COMPREHENSIVE MAJOR MEDICAL HEALTH CARE CERTIFICATE FOR GROUPS UTILIZING AN APPROVED SPECIFIED NETWORK OF PROVIDERS, WITHOUT A GATEKEEPER IDENTIFIED AS PPOBLUE

effective as of

April 1, 2024

by and between

Larson Texts, Inc.
(Called the Group)

and

HIGHMARK INC., d/b/a
HIGHMARK BLUE CROSS BLUE SHIELD*
(Called the Plan)

A Pennsylvania non-profit corporation whose mailing address is
Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222-3099.

GUARANTEED RENEWABLE

DESCRIPTION OF COVERAGE: This program sets forth a comprehensive program of inpatient and outpatient benefits, most of which are provided at both network and out-of-network levels of benefits. Cost-sharing options are available such as deductibles, coinsurance and copayments. Benefits for certain services are only available if received from a network provider. Benefits are subject to the Health Care Management Section with possible loss of benefits for non-compliance. Network services are limited to the Keystone Health Plan West Network, PremierBlue Shield Preferred Professional Provider Network, the Highmark Blue Shield Participating Facility Provider Network, the Highmark NE Participating Facility Provider Network and/or the Local PPO Network and are usually provided at a higher benefit level than out-of-network services. A gatekeeper is not necessary to access benefits from providers. This Health Care Certificate is non-participating in any divisible surplus of premium.

(NOTE: All networks described within this Health Care Certificate have been approved by the Pennsylvania Department of Health, except for the network described as the Local PPO Network. The Plan reserves the right to use other networks approved by the Pennsylvania Department of Health in the future, after notice to the Pennsylvania Insurance Department.)

*An independent licensee of the Blue Cross Blue Shield Association
Group 01717100

Discrimination is Against the Law

The Plan 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 Plan 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 Plan 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 Plan 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 Plan:

- 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 a Member needs these services, the Member should contact the Civil Rights Coordinator.

If a Member believes that the Plan 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, the Member can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. The Member can file a grievance in person or by mail, fax, or email. If the Member needs help filing a grievance, the Civil Rights Coordinator is available to help the Member. The Member 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

LANGUAGE ASSISTANCE SERVICES

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 serbisyong 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 المعاونة 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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Benefits to which You are Entitled

Highmark's benefit liability is limited to the benefits specified in this Health Care Certificate. Except as provided in the transplant services description, no person other than a member is entitled to receive benefits under this Health Care Certificate. Such right to benefits and coverage is not transferable. Benefits for covered services specified herein will be provided only for services and supplies rendered by providers as defined in this Health Care Certificate.

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 Certificate; 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 Certificate is not assignable, except to the extent required by law, nor may benefits described in this Certificate 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 Certificate 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.

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 Certificate 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 Certificate. The Summary of Benefits will tell you what you need to know about your benefits, exclusions and how your plan works.

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 in Pennsylvania as well as providers across the country who are part of the local PPO network. For a higher level of coverage, you need to receive care from network providers. However, you can go outside the network and still receive care at the lower level of coverage. To locate a network provider near you, or to learn whether your current physician is in the network, log onto 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 Certificate. 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 Highmark. 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 Pays section 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.

Unless otherwise indicated, deductible amounts are applicable to covered services provided to covered members per benefit period.

Individual Deductible

The deductible applies to all covered services, except where exempted by law or indicated herein, but is not applicable toward the satisfaction of the out-of-pocket Limit specifed in the Summary of Benefits.

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.

Covered family members under one family coverage are required to satisfy the family deductible expense for network services in each benefit period in order for the family to satisfy the family deductible for network services. See the Summary of Benefits for the network family deductible amount.

Covered family members under one family coverage are required to satisfy the family deductible expense for out-of-network services in each benefit period in order for the family to satisfy the family deductible for out-of-network services. See the Summary of Benefits for the out-of-network 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 2 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.

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 copayments, deductibles, prescription drug expenses or amounts in excess of the plan allowance. All out-of-pocket amounts are based on the plan allowance.

Individual Out-of-Pocket Limit

Network Services

Benefits payable for claims received by Highmark for network covered services for the member will be 100% of the plan allowance.

Out-of-Network Services

When a member incurs the entire individual out-of-pocket Limit amount in coinsurance expense for out-of-network covered services in one benefit period, the benefits payable for claims received by Highmark thereafter for out-of-network covered services during the remainder of the benefitperiod will increase to 100% of the plan allowance. Refer to the Summary of Benefits for the individual out-of-pocket limit amount for out-of-network covered services.

The dollar amount specified shall not include any expenses for prescription drugs.

Amounts paid for copayments or deductibles will not be applied towards the out-of-pocket limit.

Family Out-of-Pocket Limit

Network Services

Benefits payable for claims received by Highmark for network covered services for all members under the same family coverage will be 100% of the plan allowance.

Out-of-Network Services

When all members under the same family coverage have incurred the entire family out-of-pocket limit amount in coinsurance and copayment expense for out-of-network covered services in one (1) benefit period, the benefits payable for claims received by Highmark therafter for covered services for all members under that same family coverage during the remainder of the benefit period will increase to 100% of the plan allowance. Refer to the Summary of Benefits for the individual and family out-of-pocket limit amounts for out-of-network covered services.

The dollar amount specified shall not include any expenses paid for prescription drugs.

Amounts paid for copayments or deductibles will not be applied towards the out-of-pocket limit.

Out-of-Pocket Limit Credit
If the group changes group health care expense coverage during a member's benefit period, the amount the member paid toward their out-of-pocket limit during the last partial benefit period for services covered under the prior Highmark Inc. coverage will be applied to the network and out-of-network (combined) out-of-pocket limit of the initial benefit period under this Certificate.

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. All total maximum out-of-pocket amounts are based on the plan allowance.

Individual Total Maximum Out-of-Pocket
When a member incurs the entire individual total maximum out-of-pocket amount in coinsurance, copayment and deductible expense(s) for network covered services for in one benefit period, the benefits payable for claims received by Highmark therafter for network covered services for that member during the remainder of the benefit period will increase to 100% of the plan allowance. Refer to the Summary of Benefit for the individual total maximum out-of-pocket amount.

Applicable expenses incurred in the same benefit period for prescription drug coverage received through the Highmark freestanding drug contract will be credited toward the Individual total maximum out-of-pocket. Refer to the Summary of Benefits for the individual total maximum out-of-pocket amount.

Family Total Maximum Out-of-Pocket
When two (2) or more members under the same family coverage have jointly incurred the entire family total maximum out-of-pocket amount in coinsurance, copayment and deductible expense(s) for network covered services in one benefit period, the benefits payable for claims received by Highmark thereafter for network covered services for all members under that same family coverage during the remainder of the benefit period will increase to 100% of the plan allowance. Refer to the Summary of Benefits for the family total maximum out-of-pocket amount.

Applicable expenses incurred in the same benefit period for prescription drug coverage will be credited toward the family total maximum out-of-pocket set forth in this paragraph.

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. In connection with such day and/or visit limits, all services received by you during a benefit period will reduce the remaining number of days and/or visits available under that benefit, regardless of whether you have satisfied your deductible.

Laws Affecting Program Benefits

You may be subject to the laws of the Commonwealth of Pennsylvania and federal laws which impact health insurance coverage. The benefits of this program will be modified to reflect the provision of such laws.

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 Certificate. For specific covered services, refer to the Summary of Benefits.

Benefits for covered services are based upon the plan allowance at the time services are rendered. You are responsible for payment of any cost-sharing amounts due to the provider after the amounts paid by Highmark. The payments to a provider may be adjusted from time to time based on settlements with the providers. Such adjustments will not affect your deductible, coinsurance, or copayment obligation.

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.

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 particular Highmark benefits.

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

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

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

Routine Gynecological Examination and Pap Test
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. Benefits are not subject to program deductibles or maximums.

Breast Cancer Screenings
Benefits are provided for the following:

- An annual routine mammographic screening starting at forty (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:
    1. personal history of atypical breast histologies;
    2. personal history or family history of breast cancer;
    3. genetic predisposition for breast cancer;
    4. prior therapeutic thoracic radiation therapy;
    5. heterogeneously dense breast tissue based on breast composition categories with any one of the following risk factors:
        i. lifetime risk of breast cancer of greater than 20%, according to risk assessment tools based on family history;

* 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.

ii. personal history of BRCA1 or BRCA2 gene mutations;

iii. a first-degree relative with a BRCA1 or BRCA2 gene mutation;

iv. prior therapeutic thoracic radiation therapy between 10 and 30 years of age; or

v. personal history of Li-Fraumeni syndrome, Cowden syndrome or Bannayan-Riley-Ruvalcaba syndrome or a first-degree relative with one of these syndromes; or

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

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 under Pennsylvania law.

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:

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.

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.

Well-Woman Coverage
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.

Pediatric Care

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

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

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;
- 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. However, benefits for certain therapeutic injectables and 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;
- 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.

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.

Outpatient Evaluation and Management Services

Benefits are provided for outpatient medical care visits and consultations for the evaluation and management of your condition, including examination, diagnosis and treatment of an injury or illness.

Surgery

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

Maternity Services

Hospital, 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.

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

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

Newborn Care
Covered services provided to the newborn child from the moment of birth for the maximum of 31 days, includes 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. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within such period. Refer to the General Information section for further eligibility information.

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 Certificate for more information.

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. Benefits are limited to one (1) consultation per consultant per admission.

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.

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

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

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.

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 Certificate. 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.

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.

Benefits are provided for emergency care services rendered by an ambulance service even when transport is not required or refused by you.

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.

Therapy and Rehabilitation Services

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

- Physical medicine
- Speech therapy
- Occupational therapy
- Radiation therapy
- Respiratory therapy
- 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.

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.

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.

In addition to telemedicine services, a designated telemedicine provider may also provide services related to the treatment of behavioral health. This would be covered under your outpatient mental health benefit and subject to the cost sharing amount in your Summary of Benefits.

Serious Mental Illness Care Services
Benefits will be provided for covered Inpatient care and covered outpatient care for the treatment of serious mental illness. A serious mental illness service provided on a partial hospitalization basis will be deemed to be an outpatient care visit subject to outpatient care cost-sharing amounts.

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.

Other Services

Allergy Extract/Injections

Benefits are provided for allergy extract and allergy injections.

Anesthesia for Non-Covered Dental Procedures (Limited)

Benefits will be provided for general anesthesia and associated hospital and medical services normally related to the administration of general anesthesia which are rendered in connection with non-covered dental procedures or non-covered oral surgery. Benefits are provided for members age seven or under and for developmentally disabled members when determined by Highmark to be medically necessary and appropriate and when a successful result cannot be expected for treatment under local anesthesia, or when a superior result can be expected from treatment under general anesthesia.

Autism Spectrum Disorders

Benefits are provided to members 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.

Artificial Insemination

Benefits will be provided for artificial insemination and associated diagnostic, medical and surgical services and pharmacological or hormonal treatments used in conjunction with artificial insemination when ordered by a physician and determined to be medically necessary and appropriate.

Assisted Fertilization Treatment

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

Dental Services Related to Accidental Injury

Dental services 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) and the Pennsylvania Department of Health.

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.

Enteral Foods

Enteral foods is a liquid source of nutrition equivalent to a prescription drug that is administered orally or enterally and which may contain some or all nutrients necessary to meet minimum daily nutritional requirements. Enteral foods are intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are identified through medical evaluation.

Coverage is provided for enteral foods when administered on an outpatient basis for:

- amino acid-based elemental medical formulae ordered by a physician for infants and children for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short bowel syndrome; and
- nutritional supplements administered under the direction of a physician for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria; and
- enteral formulae prescribed by a physician, when administered on an outpatient basis, considered to be your sole source of nutrition and provided:
    - through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulas; or
    - orally and identified as one of the following types of defined formulae with: hydrolyzed (pre-digested) protein or amino acids, specialized content for special metabolic needs, modular components, or standardized nutrients.

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

Coverage for enteral formulae excludes the following:

- 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

This coverage does not include normal food products used in the dietary management of the disorders included above.

Covered enteral foods are exempt from all deductibles.

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. 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.

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;
- Respite care;
- 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 Recovery Care Services

Benefits will be provided for in-home recovery care services offered through a designated hospital program and coordinated through a home recovery care vendor. Home recovery care services are available at the option of both you and your physicians approval in lieu of an inpatient admission or observation stay following an emergency room visit. You must have acute medical needs and meet other eligibility requirements of the program.

Services must be rendered in your home and benefits include coverage for:

- hospital-level, physician-led care;

- home infusion services, nursing visits, therapy services and telehealth visits;
- case management that provides stepped-up care coordination services; and
- specific equipment provided in order to coordinate home recovery care with your physicians and to help monitor your progress.

Infertility Counseling, Testing and Treatment

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

Orthotic Devices

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

Pediatric Extended Care Services

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

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

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

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

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

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

Private Duty Nursing Services

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

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

Prosthetic Appliances

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

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.

Therapeutic Injections

Therapeutic injections required in the diagnosis, prevention and treatment of an injury or illness. However, benefits for certain therapeutic injectables as identified by Highmark and which are appropriate for self-administration will be provided only when received from a participating pharmacy provider.

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 Certificate or as Highmark is mandated or required to cover based on state or federal law, regulation or other directive, no benefits will be provided for services, supplies or charges:

Key Word	Exclusion
Acupuncture Therapy Services	● For acupuncture therapy services, except as otherwise set forth in the Covered Services – Medical Program section of this Certificate.
Allergy Testing	● For allergy testing, except as provided herein.
Ambulance	● For ambulance services, except as provided herein.
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.
Compounded Medications	● For compounded medications.
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 services related to accidental injury, Anesthesia for non-covered dental procedures and 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 any food including, but not limited to, enteral foods, infant formulas, supplements, substances, products, enteral solutions, or compounds used to provide nourishment through the gastrointestinal

		tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis, except as 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.
Hearing Care Services	●	For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids.
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 or intellectual disabilities, which extends beyond traditional medical management or for non-medically necessary inpatient confinement. This paragraph shall not apply to care related to autism spectrum disorders. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or vocational training, 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 and vocational training 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 and you elect this coverage as primary.
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	● For any type of interaction made through unsecured and unstructured services, such as, but not limited to skype and instant messaging (unless such a service is within the scope of the practice of the provider), 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 drugs 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.
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, including medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.
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 the treatment of obesity, except for medical 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 which were paid or are payable under a freestanding prescription drug program. ● For prescription drugs and medications, except those which are administered to an inpatient 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.

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.
TMJ	● For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
Vision Correction Surgery	● For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakic, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.
War	● For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.
Weight Reduction	● For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
Workers' Compensation	● 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.

There are instances where you may not have the opportunity to choose your provider. In such cases, claims for covered services will be processed at the network level of benefits and Highmark will prohibit the provider from balance billing you.

Provider Reimbursement and Member Liability

Highmark uses the plan allowance to calculate the benefit payable and your financial liability 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 your responsibility. Your 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 this 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; and
2. Ambulance services, when provided in conjunction with emergency care services or when provided by air.

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.

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 Certificate.

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 Certificate.

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 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 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 its contractual obligations to the member. 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 price 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, (i.e., 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. The method of claims payment by Host Blues is taken into account by Highmark in determining the member's premiums.

Special Cases: Value-Based Programs
BlueCard® Program
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. If applicable, Highmark will include any such surcharge, tax or other fee in determining your premium.

Non-Participating Providers Outside Pennsylvania

Member Liability Calculation

When covered services are provided outside 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 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 the Plan Service Area as described elsewhere in this document. This may occur where the Host Blue's corresponding payment would be more than the Plan in-service area 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, members 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 covered services 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
- Behavior specialist
- 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.

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 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 subsection, active course of treatment means;

1. 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;

2. 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;

3. confirmed pregnancy, through the postpartum period;

4. scheduled non-elective surgery, through post-operative care;

5. 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

6. treatment for a terminal illness.

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

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

Transition of Care

If you are receiving medical care from an out-of-network provider, which is not otherwise covered by prior coverage, at the time when your coverage under this Certificate begins, you may opt to continue an ongoing course of treatment with that provider for a period of up to sixty (60) days. However, if you are in the second or third trimester of pregnancy when this coverage begins, the transition of care period shall extend through postpartum care related to the delivery. You must notify Highmark as soon as possible of your request to continue an ongoing course of treatment for the transition of care period by calling the Member Service toll-free telephone number on the back of your ID card.

Emergency Care Services - No Prior Approval Requirement

In the event that you require emergency care services, all charges for such covered services will be paid at the network services level of benefits. No prior authorization is required for emergency care services. In the event of an inpatient admission, you, your provider or a family member must notify Highmark within 72 hours of the admission, or as soon as reasonably possible. Once you are stabilized Highmark may offer to transfer your care from an out-of-network provider to a network provider.

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 out-of-area, the network 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.

Out-of-area network providers 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 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.

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 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 out-of-area, 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 out-of-area.

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 and Care Management
Case Management is the process by which Highmark, in its sole discretion, identifies alternative treatment modalities commensurate with your diagnosis profile and consults with the patient and attending professional provider(s). Notwithstanding the foregoing, all decisions regarding the treatment to be provided to you shall remain the responsibility of the treating professional provider(s) and you working with Highmark.

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.

Such alternative benefits may include offering you case management that provides stepped-up care coordination services. It may also include, in Highmark's sole discretion, non-emergency transportation to provider locations.

From time to time and as deemed appropriate by Highmark, based on program or clinical criteria, Highmark may also offer care management programs, including Prescription Drug care management programs. These programs are designed to help you in maintaining good health, manage chronic conditions, reduce health risk factors or prevent adverse medical events. Care management programs may include, but are not limited to, disease or other health condition monitoring, consultations with health care providers or other health care professionals participating in the care management program, health coaching, medication management and optimization. In some instances, consultations, remote monitoring equipment, devices and/or durable medical equipment are provided as part of the program. Such items and services will be subject to the same or more favorable member cost-sharing specified for such items and services under this program.

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. The provision of such information, items, services and support programs 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.

The provider directory lists the health care providers who participate in the network, including their addresses and telephone numbers, and indicates whether a provider is accepting new patients. However, you should always contact the provider to verify whether that provider is still participating in the network and accepting new patients.

Wellness Programs
Highmark offers you the opportunity to participate in programs of health promotion and/or disease prevention. When offered, these programs will be available to you without regard to health status. Whether or not you decide to participate in such programs will not affect your continued eligibility, benefits, premiums, or cost-sharing obligations.

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.

Closely Related Service

There may be circumstances where your provider may perform a closely related service for which precertification was required but was not obtained. In that case, Highmark may not deny coverage of the closely related service for failure to obtain precertification if your provider notifies Highmark of the provided service no later than three (3) business days following completion of the closely related service but before submission of the claim for payment. Your provider's notification to Highmark must include all relevant clinical information necessary to evaluate the medical necessity and appropriateness of the closely related service.

The Plan may perform a post-service review and determine that the closely related service was not medically necessary and appropriate. The Plan may also verify the member's eligibility for coverage at the time of the post-service review.

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.

Decisions Involving Requests for Precertification Related to a Prescription Drug Request

If the request is urgent, Highmark will make a decision on the request within twenty-four (24) hours. If the request is not urgent, Highmark will make a decision on the request within two (2) business days but not more than seventy-two (72) hours of receiving the request.

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 frames referenced above.

Notices of Determination Involving Precertification Requests Including Prescription Drug 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, including the clinical rationale, and a statement describing your right to file an internal appeal or request an external review as applicable.

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 Internal Complaint Process and Appeal Procedure subsection in the How to File a Claim section of this Certificate.

Concurrent Review Process

Decisions Involving Concurrent Review

If your request for concurrent review is not urgent, Highmark will make a decision in enough time to allow for an appeal before your ongoing treatment is reduced or terminated. 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 concurrent review can be completed within the referenced time frame.

Notices of Determination Involving Concurrent Review

You will be notified in writing of the decision within one (1) business day of Highmark's receiving all supporting information reasonably necessary to complete its review. If the request is approved, the written notice will advise you of the approval. If your request has been denied, your written notification will include, among other items, the specific reason or reasons for the adverse benefit determination, including the clinical rationale, and a statement describing your right to file an internal appeal or request an external review, as applicable.

