COMPREHENSIVE HOSPITAL, MEDICAL/SURGICAL, AND MAJOR MEDICAL HEALTH CARE CERTIFICATE IDENTIFIED AS CLASSIC BLUE TRADITIONAL

effective as of

January 1, 2024

by and between

Pennsylvania Judiciary Actives
(Called the Group)

and

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

A Pennsylvania non-profit corporation whose address is
1800 Center Street, Camp Hill, Pennsylvania 17011

GUARANTEED RENEWABLE

HOSPITAL BENEFITS DESCRIPTION OF COVERAGE: this program sets forth inpatient and outpatient facility provider benefits. Cost-sharing options are available such as deductibles, copayments, coinsurance and maximums. Benefits are subject to the Health Care Management Section with possible loss of benefits for non-compliance. This Health Care Certificate is non-participating in any divisible surplus of premium.

BASIC MEDICAL/SURGICAL DESCRIPTION OF COVERAGE: This program sets forth inpatient and outpatient professional provider benefits. Cost sharing options are available such as deductibles, copayments, coinsurance and maximums. Benefits of this Certificate are maximized by the use of Participating Professional Providers. This Health Care Certificate is non-participating in any divisible surplus of premium.

MAJOR MEDICAL DESCRIPTION OF COVERAGE: This Certificate sets forth a comprehensive program of health care benefits designed to supplement the coverage provided under the Basic Blue Cross and Basic Blue Shield Plans. No payment will be made for any covered expenses that are payable under the Basic Plans or for charges that are in excess of the Highmark Blue Cross Blue Shield allowance under the Basic Plans. Cost sharing options such as deductibles, copayments and maximums are available.

*An independent licensee of the Blue Cross Blue Shield Association
Group 02862300, 01, 03, 04

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.

Introduction to Your Health Care Program

This Certificate provides you with 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.

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

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 in your Summary of Benefits and a description of how your benefits are applied. For specific amounts, refer to your Summary of Benefits.

Medical Cost-Sharing Provisions

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

Major Medical Covered Services

Benefit Period

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

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 your Summary of Benefits for the percentage amounts paid by the program.

Deductible

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

Any penalties assessed under the managed care program of the Basic Plan will not be used to satisfy the deductible as defined herein.

The deductible does not apply to the enteral foods benefit or the breast cancer screenings benefit.

The deductible does not apply to hearing aids or hearing aid exams.

Family Deductible

For a family with several covered dependents, you pay no more than Three individual deductibles per family, as specified under family deductible. After each of the Three covered persons meets the individual deductible specified in the Summary of Benefits, the deductible for the entire family is met. If one family member meets the 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 had not been met.

The deductible does not include any charges for which benefits are excluded in whole or in part under the provisions in the Health Care Management section.

Deductible Credit

For the first year of coverage, the amount the member paid for expenses incurred for covered services in the last three months of a benefit period which were applied to that benefit period's deductible will be applied to the deductible of the next benefit period.

Out-of-Pocket Limit
The out-of-pocket limit refers to the specified dollar amount of coinsurance incurred for covered services in a benefit period. When the specified dollar amount is attained, Highmark begins to pay 100% of all covered expenses. See your Summary of Benefits for the out-of-pocket limit. The out-of-pocket limit does not include deductibles or amounts in excess of the plan allowance.

Individual Out-of-Pocket Limit
When a member incurs the entire individual out-of-pocket amount of coinsurance expense for covered services in one benefit period, the benefits payable for that member during the remainder of the benefit period, will increase from to 100% of the plan allowance.

Family Out-of-Pocket Limit
The family out-of-pocket limit refers to the amount of coinsurance incurred by you and/or your covered family members for each of Three covered members of your family for covered services received in a benefit period.

When each of Three members under the same family coverage has Incurred the entire family out-of-pocket amount of coinsurance expense for covered services in one benefit period, the benefits payable for all members under that same family coverage during the remainder of the benefit period will increase to 100% of the plan allowance.

Total Maximum Out-of-Pocket
The total maximum out-of-pocket, as mandated by the federal government, refers to the specified dollar amount of coinsurance, copayment and deductible expenses incurred for covered services in a benefit period, after which the level of benefits payable by the Plan is increased to one hundred (100%) percent of the plan allowance such that no additional coinsurance, copayment and deductible expenses will be incurred for covered services in that benefit period. This does not include expenses in excess of the plan allowance. All amounts are based on plan allowance.

Individual Total Maximum Out-of-Pocket
When a member incurs the entire individual total out-of-pocket amount in coinsurance, and deductible expenses for covered services in one (1) benefit period, the benefits payable for claims received by the Plan thereafter for covered services for that member during the remainder of the benefit period will increase to 100% of the plan allowance.

Applicable expenses incurred in the same benefit period for covered services through either the Highmark Blue Cross Blue Shield hospital benefits certificate or the Highmark Blue Cross Blue Shield basic medical/surgical certificate will be credited toward the individual total maximum out-of-pocket set forth in this paragraph.

Family Total Maximum Out-of-Pocket
When two (2) or more members under the same family coverage have jointly incurred the entire family total out-of-pocket amount in coinsurance, copayment and deductible expenses for covered services in one (1) benefit period, the benefits payable for claims received by the Plan thereafter 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.

Applicable expenses incurred in the same benefit period for covered services through either the Highmark Blue Cross Blue Shield hospital benefits certificate or the Highmark Blue Cross Blue Shield basic medical/surgical certificate will be credited toward the family total maximum out-of-pocket set forth in this paragraph.

Laws Affecting Program Benefits

Employees in certain states may be subject to state 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 your Summary of Benefits.

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 physician'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

Routine 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 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;
        ii. personal history of BRCA1 or BRCA2 gene mutations;
        iii. a first-degree relative with a BRCA1 or BRCA2 gene mutation;

* 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.

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 screenings 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 participating 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 and covered medications.

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 for all members capable of pregnancy and breastfeeding support and counseling.

Preventive Covered Medications
Coverage will be provided for prescription and over-the-counter drugs, including all FDA-approved tobacco cessation medications, that are prescribed for preventive purposes when received from a participating pharmacy provider.

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, 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.

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

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;
- 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 required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.

Surgery

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

Maternity Services

Hospital, 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 participating 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 participating provider. The visit is subject to all the terms of this program.

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

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 while the mother is an inpatient.

