
- CART-T Cell Immunotherapy Medications
- Continuous Glucose Monitors (CGMs) & Supplies, except for Freestyle Libre and Dexcom Glucose Monitors & related accessories (i.e. reader, sensors, transmitters)
- Cosmetic Drugs
- Crinone 8%
- DESI Drugs
- Diagnostic Agents
- Drugs or medications lawfully obtainable without a prescription from a physician or other practitioner
- Durable Medical Equipment (DME) (except those listed under Plan terms as covered)
- Durlaza
- Experimental and Investigational Drugs
- Fertility Agents
- Gastric Acid Reducers / Proton Pump Inhibitors
- General Anesthetics
- Hepatitis C Virus treatments – the plan will only cover one course of Direct Acting Antiviral Hepatitis C Virus treatment per lifetime.
- High cost dermatologics, combination products and compound kits
- Naloxone Auto-Injector 0.4 MG/.4 ML - Evzio
- Nicotinic Acid Derivatives (Niaspan and generic niacin ER)
- Non-sedating Antihistamines (prescription strength and over the counter)
- Orkambi Granule Medication
- Over The Counter (OTC) Medications and Devices (except those listed under Plan terms as covered)
- Penlac
- Pulmonary Hypertension Medications – Ventavis, Orenitram, and Uptravi
- Services for which coverage or reimbursement is determined to be illegal by your state of residence regardless of whether you travel to a state where the service can legally be performed
- Sexual Dysfunction Medications
- Shingles Vaccines (under age 50)
- Surgical Supplies/Medical Device/Ostomy
- Therapeutic devices or appliances, including support garments and other non-medical substances regardless of their intended uses
- Non-injectable Testosterone Products
- Unit-Dose Packaged Medications. **Exceptions:** Medications that would otherwise be covered by the Plan that are only available in unit-dose packaging
- Urine Based Test Strips
- Vitamins, except those listed under Plan terms as covered

REFERENCE BASED PRICING

This initiative is used when there is one or more similarly effective, safe, and lower cost drugs in a drug category. When this occurs, the Plan will only pay the amount it would pay for the lower-cost drugs, and you will pay the difference in cost between the higher-cost drug and the lower-cost alternatives in the form of a penalty. This penalty will not count towards your annual maximum out-of-pocket amount. See more information about this program on the member portal at <https://my.maxcarerx.com>.

NOTICE OF APPEAL RIGHTS

This Notice of Appeal Rights (“Notice”) applies to the prescription drug benefit offered under the Crete Carrier Corporation Group Health Care Plan. Any conflicts between the statements below and rights stated elsewhere in this notice (or in your Summary Plan Description), will be resolved so that those rights that are more beneficial to you will apply, unless the law requires otherwise.

If MaxCare has denied your claim for benefits, in whole or in part, for a requested prescription drug, then this Notice serves as part of your notice of an adverse determination. **Contact MaxCare at the number on the back of your benefits card if you need assistance understanding this Notice or your adverse determination, the reason for the denial, why the prescription was not fully covered, or why a request for coverage was denied.**

An adverse coverage determination is eligible for appeal only if the determination concerns a medication that is otherwise covered by the individual’s health plan, but has been denied because the requested therapy does not meet the Plan’s requirement for:

- (a) Medical necessity
- (b) Medical appropriateness
- (c) Health care setting
- (d) Level of care
- (e) Effectiveness

If you do not agree with an adverse determination regarding your requested medication therapy, you have the right to appeal the adverse determination. However, you only have **180 days** from the date you receive the notice of adverse determination to file an internal appeal. Please follow the instructions below on how to apply for an internal as well as an external appeal of an adverse determination made by MaxCare.

Your Internal Appeal Rights

MaxCare will provide a full and fair review of your claim by a clinician not involved in making the initial denial of your claim. If your claim was denied due to missing or incomplete information, you or your health care provider may submit the claim with the necessary information to complete the claim without exhausting your internal appeal rights.

How do I file an internal appeal? For claim appeals, you or your prescriber may contact MaxCare at the number on the back of your ID card and request an internal appeal or send a written request. Appeals may be submitted at the following address:

**MaxCare Prescription Benefit Services
Attn: Internal Appeals Dept.
P.O. Box 16430
Oklahoma City, Oklahoma 73113
Telephone: (855) 537-5843**

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will generally be conducted as soon as possible. An urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your doctor, you experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal. Some urgent situations may also qualify for an expedited external review, as described below.