Retrospective Review Process

Decision & Notice of Determination Involving Retrospective Review

If Highmark conducts a retrospective review, Highmark will send you written notice of the decision within thirty (30) days of receiving all supporting information reasonably necessary to complete the review. If the request is approved, the notice will advise you of the approval. If your request has been denied, your written notification will include, among other items, the specific reason or reasons for the decision, including the clinical rationale, and a statement describing your right to file an internal appeal or request an external review, as applicable.

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 effective date for an individual member is the date specified by the group in writing or other documented communication received by Highmark, unless an earlier effective date is required by law.

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
- Children under 26 years of age, unless otherwise extended pursuant to applicable state or federal law, including:

    - Newborn children
    - Stepchildren
    - Children legally placed for adoption
    - Legally adopted children and children for whom the employee or the employee's spouse is the child’s legal guardian
    - Children awarded coverage pursuant to an order of court

  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 by Highmark.

- Unmarried children over age 26 who are not able to support themselves due to intellectual disability, physical disability, mental illness or developmental disability that started before age 26. Coverage automatically terminates and all benefits hereunder cease, except as otherwise indicated, on the day following the date on which the disability ceases, whether or not notice to terminate is received by Highmark.

NOTE: To the extent mandated by the requirements of Pennsylvania Act 83 of 2005, eligibility will be continued past the limiting age for children who are enrolled as dependents under their parent’s coverage at the time they are called or ordered into active military duty. They must be a member of the Pennsylvania National Guard or any reserve component of the armed forces of the United States, who is called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days, or be a member of the Pennsylvania National Guard ordered to active state duty for a period of 30 or more consecutive days. If they become a full-time student for the first term or semester starting 60 or more days after their release from active duty, they shall be eligible for coverage as a dependent past the limiting age for a period equal to the duration of their service on active duty or active state duty.

For the purposes of this note, full-time student shall mean a dependent who is enrolled in, and regularly attending, an accredited school, college or university, or a licensed technical or specialized school for 15 or more credit hours per semester, or, if less than 15 credit hours per semester, the number of credit hours deemed by the school to constitute full-time student status.

A dependent child who takes a medically necessary leave of absence from school, or who changes enrollment status (such as changing from full-time to part-time) due to a serious illness or injury may continue coverage for one year from the first day of the medically necessary leave of absence or other change in enrollment, or until the date coverage would otherwise terminate under the terms of this program, whichever is earlier. Highmark may require certification from the dependent child's treating physician in order to continue such coverage.

*The following domestic partner provision applies **only** if your group provides coverage for this benefit. Your group administrator can determine if you are eligible for this coverage.*

- A domestic partner** shall be considered for eligibility as long as a domestic partnership (a voluntary relationship between two domestic partners) exists with you. In addition, the children of the domestic partner shall be considered for eligibility as if they were your children as long as the domestic partnership exists.

**"Domestic Partner" means a member of a domestic partnership consisting of two partners, each of whom has registered with a domestic partner registry in effect in the municipality/governmental entity within which the domestic partner currently resides, or who meets the definition of a domestic partner as defined by the state or local government where the individual currently resides or meets all of the following:

- Is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time
- Is not related to the other partner by adoption or blood
- Is the sole domestic partner of the other partner and has been a member of this domestic partnership for the last six months
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner
- Meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for domestic partnerships which are currently enacted, or which may be enacted in the future

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

Changes in Membership Status

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

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

Conversion

If your employer does not offer continuation of coverage, or if you do not wish to continue coverage through your employer's program, you may be able to enroll in an individual conversion program available from Highmark. Also, conversion is available to anyone who has elected continued coverage through your employer's program and the term of that coverage has expired. The coverage may be different from the coverage provided under your employer's program. If your coverage through your employer is discontinued for any reason, except as specified below, you may be able to convert to a direct payment program.

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

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

Direct payment for coverage under the individual conversion program must be made from the date you cease to be a member under your employer's program.

Written application to enroll in an individual conversion program must be made no later than:

1. either thirty-one days after termination of membership under your employer's program; or

2. fifteen days after you have been given written notice of the existence of ability to enroll in an individual conversion program;

3. but in no event later than ninety days after termination of coverage through your employer's program.

The following domestic partner provision applies only if your group provides coverage for this benefit. Your group administrator can determine if you are eligible for this coverage.

Also, if a domestic partner ceases to be a member under this Certificate, the individual and eligible dependents are eligible for coverage under a direct pay conversion agreement available from Highmark. The former domestic partner and any of the former domestic partner's previously covered children are entitled to direct pay coverage of the type for which the former domestic partner and children are then qualified at the rate then in effect. The coverage may be different from the coverage provided under this program.

Termination of Your Coverage Under the Group Insured Contract

Your coverage can be terminated in the following instances:

- When you cease to be an employee, the group shall promptly notify Highmark that you are no longer eligible for coverage and that your coverage should be terminated as follows:
    - When prompt notification is received, coverage will be terminated no earlier than the date on which you cease to be eligible.
    - When a group requests a retroactive termination of coverage, coverage will be terminated no earlier than the first day of the month preceding the month in which Highmark received notice from the group.

- When you fail to pay the required contribution, your coverage will terminate at the end of the last month for which payment was made.
- Termination of the Group Insured Contract automatically terminates the coverage of all the members. It is the responsibility of the group to notify you of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given to you by the group.
- If it is proven that you obtained or attempted to obtain benefits or payment for benefits through fraud or intentional misrepresentation of a material fact, Highmark may, upon 30-day advance written notice to you, terminate your coverage under the program.
- It is understood that you have an affirmative obligation to notify the group or Highmark as soon as the domestic partnership has been terminated. Upon termination of the domestic partnership,

coverage of the former domestic partner and the children of the former domestic partner will terminate at the end of the month the domestic partnership terminated.

Benefits after Termination of Coverage

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

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

- If you are pregnant on the date coverage terminates, no additional coverage will be provided.
- If you are totally disabled at the time your coverage terminates due to termination of active employment benefits will be continued for covered services directly related to the condition causing such total disability. This benefit extension does not apply to covered services relating to other conditions, illnesses, diseases or injuries and is not available if your termination was due to fraud or intentional misrepresentation of a material fact. This total disability extension of benefits will be provided as long as you remain so disabled as follows:

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

- If you are required to pay any premium, your benefits will not be continued if your coverage is terminated because you failed to pay the required premium.
- Benefits will also be provided for you who, on the date this coverage terminates and as described in the Health Care Management, Benefits after Provider Termination from the Network subsection of this Certificate, is in an active course of treatment until the earlier of such time as that treatment has been completed or for a period of up to ninety (90) days from the date this coverage terminates.

College Tuition Reward Program

1. Highmark provides access to a College Tuition Reward Program ("Program") made available by SAGE CTB LLC ("Sage"). Sage represents and has agreements with a consortium of private colleges and universities that participate in the Program.

2. Participation in the Program is at the sole option of the member.

3. Members who wish to participate in the Program can earn college tuition reward points that can be converted into equivalent cash credits which may be applied to the tuition expenses that eligible students incur when attending Sage participating colleges and universities. Credits are earned and accumulate during the period in which the member is enrolled under this plan.

4. Information regarding Program details including a listing of participating colleges and universities will be provided by Sage.

5. Highmark makes no representations and assumes no liability in connection with the Program or its administration.

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 under one contract, and as a dependent under another, then the employee coverage pays first.
- When a dependent child is covered under two contracts whose parents are married or are living together, whether or not they have ever been married, the contract 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.
- 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, that contract is the primary program;
    - 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 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 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 contract covering the custodial parent;

        ii. the contract covering the spouse of custodial parent;

        iii. the contract covering the non-custodial parent; and then

        iv. the contract covering the spouse of the non-custodial parent

- 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 other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a

program covering the person as a laid-off or retired employee or as a dependent of such person and if

- the other program does not have this provision regarding laid-off or retired employees, and, as a result, plans do not agree on the order of benefits, then this rule is ignored.

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

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

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

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

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

A Recognized Identification Card

Each covered member will receive a member ID 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:

- Member name
- Member Identification number
- Group number
- Copayment for physician office visits and emergency room visits (if applicable)
- Plan deductible (if applicable)
- Out-of-pocket limit (if applicable)
- Total maximum out-of-pocket (if applicable)
- Pharmacy network logo (if applicable)
- Member Service toll-free number (on back of card)
- Member website (on back of card)
- 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

Notice of Claim and Proof of Loss

(Applies to Post-service Claims Only)

Network providers have entered into an agreement with Highmark pertaining to the payment for covered services that they provide to you. When you receive covered services from a network provider, it is the responsibility of the network provider to submit its claim to Highmark in accordance with the terms of its participation agreement. Should the network provider fail to submit its claim in a timely manner or otherwise satisfy Highmark's requirements as they relate to the filing of claims, you will not be liable, and the network provider shall hold you harmless relative to payment of the covered services that you received.

When covered services are received from other than a network provider, you are responsible for submitting the claim to Highmark. In such instances, you must submit the claim in accordance with the following procedures:

Notice of Claim
Highmark will not be liable for any claims unless proper notice is furnished to Highmark that you have received covered services. Written notice of a claim must be given to Highmark within 20 days or as soon as reasonably possible after you have received covered services. Notice given by you or on your behalf to Highmark that includes information sufficient to identify you shall constitute sufficient notice of a claim to Highmark. You can give notice to Highmark by writing to the Member Service Department. The address of the Member Service Department can be found on your ID card. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Claim Forms
Proof of loss for covered services must be submitted to Highmark on the appropriate claim form. Highmark, upon receipt of a notice of a claim will, within 15 days following the date a notice of a claim is received, furnish you with claim forms for filing proofs of loss. If claim forms are not furnished within 15 days after the giving of such notice, you shall be deemed to have complied with the requirements of this subsection as to filing a proof of loss upon submitting, within the time fixed in this subsection for filing proofs of loss, itemized bills for covered services as described below. The proof of loss may be submitted to Highmark at the address appearing on your ID card.

Proof of Loss
Claims cannot be paid until a written proof of loss is submitted to Highmark. Written proof of loss must be provided to Highmark within 90 days after the date of such loss. Proof of loss must include all data necessary for Highmark to determine benefits. Failure to submit a proof of loss to Highmark within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will Highmark be required to accept a proof of loss later than 1 year from the time proof is otherwise required.

Submission of Claim Forms
The completed claim form, with all itemized bills attached, must be forwarded to Highmark at the address appearing on your ID card to satisfy the requirement of submitting a written proof of loss and to receive payment for covered services.

To avoid delay in handling claims that you submit, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing:

Person or organization providing the service or supply

Type of service or supply
Date of service or supply
Amount charged
Name of patient

In addition to the above, private duty nursing bills must contain the shifts worked, the charge per day, the professional status of the nurse, and the signature of the professional provider prescribing the service. Professional provider bills must show specific treatment dates. Drug and medicine bills must show prescription number, date of purchase, and the patient's name. Your attending professional provider must include a signature on all bills as certification that services have been prescribed, except for doctor bills, hospital bills, or prescription drug bills. (Some bills requiring a signature of the professional provider include ambulance, prosthetic devices, rental of durable medical equipment, private duty nursing, etc.). Itemized bills cannot be returned.

A request for payment of a claim will not be reviewed and no payment will be made unless all the information and evidence of payment required on the claim form has been submitted in the manner described above. Highmark reserves the right to require additional information and documents as needed to support a claim that a covered service has been rendered.

Notice of Highmark's claim determination will be issued within a reasonable period not to exceed thirty (30) days following the receipt of a proper proof of loss. This period of time may be extended one (1) time by Highmark for an additional period of time not to exceed fifteen (15) days provided the extension is due to matters outside the control of Highmark and a written explanation for the delay is provided to you.

In the event that Highmark renders an adverse decision on the claim, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement describing your right to file an appeal.

Time of Payment of Claims
Claim payments for benefits payable under this Certificate will be processed immediately upon receipt of a proper proof of loss.

Authorized Representative
Nothing in this section shall preclude your duly authorized representative from filing or otherwise pursuing a claim on behalf of you. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

Limitation on Legal Actions

After a notice of claim has been given, you may not take legal action for sixty days. You may not take legal action later than three years after the expiration of the time within which a notice of claim is required.

Physical Examinations and Autopsy

Highmark, at its own expense, shall have the right and opportunity to examine the person of the member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

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
P.O. Box 535095
Pittsburgh, PA 15253

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 Certificate 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 Certificate.

- ***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 your area. Highmark will notify you of the amount that was paid to the provider. Any remaining amounts that you are required to pay in the form of a copayment, coinsurance or program deductible will also be identified in that EOB or notice. If you believe that the copayment, coinsurance or deductible amount identified in that EOB or notice is not correct or that any portion of those amounts are covered under your benefit program, you may file a claim with Highmark. For instructions on how to file such claims, you should contact the Member Service Department using the telephone number on your ID card.

Determinations on Benefit Claims

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

- ***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 thirty (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 fifteen (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 forty-five (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 Complaints, Adverse Benefit Determinations and Appeals subsection below.

Complaints, Adverse Benefit Determinations and Appeals

All decisions made by Highmark involving the denial of payment for a covered service will be made by qualified personnel with experience in the same or similar scope of practice. All notices of these decisions will include information regarding the basis for the determination.

Highmark maintains both a complaint and an adverse benefit determination process. At any time during either of these processes, you may designate an authorized representative to participate in the process on your behalf. An authorized representative can be (i) a person (including your provider) to whom you have given express written consent to represent you in a complaint or adverse benefit determination process; (ii) a person authorized by law to provide substituted consent for you; or (iii) a family member or treating provider involved in providing health care to you, if you are incapacitated or unable to provide consent due to a medical emergency or as necessary to prevent a serious and imminent threat to your health or safety.

You or your authorized representative shall notify Highmark, in writing, of the designation. If an authorized representative is designated, you may not file a separate complaint or adverse benefit determination appeal. You may rescind the authorized representative designation at any time. In the event that your authorized representative fails to file or pursue either a complaint or appeal of an adverse benefit determination, the authorized representative designation shall be automatically removed. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

For purposes of this Complaints, Adverse Benefit Determinations and Appeals Subsection, the word “you” shall include both you and your authorized representative.

At any time during the internal complaint or adverse benefit determination process, you can request Highmark to appoint a person from its Member Service Department to assist you, at no charge, to help in preparing the complaint or adverse benefit determination. The Highmark employee made available to you will not have participated in any previous decisions to deny coverage for the issue in dispute.

At any time during the internal complaint or adverse benefit determination process, you may call Member Service at the toll-free telephone number on the back of your ID card to inquire about the filing or status of a complaint or adverse benefit determination.

Internal Complaint Process

Highmark maintains a complaint process for the resolution of your disputes or objections regarding a network provider or the coverage (including exclusions, cost-sharing, formulary changes and non-covered benefits), operations or management policies of Highmark. A complaint does not include an adverse benefit determination.

You have the right to have your complaint internally reviewed through the two (2) level process described in this Internal Complaint Process section. However, if your complaint involves an urgent care claim, a single level review process is available as explained in the Expedited External Review paragraph, below.

You must exhaust this two (2) level process before seeking further administrative review of your complaint by the Pennsylvania Insurance Department (“Department”). Except in the case of a Second Level Review involving the denial of a pre-service claim, the entire two (2) level process described below is mandatory and must be exhausted before you are permitted to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Initial Review

An initial complaint shall be directed to the Member Service Department. You must submit the complaint, which may be oral or in written form, within one hundred-eighty (180) days from the date you received the notification of an adverse decision or on which the issue that is the subject of your complaint occurred. Upon its receipt of the complaint, Highmark will provide you with written confirmation your request has been received, and that Highmark has classified it as a complaint for purposes of internal review. If you disagree with the Highmark's classification of a request for an internal review, you may directly contact the Insurance Department for consideration and intervention with Highmark in regard to the classification that has been made.

You have the right to submit or present additional evidence or testimony which includes any written or verbal statements, comments and/or remarks, documents, records, information, data or other material in support of your complaint. You may, upon request to Highmark, review all documents, records and other information relevant to the complaint. The initial level complaint review will be performed by an Initial Review Committee that will include one (1) or more employees of Highmark.

The members of the Initial Review Committee shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny your complaint or matter.

Your complaint will be promptly investigated, and a decision will be rendered within the following timeframes, depending upon what type of claim is involved in your complaint:

- For complaints involving non-urgent care pre-service claims, within a reasonable period of time appropriate to the medical circumstance, but not to exceed thirty (30) days following Highmark's receipt of your complaint;
- For complaints involving urgent care claims, within the period of time provided in the Expedited External Review paragraph below;
- For complaints involving post-service claims, a decision by Highmark to deny an enrollment request because the individual is not eligible for coverage, or for any other complaint not set forth above, within a reasonable period of time not to exceed thirty (30) days following Highmark's receipt of your complaint;

Highmark will provide written notification of its decision within five (5) business days of the decision, not to exceed thirty (30) days from Highmark's receipt of your complaint.

If Highmark does not provide notice of its decision within the above-stated time frames or otherwise fails to strictly adhere to these complaint procedures, you shall be permitted to request an appeal and/or pursue any applicable legal action.

In the event Highmark renders a decision on the complaint not in the Member's favor, the notification shall include, among other items, the specific reason or reasons for the adverse decision, the procedure for requesting a second level of review of the decision by the Initial Review Committee and, in the case of a complaint involving the denial of a Pre-service Claim, which includes an Urgent Care Claim complaint, a statement regarding the right of the Member to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Second Level Review

You must complete the Second Level Review process before seeking further administrative review of your complaint by the Department.

If you are dissatisfied with Highmark's decision following the initial review of your complaint, you may request to have the decision reviewed by a Second Level Review Committee. The request to have the decision reviewed must be submitted in writing (or communicated orally under special circumstances)

within forty-five (45) days from the date an adverse decision is received and may include any written information from the Member or any party in interest.

The Second Level Review Committee will be comprised of three (3) individuals who were not involved or the subordinate of any individual that was previously involved in the matter under review. At least one (1) individual of the Committee will not be an employee of Highmark or Highmark's related subsidiaries or affiliates. The Committee will hold an informal hearing to consider your complaint. When arranging the hearing, Highmark will notify you in writing of the hearing procedures and your rights at the hearing, including your right to be present at the review. If you cannot appear in person at the second level review, Highmark shall provide you with the opportunity to communicate with the Committee by telephone or other appropriate means.

The hearing will be held and a decision will be rendered within thirty (30) days of Highmark's receipt of your request for review.

Highmark will provide written notification of its decision within five (5) business days of the decision, not to exceed thirty (30) days from Highmark's receipt of your request for review. In the event that Highmark renders an adverse decision, the notification shall include, among other items, the specific reason or reasons for the adverse decision, the procedure for appealing the decision to the Department and , in the case of a complaint involving the denial of a post-service claim, a statement regarding the right of the member to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Appeal of an Internal Complaint

If a second level review is completed, you will have fifteen (15) days from the receipt of the notice of the decision of the Second Level Review Committee to appeal the decision to the Department. The appeal shall be in writing unless you request to file the appeal in an alternative format.

Appeals may be filed at the following address:

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, Pennsylvania 17120

All records from the initial review and the second level review shall be forwarded to the Department in the manner, as appropriate. You or Highmark may submit additional material related to your complaint to the Department. Each shall provide to the other, copies of additional documents provided. You may be represented by an attorney or other individual before the Department.

Internal Adverse Benefit Determination Process

Highmark maintains an internal appeal process involving one level of review for adverse benefit determinations. Adverse benefit determinations include the following:

- a decision by Highmark that, based upon the information provided and utilization review, a request for a benefit does not meet Highmark's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational, such that the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;

- the denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on Highmark's determination of your eligibility for coverage under your benefit program or noncompliance with an administrative policy or
- a rescission of coverage determination by Highmark.

An adverse benefit determination does not involve a complaint.