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 and its reversal 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 non-participating provider and require an inpatient admission or observation immediately resulting from such injury or emergency medical condition and upon stabilization;

a. you are unable to travel using non-medical transportation or non-emergency medical transportation to an available participating provider located within a reasonable travel distance; or

b. you do not consent to be transferred,

you will not be subject to any balance billed amount for any covered services directly related to such injury or emergency medical condition and received during the inpatient admission or observation.

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;
- 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. Use of an ambulance as transportation to an emergency room of a facility provider for an injury or condition that is not considered emergency care will not be covered as emergency ambulance services. 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.

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
- Chemotherapy
- Dialysis treatment

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 (except room and board) 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.

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

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
Prescription Drugs approved by the Food and Drug Administration and designated by Highmark for the treatment of autism spectrum disorders, and which are prescribed by a physician, licensed physician assistant or certified registered nurse practitioner. Additionally, 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 such prescription drugs.

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.

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:

- Prescription drugs: Insulin and pharmacological agents for controlling blood sugar
- Equipment and supplies: Blood glucose monitors, monitor supplies, and insulin infusion devices
- Diabetes Education Program*: When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through a diabetes education program:

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

***Diabetes Education Program** – an outpatient program of self-management, training and education, including medical nutrition therapy, for the treatment of diabetes. Such outpatient program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education services will be covered subject to Highmark'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:

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

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.

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.

Hearing Care Services

Benefits include coverage for fitting and repair of hearing aid devices, when prescribed by a professional provider.

The hearing aid must be purchased within six months of an audiometric examination and from a contracting 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.

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.

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.

What Is Not Covered

Except as specifically provided in this program 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 or as mandated by law;
Ambulance	● For ambulance services, except as provided herein;
Assisted Fertilization	● For Artificial Insemination;
Assisted Fertilization	● For in vitro fertilization;
Assisted Fertilization	● Related to treatment provided specifically for the purpose of assisted fertilization; including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law;
Audiometric Testing	● For outpatient audiometric testing;
Compounded medications	● For compounded medications;
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 or professional other provider;
Contraceptive Medications, Devices and Implants	● For contraceptive services, including contraceptive prescription drugs, contraceptive devices, implants and injections, and all related services or except as otherwise set forth in the predefined preventive schedule. Please refer to the predefined preventive schedule. Please refer to the preventive services section of covered services for more information.
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, domicilliary care, residential care, protective and supportve 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 to sound natural teeth, 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 participating diabetes prevention provider;
Effective Date	● Incurred prior to your effective date or during an Inpatient admission that commenced prior to your effective date; except covered services will be provided for an eligible condition that commenced after your effective date;
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. This does not include those enteral foods, which are exempt from deductible requirements, that are either nutritional supplements prescribed for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria or 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;
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);
Eye Refractions	● For outpatient eye refractions;
Felonies	● for any illness or injury you suffer during your commission of a felony;
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 by capsular or bone surgery), calluses, toe nails (except surgery for ingrown nails),

		fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes;
Health Care Management program	●	For care, treatment or services which have been disallowed under the provisions of the Health Care Management section of the program;
Hearing Care Services	●	For hearing aid devices, tinnitus maskers or examinations for the prescription or fitting of hearing aids;
Hearing Care Services	●	For hearing care services or supplies, except as provided herein;
High Cost Technological Equipment	●	Performed on high cost technological equipment such as, but not limited to, computed tomography scanners (CT scanners), lithotripters, and magnetic resonance imaging (MRI) scanners, as defined by Highmark, which is not approved through the certificate of need process if applicable and/or is not approved by Highmark;
Immunizations	●	For immunizations required for employment or foreign travel, except as required by applicable state or federal law;
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 exclusion 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 those for remedial education 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; c) services related to the treatment of learning disorders or learning disabilities; and d) services provided primarily for social or environmental change or for respite care;
	●	For any care that is related to autism spectrum disorders which extends beyond traditional medical management, except as otherwise provided herein. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education 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 have no legal obligation to pay;

Managed Care Program	● For care, treatment, or service which has been disallowed under the provisions of the managed care program;
Medically Necessary and Appropriate	● Which are not medically necessary or medically 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 so elect this coverage as primary; ● For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage; ● For charges for services, other than emergency and urgent care services when a private contract has not been executed by the Medicare beneficiary, which are payable under Medicare rendered by a Medicare opt-out provider when Medicare is primary; ● For charges for any services payable under Medicare and rendered by a Medicare non-participating provider in excess of the Medicare reasonable charge, when Medicare is primary;
Mental Health	● For outpatient mental illness examinations and outpatient psychological testing, except as provided herein;
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; ● For loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of an act of war whether declared or undeclared;
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 except as provided in this Certificate; ● 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 which the fees or charges are billed by hospitals or other facilities; ● For clinical pathology services for which a hospital or other facility bills; ● Which are paid, or payable, in whole or in part, by another Blue Cross and/or Blue Shield Plan, except as provided herein; ● Performed in a facility by a professional provider or professional other provider who is, in any case, compensated by the facility for similar services performed for patients; ● For pre-operative care when the member is not an Inpatient and any post-operative care other than that normally provided following surgical procedures; ● For any care received by a member in a hospital or facility other provider which does not contract for reimbursement with any Blue Cross Plan, to the extent that coverage for such care would have been provided under the Basic Plan in the Highmark Blue Cross Blue Shield participating hospital or facility other provider;
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 any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act;
Neonatal Circumcision	● For routine neonatal circumcision;
Nutritional Counseling	● For nutritional counseling and services intended to produce weight loss counseling and services intended to produce weight loss, except as provided herein or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Care Services section of covered services for more information;
Obesity	● For treatment of obesity, except for medical and surgical treatment of morbid obesity or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Care Services section of covered services for more information;
Oral Surgery	● For oral surgery, except as provided herein;
Outpatient Hospital	● For treatment or services received as an outpatient in a non-participating hospital or facility provider except for emergency accident and emergency medical care, unless required by law;

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;
Preventive Care Services	● For preventive care services, wellness services or programs, except as provided herein or as mandated by law;
Provider of Service	● Which are not prescribed by, performed by or upon the direction of a professional provider; ● Rendered by other than hospitals, facility other providers, professional providers or professional other providers; ● Rendered by other than facility providers, professional providers, professional other providers and suppliers; ● Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or any similar person or group; ● Which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same member; ● Rendered by a provider who is a member of your immediate family; ● Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program;
Respite Care	● For respite care;
Skilled Nursing	● For skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness;
Smoking (nicotine) Cessation	● For nicotine cessation support programs and/or classes, except as required by applicable state or federal law;
Sterilization	● For sterilization, except as otherwise set forth in the predefined preventive schedule. Please refer to the preventive care services section of covered services for more information;
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;
Weight Reduction	● For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate or as otherwise required by applicable state or federal law;
Well-Baby Care	● For well-baby care, except as provided herein;
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 file a claim for benefits or compensation.