Can I provide additional information about my claim? Yes, you will be informed about how to supply additional information that relates to your claim once you initiate your appeal. In addition, MaxCare may provide you with any new or additional evidence, rationale, documents, or information used or relied upon in your adverse determination, so you have a reasonable opportunity to respond before a final decision is made.

Can I request copies of information relevant to my claim? Yes, you may request and receive copies relevant to your claim free of charge. In addition, if MaxCare relies on a rule or guideline (such as a provision excluding certain benefits within your policy booklet) in making an adverse determination, MaxCare may provide that rule or guideline to you free of charge upon request. You can request copies of this information by contacting MaxCare at the number on the back of your ID card.

What happens next? MaxCare will send you a written determination within **60 days** of receiving your appeal.

Your External Review Rights

You have the right to have MaxCare's decision reviewed by an independent review organization which has no association with MaxCare if the decision involves making a determination as to the medical necessity, appropriateness, or effectiveness of the treatment. If MaxCare denied payment for a treatment deemed experimental or investigational, you may also be entitled to file a request for external review. You must submit the external review request within **4 months** of receiving the adverse internal appeal determination.

What qualifies for an expedited external review? You may be eligible for an expedited external review if you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed. You may request an expedited external review at the time you request an external review.

How do I request external review? You or your authorized representative may file a request for external review for denial of partial or full payment of claims or coverage by completing the required forms, which

can be obtained from MaxCare at the phone number below and submitting them directly to the address noted below.

**MaxCare Prescription Benefit Services
Attn: External Appeals Dept.
P.O. Box 16430
Oklahoma City, Oklahoma 73113
Telephone: (855) 537-5843**

MaxCare will coordinate a full and fair review of your claim by an independent review organization. For standard external review, a decision will be made within **60 days** of receiving your request. There will be no charge to you for the IRO review. The IRO will notify you and your authorized representative of its decision, which will be binding on the Plan, and on you, except to the extent you have additional remedies available.

ADMINISTRATION AND PROVISIONS INCORPORATED BY REFERENCE

Crete Carrier Corporation's Group Health Care Plan (the "Plan") provides both Medical and Prescription Drug coverage benefits. Medical claim administration is provided by Highmark Blue Cross Blue Shield ("Highmark"). Prescription Drug claim administration is provided by MaxCare, LLC ("MaxCare"). This Prescription Drug Benefit Summary provides you with information concerning your Prescription Drug benefits. This Prescription Drug Benefit Summary is part of the Plan documents for the Plan, and is further incorporated in and with, the summary of medical coverage. The summary of medical coverage, this Prescription Drug Benefit Summary, and the Crete Carrier Corporation Welfare Benefits Plan and Summary Plan Description together form the Summary Plan Description ("SPD"). Provisions which are stated in the medical coverage portion of the SPD are hereby incorporated into this Prescription Drug Benefit Summary. Such provisions include, but are not limited to, those stated under the General Information section. The Plan is afforded the same rights as are generally stated in the medical coverage summary.

Please note that the information provided in the SPD is only a summary and it is not intended to be a complete description of every detail of the Plan. The Plan is administered in accordance with the provisions set forth in other Plan documents. If there is a discrepancy or conflict between the SPD and the Plan documents, the Plan documents will govern.

Should you have any questions, please contact the Plan Administrator.

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

HIGHMARK INC. NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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

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

Our Legal Duties

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

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

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

On an ongoing basis, we will review and monitor our privacy practices to ensure the privacy of our members' protected health information. Due to changing

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

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

I. Uses and Disclosures of Protected Health Information

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

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

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

Payment

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

For example:

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

Health Care Operations

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

For example:

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

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

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

(i) 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. Plan Sponsors

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

B. Required by Law

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

C. Public Health Activities

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

D. Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or

criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

E. Abuse or Neglect

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

F. Legal Proceedings

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

G. Law Enforcement

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

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

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

I. Research

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

J. To Prevent a Serious Threat to Health or Safety

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

K. Military Activity and National Security, Protective Services

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

L. Inmates

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

M. Workers' Compensation

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

N. Others Involved in Your Health Care

Unless you object, we may disclose your protected health information to a friend or family member that you have identified as being involved in your health care. We also may disclose your information to an entity assisting

in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

O. Underwriting

We may disclose your protected health information for underwriting purposes; however, we are prohibited from using or disclosing your genetic information for these purposes.