This appeal process is mandatory and must be exhausted before you are permitted to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

If you receive notice of an adverse benefit determination, you have one hundred-eighty (180) days from the date of your receipt of notification of the adverse decision to submit an appeal.

Upon receipt of the appeal, Highmark will provide written confirmation to you that the request has been received, and that Highmark has classified it as an adverse benefit determination for purposes of internal review.

Upon request to Highmark, you may review all documents, records and other information relevant to 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.

Your appeal will be reviewed by a representative from the Member Grievance and Appeals Department. The representative shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the claim or matter which is the subject of your appeal. In rendering a decision on your appeal, the Member Grievance and Appeals Department will take into account all 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 Member Grievance and Appeals Department will afford no deference to any prior adverse decision on the claim which is the subject of your appeal.

Each appeal will be promptly evaluated, and Highmark will provide written notification of its decision within the following time frames:

- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances involved not to exceed thirty (30) days following receipt of the appeal;
- When the appeal involves an urgent care claim, an admission, availability of care, continued stay or service for which you have received emergency care services but have not been discharged from a facility, or a determination that a service is experimental/investigative and, based on the written certification of the treating Provider, would be significantly less effective if not promptly initiated, as soon as possible taking into account the medical exigencies involved but not later than seventy-two (72) hours following receipt of the appeal; or
- When the appeal involves a post-service claim, a decision by Highmark to rescind coverage , or for any other adverse benefit determination not set forth above, within a reasonable period of time not to exceed thirty (30) days following receipt of the appeal.

If Highmark fails to provide notice of its decision within the above-stated time frames or otherwise fails to strictly adhere to these appeal procedures, you may be permitted to request an external review and/or pursue any applicable right to arbitration.

In the event that Highmark renders an adverse decision on the appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision including clinical rationale, the procedure

for appealing the decision and, in the case of a grievance involving the denial of a pre-service claim, which includes an urgent care claim grievance, a statement regarding your right to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

External Adverse Benefit Determination Process

If you receive an adverse benefit determination, you may appeal such decision to an external entity. The type of external review is dependent upon the type of adverse benefit determination.

If the adverse benefit determination is an administrative denial, meaning that the adverse decision was based on:

- Prior authorization, coverage or payment based on a lack of eligibility, failure to submit complete information or other failure to comply with an administrative policy; or
- is a rescission of coverage,

you must follow the appeal process outlined in the External Appeal of Administrative Denial paragraph below.

If the adverse benefit determination was based on:

- Medical necessity and appropriateness
- Health care setting;
- Level of care;
- Effectiveness of a covered service; or
- Relates to a claim regarding Highmark's compliance with the surprise billing and cost-sharing protections under the federal No Surprises Act,

You must follow the appeal process outlined in the External Review of Non-Administrative Denials paragraph below.

External Appeal of Administrative Denial

You will have fifteen (15) days from the receipt of the notice of Highmark's adverse decision on the internal appeal on an administrative denial to appeal the decision to the Department.

All records from the internal process for the administrative denial will be forwarded to the Department in the manner prescribed. You and Highmark may submit additional material related to the administrative denial to the Department. You may be represented by an attorney or other individual before the Department.

External Review of Non-Administrative Denials

You shall have four (4) months from the receipt of the notice of an adverse benefit determination of a non-administrative denial to file a request for an external review of an adverse benefit determination resulting with the Department. Administrative denials are not eligible for this external review process and must be appealed as set forth in the External Appeal of Administrative Denial paragraph, above.

Except in the instance of a request for expedited external review, the request for external review should be filed in writing to the Department. The Department may prescribe the form and content of the external review request, but the request must include an authorization form authorizing the Plan and provider to disclose pertinent protected health information to the external review. The request should include the reasons, material justification and all reasonably necessary supporting information as part of the external review request.

Preliminary Review and Notification

Within one (1) business day from receipt of the request for external review, the Department shall send a copy of the request to Highmark. Within five (5) business days from receipt of the copy of the request for external review, Highmark will complete a preliminary review of the external review request to determine:

- whether you are or were covered under this program at the time the service which is the subject of the denied claim was or would have been received;
- whether the service, which is the subject of the denied claim, is not a covered service under this because it does not meet the Plan's requirements as to medical necessity and appropriateness, health care setting, level of care or effectiveness of a covered service, or because the Plan determined the service to be experimental/investigative for a particular medical condition;
- with respect to denials based on the experimental and investigational nature of the service, whether your provider has certified that: (1) standard health care services have not been effective, are not medically appropriate or that no alternative covered service is more beneficial than the service that is the subject of the denial; and (2) that the recommended service is likely to be more than available standard health care services, or that scientifically valid studies using accepted protocols demonstrate that the requested service requested is likely to be more beneficial to you than any available standard health care services;
- whether you have exhausted Highmark's internal appeal process, unless otherwise not required to exhaust that process; and
- whether you have provided all the information and any applicable forms required to process the external review request.

Within one (1) business day following completion of its preliminary review of the request, Highmark shall in writing notify you and the Department of its determination.

In the event that the external review request is not complete, the notification will describe the information or materials needed to complete the request.

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. Highmark's determination that the request is not eligible for external review may be appealed to the Department.

Final Review and Notification

Within one (1) business day from receipt of the notification that the request is complete and eligible for external review, the Department shall assign an independent review organization (IRO) to conduct the external review and notify Highmark of the assignment. If the request relates to a determination that the treatment is experimental or investigative, within one (1) business day of receipt of the assignment notification, the IRO shall select one or more clinical reviewers to conduct the external review. The Department shall notify you that the request has been accepted and is eligible for external review. The notice will further state that any additional information which you may have in support of the request must be submitted, in writing, within fifteen (15) business days for a standard external review request, or within five (5) business days if the external review relates to an experimental or investigative service, following receipt of the notice.

Any additional information timely submitted by you and received by the assigned IRO will be forwarded to Highmark within one (1) business day of receipt. Upon receipt of the information, Highmark shall be permitted an opportunity to reconsider its prior decision regarding the claim that was denied or the matter which is the subject of the external review request. Reconsideration by Highmark of its prior decision may not delay or terminate the external review. The external review may be terminated without a determination by the IRO only if Highmark reverses its prior decision and provides coverage or payment for the claim that is the subject of the external review. Within one (1) business day of making the decision to reverse its prior determination,

Highmark shall notify the Department, the assigned IRO and you, in writing, of its decision. Upon receipt of such notice, the assigned IRO shall terminate the external review.

The assigned IRO or clinical reviewer will review all information and documents that it timely received and make a decision on the external review request. Decisions or conclusions reached during Highmark's internal appeal process are not binding on the IRO or clinical reviewer. The assigned IRO shall provide written notice of the final external review decision to the Department, Highmark and you within forty-five (45) days from receipt by the IRO of the external review request. Written notice of the decision shall provide, among other information, a statement of the principal reasons for the decision including the rationale and standards relied upon by the IRO. Upon receipt of notice that Highmark's decision was reversed by the IRO, Highmark shall within twenty-four (24) hours approve coverage of the service that was the subject of the external review request.

Expedited External Review

If Highmark's initial decision or the denial resulting from Highmark's internal appeal process involves:

- an urgent care claim;
- an admission, availability of care, continued stay or service for which you received emergency care services but have not been discharged from a facility; or
- a determination the service is experimental or investigational and, based on the written certification of the treating Provider, would be significantly less effective if not promptly initiated,

you may request an expedited external review of Highmark's decision. An expedited external review may not be provided for retrospective adverse benefit determinations.

A request for an expedited external review must be submitted to the Department. Upon receipt of a request for an expedited external review, the Department shall, within twenty-four (24) hours, send a copy of the request to Highmark.

You may choose to request expedited external review at the same time of filing a request for expedited internal review of an adverse benefit determination. If the IRO determines that an expedited internal review is first required, the IRO must notify you within twenty-four (24) hours. Additionally, Highmark may agree to waive the expedited internal review exhaustion requirement.

Within twenty-four (24) hours of receipt from the Department of the request for expedited external review, Highmark will determine whether the request is timely, complete and eligible for external review. Within twenty-four (24) hours following completion of this preliminary review of the expedited external review request, Highmark shall notify the Department and you of its determination. Highmark's determination that the request is not eligible for expedited external review may be appealed to the Department.

Within twenty-four (24) hours from receipt of the notification that the request is complete and eligible for expedited external review, the Department shall assign an IRO to conduct the external review and notify Highmark of the assignment. Upon receipt of the notification of the IRO assignment, Highmark shall transmit documents and information considered in making the adverse benefit determination to the assigned IRO in an expeditious manner. Decisions or conclusions reached during Highmark's determination or Highmark's Internal Adverse Benefit Determination Process are not binding on the IRO. The assigned IRO will conduct the review and provide notice of its final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours following receipt by the IRO of the request for expedited external review. If notice of the decision by the IRO is not provided in writing, the IRO must provide within forty-eight (48) hours following initial notice of its final external review decision, written confirmation of that decision to Highmark, you, and the Department. Written notice of the decision shall provide, among other information, a statement of the principal reasons for the decision including the rationale and standards relied upon by the IRO. Upon receipt of notice that Highmark's decision was reversed by the

IRO, Highmark shall within twenty-four (24) hours approve coverage of the service that was the subject of the expedited external review request.

Member Assistance Services

You may obtain assistance with Highmark's internal appeal and external review procedures as described herein by contacting the Pennsylvania Insurance Department Office of Consumer Services or such other applicable office of health insurance consumer assistance or ombudsman.

Autism Spectrum Disorders Expedited Review and Appeal Procedures

Upon denial, in whole or in part, of a pre-service claim or post-service claim for diagnostic assessment or treatment of autism spectrum disorders, there is an appeal procedure for expedited internal review which you may choose as an alternative to those procedures set forth above. In order to obtain an expedited review, you or your authorized representative shall identify the particular claim as one related to the diagnostic assessment or treatment of an autism spectrum disorder to the Member Service Department and request an expedited review which will be provided by Highmark. If, based on the information provided at the time the request is made, the claim cannot be determined as one based on services for the diagnostic assessment or treatment of autism spectrum disorders, Highmark may request from you or the health care provider additional clinical information including the treatment plan described in the covered services section of the Certificate.

An appeal of a denial of a claim for services for the diagnostic assessment or treatment of an autism spectrum disorder is subject to review by a Review Committee. The request to have the decision reviewed by the Review Committee may be communicated orally or be submitted in writing within 180 days from the date the denial of the claim is received and may include any written information from you or the health care provider. The Review Committee shall be comprised of three employees of Highmark who were not involved or the subordinate of any individual that was previously involved in any decision to deny coverage or payment for the health care service. The Review Committee will hold an informal hearing to consider the appeal. When arranging the hearing, Highmark will notify you or the health care provider of the hearing procedures and rights at such hearing, including your or the health care provider's right to be present at the review and to present a case. If you or the health care provider cannot appear in person at the review, Highmark shall provide you or the health care provider the opportunity to communicate with the Review Committee by telephone or other appropriate means.

Highmark shall conduct the expedited internal review and notify you or your authorized representative of its decision as soon as possible but not later than 48 hours following the receipt of your request for an expedited review. The notification to you and the health care provider shall include, among other items, the specific reason or reasons for the adverse decision including any clinical rationale, the procedure for obtaining an expedited external review and a statement regarding your right to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Following the receipt of the expedited internal review decision, you may contact Highmark to request an expedited external review pursuant to the expedited external review procedure for autism spectrum disorders established by the Pennsylvania Insurance Department.

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.

Blues On Call℠ - 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 do not 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.

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 Highmark, its products and its services, its practitioners and providers, and your rights and responsibilities.

2. Be treated with respect and recognition of your dignity and right to privacy.

3. Participate with practitioners in decision-making regarding your health care. This includes the right to be informed of your diagnosis and treatment plan in terms that you understand and participate in decisions about your care.

4. Have a candid discussion of appropriate and/or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Highmark does not restrict the information shared between practitioners and patients and has policies in place, directing practitioners to openly communicate information with their patients regarding all treatment options regardless of benefit coverage.

5. Voice a complaint or file an appeal about Highmark or the care provided and receive a reply within a reasonable period of time.

6. Make recommendations regarding the Highmark Members' Rights and Responsibilities policies.

You have a responsibility to:

1. Supply to the extent possible, information that the organization needs in order to make care available to you, and that its practitioners and providers need in order to care for you.

2. Follow the plans and instructions for care that you have agreed on with your practitioners.

3. Communicate openly with the physician you choose. Ask questions and make sure you understand the explanations and instructions you are given, and participate in developing mutually agreed upon treatment goals. Develop a relationship with your doctor based on trust and cooperation.

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 Summary of Benefits section of this Certificate.*

Affordable Care Act (ACA) - The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) and its implementing regulations.

Ambulance Service - An ancillary provider licensed by the state which, for compensation from its patients, provides local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured. Ambulance service includes an emergency medical services (EMS) agency licensed by the state.

Ambulatory Surgical Facility - A facility provider, with an organized staff of physicians, which is licensed as required by the state and which, for compensation from its patients:

a. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;

b. provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility;

c. does not provide inpatient accommodations; and

d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a professional provider.

Amendatory Rider - a legal document which modifies the terms of this Certificate, either by expanding, decreasing, or defining benefits, or adding or excluding certain conditions from coverage.

Ancillary Provider - A person or entity licensed where required and performing services within the scope of such licensure. Ancillary providers include, but are not limited to:

Ambulance Service
Clinical Laboratory
Diabetes Prevention Provider
Home Infusion Therapy Provider
Independent Diagnostic Testing Facility (IDTF)
Suite Infusion Therapy Provider
Suppliers

Anesthesia - The administration of a regional or rectal anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, induce an altered state, loss of sensation or loss of consciousness.

Applied Behavioral Analysis - The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

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.

Artificial Insemination - A procedure, also known as intrauterine insemination (IUI) or intracervical/intravaginal insemination (ICI), by which sperm is directly deposited into the vagina, cervix or uterus to achieve fertilization and pregnancy.

Assisted Fertilization - Any method used to enhance the possibility of conception through retrieval or manipulation of the sperm or ovum. This includes, but is not limited to, artificial insemination, in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), tubal embryo transfer (TET), peritoneal ovum sperm transfer, zona drilling, and sperm microinjection.

Autism Service Provider - A professional provider or a facility provider licensed or certified, where required, and performing within the scope of such license or certification providing treatment for autism spectrum disorders, pursuant to a treatment plan, as provided herein.

Autism Spectrum Disorders - Any disorder defined as an autism spectrum disorder by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor.

Bariatric Surgery - An operation on the stomach and/or intestines intended to help promote weight loss including, but not limited to, vertical banded gastroplasty, gastric stapling, laparoscopic adjustable gastric banding, mini-gastric bypass, gastric bypass with Roux-en-Y, biliopancreatic diversion, biliopancreatic diversion with duodenal switch, long-limb gastric bypass, intestinal gastric bypass, or any other surgical procedure designed to restrict an individual's ability to assimilate food.

Behavior Specialist - An individual licensed or certified, where required, and performing within the scope of such licensure or certification, who designs, implements or evaluates a behavior modification intervention component of a treatment plan for the treatment of autism spectrum disorders, including those based on

applied behavioral analysis, to produce socially significant improvements in human behavior or to prevent loss of attained skill or function through skill acquisition and the reduction of problematic behavior.

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.

Birthing Facility - A facility provider licensed by the state which, for compensation from its patients, is primarily organized and staffed to provide maternity care and is under the supervision of a nurse-midwife.

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.

Certified Registered Nurse - A certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any registered professional nurses employed by a health care facility, as defined in the Pennsylvania Health Care Facilities Act, or by an anesthesiology group.

Chemotherapy Medication - A medication prescribed to kill or slow the growth of cancerous cells.

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.

For purposes of the claim determination and appeal procedure provisions, whether a claim or an appeal of a denied claim involves a pre-service claim, an urgent care claim or a post-service claim will be determine at the time that the claim or appeal is filed with Highmark in accordance with its procedures for filing claims and appeals.

Clinical Laboratory - A medical laboratory licensed where required, performing within the scope of such licensure, and is not affiliated or associated with a hospital or physician.

Clinical Social Worker - A licensed clinical social worker performing within the scope of such licensure. Where there is no licensure law, the clinical social worker must be certified by the appropriate professional body.

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.

Coinsurance - The percentage of the plan allowance for covered services that is your responsibility. The remaining percentage is the responsibility of Highmark subject to the provisions of this program.

Colorectal Cancer Screenings - Tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer. Colorectal cancer screenings are covered to the extent specified herein. Please refer to the Summary of Benefits section of this Certificate.

Copayment - A specified dollar amount of eligible expenses which you are required to pay for a specified covered service and which will be deducted from the plan allowance before the determination of the benefits payable under this program is made.

Covered Service - 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.

Deductible - A specified dollar amount of liability for covered services that must be incurred by you before Highmark will assume any liability for all or part of the remaining covered services.

Dentist - A person who is a doctor of dental surgery (D.D.S.) or doctor of medical dentistry (D.M.D.), licensed where required and performing services within the scope of such licensure.

Dependent - A member other than the employee as specified herein.

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.

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 Highmark to provide medical services, including telemedicine services.

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.

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 the criteria of Highmark. These criteria are based on the certification programs for outpatient diabetes education developed by the American Diabetes Association (ADA) and the Pennsylvania Department of Health.

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.

Diagnostic Service - A testing procedure ordered by a professional provider because of specific symptoms to determine a definite condition or disease.

Dietitian-Nutritionist - A licensed dietitian-nutritionist performing within the scope of such licensure. Where there is no licensure law, the dietitian-nutritionist must be certified by the appropriate professional body.

Domestic Partner - (Please check with your Group Administrator to see if the following is applicable.) A member of a domestic partnership consisting of two (2) partners, each of whom has registered with a domestic partner registry in effect in the municipality/governmental entity within which the domestic partner currently resides, or who meets the definition of a domestic partner as defined by the state or local government where the individual currently resides or meets all of the following:

- Is unmarried, at least eighteen (18) years of age, resides with the other partner and intend to continue to reside with the other partner for an indefinite period of time;
- Is not related to the other party by adoption or blood;
- Is the sole domestic partner of the other partner and has been a member of this domestic partnership for the last six (6) months;
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and
- Meets (or agrees to meet) the requirements of any applicable federal, state or local laws or ordinances for domestic partnerships which are currently enacted, or which may be enacted in the future.

Domestic Partnership - A voluntary relationship between two (2) domestic partners.

Durable Medical Equipment - Items which can withstand repeated use; are primarily and customarily used to serve a productive medical purpose; are generally not useful to a person in the absence of illness, injury or disease; are appropriate for use in the home and do not serve as comfort or convenience items.

Effective Date - The date when your coverage begins.

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.

Employee - An individual who meets the eligibility requirements specified herein.

Enteral Foods - A liquid source of nutrition equivalent to a prescription drug that is administered orally or enterally and which may contain some or all nutrients necessary to meet minimum daily nutritional requirements. Enteral foods are intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are identified through medical evaluation.

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

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.

Facility Provider - An entity which is licensed, where required, to render covered services. Facility providers include:

Ambulatory Surgical Facility
Birthing Facility
Freestanding Dialysis Facility
Freestanding Nuclear Magnetic Resonance Facility/Magnetic Resonance Imaging Facility
Home Health Care Agency
Hospice
Hospital
Outpatient Physical Rehabilitation Facility
Outpatient Psychiatric Facility
Outpatient Substance Abuse Treatment Facility
Pediatric Extended Care Facility
Psychiatric Hospital
Rehabilitation Hospital
Residential Treatment Facility
Skilled Nursing Facility
State-Owned Psychiatric Hospital
Substance Abuse Treatment Facility

Family Counseling - Counseling with family members in the assessment of the patient's diagnosis and treatment. Such counseling may assist family members to gain insight into the patient's illness and serve as an adjunct of the treatment regimen. Nevertheless, the services must primarily relate to the management of the patient's illness.

Family Coverage - Coverage for the employee and one (1) or more of the employee's dependents.

Family Deductible - A specified dollar amount of liability for covered services that must be incurred by one (1) or more family members, who are covered, before Highmark will assume any liability for all or part of the remaining covered services. Once the family deductible is met, no further deductible amounts must be satisfied by any covered family member.