Provider/Supplier Reimbursement and Member Liability

Highmark uses the plan allowance to calculate the benefit payable and the financial liability of the member for medically necessary and appropriate services covered under this plan. Refer to the Terms You Should Know section for the definition of plan allowance.

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

When you receive covered services from a non-participating provider, in addition to your cost-share liability described above, you are responsible for the difference between Highmark'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, when the following covered services when received from a non-participating provider you will not be responsible for such difference:

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

2. Ambulance services 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 participating providers. A participating facility provider may have an arrangement with a non-participating professional provider or ancillary providers to render certain items and professional services (such as, but not limited to, equipment, devices, anesthesiology, radiology or pathology services) to patients of the participating 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 that non-participating professional provider or ancillary providers.

No prior approval requirement or pre-certification requirement applies when members receive emergency care services.

Participating and Non-Participating Provider Reimbursement

The benefits for covered services rendered by a participating provider which are regularly included in the charges billed by and payable to such provider, are as specified in the Summary of Benefits section.

The benefits for covered services rendered by a non-participating provider which are regularly included in the charges billed by and payable to such non-participating provider are as follows:

1. When rendered by a professional provider that is not participating with Highmark the benefit amount is the same as for a participating provider, i.e., Highmark's allowance for a professional provider that is not participating with Highmark will be the same as the plan allowance established for a participating professional provider.

2. When rendered by a hospital or facility other provider that is not participating with Highmark the benefit amount will be an indemnity allowance which at all times will be subject to the determination of Highmark.

   In the event covered services are provided by a non-participating provider, Highmark reserves the right to make payment to the member. Furthermore, when covered services are provided by a non-participating provider, you are responsible for the difference between Highmark's payment and the provider's billed charge. If you receive services which are not covered under this plan, you shall be responsible for all charges associated with those services.

3. When you receive benefits for emergency ambulance services or ambulance services provided by air from a non-participating provider, you will not be responsible for the difference between Highmark's payment and the provider's billed charge.

4. In very limited circumstances, you may not be liable for charges for non-emergency covered services received from certain professional providers who are not participating providers. A hospital or facility other provider that participates with Highmark may have an arrangement with a professional provider that does not participate with Highmark to render certain items and professional services (such as, but not limited to, equipment, devices, anesthesiology, radiology or pathology services) to patients of the hospital or facility other provider. The selection of such professional providers may be beyond your control. In that situation, you will not be liable, except for applicable deductible, copayment or coinsurance obligations, for the charges of that professional provider that does not participate with Highmark.

5. When Medicare provides primary coverage and the services rendered by a professional provider or professional other provider are payable under Medicare, Highmark will reimburse the professional provider or professional other provider as follows:

   a. Medicare Participating Providers

      i. When you have Medicare supplemental insurance coverage, no benefits will be paid by Highmark.

      ii. When you do not have Medicare supplemental insurance coverage, Highmark will reimburse the Medicare participating provider 20% of the Medicare reasonable charge. A Medicare participating provider will accept this amount and its Medicare reimbursement as payment in full.

   b. Medicare Non-Participating Providers

      i. When you have Medicare supplemental insurance coverage, no benefits will be paid by Highmark

      ii. When you do not have medical supplemental insurance coverage, Highmark will reimburse the Medicare non-participating provider 20% of the Medicare reasonable charge.

   c. Medicare Opt-Out Providers

      Highmark will make no reimbursement to the Medicare opt-out provider, except in cases where the Medicare opt-out provider renders emergency or urgent care services, the

Medicare beneficiary has not executed a private contract with that provider and you do not have Medicare supplemental insurance coverage.

In such situations, Highmark will reimburse the Medicare opt-out provider 20% of the Medicare reasonable charge.

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 our contractual obligations to you. Highmark's payment practices in both instances are described below.

BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this arrangement, when members access covered services outside Pennsylvania, the Host Blue will be responsible for contracting and handling all interactions with its participating health care providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method per Claim

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

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

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

Host Blues determine whether or not they will use an actual price, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to

correct for over- or underestimation of past prices, (ie, prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. 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, they will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if members contact the Blue Cross Blue Shield Global Core service center ("service center") for assistance, hospitals will not require members to pay for inpatient covered services, except for their cost-sharing amounts. In such cases, a Blue Cross Blue Shield Global Core contracting hospital will submit member claims to the service center to initiate claims processing. However, if the member paid in full at the time of service, the member must submit a claim to obtain reimbursement for covered services. **Members must contact Highmark to obtain precertification or preauthorization for non-emergency inpatient services**.

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

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

Eligible Providers

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

Facility Providers:

- Ambulance service
- Ambulatory surgical facility
- Birthing facility
- Diabetes prevention provider
- Freestanding dialysis facility
- Freestanding nuclear magnetic resonance facility/magnetic resonance imaging
- Home health care agency
- Home infusion therapy provider
- Hospice
- Hospital
- Independent diagnostic testing facility
- Outpatient physical rehabilitation facility
- Outpatient psychiatric facility
- Outpatient substance abuse treatment facility
- Pharmacy provider
- Psychiatric hospital
- Rehabilitation hospital
- Residential treatment facility
- Skilled nursing facility
- State-owned psychiatric hospital
- Substance abuse treatment facility
- Suite infusion therapy provider

Professional Providers:

- Audiologist
- Behavior specialist
- Certified registered nurse*
- Chiropractor
- Clinical laboratory
- 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 pathologist

- Speech therapist
- Teacher of hearing impaired

Suppliers and Contracting Suppliers (for the sale or lease of):

- Durable medical equipment
- Supplies
- Hearing aids
- Orthotics
- Prosthetics

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

Participating Providers

Participating providers have a contract with Highmark pertaining to payment for covered services and agree to accept Highmark's allowance as full payment for covered services.

Non-Participating Providers

Some providers do not have an agreement with Highmark and do not accept Highmark's allowance as payment-in-full.