P. Health Information Exchange

We all participate in a Health Information Exchange (HIE). An HIE is primarily a secure electronic data sharing network. In accordance with federal and state privacy regulations, regional health care providers participate in the HIE to exchange patient information in order to facilitate health care, avoid duplication of services, such as tests, and to reduce the likelihood that medical errors will occur.

The HIE allows your health information to be shared among authorized participating healthcare providers, such as health systems, hospitals and physicians, for the purposes of Treatment, Payment or Healthcare Operations purposes. Examples of this health information may include:

- General laboratory, pathology, transcribed radiology reports and EKG Images
- Results of outpatient diagnostic testing (GI testing, cardiac testing, neurological testing, etc.)
- Health Maintenance documentation/Medication
- Allergy documentation/Immunization profiles
- Progress notes, Urgent Care visit progress notes
- Consultation notes
- Inpatient operative reports
- Discharge summary/Emergency room visit discharge summary notes

All participating providers who provide services to you will have the ability to access your information. Providers that do not provide services to you will not have access to your information. Information may be provided to others as necessary for referral, consultation, treatment or the provision of

other healthcare services, such as pharmacy or laboratory services. All participating providers have agreed to a set of standards relating to their use and disclosure of the information available through the HIE. Your health information shall be available to all participating providers through the HIE.

You cannot choose to have only certain providers access your information. Patients who do not want their health information to be accessible through the HIE may choose not to participate or may "opt-out."

In order to opt-out, you must call the customer service number located on the back of your membership card. You should be aware, if you choose to opt-out, your health care providers will not be able to access your health information through the HIE. Even if you chose to opt-out, your information will be sent to the HIE, but providers will not be able to access this information. Additionally, your opt-out does not affect the ability of participating providers to access health information entered into the HIE prior to your opt-out submission.

III. Required Disclosures of Your Protected Health Information

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

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

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

B. Disclosures to You

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

IV. Other Uses and Disclosures of Your Protected Health Information

Sometimes we are required to obtain your written authorization for use or disclosure of your health information. The uses and disclosures that require an authorization under 45 C.F.R. § 164.508(a) are:

1. For marketing purposes
2. If we intend to sell your PHI
3. For use of Psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. An Authorization for use of psychotherapy notes is required unless:
 - a. Used by the person who created the psychotherapy note for treatment purposes, or
 - b. Used or disclosed for the following purposes:
 - (i) the provider's own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;
 - (ii) for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;
 - (iii) if required for enforcement purposes;
 - (iv) if mandated by law;
 - (v) if permitted for oversight of the provider that created the note;
 - (vi) to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or
 - (vii) if needed to avert a serious and imminent threat to health or safety.

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

V. Your Individual Rights

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

A. Right to Access

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

You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so, if you request the information in an electronic format that is not readily producible, we will provide the information in a readable electronic format as mutually agreed upon. You must make a request in writing to obtain access to your protected health information.

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

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

B. Right to an Accounting

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

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

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or submitting your request in writing to the Highmark Privacy Department, 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

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

C. Right to Request a Restriction

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

agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing. We have a right to terminate this restriction, however if we do so, we must inform you of this restriction.

You may request a restriction by contacting us at the Customer Service phone number on the back of your identification card, or writing to the Highmark Privacy Department, 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222. In your request tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

D. Right to Request Confidential Communications

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

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

In the event that a Confidential Communication is placed against you, then you will no longer have the ability to access any of your health and/or policy information online.

E. Right to Request Amendment

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

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

F. Right to a Paper Copy of this Notice

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

VI. Questions and Complaints

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

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

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

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

Contact Office: Highmark Privacy Department
Telephone: 1-866-228-9424 (toll free)
Fax: 1-412-544-4320
Address: 120 Fifth Avenue Place 1814
Pittsburgh, PA 15222

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

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

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

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

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

charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

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

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

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

For questions about this Privacy Notice, please contact:

Contact Office: Highmark Privacy Department

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

Fax: 1-412-544-4320

Address: 120 Fifth Avenue Place 1814
Pittsburgh, PA 15222