Freestanding Dialysis Facility - A facility provider licensed and approved by the appropriate governmental agency which, for compensation from its patients, is primarily engaged in providing dialysis treatment, maintenance or training to patients on an outpatient or home-care basis.

Freestanding Nuclear Magnetic Resonance Facility/Magnetic Resonance Imaging Facility - A facility provider which, for compensation from its patients, is primarily engaged in providing, through an organized professional staff, nuclear magnetic resonance/magnetic resonance imaging scanning. These facilities do not include Inpatient beds, medical or health-related services.

Group - the party entering into a contract of insurance on your behalf and the representative of and remitting agent for you who collects and remits premium payments on your behalf.

Group Insured Contract - The agreement (including the Group Application, Plan's Acceptance and this Certificate) between your group and Highmark.

Health Care Certificate (Certificate) – The document(s) that describe(s) covered services and other contractual terms affecting the payment of, or eligibility for, benefits. Health Care Certificate includes Summary of Benefits, Exhibits, and any amendatory riders or other amendments to such forms thereto.

Health Care Management Services - A program which integrates all activity related to managing your medical care from the time that an admission, surgical or diagnostic procedure, or certain services become necessary. The program consists of any applicable pre-admission certification, admission certification of emergency admissions, continued stay review, discharge planning, procedure or covered service precertification, case management and skilled nursing facility precertification.

Highmark Blue Cross Blue Shield - An independent licensee of the Blue Cross Blue Shield Association. Any reference to Highmark Blue Cross Blue Shield may also include its Designated Agents with whom Highmark Blue Cross Blue Shield has contracted to perform a function or service.

Highmark Blue Shield - An independent licensee of the Blue Cross Blue Shield Association. Any reference to Highmark Blue Shield may also include its designated agents with whom Highmark Blue Shield has contracted to perform a function or service.

Highmark Blue Shield Participating Facility Provider - A facility provider, licensed where required and performing within the scope of such licensure, that has an agreement, either directly or indirectly with Highmark Blue Shield, operating as a hospital plan corporation, pertaining to payment for covered services rendered to you.

Highmark Blue Shield Participating Facility Provider Network - All Highmark Blue Shield participating facility providers, approved as a network by the Pennsylvania Department of Health, that have entered into a network agreement, either directly or indirectly with Highmark Blue Shield to provide health care services to you.

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

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

Highmark NE Participating Facility Provider – A facility provider, located in the Plan Service Area, licensed where required and performing within the scope of such licensure, that has an agreement, either directly or indirectly, with Highmark pertaining to payment for covered services rendered to you.

Highmark NE Participating Facility Provider Network – All Highmark NE participating facility providers, approved as a network by the Pennsylvania Department of Health, that have entered into an agreement, either directly or indirectly with Highmark Blue Cross Blue Shield to provide health care services to you.

Highmark Northeastern Pennsylvania Service Area - The geographic area within northeastern Pennsylvania consisting of the following counties in Pennsylvania:

Bradford	Lycoming	Susqehanna
Carbon	Monroe	Tioga
Clinton	Pike	Wayne
Lackawanna	Sullivan	Wyoming
Luzerne		

Highmark Southeastern Pennsylvania Service Area - The geographic area within southeastern Pennsylvania consisting of the following counties in Pennsylvania:

Bucks	Chester	Delaware	Philadelphia
Montgomery			

Home Health Care Agency - A facility provider program for home health care, licensed by the state and certified by Medicare which, for compensation from its patients:

a. provides skilled nursing and other services on a visiting basis in the your home, and

b. is responsible for supervising the delivery of such services under a plan prescribed by the attending physician.

Home Infusion Therapy Provider - An ancillary provider licensed by the state, accredited by The Joint Commission, if appropriate, and organized to provide infusion therapy to patients at their place of residence.

Hospice - A facility provider, licensed by the state which, for compensation from its patients, is primarily engaged in providing palliative care to terminally ill individuals.

Hospice Care - A program which provides an integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients and their families. Hospice services are centrally coordinated through an interdisciplinary team directed by a physician.

Hospital - A duly licensed facility provider that is a general or special hospital which has been approved by Medicare, The Joint Commission or the American Osteopathic Hospital Association which, for compensation from its patients:

a. is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment and care of injured and sick persons, and

b. provides twenty-four hour nursing services by or under the supervision of registered nurses.

Identification Card (ID Card) - The currently effective card issued to you by Highmark.

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 - The geographic area covering Pennsylvania.

Incurred - a charge is considered incurred on the date you receive the service or supply for which the charge is made.

Independent Diagnostic Testing Facility - An ancillary provider operating from a fixed or mobile location, which performs diagnostic testing services, other than clinical laboratory or pathology testing, using diagnostic testing and imaging equipment including, but not limited to, sleep centers/home sleep testing providers, mobile x-ray providers and cardiac event monitoring providers, and other diagnostic imaging providers. Such technical services do not include the interpretation of test results by a professional provider.

Infertility - an interruption, cessation, or disorder of body functions, systems, or organs of the reproductive tract which prevents an individual or couple from the conception of a child or the ability to carry a pregnancy to delivery after regular, unprotected sexual intercourse without medical intervention or as diagnosed by a licensed physician based on the individual's medical, sexual, and reproductive history, age, physical findings, and/or diagnostic testing.

Infusion Therapy - The administration of medically necessary and appropriate fluid or medication via a central or peripheral vein to patients.

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.

Keystone Health Plan West Facility Provider - A facility provider, licensed where required and performing within the scope of its license, that has an agreement, either directly or indirectly, with Highmark pertaining to payment as a participant in the Keystone Health Plan West Network for covered services rendered to you.

Keystone Health Plan West Network - All Keystone Health Plan West facility providers and Keystone Health Plan West professional providers approved as a network by the Pennsylvania Department of Health that have entered into a network agreement, either directly or indirectly with Highmark to provide health care services to you.

Keystone Health Plan West Professional Provider - A professional provider, licensed where required and performing within the scope of such licensure, who has an agreement, either directly or indirectly, with Highmark pertaining to payment as a participant in the Keystone Health Plan West Network for covered services rendered to you.

Local PPO Network - All providers who have entered into an agreement, either directly or indirectly, with any licensee of the Blue Cross Blue Shield Association located out-of-area pertaining to payment as a participant in that licensee’s PPO network for covered services rendered to you.

Marriage and Family Therapist - A licensed marriage and family therapist performing within the scope of such licensure. Where there is no licensure law, the marriage and family therapist must be certified by the appropriate professional body.

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.

Medical Care - Professional services rendered by a professional provider for the treatment of an illness or injury.

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 - The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Member - An individual who meets the eligibility requirements specified in General Information section provided herein.

Mental Illness - An emotional or mental disorder characterized by a neurosis, psychoneurosis, psychopathy, or psychosis without demonstrable organic origin.

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

- When you receive covered services within the Plan Service Area, the designated network for professional providers, facility providers and ancillary providers is the Keystone Health Plan West Network.
- When you receive covered services within the Highmark Blue Shield Service Area, the designated network for professional providers is the PremierBlue Shield Preferred Professional Provider Network and the designated network for facility providers is the Highmark Blue Shield Participating Facility Provider Network. Also included are Ancillary Providers who have an agreement, directly or indirectly, with Highmark pertaining to payment for covered services rendered to you as a network participant.
- When you receive covered services within the Highmark Northeastern Pennsylvania Service Area, the designated network for professional providers is the PremierBlue Shield Preferred Professional Provider Network and the designated network for facility providers is the Highmark NE Participating Facility Provider Network. Also included are ancillary providers who have an agreement, directly or indirectly with Highmark pertaining to payment for covered services rendered to you as a network participant.
- When you receive covered services outside Pennsylvania, the designated network for professional providers and facility providers is the Local PPO Network. Also included are ancillary providers who have an agreement, directly or indirectly, with Highmark pertaining to payment for covered services rendered to you as a network participant.

For the purposes of this definition, when you receive covered services from a clinical laboratory, you are deemed to receive covered services at the site the specimen is collected from you.

Network Diabetes Prevention Provider - A diabetes prevention provider that contracts with:

a. Highmark to offer a diabetes prevention program based on a digital model; or

b. Highmark or the local licensee of the Blue Cross Blue Shield Association to offer a diabetes prevention program based on an in-person/onsite model.

Network Facility Provider - a facility provider that has an agreement, either directly or indirectly, with Highmark pertaining to payment as a network participant for covered services rendered to a member.

Network Provider - An ancillary provider, professional provider or facility provider who has entered into an agreement, either directly or indirectly, with Highmark or with any licensee of the Blue Cross Blue Shield

Association located out-of-area, 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.

Nurse-Midwife - A licensed nurse-midwife. Where there is no licensure law, the nurse-midwife must be certified by the appropriate professional body.

Occupational Therapist - A licensed occupational therapist performing within the scope of such licensure. Where there is no licensure law, the occupational therapist must be certified by the appropriate professional body.

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.

Open Enrollment Period - The period during which you and your eligible dependents may enroll for coverage.

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.

Out-of-Network Provider - a provider who does not have an agreement, either directly or indirectly, with Highmark pertaining to payment as a network participant for covered services provided to a member.

Out-of-Network Service - a Service, treatment or care that is provided by an out-of-network provider.

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 copayments, deductibles, prescription drug expenses or amounts in excess of the plan allowance.

Outpatient - A member who receives services or supplies while not an inpatient.

Outpatient Physical Rehabilitation Facility - A facility provider which, for compensation from its patients, is primarily engaged in providing a variety of rehabilitation services on an outpatient basis.

Outpatient Psychiatric Facility - A facility provider which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the treatment of mental illness on an outpatient basis.

Outpatient Substance Abuse Treatment Facility - A facility provider which, for compensation from its patients, is primarily engaged in providing detoxification services and/or rehabilitative counseling services for the treatment of substance abuse and diagnostic and therapeutic services for the treatment of substance abuse on an outpatient basis. This facility must also meet the minimum standards set by the Pennsylvania

Department of Health, the Pennsylvania Office of Drug and Alcohol Programs, or another appropriate governmental agency.

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.

Participating Pharmacy Provider - A pharmacy provider that has an agreement, either directly or indirectly, with Highmark pertaining to the payment of covered medications or specific covered medical devices provided to you. To the extent permitted by state and federal law, participating pharmacy providers with the capability to provide certain immunizations as specified by Highmark, may also receive payment under the agreement for such immunizations and for the administration thereof, provided to members.

Pediatric Extended Care Facility - A facility provider licensed by the state which, for compensation from its patients, 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.

Physical Therapist - A licensed physical therapist. Where there is no licensure law, the physical therapist must be certified by the appropriate professional body.

Physician - a person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed and legally entitled to practice medicine in all of its branches, perform Surgery and dispense drugs.

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

Plan Allowance - The amount used to determine payment by Highmark 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 the case of a network provider, the plan allowance is the contractual allowance for covered services rendered by a network provider in a specific geographic region. A listing of network providers is found in the provider directory.

In the case of an out-of-network provider located in-area, the plan allowance shall be based on an adjusted contractual allowance for like services rendered by a network provider in the same geographic region. A listing of network providers is found in the provider directory.

In the case of a provider located out-of-area, the plan allowance shall be determined based on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with Highmark's participation in the Inter-Plan Arrangements section as described in the How Your Health Care Program Works section of this Certificate.

The plan allowance for an out-of-network provider that is a state-owned psychiatric hospital is what is required by law.

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

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

Precertification (Preauthorization/Certification) - 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.

PremierBlue Shield Preferred Professional Provider - A professional provider who has an agreement, either directly or indirectly, with Highmark or Highmark Blue Shield pertaining to payment as a participant in the PremierBlue Shield Professional Provider Network for covered service rendered to you.

PremierBlue Shield Preferred Professional Provider Network - All PremierBlue Shield Preferred Providers approved as a network by the Pennsylvania Department of Health, who have an agreement, either directly or indirectly, with Highmark to provide health care services to you.

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.

Professional Counselor - a licensed professional counselor performing within the scope of such licensure. Where there is no licensure law, the professional counselor must be certified by the appropriate professional body.

Professional Provider - A person or practitioner licensed where required and performing services within the scope of such licensure.

Audiologist	Occupational Therapist
Behavioral Specialist	Optometrist

Certified Registered Nurse
Chiropractor
Clinical Social Worker
Dietitian-Nutritionists
Dentist
Licensed Practical Nurse
Marriage and Family Therapist
Nurse-Midwife
Physical Therapist
Physician
Podiatrist
Professional Counselor
Psychologist
Registered Nurse
Respiratory Therapist
Speech-Language Pathologist
Teacher of the Hearing Impaired

Provider - An ancillary provider, facility provider or professional provider, licensed where required and performing within the scope of such licensure.

Provider Directory - a listing of network providers, which is updated periodically. The provider directory contains a description of network providers, including contact information, areas of expertise and whether the network provider is accepting new patients. Your plan's provider directory can be accessed at the website appearing on the back of your ID card or by calling the number on the back of your ID card.

Psychiatric Hospital - A facility provider approved by The Joint Commission, the American Osteopathic Hospital Association, Council on Accreditation or Commission on Accreditation of Rehabilitation Facilities which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the inpatient treatment of mental illness. Such services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Psychologist - A licensed psychologist. When there is no licensure law, the psychologist must be certified by the appropriate professional body.

Rehabilitation Hospital - a facility provider approved by The Joint Commission or by the Commission on Accreditation of Rehabilitation Facilities or certified by Medicare which, for compensation from its patients, is primarily engaged in providing skilled rehabilitation services on an inpatient basis.

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.

Respite Care - Short-term care for a terminally ill member provided by a facility provider when necessary to relieve a person (caregiver) who is caring for the member at home free of charge.

Retail Clinic - A retail-based clinic that provides basic and preventive health care services seven days a week, including evenings and weekends. A retail clinic is generally staffed by certified registered nurses that diagnose and treat minor health problems and triage patients to appropriate levels of care.

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.

Serious Mental Illness - Any of the following mental illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.

Service - Each treatment rendered by a provider to you for a covered service.

Skilled Nursing Facility - A facility provider approved by the state and certified by Medicare, which, for compensation from its patients, is primarily engaged in providing skilled nursing services on an inpatient basis to patients requiring twenty-four (24) hour skilled nursing Services but not requiring confinement in an acute care general hospital. Such care is rendered by or under the supervision of physicians. A skilled nursing facility is not, other than incidentally, a place that provides:

a. minimal care, custodial care, ambulatory care, or part-time care services; or

b. care or treatment of mental illness, substance abuse or pulmonary tuberculosis.

Skilled Nursing Services/Skilled Rehabilitation Services - Services which have been ordered by and under the direction of a physician and are provided either directly by or under the supervision of a medical professional, e.g., registered nurse, physical therapist, licensed practical nurse, occupational therapist, speech pathologist or audiologist with the treatment described and documented in the patient's medical records. Unless otherwise determined in the sole discretion of Highmark, skilled nursing services/skilled rehabilitation services shall be subject to the following:

a. the skilled nursing services/skilled rehabilitation services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified licensed medical professional and must be such that the care could not be performed by a non-medical individual instructed to deliver such services.

b. the skilled rehabilitation services must be provided with the expectation that the patient has restorative potential and the condition will improve materially in a reasonable and generally predictable period of time. Once a maintenance level has been established or no further progress is attained, the services are no longer classified as skilled rehabilitation and will be considered to be custodial care.

The mere fact that a physician has ordered or prescribed a therapeutic regimen does not, in itself, determine whether a service is a skilled nursing service or a skilled rehabilitation service.

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.

State-Owned Psychiatric Hospital - A facility provider, that is owned and operated by the Commonwealth of Pennsylvania, which is primarily engaged in providing treatment and/or care for the Inpatient treatment of mental illness for individuals aged eighteen and older whose hospitalization is ordered by a court of competent jurisdiction through a civil commitment proceeding.

Substance Abuse Treatment Facility - A facility provider licensed by the state and approved by an external accreditation body (i.e., The Joint Commission, Commission on Accreditation of Rehabilitation Facilities, Council on Accreditation) which, for compensation from its patients, is primarily engaged in providing detoxification and/or rehabilitation treatment for alcohol abuse and/or drug abuse. This facility must also meet the minimum standards set by the Pennsylvania Department of Health, the Pennsylvania Office of Drug and Alcohol Programs, or another appropriate governmental agency.

Suite Infusion Therapy Provider - An ancillary provider licensed by the state, accredited by The Joint Commission, if appropriate, and organized to provide infusion therapy to patients at an infusion suite.

Summary of Benefits and Coverage - the summary document required under the Public Health Service Act, as added by the ACA, which describes certain covered services, member cost-sharing obligations, benefit limitations, exclusions and certain other coverage information.

Supplier - An individual or entity that is in the business of leasing and selling durable medical equipment and supplies. Suppliers include, but are not limited to, the following:

- durable medical Equipment suppliers,
- hearing aid device vendors,
- vendors/fitters,
- orthotic and prosthetic suppliers,
- pharmacy/durable medical equipment suppliers.

Surgery - a.) The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures; b.) the correction of fractures and dislocations; and c.) usual and related inpatient pre-operative and post-operative care.

Telemedicine Service - A real time interaction between a member and a designated telemedicine provider that is available on-demand 24 hours a day, 7 days a week, 365 days a year and is conducted by means of telephonic or audio and video telecommunications system, for the purpose of providing immediate, one-on-one access to a clinical consultation for the diagnosis and treatment of non-emergency medical conditions which are serious or acute but pose no immediate threat to life and health but which require medical attention within 24 hours.

Therapy and Rehabilitation Service - The following services or supplies ordered by a professional provider to promote your recovery. Therapy and rehabilitation services are covered to the extent specified in the Summary of Benefits provided herein.

a. **Cardiac Rehabilitation** - the physiological and psychological rehabilitation of patients with cardiac conditions through regulated exercise programs.

b. **Chemotherapy** - the treatment of malignant disease by chemical or biological antineoplastic agents.

c. **Dialysis Treatments** - the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body through hemodialysis or peritoneal dialysis. Dialysis treatment includes home dialysis.

d. **Infusion Therapy** - the treatment by the administration of medically necessary and appropriate fluid or medication via a central or peripheral vein when performed, furnished, and billed by a facility provider or ancillary provider in accordance with accepted medical practice.

e. **Occupational Therapy** - the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational.

f. **Physical Medicine** - the treatment by physical means or modalities such as, but not limited to, mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities, and rehabilitative procedures, performed to relieve pain and restore level of function following disease, illness, or injury.

g. **Radiation Therapy** - the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

h. **Respiratory Therapy** - the introduction of dry or moist gases into the lungs for treatment purposes.

i. **Speech Therapy** - the treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

Total Maximum Out-of-Pocket - The total maximum out-of-pocket, as mandated by the federal government, is **the most you have to pay for covered services in a benefit period**. After you spend this amount on deductibles, copayments, and coinsurance for network care and services, your program pays 100% of the costs of covered services. See How Your Benefits are Applied and the Summary of Benefits for the total maximum out-of-pocket applicable to you.

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

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.

Vision Provider - A physician or professional provider licensed, where required, and performing services related to the examination, diagnosis, and treatment of conditions of the eye and associated structures.

Visit - an interaction between you and a professional provider for the purpose of providing covered services. This may include seeking advice for the purpose of determining what medical examinations, procedures, or treatment if any, are appropriate for your condition. A visit may be performed in-person or via telephone, internet or other electronic communication.

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

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You are hereby notified, your health care benefit program is between the Group, on behalf of itself and its employees in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA) and Highmark Blue Cross Blue Shield. Highmark Blue Cross Blue Shield is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield 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 shall be liable to the Group, on behalf of itself and its employees, for any Highmark Blue Cross Blue Shield obligations under your health care benefit program.