Health Care Management

Medical Management

Your benefits are subject to review by Highmark, or its designated agent, as part of its health care management program. This program is to help ensure that you receive:

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

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

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

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

The health care management services provided by Highmark depend on your benefit program. They may include:

- precertification;
- pre-admission certification;
- admission certification;
- pre-procedure certification;
- pre-service certification;
- continued stay review;
- discharge planning; and
- case management.

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

Precertification

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

Precertification is required for the following services:

- Hospital admissions
- Inpatient rehabilitation admissions
- Psychiatric treatment
- Substance abuse

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

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

If you use a* Highmark *Participating Provider:

A* Highmark *participating provider WILL CONTACT* Highmark *FOR YOU in order to determine whether services are medically necessary and appropriate. You are not financially liable for services performed by a* Highmark *participating provider unless you elect to receive services that have been determined by* Highmark *to be not medically necessary and appropriate.

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

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

For an emergency or maternity-related admission, a Highmark participating provider is responsible for contacting Highmark following the admission, at which time the admission will be reviewed.

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

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

- **For Emergency or delivery-related Maternity Admissions:**
  YOU MUST CONTACT Highmark to certify any emergency or delivery-related maternity admission. For emergency or delivery-related maternity admissions, you should call Highmark within forty-eight (48) hours of the admission, or as soon as reasonably possible.

- **All Planned Admissions, Procedures and Services:**
  YOU MUST CONTACT Highmark PRIOR TO YOUR ADMISSION OR SERVICE. You should call Highmark 7 to 14 days prior to your planned admission or service.

IMPORTANT: **NON-PARTICIPATING FACILITY PROVIDERS OR NON-PARTICIPATING PROFESSIONAL PROVIDERS ARE NOT OBLIGATED TO CONTACT Highmark OR TO ABIDE BY ANY DETERMINATION OF MEDICAL NECESSITY AND APPROPRIATENESS RENDERED BY Highmark. A non-participating facility provider or non-participating professional provider may, therefore, bill you, the customer, for services that are not medically necessary and appropriate.**

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

- If an admission, procedure or service is found to be medically necessary and appropriate, your benefit program will pay up to the non-participating facility provider or non-participating professional provider allowance for covered services and your provider can bill you for any balance of the charges which are not covered under your benefit program.
- If the entire admission/service is determined not to be medically necessary and appropriate, you will be responsible for full payment.
- If a specific number of days or visits for an admission or service are approved and you continue to receive services beyond the approved number of days or visits, you will be responsible for full payment of those days or visits which are not approved.

* * *

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

Benefits after Provider Termination

If, at the time you are receiving medical care from a participating provider, notice is received from Highmark that Highmark intends to terminate or has terminated all or portions of the contract of that participating provider for reasons other than cause; or the contract of that participating provider will not be renewed, or the participation status of the participating 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.

During this time, any services authorized under this section will be covered in accordance with the same terms and conditions as applicable to a participating provider. Nothing in this section shall require Highmark to pay benefits for health care services that are not otherwise provided herein.

If you continue to receive care from this provider after this time period ends or if the participating provider has been terminated for cause and you continue to receive care from that provider, then you may be liable for any amounts billed by that provider which exceed the Highmark non-participating provider allowance.

Transition of Care

If you are receiving medical care from a non-participating 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.

Health Care Management Services

You are entitled to benefits for covered services, subject to exclusions, conditions and limitations, and subject to health care management services administered by Highmark.

When precertification is required, medical necessity and appropriateness for covered services will be determined prior to the service being rendered. However, when preadmission certification is not required, Highmark may determine that a service was not medically necessary and appropriate after the Service has been rendered.

Whenever a non-participating facility provider is used, you are encouraged to consult Highmark to help guide you through the care management program.

In the event of an inpatient admission following your receipt of emergency care services, you, your provider or a family member must notify Highmark within 48 hours of the admission, or as soon as reasonably possible. Once you are stabilized, Highmark may offer to transfer your care to a participating provider.

In-Area Services

Highmark only pays for covered services which it determines to be medically necessary and appropriate. However, not all medically necessary and appropriate services are covered. A participating facility provider in the Plan service area will accept Highmark's determination of medical necessity and appropriateness and not bill you for services which Highmark determines are not medically necessary and appropriate. A non-participating facility provider is not obligated to accept Highmark's determination and, therefore, may bill you for services determined not to be medically necessary and appropriate. You are solely responsible for payment of such services. You can avoid this responsibility by choosing a participating facility provider. If you

have a concern about a service being covered, you should contact Highmark prior to the service being rendered.

Out-of-Area Services
For covered services received out-of-area that are subject to precertification requirements, you are required to call the precertification toll-free number on the back of your identification card, prior to the receipt of the covered services, to determine what, if any, Precertification requirements you must follow.

Pre-Admission Certification

When you require hospital, psychiatric hospital, rehabilitation hospital, residential treatment facility, substance abuse treatment facility or skilled nursing facility care, benefits for covered services will be provided subject to the following:

Participating Facility Provider Services
In the event of a proposed inpatient stay for other than an emergency or delivery-related maternity admission to a participating facility provider, it shall be the responsibility of the participating facility provider to contact Highmark prior to the proposed admission to obtain precertification of the admission. In addition, if the Inpatient stay is to a participating facility provider located out-of-area, you must contact Highmark to confirm Highmark's determination of medical necessity and appropriateness prior to the admission.

If a participating facility provider DOES NOT CONTACT Highmark for precertification, as required under this contract, any claim for benefits will be reviewed for medical necessity and appropriateness. If the admission is determined to be medically necessary and appropriate, benefits will be paid in accordance with this Certificate.

If the inpatient stay is to a participating facility provider located out-of-area, it is important that you confirm Highmark's determination of medical necessity and appropriateness otherwise, if such admission is determined not to be medically necessary and appropriate, no benefits will be provided and you will be financially responsible for the full amount of the participating facility provider's charge. However, if the inpatient stay is to a participating facility provider located in-area, you will be held harmless and will not be financially responsible for payment for admissions which are determined not to be medically necessary and appropriate, except when Highmark provides prior written notice to you that any portion of the admission will not be covered. In such case, you will assume financial responsibility for such Inpatient charges.

Non-Participating Facility Provider Services
For a proposed inpatient stay for other than an emergency or delivery-related maternity condition to a non-participating facility provider, you are responsible for contacting Highmark prior to a proposed admission to determine the medical necessity and appropriateness of the proposed admission.