PPO Blue $1,000 Benefit Summary

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Group Number(s): 017171-00

Benefit	In Network	Out of Network
General Provisions		
Effective Date	April 1, 2024	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual Family	 $1,000 $2,000	 $2,000 $4,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 $3,000 $6,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing 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 Family	 $8,700 $17,400	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $20 copay	80% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $20 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after $25 copay	80% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $40 copay	80% after deductible
Telemedicine Services (3)	100% after $15 copay	Not Covered
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 80% after deductible
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Breast Cancer Screenings (annual routine and supplemental)	100% (deductible does not apply)	80% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	80% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 80% after deductible
Pediatric Immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services (5)	100% after $75 copay (waived if admitted)	
Ambulance - Emergency (6)	100% after in-network deductible	
Ambulance - Non-Emergency (6)	100% after deductible	80% after deductible
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Maternity (non-preventive professional services) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $25 copay limit: 20 visits/benefit period	80% after deductible
Speech Therapy	100% after $25 copay limit: 20 visits/benefit period	80% after deductible
Occupational Therapy	100% after $25 copay	80% after deductible

Benefit	In Network	Out of Network
	limit: 20 visits/benefit period	
Respiratory Therapy	100% after deductible	80% after deductible
Spinal Manipulations	100% after $25 copay	80% after deductible
	limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	80% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $25 copay	80% after deductible
Outpatient Substance Abuse Services	100% after $25 copay	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	100% after deductible	80% after deductible
Assisted Fertilization Procedures	100% after deductible	80% after deductible
	limit: $15,000/benefit period	
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
	limit: 90 visits/benefit period aggregate with visiting nurse	
Hospice	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment (8)	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible	80% after deductible
	limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after deductible	80% after deductible
	limit: 100 days/benefit period	
Transplant Services	100% after deductible	80% after deductible
Precertification/Authorization Requirements (9)	Yes	
Prescription Drugs		
Prescription Drug Deductible Individual Family	 None None	
Prescription Drug Program (10) SensibleRx Choice Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (31/60/90-day Supply)** $8 / $16 / $24 Generic copay $35 / $70 / $105 Formulary brand copay $50 / $100 / $150 Non-Formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $20 Generic copay $90 Formulary brand copay $125 Non-Formulary brand copay	

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 Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
(6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
(7) After initial evaluation, Applied Behavioral Analysis will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g. speech therapy, diagnostic services). Treatment for Autism Spectrum Disorders does not reduce visit/day limits.
(8) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(9) 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.
(10) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under SensibleRx Choice, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed. Your plan requires that you use a specific specialty pharmacy for hemophilia medications. Please contact member services for more details. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment. Your plan offers the Free Market Health program for select specialty medications. You will be contacted by one of the specialty network pharmacies who will provide quality service, care, and coordination of your specialty prescription fill and delivery. No enrollment necessary.

Sí 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. To Plan Sponsors

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

B. Required by Law

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

C. Public Health Activities

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

D. Health Oversight Activities

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

E. Abuse or Neglect

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

F. Legal Proceedings

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

G. Law Enforcement

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

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

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

I. Research

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

J. To Prevent a Serious Threat to Health or Safety

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

K. Military Activity and National Security, Protective Services

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

L. Inmates

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

M. Workers' Compensation

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

N. Others Involved in Your Health Care

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

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 will 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
   (vi) 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 Inc. 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

OUTPATIENT NON-FACILITY DRUG CERTIFICATE

effective as of

April 1, 2024

by and between

Larson Texts, Inc.
(Called the Group)

and

Highmark Inc. d/b/a
Highmark Blue Cross Blue Shield*

A Pennsylvania non-profit corporation whose address is
Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222-3099

GUARANTEED RENEWABLE

DESCRIPTION OF COVERAGE: This program sets forth a comprehensive program of outpatient prescription drug coverage. Cost-sharing options available under this Contract include deductibles, coinsurance, and copayments. This Contract is non-participating in any divisible surplus of premium.

*An independent licensee of the Blue Cross Blue Shield Association
Group 01717100

Discrimination is Against the Law

The Plan 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 Plan 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 Plan 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 Plan 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 Plan:

- 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 a Member needs these services, the Member should contact the Civil Rights Coordinator.

If a Member believes that the Plan 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, the Member can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. The Member can file a grievance in person or by mail, fax, or email. If the Member needs help filing a grievance, the Civil Rights Coordinator is available to help the Member. The Member 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

LANGUAGE ASSISTANCE SERVICES

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 serbisyong 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 المعاونة 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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Benefits to which You are Entitled

Highmark's benefit liability is limited to the benefits specified in this Health Care Certificate. Except as provided in the Transplant Services description, no person other than a member is entitled to receive benefits under this Health Care Certificate. Such right to benefits and coverage is not transferable. Benefits for covered services specified herein will be provided only for services and supplies rendered by providers as defined in this Health Care Certificate.

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 Certificate; 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 Certificate is not assignable, except to the extent required by law, nor may benefits described in this Certificate 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 Certificate 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.

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 Prescription Drug Program

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

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

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

How Your Prescription Drug Benefits Are Applied

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

Benefit Period

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

Twelve (12) consecutive months beginning on the date set forth in the contract between Highmark and the Group.

Cost-Sharing Provisions

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

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

Copayment

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

Total Maximum Out-of-Pocket

The total maximum out-of-pocket for prescription drug, as mandated by the federal government, refers to the specified dollar amount of deductible, coinsurance, copayments incurred for covered medications 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, Highmark begins to pay 100% of all covered medications and no additional coinsurance, copayments and deductible will be incurred for covered medications in that benefit period. See your Summary of Benefits for the total maximum out-of-pocket. The total maximum out-of-pocket does not include amounts in excess of the plan allowance.

Individual Total Maximum Out-of-Pocket

Expenses for Covered Medications dispensed by a Participating Pharmacy Provider incurred in the same Benefit Period under this Certificate will be credited toward the Individual Total Maximum Out-of-Pocket set forth in your Highmark medical Health Care Certificate. When a member incurs expenses satisfying the Individual Total Maximum Out-of-Pocket set forth in your Highmark medical Health Care Certificate in one (1) Benefit Period, the benefits payable for claims received by Highmark thereafter for Covered Medications dispensed by a Participating Pharmacy Provider for that individual during the remainder of the Benefit Period will increase to 100% of the Provider's Allowable Price. See your Summary of Benefits for the Individual Total Maximum Out-of-Pocket.

Cost-sharing assistance such as coupons or rebates provided by a drug manufacturer for a specialty prescription drug or for certain other high-cost prescription drugs will not apply toward the annual Individual Total Maximum Out-of-Pocket limit.

Family Total Maximum Out-of-Pocket

Expenses for Covered Medications dispensed by a Participating Pharmacy Provider incurred in the same Benefit Period under this Certificate will be credited toward the Family Total Maximum Out-of-Pocket set forth in your Highmark medical Health Care Certificate. When a member incurs expenses satisfying the Family Total Maximum Out-of-Pocket set forth in your Highmark medical Health Care Certificate in one (1) Benefit Period, the benefits payable for claims received by Highmark thereafter for Covered Medications dispensed by a Participating Pharmacy Provider for all members under your Family Coverage during the remainder of the Benefit Period will increase to 100% of the Provider's Allowable Price. See your Summary of Benefits for the Family Total Maximum Out-of-Pocket limit.

Cost-sharing assistance such as coupons or rebates provided by a drug manufacturer for a specialty prescription drug or for certain other high-cost prescription drugs will not apply toward the annual Family Total Maximum Out-of-Pocket.

Maximum

The greatest amount of benefits that the program will provide for covered medications within a prescribed period of time. This could be expressed in dollars, dosage units or supply for a specified period of time.

Covered Services - Prescription Drug Program

Subject to the exclusions, conditions and limitations of this program, you are entitled to the benefits of this Section for Covered Medications when dispensed by a Pharmacy Provider in the amounts specified in the Summary of Benefits. Deductible, Copayment and Coinsurance, if any, and in the amounts as set forth in the Summary of Benefits, are applicable.

Certain retail Participating Pharmacy Providers may have agreed to make Covered Medications available pursuant to the same terms and conditions, including cost-sharing and quantity limits if applicable, as mail service coverage set forth in this Contract. You may contact Highmark at the toll-free number or website appearing on the back of your ID card for a listing of those retail Participating Pharmacy Providers who have agreed to do so.

No Member cost-sharing will apply to self-administered Chemotherapy Medications, including oral Chemotherapy Medications.

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

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

Should you purchase a brand name drug when a generic is available and authorized by your doctor, you must pay the price difference between the brand and generic prices in addition to the applicable copayment or coinsurance amount. However, for certain specified brand drugs, benefits are only provided if an appropriate authorization is received. See the subsection titled Step Therapy Program in the Prescription Drug Management section of this Certificate for more information.

Benefits are provided for the following drugs when prescribed by a licensed Physician on a valid Prescription Order and dispensed on or after your Effective Date by an eligible Pharmacy Provider upon the presentation of a valid Identification Card:

- Prescription Drugs or refills listed in the Formulary and dispensed by a Participating Pharmacy Provider. No Benefits are available for Prescription Drugs or refills dispensed by a Non-Participating Pharmacy Provider. No benefits are available for any Prescription Drug that does not appear on the Closed Formulary.

- Maintenance Prescription Drugs or refills for a 90 day supply.

  A partial supply of a Maintenance Prescription Drug will be provided for the purpose of Medication Synchronization if the pharmacist or Physician determines that the fill or refill is in the best interest of you and you agree to such a partial supply. Member cost-sharing will be prorated accordingly for each partial supply provided. A partial fill in excess of three (3) times per year for each Maintenance Prescription Drug will be provided at the discretion of Highmark.

- The Copayment applicable to each Prescription Order or refill for drugs listed above is described in the Summary of Benefits. Prescription Drugs are not subject to the program deductibles, coinsurance and maximums applicable to any other medical/surgical and hospitalization benefit program.

- Limitations and Exclusions applicable to each Prescription Order or refill are described in the What is Not Covered section.

- Refills are limited to one (1) year from the date of the Prescription Order.

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

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

  - Oncology related therapies
  - Interferons
  - Agents for multiple sclerosis and neurological related therapies
  - Antiarthritic therapies
  - Anticoagulants
  - Hematinic agents
  - Immunomodulators
  - Growth hormones
  - Hemophilia related therapies
  - Antivirals
  - Agents for chronic inflammatory diseases
  - Pulmonary arterial hypertension therapies
  - Agents for respiratory diseases
  - Hereditary angioedema therapies
  - Osteoporosis therapies
  - Enzyme replacement therapies
  - Thrombopoietin-receptor agonists
  - Fertility drugs

- These selected Prescription Drugs are subject to the cost-sharing provision(s) set forth in the Summary of Benefits.

- These selected Prescription Drugs may be ordered by a Physician or other health care provider on your behalf or you may submit the Prescription Order directly to the Exclusive Pharmacy Provider. In either situation, the Exclusive Pharmacy Provider will deliver the Prescription Drug to you.

- Coverage will be provided for Prescription Drugs, Over-the-Counter Drugs and immunizations that are set forth within a predefined schedule* and that are prescribed for preventive purposes. Coverage includes all Food and Drug Administration approved tobacco cessation medications.

- No coverage is provided for Market Watch Prescription Drugs unless an exception is granted pursuant to the process set forth in the section Prescription Drug Managed Care, Market Watch Prescription Drug Exceptions.

Continuous Glucose Monitoring Devices

Benefits are provided for continuous glucose monitoring devices when prescribed by a Professional Provider in connection with a covered service, when purchased at a Participating Pharmacy Provider upon presentation of a valid Identification Card and when dispensed on or after your Effective Date for outpatient use.

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* This schedule is reviewed and updated periodically by the Plan 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..

Receiver/Reader kits are limited to one (1) per benefit period. Sensor kits are limited to one (1) refill every thirty (30) days. Transmitter kits are limited to one (1) refill every ninety (90) days.

Retail Cost Share Amounts for Continuous Glucose Monitoring Devices

1. Retail Copayment Amounts

   The Member's copayment obligation for each device is the amount specified or the cost of the device, whichever is lower.

   A Member Copayment of $35 for each receiver/reader kit.

   A Member Copayment of $35 for each sensor kit.

   A Member Copayment of $35 for each transmitter kit.

2. Retail Sensor Kit Quantity Limits - Indexed

   Copayments for sensor kits for up to a 90-day supply at retail shall be indexed as follows.

   The applicable Copayment amount for up to a 30-day supply.

   Two (2) times the applicable Copayment amount for between a 31 and 60-day supply.

   Three (3) times the applicable Copayment amount for between a 61 and 90-day supply.

3. Retail Refill Limits

   Receiver/Reader kits are limited to one (1) per Benefit Period. Sensor kits are limited to one (1) refill every (30) days, unless otherwise required due to manufacturer packaging restrictions. Transmitter kits are limited to one (1) refill every ninety (90) days.

Mail-Order Cost Share Amounts For Continuous Glucose Monitoring Devices

1. Mail-Order Copayment Amounts

   The Member's copayment obligation for each device is the amount specified or the cost of the device, whichever is lower.

   A Member Copayment of $90 for each device.

2. Mail-Order Refill Limits

   Receiver/Reader kits are limited to one (1) per Benefit Period.

   Sensor kits are limited to one (1) refill every thirty (30) days, unless otherwise required due to manufacturer packaging restrictions.

   Transmitter kits are limited to one (1) refill every ninety (90) days.

Diabetes Treatment Program

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:

1. Prescription Drugs: Insulin and pharmacological agents for controlling blood sugar.

2. Equipment and Supplies: and injection aids, and syringes.

Predefined Preventive Covered Medications

Coverage will be provided for prescription and Over-the-Counter Drugs that are set forth within a predefined schedule* and that are prescribed for preventive purposes.

Coverage includes all Food and Drug Administration approved tobacco cessation medications.

Specialty Prescription Drug

The cost-sharing amounts for specialty prescription drugs or for certain other high-cost prescription drugs are applicable to those prescription drugs dispensed to you when you do not receive cost-sharing assistance such as coupons provided by a drug manufacturer.

In the event you receive such cost-sharing assistance, amounts paid or credited by a drug manufacturer on your behalf will not accrue toward the satisfaction of the deductible or out-of-pocket maximums. Additionally, each separate prescription order or refill for the prescription drug will be paid by the program subject to a coinsurance of 30% Provider's Allowable Price. If you exhaust cost-sharing assistance available from a manufacturer you will not be responsible for more cost-sharing for the prescription drug or refill than the amount for which you were responsible while receiving such cost-sharing assistance.

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* This schedule is reviewed and updated periodically by the Plan 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..

What Is Not Covered

Except as specifically provided in this Certificate or as Highmark is mandated or required to cover based on state or federal law, regulation or other directive, no benefits will be provided for:

Key Word	Exclusions
	● Allergy serums. ● Antihemophilia drugs. ● Any amounts above the deductible, coinsurance, copayment or other cost-sharing amounts for each prescription order or refill that are your responsibility. ● Any amounts you are required to pay directly to the pharmacy for each prescription order or refill order. ● Any charges by any pharmacy provider or pharmacist except as provided herein. ● Any drug or medication except as provided herein. ● Any drug or medication which does not meet the definition of covered maintenance prescription drug, except those set forth in the predefined preventive schedule. Please refer to the Covered Drugs section for more information. ● Any drugs and supplies which can be purchased without a prescription order, including, but not limited to blood glucose monitors and injection aids, except as provided herein. ● Any drugs prescribed for cosmetic purposes only. ● Any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes. ● Any drugs used to abort a pregnancy. ● Any drugs which are experimental/investigative in nature, except as provided herein for Routine Patient Costs incurred in connection with an Approved Clinical Trial. ● Any prescription drug purchased through mail order but not dispensed by a designated mail order pharmacy provider. ● Any prescription drug which has been disallowed under the Prescription Drug Managed Care section of this Certificate. ● Any prescription drugs or supplies purchased at a non-participating pharmacy provider, except in connection with emergency care services as described herein.

- Any prescription for more than the retail days supply or mail-service days supply as outlined in the Summary of Benefits.
- Any selected diagnostic agents.
- Blood products.
- Charges for a prescription drug when such drug or medication is used for unlabeled or unapproved indications and where such use has not been approved by the Food and Drug Administration (FDA).
- Charges for administration of prescription drugs and/or injectable insulin, whether by a physician or other person.
- Charges for any prescription drug for more than the retail days supply or mail-service days supply as outlined in the Summary of Benefits.
- Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances).
- Compounded medications.
- Drugs and supplies that are not medically necessary and appropriate or otherwise excluded herein.
- Fertility drugs even if such medication is a prescription drug.
- Food supplements.
- 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.
- For contraceptive prescription drugs or except as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
- For Market Watch Prescription Drugs, except as provided herein.
- Hair growth stimulants.
- Otherwise covered medications ordered by a court or other tribunal unless medically necessary and appropriate or if the reimbursement of such services is required by law.

- Over-the-Counter Drugs, except those set forth in the predefined preventive schedule. Please refer to the Covered Drugs section for more information.

- Pharmacological or hormonal treatment used in conjunction with assisted fertilization.

- Prescription drugs dispensed for treatment of an illness or an injury for which the group is required by law to furnish hospital care in whole or in part-including, but not limited to-state or federal workers' compensation laws, occupational disease laws and other employer liability laws.

- Prescription drugs or refills dispensed by a non-participating pharmacy provider.

- Prescription drugs to which you are entitled, with or without charge, under a plan or program of any government or governmental body.

- Services of your attending physician, surgeon or other medical attendant.

- Any drug requiring refrigeration (if delivered through the mail) or injectables, except insulin and other injectables used to treat diabetes.

- Any drug or medication which is otherwise excluded under the terms of the Certificate.

Eligible Prescription Drug Providers

- **Participating Pharmacy Providers:** Participating Pharmacy Providers have an arrangement with Highmark to provide prescription drugs to you at an agreed upon price. When you purchase covered drugs from a Participating Pharmacy Provider applicable to your program, present your prescription and ID card to the pharmacist. (Prescriptions that the pharmacy receives by phone from your physician or dentist may also be covered.) You should request and retain a receipt for any amounts you have paid if needed for income tax or any other purpose. If you fail to show your ID card to the pharmacy, you may be responsible for paying the full charge for your prescriptions. For a description on how to obtain reimbursement, see the How to File a Claim section of this benefit Certificate.

- **Mail Order Pharmacy:** Express Scripts® is your program's mail order pharmacy. This option offers savings and convenience for prescriptions you may take on an ongoing basis.

  To start using mail order:

  1. Ask your doctor to write a prescription for up to a 90-day supply, plus refills for up to one year, if appropriate.

  2. Complete the Pharmacy Mail Order Form and Health, Allergy & Medication Questionnaire. You can get these forms by calling Member Service or from your member website. After logging in, click on the "Prescriptions" tab. Scroll down the page to "Forms to Manage Your Plan" and click on "Mail order form and health questionnaire (PDF)".

  3. Send the completed forms and your payment to the address listed on the mail order form. It usually takes about five days to get your prescription after it has been processed.

  Your mail order will include directions for ordering refills.

- **Exclusive Pharmacy Provider:** The exclusive pharmacy provider has an agreement, either directly or indirectly, with Highmark pertaining to the payment and exclusive dispensing of selected prescription drugs provided to you. In addition, this pharmacy provider may also, but is not limited to, exclusively dispensing drugs: a. that may require special handling; b. for which special instructions must be provided upon dispensing; or c. are considered to be limited distribution drugs. Please refer to the Covered Services - Prescription Drug Program section for a list of the selected prescription drug categories.

  If you travel within the United States and need to refill a prescription, call Member Service for help. They can help you find a Participating Pharmacy Provider near the area you are visiting. You also can use the member website to find a pharmacy. Once you have the name and address of the Participating Pharmacy Provider, take the prescription bottle to that pharmacy. The pharmacist will contact your home pharmacy to start the refill process. **Note: Save the new medicine container. This will make it easier to transfer the prescription back to your pharmacy at home**.

Prescription Drug Management

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

Early Refill

Except for the purposes of Medication Synchronization and refills of covered medications that are eyedrops, no coverage is provided for any refill of a covered medication that is dispensed before your predicted use of at least 75% of the days' supply of the previously dispensed covered medication, unless your physician obtains precertification from Highmark for an earlier refill.

Coverage for refills of covered medications shall be provided for any refill dispensed between either:

- twenty-one (21) and thirty (30) days (for 30-day supply);
- forty-two (42) and sixty (60) days (for 60-day supply); or
- sixty-three (63) and ninety (90) days (for 90-day supply)

after the date on which the Member received the original prescription or the most recent refill.

Unexpected Event

If your prescription is lost or stolen due to an event such as a fire or theft, you may be able to get an early refill. Call Member Service at the number on your member ID card for help. You will need a copy of the report from the fire department, police department or other agency.

Please note: The early refill authorization does not apply to events that can be controlled, such as spilling or losing the medicine.

Traveling Abroad

If you will be out of the country when it is time to refill your prescription, call Member Service for help. Be sure to have your member ID card and your prescription information. Please allow at least five business days to complete the request.

Individual Case Management

From time to time, Highmark may offer you the opportunity to participate in Prescription Drug care management programs. These programs are designed to help you maintain good health, manage chronic conditions or special health care needs and reduce risk factors. Such care management programs may include the provision of devices or durable medical equipment at no additional cost to you. Participation in these programs is voluntary and Highmark reserves the right to modify or discontinue any such program at any time.

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.

Managed Prescription Drug Coverage

The Managed Prescription Drug Coverage program focuses on select drug therapies. The program promotes the appropriate dose and duration of drug therapy. A Prescription Order or refill which may exceed the manufacturer’s recommended dosage over a specified period of time may be denied by Highmark when presented to the Pharmacy Provider. Highmark may contact the prescribing Physician to determine if the Prescription Drug is Medically Necessary and Appropriate. If it is determined by Highmark that the Prescription Drug is Medically Necessary and Appropriate, the Prescription Drug will be dispensed. If it is determined by Highmark that the Prescription Drug is not Medically Necessary and Appropriate, you are responsible for the

full cost of the Prescription Drug if you elect to have the prescription drug dispensed. The drug therapies reviewed under the Managed Prescription Drug Coverage program are updated periodically.

Market Watch Prescription Drug Exceptions

Coverage is not provided for Market Watch Prescription Drugs, unless an exception has been granted by Highmark. You, your authorized representative or your prescribing physician may request coverage of the Market Watch Prescription Drug. Highmark will review the exception request and notify you of its determination within two business days of the request, not to exceed seventy-two hours.

If you are suffering from a health condition that may seriously jeopardize your life, health or ability to regain maximum function or when you are undergoing a current course of treatment using a Market Watch Prescription Drug appearing on the Market Watch Program List, you, your authorized representative or your prescribing physician may request an expedited review based on exigent circumstances. In the case of such an exigent circumstance, Highmark will notify you, your authorized representative or your prescribing physician of its coverage determination with twenty-four hours of receiving sufficient information to begin its review of the request.

In the event that Highmark denies a request for exception, you, your authorized representative or your prescribing physician may request that the exception request and subsequent denial of the request be reviewed by an independent review organization. Highmark must make its determination on the external exception request and notify you, your authorized representative or your prescribing physician of its coverage determination no later than seventy-two hours following its receipt of sufficient information to begin its review or the request or if the request was an expedited, exception request, not later than twenty-four hours following its receipt of sufficient information to begin its review of the request.

If Highmark grants the request for an exception, the prescription drug will be covered for the duration of the prescription or if pursuant to an expedited exception request, for the duration of the exigency. Coverage will be provided as described herein.

Contraceptive Exceptions

Your prescribing physician may request coverage of a non-formulary contraceptive service, including contraceptive prescription drugs, contraceptive devices, implants and injections, for the purposes of birth control, through your plan’s contraceptive exception process. If the plan grants the request for an exception, the non-formulary contraceptive service will be covered for the calendar year. Coverage will be provided in accordance with the Preventive Care Services section of the Summary of Benefits.

Preauthorization

Certain prescription drugs may require Preauthorization to ensure the Medical Necessity and Appropriateness of the Prescription Order. The Prescribing Physician must obtain authorization from Highmark prior to the dispensing of the drug at a Participating Pharmacy Provider or from a Mail-Order Pharmacy, if applicable. If it is determined by the Highmark that the Prescription Drug is Medically Necessary and Appropriate, the Prescription Drug will then be dispensed by the Participating Pharmacy Provider or Mail-Order Pharmacy, if applicable. The specific drugs or drug classifications which require preauthorization may be obtained by calling the toll-free Member Service telephone number appearing on your ID card.

Quantity Level Limits

Quantity level limits may be imposed on certain prescription drugs by Highmark. Such limits are based on the manufacturer’s recommended daily dosage or as determined by Highmark. Quantity level limits control the quantity covered each time a new prescription order or refill is dispensed for selected prescription drugs. Each time a prescription order or refill is dispensed, the participating pharmacy may limit the amount dispensed.

Quantity Level Limits for Initial Prescription Orders
Additional quantity level limits may be imposed for your initial prescription order for certain covered medications. In such instances, the quantity dispensed will be reduced to the level necessary to establish that you can tolerate the covered medication. Consequently, the applicable cost-sharing amount will be adjusted according to the quantity level dispensed for the initial prescription order.

Step Therapy Program
Coverage includes drugs dispensed on a "stepped basis", referred to as the Step Therapy Program. Within selected drug categories, benefits are only provided for specific prescription drugs when one or more alternative drugs prove ineffective or intolerable and the following criteria are met:

- You have used alternative drugs within the same therapeutic class/category as the specified prescription drug.
- You have used the alternative drugs for a length of time necessary to constitute an adequate trial.
- The specified prescription drug is being used for an FDA approved indication.

If these criteria are met, the participating pharmacy provider will dispense the specified prescription drug to you. You shall be responsible for any cost-sharing amounts and will be subject to any quantity limit requirements or other limitations described herein. When these criteria are not met, your treating physician may submit a request for authorization to dispense a specified prescription drug to you for Highmark's consideration.

The Step Therapy Program will not apply to covered medications prescribed for the treatment of stage 4 advanced metastatic cancer if: (1) the specified prescription drug is approved by the FDA for this indication and (2) the specified prescription drug is consistent with the best clinical practices for the treatment of stage 4 advanced metastatic cancer or a severe adverse health condition experienced as a result of stage 4 advanced metastatic cancer.

This authorization is not applicable to those brand drugs which are subject to the requirements described above in the Preauthorization subsection.

Preauthorization and Pre-Service Claims Review Processes

Preauthorization of Covered Medications, when required, and all other Pre-service Claims including requests to extend a previously approved course of treatment will be processed and notice of Highmark’s determination, whether adverse or not, will be given to you within the following time frames unless otherwise extended by Highmark for reasons beyond its control:

Authorized Representatives
You have the right to designate an authorized representative to file or pursue a request for preauthorization 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 Preauthorization and Other Non-Urgent Care Pre-Service Claims
In the case of a non-urgent care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days following Highmark’s receipt of the non-urgent care Pre-service Claim.

Decisions Involving Urgent Care Claims

In the case of an Urgent Care Claim, as soon as possible, taking into account the medical exigencies involved, but not later than seventy-two (72) hours following Highmark's receipt of the Urgent Care Claim. Similarly, when the Urgent Care Claim seeks to extend a previously approved course of treatment and the request is made at least twenty-four (24) hours prior to the expiration of such previously approved course of treatment, notice of Highmark's determination will be given to you as soon as possible, taking into account the medical exigencies involved, but no later than twenty-four (24) hours following receipt of the request.

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

Notice of Highmark's approval of a Pre-service Claim will include information sufficient to apprise you that the request has been approved. In the event Highmark renders an adverse determination on a Pre-service Claim, the notification shall include, among other items, the specific reason or reasons for the adverse determination and a statement describing your right to file an internal appeal or request an external review.

General Information - Prescription Drug

From time to time eligible new employee's, or Dependents may be added to the Group originally covered in accordance with the terms of the Certificate or as required by applicable law. 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 provided under the terms of this Certificate.

Who is Eligible for Coverage

Eligible Person

- An Eligible Person is a full-time, hourly, Employee.
- Eligible Person does not include any Employee who is a non-active work status unless such status is due to illness or health-related conditions or unless otherwise indicated in this section.
- Eligible Person includes any Employee who is in a non-active work status or whose employment is terminated due to deployment for military duty and is eligible for and elects to continue health care coverage during such deployment from the Group pursuant to applicable law.
- The date the person becomes eligible is the date specified to Highmark by the Group.
- The Group may not discriminate in enrollment or contribution based on the health status, as defined in the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), of an Eligible Person. If the Group does discriminate in enrollment or contribution based on health status, the Group shall be solely liable for any claims or expenses, including medical claims or expenses, incurred by the Eligible Person who has been discriminated against.

Eligible Dependent

- An Eligible Dependent includes the Employee’s spouse under a legally valid existing marriage.
- An Eligible Dependent includes the children of the Employee or spouse, including newborn children, stepchildren, children legally placed for adoption, children awarded coverage pursuant to an order of court, legally adopted children and children for whom the Employee or the Employee's spouse is the child's legal guardian. The limiting age for covered children is age 26 unless the period of eligibility for such Dependent child is otherwise extended pursuant to applicable state or federal law.

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 by Highmark.

NOTE: To the extent mandated by the requirements of Pennsylvania Act 83 of 2005, eligibility will be continued past the limiting age for children who are enrolled as dependents under their parent’s coverage at the time they are called or ordered into active military duty. They must be a member of the Pennsylvania National Guard or any reserve component of the armed forces of the United States, who is called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days or be a member of the Pennsylvania National Guard ordered to active state duty for a period of 30 or more consecutive days. If they become a full-time student for the first term or semester starting 60 or more days after their release from active duty, they

shall be eligible for coverage as a dependent past the limiting age for a period equal to the duration of their service on active duty or active state duty.

For the purposes of this note, full-time student shall mean a dependent who is enrolled in, and regularly attending, an accredited school, college or university or a licensed technical or specialized school for 15 or more credit hours per semester or, if less than 15 credit hours per semester, the number of credit hours deemed by the school to constitute full-time student status.

A dependent child who takes a medically necessary leave of absence from school or who changes enrollment status (such as changing from full-time to part-time) due to a serious illness or injury may continue coverage for one year from the first day of the medically necessary leave of absence or other change in enrollment or until the date coverage would otherwise terminate under the terms of this program, whichever is earlier. Highmark may require certification from the dependent child's treating physician in order to continue such coverage.

- Eligibility will be continued past the limiting age for unmarried children who, as medically certified by a Physician, are incapable of self-support due to intellectual disability, physical disability, Mental Illness or developmental disability that started before the age of twenty-six (26). Highmark may require proof of such Member's disability from time to time. An Eligible Dependent child's coverage under this paragraph automatically terminates and all benefits hereunder cease, whether or not notice to terminate is received by Highmark, on the day following the date on which the disability ceases.

- An Eligible Dependent includes the newborn child of an Employee or Eligible Dependent from the moment of birth to a maximum of thirty-one (31) days from date of birth. To be covered as a Dependent beyond the thirty-one (31)-day period, the newborn child must be enrolled as a Dependent under this program and appropriate premium payment must be received within such period. In the event that a newborn child is not eligible for continuing coverage as a Dependent under this Certificate, the parent may convert such child's coverage to individual coverage provided an application for conversion is made within thirty-one (31) days of the child's birth and the appropriate premium is received within such period.

- The Domestic Partner, as defined in **Terms You Should Know** section, shall be considered for eligibility as long as a Domestic Partnership exists with the Employee. In addition, the child(ren) of the Domestic Partner shall be considered for eligibility as if they were the child(ren) of the Employee as long as the Domestic Partnership exists.

Change in Membership Status

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

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 program administrator/employer to determine whether your group program has adopted such a policy.

Continuation of Coverage

In general, the Consolidated Omnibus Budget Reconciliation Act ("COBRA") requires employers, (other than certain church employers) who normally employed at least 20 or more employees in the prior calendar year, to extend temporary health care coverage to certain categories of employees and their covered dependents when, due to certain "qualifying events," they are no longer eligible for group coverage.

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

Termination of Your Coverage Under the Group Insured Contract

Your coverage can be terminated in the following instances:

- When you cease to be an employee or eligible dependent the employer shall promptly notify Highmark that you are no longer eligible for coverage and that your coverage should be terminated.

- Prompt notification requires that the employer submit the disenrollment request to Highmark at the time of its next enrollment report. Prospective terminations of your coverage shall become effective no earlier than the date on which you cease to be eligible. In those instances, in which the employer requests a retroactive termination of coverage, the effective date of cancellation of your coverage shall be no earlier than the date on which you cease to be eligible and, in no event, shall be earlier than the first day of the month preceding the month in which Highmark received notice from the employer that your coverage should be terminated.

- When you or Eligible Dependent fail to pay the required contribution, coverage will terminate at the end of the last month for which payment was made.

- Termination of the employer Group Insured Contract automatically terminates the coverage of all the members. It is the responsibility of the employer to notify you of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given to you by the employer.

- If it is proven that you obtained or attempted to obtain benefits or payment for benefits through fraud or intentional misrepresentation of a material fact, Highmark may, upon thirty (30) days advance written notice to you, terminate your coverage under the program.

- It is understood that you have an affirmative obligation to notify the Group or Highmark as soon as the Domestic Partnership is terminated. Upon termination of the Domestic Partnership, coverage of the former Domestic Partner and the children of the former Domestic Partner will terminate at the end of the month the Domestic Partnership terminated.

Benefits after Termination of Coverage

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

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

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

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

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

- If you are required to pay any premium, your benefits will not be continued if your coverage is terminated because you failed to pay the required premium.
- Benefits will also be provided for you who, on the date this coverage terminates and as described in the Health Care Management, Benefits after Provider Termination from the Network subsection of this Certificate, is in an active course of treatment until the earlier of such time as that treatment has been completed or for a period of up to ninety (90) days from the date this coverage terminates.

Coordination of Benefits

Benefits provided in this Certificate are not coordinated against any other health care or drug benefit program.

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

To the extent that benefits for Covered Medications are provided or paid, Highmark shall be subrogated and succeed to any rights of recovery of your expenses Incurred against any person, firm or organization except insurers on policies or health insurance issued to and in your name.

You shall execute and deliver such instruments and take such other reasonable action as Highmark may require securing such rights, as permitted by law. You shall do nothing to prejudice the rights given Highmark by this paragraph without its consent.

These provisions shall not apply where subrogation is specifically prohibited by law.

How to File a Prescription Drug Claim

Notice of Claim and Proof of Loss

Network Providers have entered into an agreement with Highmark pertaining to the payment for covered services that they provide to you. When you receive covered services from a network Provider, it is the responsibility of the network Provider to submit its claim to Highmark in accordance with the terms of its participation agreement. Should the network Provider fail to submit its claim in a timely manner or otherwise satisfy Highmark's requirements as they relate to the filing of claims, you will not be liable and the network Provider shall hold you harmless relative to payment of the covered services that you received.

When covered services are received from other than a network Provider, you are responsible for submitting the claim to Highmark. In such instances, you must submit the claim in accordance with the following procedures:

Notice of Claim
Highmark will not be liable for any claims unless proper notice is furnished to Highmark that you have received covered services. Written notice of a claim must be given to Highmark within twenty (20) days or as soon as reasonably possible after you have received covered services. Notice given by you or on your behalf to Highmark that includes information sufficient to identify you shall constitute sufficient notice of a claim to Highmark. You can give notice to Highmark by writing to the Member Service Department. The address of the Member Service Department can be found on your ID card. A charge shall be considered Incurred on the date a Member receives the Service or supply for which the charge is made.

Claim Forms
Proof of loss for covered services must be submitted to Highmark on the appropriate claim form. Highmark, upon receipt of a notice of a claim will, withing fifteen (15) days following the date a notice of a claim is received, furnish you with claim forms for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of such notice, you shall be deemed to have complied with the requirements of this subsection as to filing a proof of loss upon submitting, within the time fixed in this subsection for filing proofs of loss, itemized bill for covered services as described below. The proof of loss may be submitted to Highmark at the address appearing on your ID card.

Proof of Loss
Claims cannot be paid until a written proof of loss is submitted to Highmark. Written proof of loss must be provided to Highmark within ninety (90) days after the date of such loss. Proof of loss must include all data necessary for Highmark to determine benefits. Failure to submit a proof of loss to Highmark within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will Highmark be required to accept a proof of loss later than one (1) year from the time proof is otherwise required.

Submission of Claim Forms
The completed claim form, with all itemized bills attached, must be forwarded to Highmark at the address appearing on your ID Card in order to satisfy the requirement of submitting a written proof of loss and to receive payment for Covered Services.

To avoid delay in handling claims that you submit, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing:

Person or organization providing the Service or supply
Type of Covered Medication
Date Covered Medication was dispensed
Amount charged
Prescription number

Name of patient

Itemized bills cannot be returned.

A request for payment of a claim will not be reviewed and no payment will be made unless all of the information and evidence of payment required on the claim form has been submitted in the manner described above. Highmark reserves the right to require additional information and documents as needed to support a claim that a Covered Medication has been rendered.

Notice of Highmark's claim determination will be issued within a reasonable period of time not to exceed thirty (30) days following the receipt of a proper proof of loss. This period of time may be extended one (1) time by Highmark for an additional period of time not to exceed fifteen (15) days provided the extension is due to matters outside the control of Highmark and a written explanation for the delay is provided to the you.

In the event that Highmark renders an adverse decision on the claim, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement describing your right to file an appeal.

Time of Payment of Claims
Claim payments for benefits payable under this program will be processed immediately upon receipt of a proper proof of loss.

Authorized Representative
Nothing in this subsection shall preclude your duly authorized representative from filing or otherwise pursuing a claim on behalf of you. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

Limitation on Legal Actions

After a notice of claim has been given, you may not take legal action for sixty days. You may not take legal action later than three years after the expiration of the time within which a notice of claim is required.

Physical Examinations and Autopsy

Highmark, at its own expense, shall have the right and opportunity to examine the person of the member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Appeal Procedure

1. **Internal Appeal Process**

   a. The Plan maintains an appeal process involving one (1) level of review. This appeal process is mandatory and must be exhausted before the Member is permitted to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

   b. At any time during the appeal process, a Member may choose to designate an authorized representative to participate in the appeal process on the Member's behalf. The Member or the Member's authorized representative shall notify the Plan, in writing, of the designation. For purposes of the appeal process, authorized representative includes designees, legal

representatives and, in the case of a minor, parents of a Member entitled or authorized to act on the Member's behalf. The Plan reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member. Such procedures as adopted by the Plan shall, in the case of an Urgent Care Claim, permit a Professional Provider or Professional Other Provider with knowledge of the Member's medical condition to act as the Member's authorized representative.

At any time during the appeal process, a Member may contact the Member Service Department at the toll-free telephone number listed on the Member's Identification Card to inquire about the filing or status of an appeal.

c. If a Member has received notification that a Claim has been denied by the Plan, in whole or in part or is not subject to legal prohibitions against balance billing, the Member may appeal the decision. For purposes of this Subsection, determinations made by the Plan to rescind a Member's coverage can also be appealed in accordance with the procedures set forth in this Subsection. The Member's appeal must be submitted within one hundred eighty (180) days from the date of the Member's receipt of notification of the adverse decision.

d. The Member, upon request to the Plan, may review all documents, records and other information relevant to the 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 the appeal.

e. The appeal will be reviewed by a representative from the Member Grievance and Appeals Department. The representative shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the Claim or matter which is the subject of the Member's appeal. In rendering a decision on the appeal, the Member Grievance and Appeals Department will take into account all evidence, comments, testimony, documents, records and other information submitted by the Member without regard to whether such information was previously submitted to or considered by the Plan. The Member Grievance and Appeals Department will afford no deference to any prior adverse decision on the Claim which is the subject of the appeal.

f. Each appeal will be promptly investigated, and the Plan will provide written notification of its decision within the following time frames:

   i. when the appeal involves a non-urgent care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances involved not to exceed thirty (30) days following receipt of the appeal;

   ii. when the appeal involves an Urgent Care Claim, as soon as possible taking into account the medical exigencies involved but not later than seventy-two (72) hours following receipt of the appeal; or

   iii. when the appeal involves a Post-service Claim or a decision by the Plan to rescind coverage, within a reasonable period of time not to exceed thirty (30) days following receipt of the appeal.

g. If the Plan fails to provide notice of its decision within the above-stated time frames or otherwise fails to strictly adhere to these appeal procedures, the Member shall be permitted to request an external review and/or pursue any applicable legal action.

h. In the event that the Plan renders an adverse decision on the internal appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding the right of the Member to pursue any applicable legal action.