1. If precertification for a medically necessary and appropriate Inpatient admission has been obtained, benefits will be paid in accordance with this program. You will be financially responsible for the difference between the payment by Highmark and the non-participating facility provider's full charge.

2. 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 care that has been determined not to be medically necessary and appropriate.

3. If you DO NOT CONTACT Highmark for precertification, any claim for benefits will be reviewed for medical necessity and appropriateness. If the admission is determined to be medically necessary and appropriate, benefits will be paid in accordance with this program. You will be financially

responsible for the difference between the payment by Highmark and the full amount of the non-participating facility provider's charge.

If such admission is determined not to be medically necessary and appropriate, no benefits will be provided, and you will be financially responsible for the full amount of the non-participating facility provider's charge.

Admission Certification of Emergency/Delivery-Related Maternity Admissions

Participating Facility Provider Services

In the event of an emergency or delivery-related maternity admission to a hospital, psychiatric hospital, rehabilitation hospital, residential treatment facility, substance abuse treatment facility or skilled nursing facility, it shall be the responsibility of the participating facility provider to contact Highmark within forty-eight (48) hours, or as soon as reasonably possible, after such admission to obtain certification of the admission. In addition, if the admission is to a participating facility provider located out-of-area, you must contact Highmark to confirm Highmark's determination of medical necessity and appropriateness.

If a participating facility provider DOES NOT CONTACT Highmark for certification, any claim for benefits will be reviewed for medical necessity and appropriateness. If the admission is determined to be medically necessary and appropriate, benefits will be paid in accordance with this program.

If the admission is to a participating facility provider located out-of-area, it is important that you confirm Highmark's determination of medical necessity and appropriateness otherwise, if such admission is determined not to be medically necessary and appropriate, no benefits will be provided and you will be financially responsible for the full amount of the participating facility provider's charge. However, if the admission is to a participating facility provider located In-Area, you will be held harmless and will not be financially responsible for payment for admissions which are determined not to be medically necessary and appropriate, except when Highmark provides prior written notice to you that any portion of the admission will not be covered. In such case, you will assume financial responsibility for such inpatient charges.

Non-Participating Facility Provider Services

In the event of an emergency or delivery-related maternity admission to a hospital, psychiatric hospital, rehabilitation hospital, residential treatment facility, substance abuse treatment facility, or skilled nursing facility, which is a non-participating provider, you must contact Highmark within forty-eight (48) hours, or as soon as reasonably possible, after such admission to determine if the admission is medically necessary and appropriate.

1. If certification for a medically necessary and appropriate emergency or maternity-related admission has been obtained, and the admission has been determined to be medically necessary and appropriate, benefits will be paid in accordance with this program.

2. If a member elects to remain hospitalized after receiving written certification from Highmark that such level of care is no longer medically necessary and appropriate, you will be financially responsible for the full amount of the facility provider's charges from the date appearing on the written notification.

3. If you DO NOT CONTACT Highmark for certification, any claim for benefits will be reviewed for medical necessity and appropriateness. If the admission is determined to be medically necessary and appropriate, benefits will be paid in accordance with this program. You will be financially

responsible for the difference between the payment by this Certificate and the full amount of the non-participating facility provider's charge.

If such admission or services are determined not to be medically necessary and appropriate, no benefits will be provided, and you will be financially responsible for the full amount of the non-participating facility provider's charge.

Continued Stay Review

Participating and non-participating facility provider services

The medical progress of patients is reviewed to identify the continued medical necessity and appropriateness of the inpatient stay.

If you elect to continue to receive Inpatient services after receipt of written notification from Highmark that such level of care is no longer medically necessary and appropriate, you will be financially responsible for the full amount of the facility provider's charges from the date appearing on the written notification.

Discharge Planning

Participating and non-participating facility provider services

Discharge planning is a collaborative effort on the part of Highmark, the facility provider, the professional provider you and your family to assure that the patient receives safe and uninterrupted care when needed at the time of discharge.

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 Care and Case Management

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

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

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

Notification of Precertification and Other Pre-Service Claim Determinations

The precertification 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 or pre-service claims review, please call the toll-free Member Service telephone number located on the back of your ID card.

Precertification of covered services, 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:

a. 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. This time frame may be shortened 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. In that situation, 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.

b. 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.

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 that 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 the 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 Determination and Appeals subsection provided herein.

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 Procedures subsection in the How to File a Claim section of this benefit Certificate.

Selection of Providers

You have the option of choosing where and from whom to receive covered services. Covered facility provider services may be rendered by a participating facility provider or a non-participating facility provider. Covered services may also be rendered by a contracting supplier or a non-contracting supplier.

The allowance for covered services, when rendered by such facility providers and suppliers, is specified in the Provider/Supplier Reimbursement and Member Liability subsection of this document.

Wellness Programs

Highmark may offer 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 their continued eligibility, benefits, premiums, or cost-sharing obligations under this program.

At times, Highmark may offer rewards for your participation in certain of these programs. Any reward provided by Highmark in connection with these programs will not be offered or conditioned upon you satisfying a standard that is based on a health-related factor.

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.

General Information

Basic Plan

The "Basic Plan" refers to the regular hospital and medical-surgical benefits made available to you through your group. Dependents eligible for enrollment under the Basic Plan are also eligible under Major Medical.

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'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 on the day following the date 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.

Medicare

Retirees or Dependents

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

The deductible and coinsurance will not be covered if the services are not covered under your program, even if they are covered under Medicare.

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

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

Conversion

If your employer does not offer continuation of coverage, or if you do not wish to continue coverage through your employer's program, you may be able to enroll in an individual conversion program available from Highmark. Also, conversion is available to anyone who has elected continued coverage through your employer's program and the term of that coverage has expired. 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 contract, the individual and eligible dependents are eligible for coverage under a direct pay conversion agreement available from the Plan.The former domestic partner and eligible dependents 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 last month for which payment was made.

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 document, 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

The Blue Cross and Blue Shield symbols on your Highmark identification (ID) card are recognized throughout the country and around the world. 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)
- Precertification toll-free number (on back of card)

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 12 months 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 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 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. Your attending professional provider must include a signature on all bills as certification that services have been prescribed, except for doctor bills or hospital 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; and
- the total amount you owe.

In those instances where you are not required to submit a claim because, for example, the 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.