2. **External Review Process**

A Member will have four (4) months from the receipt of notice of the Plan's decision to appeal the denial resulting from the Internal Appeal Process by requesting an external review of the decision. To be eligible for external review, the decision of the Plan to be reviewed must involve:

a. a Claim that was denied involving medical judgment, including application of the Plan's requirements as to medical necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Medication or a determination that the treatment is experimental or investigational; or

b. a Claim that the Plan has concluded is not subject to legal prohibitions against balance billing; or

c. a determination made by the Plan to rescind a Member's coverage.

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

a. **Preliminary Review and Notification**

Within five (5) business days from receipt of the request for external review, the Plan will complete a preliminary review of the external review request to determine:

i. in the case of a denied Claim, whether the Member is or was covered under this program at the time the Covered Medication which is the subject of the denied Claim was or would have been received;

ii. whether the Member has exhausted the Plan's Internal Appeal Process, unless otherwise not required to exhaust that process; and

iii. whether the Member has provided all of the information and any applicable forms required by the Plan to process the external review request.

Within one (1) business day following completion of its preliminary review of the request, the Plan shall notify the Member or health care provider filing the external review request on behalf of the Member, of its determination. In the event that the external review request is not complete, the notification will describe the information or materials needed to complete the request in which case the Member or health care provider filing the external review request on behalf of the Member, must correct and/or complete the external review request no later than the end of the four (4) month period in which the Member was required to initiate an external review of the Plan's decision or, alternatively, forty-eight (48) hours following receipt of the Plan's notice of its preliminary review, whichever is later.

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

b. **Final Review and Notification**

Requests that are complete and eligible for external review will be assigned to an Independent Review Organization (IRO) to conduct the external review. The assigned IRO will notify the Member or health care provider filing the external review request on behalf of the Member, that the request has been accepted and is eligible for external review. The notice will further state that the IRO has been assigned to conduct the external review and that any additional information which the Member or health care provider may have in support of the request must be submitted, in writing, within ten (10) business days following receipt of the notice. Any additional information timely submitted by the Member or health care provider and received by the assigned IRO will be forwarded to the Plan. Upon receipt of the information, the Plan shall be permitted an opportunity to reconsider its prior decision regarding the Claim that was denied or the matter which is the subject of the external review request.

The assigned IRO will review all of the information and documents that it timely received and make a decision on the external review request. The decision shall be made without regard or deference to the decision that was made in the Plan's Internal Appeal Process. The assigned IRO shall provide written notice of its final external review decision to the Plan and Member or the health care provider filing the external review request on behalf of the Member, within forty-five (45) days from receipt by the IRO of the external review request. Written notice of the decision shall provide, among other information, a statement of the principal reasons for the decision including the rationale and standards relied upon by the IRO, a statement regarding the right to pursue any applicable legal action that may be available to the Member and current contact information for the Pennsylvania Insurance Department Office of Consumer Services or such other applicable office of health insurance consumer assistance or ombudsman.

c. **Expedited External Review**
(Applies to Urgent Care Claims only)

If the initial decision of the Plan or the denial resulting from the Plan's Internal Appeal Process involves an Urgent Care Claim, a Member or health care provider on behalf of the Member may request an expedited external review of the Plan's decision. Requests for expedited external review are subject to review by the Plan to determine whether they are timely, complete and eligible for external review. When the request involves a denied Urgent Care Claim, the Plan must complete its preliminary review and provide notice of its eligibility determination immediately upon receipt of the request for expedited external review. If the request is eligible for expedited external review, the Plan must then transmit all necessary documents and information that was considered in denying the Urgent Care Claim involved to an assigned IRO in an expeditious manner. The assigned IRO will conduct the review and provide notice of its final external review decision as expeditiously as the Member's medical condition or circumstances require, but in no event more than seventy-two (72) hours following receipt by the IRO of the request for expedited external review. If notice of the decision by the IRO is not provided in writing, the IRO must provide within forty-eight (48) hours following initial notice of its final external review decision, written confirmation of that decision to the Plan and the Member or health care provider filing the expedited external review request on behalf of the Member.

3. **Member Assistance Services**

Members may obtain assistance with the Plan's internal appeal and external review procedures set forth in this Subsection by contacting the Pennsylvania Insurance Department Office of Consumer Services or such other applicable office of health insurance consumer assistance or ombudsman.

Terms You Should Know - Prescription Drug

*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 Summary of Benefits section of this Certificate.*

Affordable Care Act (ACA) - The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) and its implementing regulations.

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 medications 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 benefit for which the charge is made.

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

Chemotherapy Medication - A medication prescribed to kill or slow the growth of cancerous cells.

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

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

- **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 prescription drug. 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 Medication that you have received.

For purposes of the Claim determination and appeal procedure provisions of this program, whether a Claim or an appeal of a denied Claim involves a Pre-service Claim, an Urgent Care Claim or a Post-service Claim will be determined at the time that the Claim or appeal is filed with Highmark in accordance with its procedures for filing Claims and appeals.

Coinsurance - The percentage of the provider's allowable price for covered medications that is your responsibility. The remaining percentage is the responsibility of Highmark subject to the provisions of this program.

Copayment - A specified dollar amount of eligible expenses which you are required to pay for a specified Covered Medication, and which will be deducted from the provider's allowable price before the determination of the benefits payable under this program is made.

Covered Maintenance Prescription Drug - A maintenance prescription drug, which Highmark is contractually obligated to pay or provide as a benefit to you under this program when dispensed by a participating maintenance pharmacy. Any prescription order for not less than a 1-day supply and not more than a 90-day supply of a legend drug shall be considered a covered maintenance prescription drug, unless otherwise expressly excluded.

Covered Medications - Prescription drugs ordered by a professional provider by means of a valid prescription order, which Highmark is contractually obligated to pay or provide as a benefit to you.

Deductible - A specified dollar amount of liability for covered medications that must be incurred by you before Highmark will assume any liability for all or part of the remaining covered expenses.

Dependent - A member other than the Employee as specified herein.

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

Designated Mail-Order Pharmacy Provider - A Participating Pharmacy Provider which has been selected by Highmark as a "Designated Mail-Order Pharmacy Provider" and has entered into an agreement, either directly or indirectly, with Highmark to provide Covered Medications or specific covered medical devices through mail-order to you at a contractually agreed upon price (Provider's Allowable Price).

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 the criteria of Highmark. These criteria are based on the certification programs for Outpatient diabetes education developed by the American Diabetes Association (ADA) and the Pennsylvania Department of Health.

Domestic Partner - (Please check with your Group Administrator to see if the following is applicable.) A member of a Domestic Partnership consisting of two (2) partners, each of whom has registered with a domestic partner registry in effect in the municipality/governmental entity within which the Domestic Partner currently resides or who meets the definition of a domestic partner as defined by the state or local government where the individual currently resides or meets all of the following:

- Is unmarried, at least eighteen (18) years of age, resides with the other partner and intend to continue to reside with the other partner for an indefinite period of time;
- Is not related to the other party by adoption or blood;
- Is the sole domestic partner of the other partner and has been a member of this domestic partnership for the last six (6) months;
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and
- Meets (or agrees to meet) the requirements of any applicable federal, state or local laws or ordinances for domestic partnerships which are currently enacted or which may be enacted in the future.

Domestic Partnership - A voluntary relationship between two (2) domestic partners.

Effective Date - The date when your coverage begins.

Emergency Care Services - The treatment:

a. of bodily injuries resulting from an accident;

b. following the sudden onset of a medical condition; or

c. 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 one (1) or more of the following:

i. placing your health or, with respect to a pregnant member, the health of the member or the unborn child in serious jeopardy;

ii. causing serious impairment to bodily functions; or

iii. 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.

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.

Employee - An individual who meets the eligibility requirements specified herein.

Exclusive Pharmacy Provider - The exclusive pharmacy provider has an agreement, either directly or indirectly, with Highmark pertaining to the payment and exclusive dispensing of selected prescription provided to you. In addition, this pharmacy provider may also, but it not limited to, exclusively dispense drugs: a. that may require special handling; b. for which special instructions must be provided upon dispensing c. that are subject to a manufacturer's limited distribution plan; or d. are subject to a competitive price bidding process between Pharmacy Providers.

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

Family Coverage - Coverage for the Employee and one (1) or more of the Employee's dependents.

Formulary - A listing of prescription drugs selected by Highmark based on an analysis of clinical efficacy, unique value, safety, and pharmacoeconomic impact. This listing is subject to periodic review and modification by Highmark or a designated committee of Physicians and Pharmacists.

Generic Drug - A drug that is available from more than one (1) manufacturing source and accepted by the Food and Drug Administration (FDA) as a substitute for those products having the same active ingredients as a Brand Drug and listed in the FDA "Approved Drug Products with Therapeutic Equivalence Evaluations," otherwise known as the Orange Book, and noted as such in the pharmacy database used by Highmark.

Group - The party entering into a contract of insurance on your behalf and the representative of and remitting agent for you who collects and remits premium payments on your behalf.

Group Insured Contract - The agreement (including the Group Application, Plan’s Acceptance, and this Certificate) between your Group and Highmark.

Home Host Provider - All Participating Pharmacy Providers, owned by the Group or an affiliated company of the Group, which the Group has designated to qualify as the Pharmacy Provider for which, in connection with Covered Medications dispensed:

a. certain Member Deductible requirements will not apply; and

b. certain Member Copayment requirements will not apply; and

c. the Coinsurance amounts payable by Highmark are greater than those amounts paid when dispensed by any other Participating Pharmacy Provider; and

d. greater quantity limits are available than are available from any other Participating Pharmacy Provider.

Identification Card (ID Card) - The currently effective card issued to you by Highmark.

Incurred - A charge is considered incurred on the date you receive the covered medication for which the charge is made.

Mail Order Pharmacy - A pharmacy provider that has an agreement, either directly or indirectly, with Highmark or its Designated Agent to supply Covered Medications to you by mail service at a contractually agreed upon price.

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

Market Watch Prescription Drug - A select prescription drug identified by Highmark as:

- having an Over-the-Counter Drug equivalent.
- having relatively low value with respect to the cost in light of available alternative Covered Medications.
- being newly approved by the Food and Drug Administration (FDA) for treating a condition for which there are existing Covered Medications have previously been approved.

Maximum - The greatest amount payable by Highmark for covered medications, within a prescribed period of time. This could be expressed in dollars, dosage units or supply for a specified period of time.

Medically Necessary and Appropriate (Medical Necessity and Appropriateness) - Medications or supplies that a Provider, exercising prudent clinical judgement, 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; (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 medication or supply is Medically Necessary and Appropriate. No benefits will be provided unless Highmark determines that the medication or supply is medically necessary and appropriate.

Medication Synchronization - The coordination of Prescription Drug filling or refilling by a pharmacist or dispensing Physician for a member taking two or more Maintenance Prescription Drugs for the purpose of improving medication adherence.

Member - An individual who meets the eligibility requirements specified in General Information section provided herein.

Non-Participating Pharmacy Provider - Any pharmacy provider which has not entered into an agreement, either directly or indirectly, with Highmark pertaining to payment for covered medications provided to you.

Open Enrollment Period - The period during which you and your eligible dependents may enroll for coverage.

Out-of-Pocket Limit - The out-of-pocket limit refers to the specified dollar amount of Deductible and Coinsurance 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.

Participating Pharmacy Provider - A Pharmacy Provider that has an agreement, either directly or indirectly, with Highmark pertaining to the payment of Covered Medications or specific covered medical devices provided to you. To the extent permitted by state and federal law, Participating Pharmacy Providers

with the capability to provide certain immunizations as specified by Highmark, may also receive payment under the agreement for such immunizations and for the administration thereof, provided to you.

Pharmacist - A person who is legally licensed to practice the profession of pharmacy and performing services within the scope of such licensure.

Pharmacy Provider - Any entity licensed by any state which is engaged in dispensing Prescription Drugs or specific medical devices through a licensed pharmacist.

Physician - A person who is a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), licensed and legally entitled to practice medicine in all of its branches, perform surgery and dispense drugs. For benefits covered by this Certificate and for no other purposes, Podiatrists, Doctor of Dental Surgery (D.D.S.), and Doctor of Dental Medicine (D.M.D.), when acting within the scope of their licenses are deemed to be Physicians.

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

Preauthorization (Precertification) - The process whereby a physician must contact Highmark to determine the eligibility and/or the Medical Necessity and Appropriateness of certain Covered Medications. Such prior authorization must be obtained before the specific Covered Medication is dispensed to you.

Prescription Drug - Any drug or medication ordered by a professional provider by means of a valid Prescription Order, bearing the federal legend: "Caution: Federal law prohibits dispensing without a prescription," or a legend drugs under applicable state law and dispensed by a licensed pharmacist. Also included are prescribed injectable insulin and other pharmacological agents used to control blood sugar, diabetic supplies, disposable insulin syringes, as well as compounded medications, consisting of the mixture of at least two (2) ingredients other than water, one of which must be a legend drug.

Prescription Order - The request for medication issued by a professional provider.

Provider's Allowable Price - The amount at which a Participating Pharmacy Provider has agreed, either directly or indirectly, with Highmark to provide Covered Medications or specific medical devices to you under this program.

Provider Reimbursement - The Participating Pharmacy Providers will accept the Providers' Allowable Price, less your Deductible or Copayment and Coinsurance obligation as payment in full.

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.

Special Enrollment Period - The period during which you and your eligible dependents who experience(s) certain qualifying events may enroll for coverage outside of the open enrollment period.

Specialty Prescription Drugs - Selected Prescription Drugs which are typically used to treat rare or complex conditions, and which may require special handling, monitoring and/or special or limited distribution systems.

Specialty Tier - A listing of Specialty Prescription Drugs, as designated by Highmark. This listing is subject to periodic review and modification by Highmark or a designated committee of physicians and Pharmacists.

Summary of Benefits and Coverage - The summary document required under the Public Health Service Act, as added by the ACA, which describes certain Covered Services, Member cost-sharing obligations, benefit limitations, exclusions and certain other coverage information.

Total Maximum Out-of-Pocket - The total maximum out-of-pocket, as mandated by the federal government, is **The most you have to pay for covered services in a benefit period**. After you spend this amount on deductibles, copayments, and coinsurance for care and services, your program pays 100% of the costs of covered services. See How Your Prescription Drug Benefits are Applied and the Summary of Benefits for the total maximum out-of-pocket applicable to you.

Refer to the Medical Summary of Benefits for the Prescription Drug Benefits

Sí 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. To Plan Sponsors

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

B. Required by Law

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

C. Public Health Activities

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

D. Health Oversight Activities

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

E. Abuse or Neglect

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

F. Legal Proceedings

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

G. Law Enforcement

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

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

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

I. Research

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

J. To Prevent a Serious Threat to Health or Safety

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

K. Military Activity and National Security, Protective Services

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

L. Inmates

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

M. Workers' Compensation

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

N. Others Involved in Your Health Care

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

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 will 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
   (vi) 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 Inc. 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

VISION CARE BENEFITS

Vision Program

Highmark Inc. d/b/a Highmark Blue Cross Blue Shield

Larson Texts, Inc.

Group 01717100

Effective April 01, 2024

This booklet relates to a Limited Policy - Read it Carefully

BB-VPPP-WG-NG-3

Discrimination is Against the Law

The Plan 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 Plan 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 Plan 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 Plan 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 Plan:

- 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 a Member needs these services, the Member should contact the Civil Rights Coordinator.

If a Member believes that the Plan 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, the Member can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. The Member can file a grievance in person or by mail, fax, or email. If the Member needs help filing a grievance, the Civil Rights Coordinator is available to help the Member. The Member 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

LANGUAGE ASSISTANCE SERVICES

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 serbisyong 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 المعاونة 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.

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

This booklet does not constitute a contract of benefits and provisions. The complete set of terms of coverage are set forth in the group contract issued by Highmark Blue Cross Blue Shield, an Independent Licensee of the Blue Cross and Blue Shield Association. Should the information in this booklet differ from the information contained in the group contract, the terms of the group contract shall govern. This booklet is merely a description of the principal features of your program.

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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 benefits 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.

How Your Benefits Are Applied

Payment For Network Covered Expenses

Professional Services

Eye Examination and Refractive Services

When a network provider is used, payment for eye examinations and refractive services is based on the plan allowance.

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

Low Vision Care Services

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

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

Laser Vision Correction Services

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

Post-Refractive Products

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

Payment of the plan allowance is made directly to the provider and is accepted as payment-in-full. If the covered post-refractive product is subject to a copayment, as indicated in the Covered Services, you are responsible for paying that copayment amount to the provider.

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

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

Payment For Out-of-Network Covered Expenses

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

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

Schedule of Benefits: Professional and Post Refractive

Benefits	Network	Out-of-Network1
FREQUENCY		
• Eye examination (including dilation as professionally indicated)	One visit every 12 months[2]	
• Eyeglass lenses	One pair every 12 months[2]	
• Frames	One frame every 12 months[2]	
• Contact lenses		
• Formulary	One pair of standard daily wear or an initial supply of disposable (4 multi-packs) or planned replacement (2 multipacks) contact lenses every 12 months [2]	
• Non-Formulary	Payment of the program allowance [2]	
EYE EXAMINATION (including dilation as professionally indicated)	Covered in full	Plan pays up to $40
FRAMES		
• Fashion level frames from "The Collection"	Covered in full	
• Designer level frames from "The Collection"	Member pays $20	
• Premier level frames from "The Collection"	Member pays $40	
• Retail allowance toward a provider's frame	Plan pays up to $150	Plan pays up to $64
STANDARD EYEGLASS LENSES (per pair) [3]		
• Single vision lenses	Covered in full	Plan pays up to $30
• Bifocal vision lenses	Covered in full	Plan pays up to $40
• Trifocal vision lenses	Covered in full	Plan pays up to $60
• Lenticular vision lenses	Covered in full	Plan pays up to $80
OPTIONAL EYEGLASS LENSES (per pair)		
• Standard progressive lenses(in lieu of bifocal or trifocal lenses)[4]	Covered in full	Plan pays up to $130
• Premium progressive lenses [4]	Member pays $40	Not Covered
• Ultra progressive lenses [4]	Member pays $90	Not Covered
• Ultimate progressive lenses [4]	Member pays $125	Not Covered
• Glass-Grey #3 prescription sunglasses	Member pays $11	Not Covered
• Polycarbonate lenses		
• Adult [5]	Member pays $30	Not Covered
• Dependent children		
• Single vision Polycarbonate lenses (in lieu of single vision eyeglass lenses)	Covered in full	Plan pays up to $70
• Bifocal Polycarbonate lenses (in lieu of bifocal eyeglass lenses)	Covered in full	Plan pays up to $80
• Trifocal Polycarbonate lenses (in lieu of trifocal eyeglass lenses)	Covered in full	Plan pays up to $95
• Blended segment lenses	Member pays $20	Not Covered

Benefits	Network	Out-of-Network1
• Intermediate vision lenses	Member pays $30	Not Covered
• Glass photochromic lenses	Member pays $20	Not Covered
• Plastic photosensitive lenses	Member pays $65	Not Covered
• High-index (thinner and lighter) lenses	Member pays $55	Not Covered
• Polarized lenses	Member pays $75	Not Covered
• Blue light lenses	Member pays $15	Not Covered
OPTIONAL EYEGLASS LENS COATINGS/TREATMENTS		
• Fashion, sun or gradient tinted plastic lenses	Member pays $11	Not Covered
• Ultraviolet coating	Member pays $12	Not Covered
• Scratch-resistant coating	Covered in full	Not Covered
• Standard ARC (anti-reflective coating)	Member pays $35	Not Covered
• Premium ARC (anti-reflective coating)	Member pays $48	Not Covered
• Ultra ARC (anti-reflective coating)	Member pays $60	Not Covered
• Ultimate ARC (anti-reflective coating)	Member pays $85	Not Covered
• Scratch protection plan	Member pays $20 for single vision Member pays $40 for multifocal	Not Covered
CONTACT LENSES (per pair or initial supply of disposable contact lenses) [6]		
• Contact lens evaluation and fitting		
◦ Daily wear	Covered in full when the performing provider dispenses formulary contact lenses	Not Covered
◦ Extended wear	Covered in full when the performing provider dispenses formulary contact lenses	Not Covered
	Formulary /Non-Formulary	
• Standard daily wear contact lenses	Covered in full / Plan pays up to $150[8]	Plan pays up to $115
• Specialty contact lenses	Covered in full / Plan pays up to 150 [8]	Plan pays up to $115
• Disposable contact lenses Specialty contact lenses	Covered in full / Plan pays up to $150 [8]	Plan pays up to $115
• Medically necessary contact lenses ***(prior approval required)***	Covered in full	Plan pays up $225
LASER VISION CORRECTION SERVICES DISCOUNT PROGRAM	Discount available at participating providers only.	Not Covered
LOW VISION SERVICES [9]	Plan pays up to $300 per visit	
• Initial evaluation ***(prior approval required)***	Plan pays up to $100 per visit	
• Follow-up visits	Plan pays up to $600 per aid	
• Low vision aids	Plan pays up to $1,200 lifetime maximum	

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

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

[3] Includes glass, plastic or oversized lenses.