If you do not have access to a computer or prefer to continue receiving printed EOBs, please notify Member Service by calling the number on the back of your ID card.

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 226
Pittsburgh, PA 15222

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

If the informal dissatisfaction process is not successful and does not meet your needs, you have the right to have your objection reviewed by our Member Grievance and Appeals Department. For details about how this process works, please refer to the Complaints, Adverse benefit Determination and Appeals 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.

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.

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 authorize 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”).

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 a statement regarding the right of the member to pursue legal action.

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 a statement regarding the right of the Member to pursue legal action.

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 a statement regarding your right to pursue legal action.

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.

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

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

- Stress
- Personal nutrition
- Weight management
- Physical activities
- Insomnia
- Depression

Help with chronic conditions

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

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

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 homepage to take advantage of all kinds of programs and resources to help you understand your health status, through the 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 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.

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 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 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

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.

Ancillary Provider - A person or entity licensed where required and performing services within the scope of such licensure. Ancillary providers include:

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

Ancillary Providers that have an agreement, either directly or indirectly, with Highmark, Highmark Blue Shield or with any licensee of the Blue Cross Blue Shield Association located out-of-area pertaining to payment for covered services rendered to members shall be considered a participating provider when calculating the provider/supplier reimbursement and member liability.

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.

Basic Plan - The Blue Cross basic hospital benefits and the Blue Shield basic medical/surgical benefits and any additional Blue Cross or Blue Shield benefits, or any other group health care expense program providing similar hospital and/or medical/surgical benefits, other than as specified under the groups' program of benefits.

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.

Blue Cross - Any of the Blue Cross plans which are members of the Blue Cross Blue Shield Association.

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.

Chiropractor - A licensed chiropractor performing services within the scope of such licensure.

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

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

- **Urgent Care Claim** - A pre-service claim which, if decided within the time periods established for making non-urgent care pre-service claim decisions, could seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service. 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.

Clinic Visit - Routine outpatient medical treatment or care at a hospital. Such care must be received in the outpatient clinic portion of the hospital rather than the emergency room. The charge must be billed by the hospital to be considered under this benefit program.

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.

a. **Program Coinsurance** - a specified percentage amount of the plan allowance applied to all covered services for which the member is responsible.

b. **Benefit Coinsurance** - a specified percentage amount of the plan allowance applied to a specific covered service for which the member is responsible. The benefit coinsurance, if applicable, will supersede any program coinsurance.

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.

Contracting Supplier - A supplier who has an agreement, either directly or indirectly, with Highmark or with any licensee of the Blue Cross Blue Shield Association when the supplier is located out-of-area, pertaining to payment for the sale or lease of durable medical equipment, supplies, hearing aids, prosthetics, and orthotics to you.

Contracting Supplier Allowance - An amount agreed upon between the contracting supplier and Highmark, or the local licensee of the Blue Cross Blue Shield Association when the supplier is located out-of-area as payment in full for the sale or lease of durable medical equipment, supplies, prosthetics, and orthotics to you.

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

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

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.

a. Program deductible - a specified amount of expenses for covered services that must be incurred by you before Highmark will assume any liability for all or part of the remaining expenses for covered services.

b. Benefit deductible - a specified amount of expenses applied to a specific covered service for which you are responsible per benefit period.

The program deductible and any applicable benefit deductible must be satisfied before Highmark makes payment for the specific services to which the benefit deductible applies.

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 the Plan 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.

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.

Elective Abortion - Abortions which are not necessary to avert the death of the member or which are not performed in order to terminate a pregnancy caused by rape or incest.

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.

Transportation and other emergency services provided by an ambulance service shall constitute emergency ambulance services if the injury or the condition satisfies the criteria above.

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.

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:

Ambulance Service
Ambulatory Surgical Facility
Birthing Facility
Diabetes Prevention Provider
Freestanding Dialysis Facility
Freestanding Nuclear Magnetic Resonance Facility/Magnetic Resonance Imaging Facility
Home Health Care Agency
Home Infusion Therapy Provider
Hospice
Hospital
Independent Diagnostic Testing Facility (IDTF)
Outpatient Physical Rehabilitation Facility
Outpatient Psychiatric Facility
Outpatient Substance Abuse Treatment Facility
Pharmacy Provider
Psychiatric Hospital
Rehabilitation Hospital
Residential Treatment Facility
Skilled Nursing Facility
State-Owned Psychiatric Hospital
Sutstance Abuse Treatment Facility
Suite Infusion Therapy Provider

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 - The sum of the individual deductible amounts for a specified number of family members, who are covered under this program, and the point at which 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 on behalf of the members and the employer or representative of and remitting agent for the members who collects and remits premium payments on behalf of the members.

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.

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

Adams	Chester	Fulton	McKean	Snyder
Allegheny	Clarion	Greene	Mercer	Somerset
Armstrong	Clinton	Huntingdon	Mifflin	Sullivan
Beaver	Clearfield	Indiana	Monroe	Susquehanna
Bedford	Columbia	Jefferson	Montour	Tioga
Berks	Crawford	Juniata	Montgomery	Union
Blair	Cumberland	Lackawanna	Northampton	Venango
Bradford	Dauphin	Lancaster	Northumberland	Warren
Bucks	Delaware	Lawrence	Perry	Washington
Butler	Elk	Lebanon	Philadelphia	Wayne
Cambria	Erie	Lehigh	Pike	Westmoreland
Cameron	Fayette	Luzerne	Potter	Wyoming
Carbon	Forest	Lycoming	Schuylkill	York
Centre	Franklin			

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 Member's 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 a member receives 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.

Licensed Practical Nurse (LPN) - A nurse who has graduated from a formal practical nursing education program and is licensed by appropriate state authority.

Managed Care Program - Consists of any applicable pre-admission review, admission review, home health care review, mandatory second surgical opinion, individual case management, plan of treatment, or any other benefits management or utilization review provisions as defined in the groups' program of benefits.

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 for which Highmark may be liable for covered services within a set amount 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 a member during a benefit period will reduce the remaining number of days and/or visits available under that benefit, regardless of whether the member has satisfied the deductible. 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.

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

Medicare Non-Participating Provider - A professional provider or professional other provider eligible to provide services or supplies under Medicare Part B but who does not sign a participation agreement with Medicare and may or may not elect to accept assignment on each Medicare claim that is filed. A Medicare non-participating provider who does not accept assignment does not accept the Medicare reasonable charge for a certain service or supply as payment in full and may charge their patient more than the Medicare reasonable charge, unless otherwise prohibited by law.

Medicare Opt-Out Provider - A professional provider eligible to provide services or supplies under Medicare Part B but who has ‘opted out’ of Medicare such that they forego any payments from Medicare, to their patients or themselves, and enters into private contracts with Medicare beneficiaries to provide eligible services, and bills Medicare beneficiaries directly for services provided.

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

Member - 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 Provider - a provider that has an agreement, either directly or indirectly, with the Plan pertaining to payment as a network participant for covered services rendered to members.

Non-Contracting Ancillary Provider - An ancillary provider that does not have an agreement with Highmark located in-area, either directly or indirectly, or with any licensee of the Blue Cross Blue Shield Association when the ancillary provider is located out-of-area, pertaining to payment for covered services rendered to you. A non-contracting ancillary provider shall be considered a non-participating provider when calculating the provider/supplier reimbursement and your liability.

Non-Contracting Supplier - A supplier who does not have an agreement with Highmark, either directly or indirectly, or with any licensee of the Blue Cross Blue Shield Association when the supplier is located out-of-area, pertaining to payment for the sale or lease of durable medical equipment, supplies, hearing aids, prosthetics and orthotics to you.

Non-Participating Facility Provider - A facility provider, licensed where required and performing within the scope of its license, that does not have an agreement with Highmark located in-area, either directly or indirectly, or with any licensee of the Blue Cross Blue Shield Association located out-of-area operating as a hospital plan corporation pertaining to payment for covered services rendered to you.

Non-Participating Professional Provider - A professional provider licensed where required and performing within the scope of such licensure, who does not have an agreement with Highmark located in-area, either directly or indirectly, or with any licensee of the Blue Cross Blue Shield Association when the professional provider or professional other provider is located out-of-area, pertaining to payment for covered services rendered to you.

Non-Participating Providers - All non-participating facility providers, non-participating professional providers and non-contracting suppliers, collectively.

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.

Optometrist - A licensed optometrist performing services within the scope of such licensure.

Orthotics - A rigid or semi-rigid appliance (i.e., brace or support) used for the purpose of supporting a weak or deformed body part or for restricting or eliminating motion in a diseased or injured part of the body.

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

Out-of-Pocket Limit - A specified dollar amount of coinsurance incurred by you for covered services in a benefit period. It does not include the deductible amount or charges in excess of the plan allowance. When the out-of-pocket limit is reached, the level of benefits is increases as specified in the Summary of Benefits.

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

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

Participating Facility Provider - A facility provider, licensed where required and performing within the scope of its license, that has an agreement with Highmark, either directly or indirectly, or any licensee of the Blue Cross Blue Shield Association located out-of-area pertaining to payment for covered services rendered to you.

Participating Professional Provider - A professional provider or professional other provider, licensed where required and performing within the scope such license, who has an agreement with Highmark, either directly or indirectly, or with any licensee of the Blue Cross Blue Shield Association located out-of-area pertaining to payment for covered services rendered to you.

Participating Providers - All participating facility providers and contracting suppliers, collectively.

Participating Providers - All ancillary providers that have an agreement, either directly or indirectly with Highmark, pertaining to covered services rendered to a member, participating facility providers, participating professional providers and contracting suppliers, collectively.

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 Blue Shield, 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. 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.

In the case of a non-participating provider located in-area, the plan allowance shall be based on an adjusted contractual allowance for like services rendered by a participating provider in the same geographic region, or as required by law.

In the case of a non-participating 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 Program Works section of this Certificate.

The plan allowance for a non-participating facility provider that is a state-owned psychiatric hospital is what is required by law.

Plan of Treatment - A managed care program through which you may obtain additional physical therapy and outpatient medical care visits if it has been determined by Highmark or its designated agent to meet the criteria as outlined herein.

Podiatrist - A licensed podiatrist performing services within the scope of such licensure.

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

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 Other Provider - A person or entity other than a facility provider or professional provider who is licensed, where required, to render covered services as prescribed by a professional provider within the scope of such licensure or under the supervision of a professional provider within the scope of such licensure. Professional other providers include:

Behavioral Specialist
Licensed Practical Nurse
Respiratory Therapist
Registered Nurse

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

Audiologist
Behavior Specialist
Certified Registered Nurse
Chiropractor
Clinical Laboratory
Clinical Social Worker
Dentist
Dietitian-Nutritionists
Marriage and Family Therapist
Nurse-Midwife
Occupational Therapist
Optometrist
Physical Therapist
Physician
Podiatrist
Professional Counselor
Psychologist
Speech-Language Pathologist
Teacher of the Hearing Impaired

Prosthetics - An artificial body part which replaces all or part of a body organ or which replaces all or part of the function of a permanently inoperative or malfunctioning body part.

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

a. **Participating Provider** - a provider that has an agreement with Highmark, either directly or indirectly, pertaining to payment for covered services rendered to you.

b. **Non-Participating Provider** - a provider that is not a participating provider.

c. **Medicare Participating Provider** - a provider which has been certified by the Department of Health and Human Services of the United States for participation in the Medicare program.

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. Skilled rehabilitation services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Skilled rehabilitation 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.

Residential Care - Institutional care, often following inpatient hospitalization in a facility provider, which is intended to provide a structured living environment or simulate a structured school or work environment in a therapeutic setting provided or supervised by medical professionals.

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 a member 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.

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.

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 - Any use of alcohol or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

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

b. 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.

c. 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 in accordance with accepted medical practice.

d. 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 role.

e. 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.

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

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

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

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.

Your 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.

Pennsylvania Judiciary Classic Blue Traditional Benefit Summary

Group #s 028623-00, -01, -03, -04

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.