[4] Progressive multifocals can be worn by most people. Conventional bifocals will be supplied at no additional charge for anyone who is unable to adapt to progressive lenses; however, the member's payment toward the progressive upgrade will not be refunded.

[5] Member payment is waived for monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

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

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

[8] The plan's payment is applied toward the cost of contact lenses and may or may not apply to the evaluation/fitting. The member is responsible for any remaining balance.

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

Description of Benefits

Eye Examination and Refractive Services

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

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

Post-Refractive Products

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

Eyeglasses and Frames

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

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

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

Benefits also include discounted prices in connection with the following:

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

- Blue light lenses

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

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

Contact Lenses

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

- Contact lens evaluation and fitting
  Evaluation and fitting services are only covered when the network provider performing those services also dispensed the formulary contact lenses and has been credentialed by Highmark to perform those services.

- Ordering of lenses according to specifications
- Cost of the materials
- Verification of the completed prescription
- Fitting
- Dispensing

The contact lenses covered under this program include the following:

- Standard daily wear contact lenses - Contact lenses that are placed in the eye at the beginning of the day and removed at the end of the day.
- Specialty contact lenses - Includes standard daily wear, disposable or planned replacement types of contact lenses.
- Disposable contact lenses/planned replacement contact lenses - Contact lenses that are worn for a prescribed length of time and then are discarded. Compared to conventional contact lenses, these lenses are intended to offer you better eye health, clearer vision, increased comfort and a "fresh lens feeling" on a continuous basis. There is very little to no maintenance involved with these lenses.
- Medically necessary contact lenses - A contact lens considered eligible only after cataract surgery, corneal transplant surgery or other conditions such as, but not limited to, keratoconus or when adequate visual acuity is not attainable with eyeglasses but can be achieved through the use of contact lenses. Medically necessary contact lenses are a contact lens that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

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

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

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

Low Vision Care Services

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

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

Laser Vision Correction Services Discount Program

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

What Is Not Covered

Except as specifically provided in this booklet, or as Highmark is mandated or required to pay based on state or federal law, no program payment will be provided for services, products or supplies which are:

- for examinations, materials or products which are not listed herein as a covered service;
- for medical or surgical treatment of eye disease or injury;
- for visual therapy;
- for diagnostic services, such as diagnostic x-rays, cardiographic and encephalographic examinations, and pathological or laboratory tests;
- for drugs or any other medications;
- for procedures determined by Highmark to be special or unusual, such as but not limited to, orthoptics, vision training and tonography;
- for eye examinations or materials necessitated by your employment or furnished as a condition of employment;
- for any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state or local government's workers' compensation, occupational disease or similar type of legislation. This exclusion applies whether or not you file a claim for said benefits or compensation;
- to the extent benefits are provided by any governmental unit, unless payment is required by law;
- for which you would have no legal obligation to pay;
- received from a 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;
- rendered prior to your effective date;
- for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
- for temporary devices, appliances and services;
- for which you incur no charge;
- the cost of which has been or is later recovered in any action at law or in compromise or settlement of any claim except where prohibited by law;
- in a facility performed by a professional provider who is compensated by the facility for similar covered services performed for you;
- to the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program and you so elect this coverage as primary;
- for treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits, payable in any manner under any state law governing liability for injuries arising from the maintenance or use of a motor vehicle;
- for professional services not performed by licensed personnel;
- for the cost of any insurance premiums indemnifying you against losses for lenses or frames;
- for non-prescription industrial safety glasses and safety goggles;
- for sports glasses;
- incurred after the date of termination of your coverage except for lenses and frames prescribed prior to such termination and delivered within 31 days from such date;
- for duplicate devices, appliances and services;
- for any lenses which do not require a prescription;
- for prosthetic devices and services;
- for low vision aids and services not otherwise specified herein;
- for non-prescription (Plano) lenses;
- for special lens designs or coatings not otherwise specified herein;

- for replacement of lost or stolen eyeglass lenses or frames or lost, stolen or damaged contact lenses and safety eyeglasses;
- for replacement of broken frames and eyeglass lenses that are not supplied by Davis Vision's ophthalmic laboratories;
- for replacement of lost, damaged or broken safety eyeglasses supplied by Davis Vision's ophthalmic laboratories or any other manufacturer;
- for additives for glass lenses or contact lenses not otherwise specified herein;
- for sales tax and shipping charges that may be associated with purchases of post-refractive products covered 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 your attending professional provider as being medically appropriate; and
- for any other medical or vision service or treatment except as provided herein.

How Your Program Works

Network Care

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

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

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

Out-of-Network Care

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

Eligible Providers

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

General Information

Who is Eligible for Coverage

You may enroll your:

- Spouse under a legally valid existing marriage
- Children under 26 years of age, unless otherwise extended pursuant to applicable state or federal law, including:
    - Newborn children
    - Stepchildren
    - Children legally placed for adoption
    - Legally adopted children or children for whom the employee or the employee's spouse is the child's legal guardian
    - Children awarded coverage pursuant to an order of court

  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 by Highmark.

- Unmarried children over age 26 who are not able to support themselves due to intellectual disability, physical disability, mental illness or developmental disability. Highmark may require proof of such disability from time to time.

NOTE: To the extent mandated by the requirements of Pennsylvania Act 83 of 2005, eligibility will be continued past the limiting age for children who are enrolled as dependents under their parent's coverage at the time they are called or ordered into active military duty. They must be a member of the Pennsylvania National Guard or any reserve component of the armed forces of the United States, who is called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days, or be a member of the Pennsylvania National Guard ordered to active state duty for a period of 30 or more consecutive days. If they become a full-time student for the first term or semester starting 60 or more days after their release from active duty, they shall be eligible for coverage as a dependent past the limiting age for a period equal to the duration of their service on active duty or active state duty.

For the purposes of this note, full-time student shall mean a dependent who is enrolled in, and regularly attending, an accredited school, college or university, or a licensed technical or specialized school for 15 or more credit hours per semester, or, if less than 15 credit hours per semester, the number of credit hours deemed by the school to constitute full-time student status.

- A domestic partner* shall be considered for eligibility as long as a domestic partnership (a voluntary relationship between two domestic partners) exists with you. In addition, the children of the domestic partner shall be considered for eligibility as if they were your children as long as the domestic partnership exists.

  "Domestic Partner" means a member of a domestic partnership consisting of two partners, each of whom has registered with a domestic partner registry in effect in the municipality/governmental entity within which the domestic partner currently resides, or who meets the definition of a domestic partner as defined by the state or local government where the individual currently resides or meets all of the following:

  - Is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time
  - Is not related to the other partner by adoption or blood
  - Is the sole domestic partner of the other partner and has been a member of this domestic partnership for the last six months

- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner
- Meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for domestic partnerships which are currently enacted, or which may be enacted in the future

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

Changes in Membership Status

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

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

Continuation of Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that covers group health plans sponsored by an employer (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 that are subject to COBRA must temporarily extend their vision coverage to certain categories of employees and their covered dependents when, due to certain "qualifying events," they are no longer eligible for group coverage.

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

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.

Leave of Absence or Layoff

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

Termination of Your Coverage Under the Employer Contract

Your coverage can be terminated in the following instances:

- When you cease to be an employee, the group shall promptly notify Highmark that you are no longer eligible for coverage and that your coverage should be terminated as follows:
    - When prompt notification is received, coverage will be terminated no earlier than the date on which you cease to be eligible.
    - When a group requests a retroactive termination of coverage, coverage will be terminated no earlier than the first day of the month preceding the month in which Highmark received notice from the group.
- When you fail to pay the required contribution, your coverage will terminate at the end of the last month for which payment was made.
- Termination of the employer contract automatically terminates the coverage of all the members. It is the responsibility of the employer to notify you of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given to you by the employer.
- If it is proven that you obtained or attempted to obtain benefits or payment for benefits through fraud or intentional misrepresentation of a material fact, Highmark may, upon notice to you, terminate your coverage under the program.
- It is understood that you have an affirmative obligation to notify the group or Highmark as soon as the domestic partnership has been terminated. Upon termination of the domestic partnership, coverage of the former domestic partner and the children of the former domestic partner will terminate at the end of the last month the domestic partnership terminated.

How to File a Claim

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

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

Your claims must be submitted to within 20 days after the date of service or as soon thereafter as reasonably possible, but not later than within one year of the date. Proof of loss is otherwise required.
Only one claim per service may be submitted for reimbursement each benefit cycle. To file a claim, take the following steps:

- Request an itemized bill which shows:
  - the patient's name and address;
  - the date of service;
  - the type of service and diagnosis;
  - itemized charges; and
  - the provider's complete name and address.
- Make a copy of your itemized bill for your records.
- Complete a claim form. To request claim forms, please visit Davis Vision's website at www.davisvision.com or call 1-800-999-5431.

NOTICE OF CLAIM AND PROOF OF LOSS
Network Providers have directly or indirectly entered into an agreement with the Plan pertaining to the payment for Covered Services rendered to a Member. When a Member receives Covered Services from a Network Provider, it is the responsibility of the Network Provider to submit its claim to the Plan in accordance with the terms of its participation agreement. Should the Network Provider fail to submit its claim in a timely manner or otherwise satisfy the Plan’s requirements as they relate to the filing of claims, the Member will not be liable and the Network Provider shall hold the Member harmless relative to payment of the Covered Services received by the Member.

When Covered Services are received from other than a Network Provider, the Member is responsible for submitting the claim to the Plan. In such instances, the Member must submit the claim in accordance with the following procedures:

1. Notice of Claim

The Plan will not be liable for any claims under this Contract unless proper notice is furnished to the Plan that Covered Services in this Contract have been rendered to a Member. Written notice of a claim must be given to the Plan within twenty (20) days or as soon as reasonably possible after Covered Services have been rendered to the Member. Notice given by or on behalf of the Member to the Plan that includes information sufficient to identify the Member that received the Covered Services shall constitute sufficient notice of a claim to the Plan. The Member can give notice to the Plan by writing to the Member Services Department. The address of the Member Services Department can be found on the Member’s Identification Card. A charge shall be considered Incurred on the date a Member receives the Service for which the Charge is made.

2. Claim Forms

Proof of loss for benefits under this Contract must be submitted to the Plan on the appropriate claim form. The Plan, upon receipt of a notice of a Claim will, within fifteen (15) days following the date a notice of a claim is received, furnish to the Member claim forms for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of such notice, the Member shall be deemed to have complied with the

requirements of this Subsection as to filing a proof of loss upon submitting, within the time fixed in this Subsection for filing proofs of loss, itemized bills for Covered Services as described below. The proof of loss may be submitted to the Plan at the address appearing on the Member's Identification Card.

3. Proof of Loss

Claims cannot be paid until a written proof of loss is submitted to the Plan. Written proof of loss must be provided to the Plan within ninety (90) days after the date of such loss. Proof of loss must include all data necessary for the Plan to determine benefits. Failure to submit a proof of loss to the Plan within the time specified will not invalidate or reduce any Claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will the Plan be required to accept a proof of loss later than 24 months after the charge for Covered Services in this Contract is Incurred.

4. Submission of Claim Forms

The completed claim form, with all itemized bills attached, must be forwarded to the Plan at the address appearing on the Member's Identification Card in order to satisfy the requirement of submitting a written proof of loss and to receive payment for benefits provided under this Contract.
To avoid delay in handling Member-submitted claims, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing:

Person or organization providing the Service
Type of Service
Date of Service
Amount charged
Name of patient
Itemized bills cannot be returned.

A request for payment of a Claim will not be reviewed and no payment will be made unless all of the information and evidence of payment required on the Claim form has been submitted in the manner described above. The Plan reserves the right to require additional information and documents as needed to support a claim that a Covered Service has been rendered.

Notice of the Plan's claim determination will be issued within a reasonable period of time not to exceed thirty (30) days following the receipt of a proper proof of loss. This period of time may be extended one (1) time by the Plan for an additional period of time not to exceed fifteen (15) days provided the extension is due to matters outside the control of the Plan and a written explanation for the delay is provided to the Member.

In the event that the Plan renders an adverse decision on the Claim, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement describing the right of the Member to file an appeal.

5. Time of Payment of Claims

Claim payments for benefits payable under this Contract will be processed immediately upon receipt of a proper proof of loss.

6. Authorized Representative

Nothing in this Subsection shall preclude a duly authorized representative of the Member from filing or otherwise pursuing a Claim on behalf of the Member. The Plan reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of the Member.

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

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

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

- Request an itemized bill which shows:
  - the patient's name and address;
  - the date of service;
  - the type of service and diagnosis;
  - itemized charges; and
  - the provider's complete name and address.

- Make a copy of your itemized bill for your records.
- Complete a claim form. To request claim forms, please visit the Davis Vision website at www.davisvision.com or call 1-800-999-5431.

Your Explanation of Benefits Statement

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

Additional Information on How to File a Claim

Member Inquiries

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

Filing Benefit Claims

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

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

  If services requiring preauthorization are to be received from an out-of-network provider, the out-of-network provider will not initiate the preauthorization process on your behalf. In that case, you should ask the doctor to provide you with a letter explaining why the services you received were medically necessary (letter of medical necessity). Attach the letter of medical necessity and copies of the bill that you paid to your completed claim form and file that with Highmark in order to be reimbursed. You will receive written notice of any decision on a request for preauthorization or other pre-service claim within 15 days from the date Davis Vision receives your claim. However, this 15-day period of time may

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

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

- ***Requests for Reimbursement and Other Post-Service Claims***
  When you receive services from a network provider, the provider will report the services to Davis Vision and payment will be made directly to the provider. Davis Vision will also notify the provider of any amounts that you are required to pay in the form of a copayment. If you believe that the copayment amount is not correct or that any portion of those amounts are covered under your benefit program, you may file an appeal.

Determinations on Benefit Claims

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

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

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

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

Appeal Procedure

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

The appeal process involves one level of review. This process is mandatory and must be exhausted before you are permitted to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

At any time during the appeal process, you may choose to designate an authorized representative to participate in the appeal process on your behalf. You or your authorized representative shall notify Highmark in writing of the designation. For purposes of the appeal process described below, “you” includes designees,

legal representatives and, in the case of a minor, parents entitled or authorized to act on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

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

Upon request, you may review all documents, records and other information relevant to your appeal and shall have the right to submit 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. Your appeal will be reviewed by a representative from the Member Service Department. The representative shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the claim or matter which is the subject of your appeal. In rendering a decision on your appeal, the Member Service Department will take into account all evidence, comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Highmark. The Member Service Department will afford no deference to any prior adverse decision on the claim which is the subject of your appeal.

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

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

- When the appeal involves a pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of the appeal;
- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 60 days following receipt of the appeal.

In the event Highmark renders an adverse decision on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding your right to pursue any applicable legal action, right to arbitration in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Member Service

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

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

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

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

Member Services

Replacement Contact Lenses by Mail

As a member of this program, Highmark offers a contact lens replacement program. This mail order program exclusively allows you to enjoy the guaranteed lowest prices on contact lens replacement materials. Visit www.davisvisioncontacts.com or call 1-855-589-7911 with a current prescription.

Warranty Information

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

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 review 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

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

Blue Light Lenses - Blue light blocking glasses have specially crafted lenses that are designed to block or filter out the blue light that is given off from digital screens (phones, tablets, computers, laptops, televisions, etc.). The lens is designed to protect your eyes from glare and can help to reduce potential damage to the retina from prolonged exposure to blue light.

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

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

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

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

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

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

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

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

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

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

Medically Necessary Contact Lenses - A contact lens considered eligible only after cataract surgery, corneal transplant surgery or other conditions such as, but not limited to, keratoconus or when adequate visual acuity is not attainable with eyeglasses but can be achieved through the use of contact lenses. Medically necessary contact lenses are contact lenses that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;

- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

- not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

Network Provider - A provider who has an agreement, either directly or indirectly, with Highmark pertaining to payment of covered services.

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

Non-Network (Out-of-Network) Provider - A provider who has not entered into a participation agreement, either directly or indirectly, with Highmark pertaining to payment for covered services.

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

Optician - A technician who makes, verifies and delivers lenses, frames and other specially fabricated optical devices and/or contact lenses upon prescription to the intended wearer. The Optician’s functions include: prescription analysis and interpretation; determine of the lens forms best suited to the wearer’s needs; the preparation and delivery of work orders for the grinding of lenses and the fabrication of eye wear; the verification of the finished ophthalmic products; the adjustment, replacement, repair and reproduction of previously prepared ophthalmic lenses, frames and other specially fabricated ophthalmic devices.

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

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

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

Plan Allowance - The amount used to determine payment by Highmark for covered services provided to you and to determine your liability.

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

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

Polycarbonate Lenses - Impact resistant and lightweight eyeglass lenses.

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

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

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

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

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

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

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

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

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

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

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

Tinted Plastic Lenses -

a. Fashion tinting - Eyeglass lenses dyed or coated with pigment of uniform color and density throughout the entire lens.

b. Gradient tinting - Eyeglass lens coating that is darker at the top of the lens, fading to light at the bottom of the lens.

Ultimate Anti-Reflective Coating (ARC) - A clear coating placed on eyeglass lenses that provide exceptional visual clarity and protection against glare, reflections, harmful blue light, and ultraviolet rays. Lenses repel dust and dirt for clearer lenses and less cleaning.

Ultimate Progressive Lenses - Eyeglass lenses designed with the widest viewing areas for both distance and reading and every distance in between. Lenses are the best in digital design and cutting edge technology.

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

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

Ultra Progressive Lenses - Eyeglass lenses designed with no clear line of demarcation between power changes but which progress gradually from distance to intermediate to near vision correction as needed.

You are hereby notified, your health care benefit program is between the Group, on behalf of itself and its employees and Highmark Blue Cross Blue Shield. Highmark Blue Cross Blue Shield is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield 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 shall be liable to the Group, on behalf of itself and its employees, for any Highmark Blue Cross Blue Shield obligations under your health care benefit program.

Sí 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. To Plan Sponsors

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

B. Required by Law

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

C. Public Health Activities

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

D. Health Oversight Activities

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

E. Abuse or Neglect

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

F. Legal Proceedings

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

G. Law Enforcement

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

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

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

I. Research

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

J. To Prevent a Serious Threat to Health or Safety

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

K. Military Activity and National Security, Protective Services

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

L. Inmates

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

M. Workers' Compensation

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

N. Others Involved in Your Health Care

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

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 will 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
   (vi) 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 Inc. 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