Benefit	Hospital	Medical/Surgical	Major Medical
General Provisions			
Effective	January 1, 2024		
Benefit Period (1)	Calendar Year		
Deductible (per benefit period) Individual Family	 None None	 None None	 $100 $300
Plan Pays – payment based on the plan allowance	100% (Non-participating provider - 100% of charge for emergency services)	100%	80% after deductible (Non-participating provider - 80% RBM after deductible)
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family (Non-Aggregate)	 None None	 None None	 $480 $1,440
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family (Non-Aggregate)		 $580 $1,740	
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits	Not Covered	Not Covered	80% after deductible
Primary Care Provider Office Visits	Not Covered	Not Covered	80% after deductible
Specialist Office & Virtual Visits	Not Covered	Not Covered	80% after deductible
Virtual Visit Originating Site Fee	Not Covered	Not Covered	80% after deductible
Urgent Care Center Visits	Not Covered	Not Covered	80% after deductible
Telemedicine Services (3)	Not Covered	Not Covered	80% after deductible
Preventive Care(4)			
Routine Adult Physical exams	 100%	 100%	 100% no deductible
Adult immunizations	100%	100%	100% no deductible
Colorectal cancer screening	100%	100%	100% no deductible
Routine gynecological exams, including a Pap test	100%	100%	100% no deductible
Breast Cancer Screenings (annual routine and supplemental)	100%	100%	100% no deductible
BRCA-Related Genetic Counseling and Genetic Testing	100%	100%	100% no deductible
Diagnostic services and procedures	100%	100%	100% no deductible
Routine Foot Care - *Treatment of bunions, corns, calluses, and keratosis, cutting, trimming or removal of nails, hygienic and preventative self-care, treatment of fallen arches includes foot orthotic devices, flat or weak feet, chronic foot strain or symptomatic complaints of the feet.*	100%	100%	100% no deductible
Prostate Cancer Screening (Males Age 19 and over) - One Examination per Benefit Period	100%	100%	100% no deductible
Routine Pediatric Physical exams	 100%	 100%	 100% no deductible
Pediatric immunizations	100%	100%	100% no deductible
Diagnostic services and procedures	100%	100%	100% no deductible
Emergency Services			
Emergency Room Services	100% (Non-participating 100% of charge)	100%	80% after deductible
Ambulance – Emergency (ground/water/air)	100%	Not Covered	100% of charge for emergency transport
Ambulance – Non-Emergency (ground/water/air)	100%	Not Covered	80% after deductible
Hospital and Medical/Surgical Expenses (including Maternity)			
Hospital Inpatient	100%	100%	80% after deductible (private room $10 maximum per day)
Hospital Outpatient	100%	Not Covered	80% after deductible
Maternity (non-preventive facility & professional services) Includes Dependent Daughter	100%	100%	80% after deductible
Medical Care (except office visits) Includes Inpatient Visits and Consultations	Not Applicable	100%	80% after deductible
Surgical Expenses (except office visits) Includes Assistant Surgery, Anesthesia, Sterilization, Reversal Procedures and Neonatal Circumcision	Not Applicable	100%	80% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Therapy and Rehabilitation Services			
Physical Medicine Outpatient	100% 40 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	100% 40 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	80% after deductible 20 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse
Respiratory Therapy	100%	Not Covered	80% after deductible
Spinal Manipulations	Not Covered	100% 30 visits/benefit period	80% after deductible 30 visits/benefit period
Speech & Occupational Therapy Outpatient	100% 12 visits per therapy/benefit period- limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	Not Covered	80% after deductible 12 visits per therapy/benefit period- limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse
Other Therapy Services - Cardiac Rehabilitation, Chemotherapy, Radiation Therapy, Dialysis and Infusion Therapy	100% (Cardiac Rehab: Not Covered)	100% (Cardiac Rehab & Infusion Therapy: Not Covered)	80% after deductible
Mental Health/Substance Abuse			
Inpatient Mental Health	100%	100%	80% after deductible
Inpatient Detoxification/Rehabilitation	100%	100%	Not Covered
Outpatient Mental Health	Not Covered	Not Covered	100% no deductible
Outpatient Substance Abuse	100%	Not Covered	80% after deductible
Other Services			
Allergy Extracts and Injections	Not Covered	Not Covered	80% after deductible
Autism Spectrum Disorders including Applied Behavior Analysis (5)	100%	100%	80% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered	Not Covered
Contraceptives Devices, Implants and Injectables	Not Covered	Not Covered	100% no deductible
Dental Services Related to Accidental Injury	Not Covered	Not Covered	80% after deductible
Diabetic Supplies	Not Covered	Not Covered	100% of charge no deductible
Diabetes Treatment	100%	100%	80% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	100%	80% after deductible
All Other Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	Not Covered	Not Covered	80% after deductible
Elective Abortions (includes dependent daughters)	100%	100%	80% after deductible
	Only for cases of rape, incest or to avert the mother's death		
Hearing Care Services – includes evaluation, fitting, hearing aids, repair and maintenance of the hearing aid	Not Covered	100% up to $1,500 per ear maximum every 36 months	Not Covered
Home Health Care (Excludes Respite Care)	100% 60 visits per 90 day period	Not Covered	80% after deductible
Hospice (Includes Respite Care)	100%	Not Covered	Not Covered
Infertility Counseling, Testing and Treatment (6)	100%	100%	80% after deductible
Oral Surgery	100%	100%	80% after deductible
Private Duty Nursing	Not Covered	Not Covered	80% after deductible Unlimited hours/benefit period
Skilled Nursing Facility Care	100% 100 days/benefit period	100%	80% after deductible
Transplant Services	100%	100%	80% after deductible
Precertification Requirements (7)	Yes	No	No

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

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

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

(3) 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 with Enhancements (Women's Health Preventive Schedule may apply).

(5) 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.

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

(7) If you receive services from an out-of-area provider or a provider who does not participate with the local Blue Cross and/or Blue Shield plan, you must contact Highmark Utilization Management prior to a planned inpatient admission, 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.

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

HIGHMARK INC., d/b/a HIGHMARK BLUE SHIELD
1800 Center Street,
Camp Hill, Pennsylvania 17011

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

Specifically Held By
Pennsylvania Judiciary
and Only Applicable to
Group Contract Numbers:
028623-00, 028623-01, 028623-03, 028623-04

Providing for access to Fitness and Wellness Programs

This Amendatory Rider is issued to be attached to and form part of the Health Care Certificates for the groups identified as PPOBlue ("Certificate").

Notwithstanding any provision to the contrary, said Certificate is modified as indicated:

I. Add the following new subsection to the **General Information** Section:

"FITNESS AND WELLNESS PROGRAMS
The Plan will identify and arrange for Members to have access to Participating Fitness Centers where Members are able to exercise on-site and receive exercise instruction. Depending on the location selected by the Member, additional fitness classes and/or other fitness center amenities may also be available to the Member. From time to time, the Plan or its designee may provide information to Members concerning online wellness and fitness resources or opportunities to voluntarily attend classes, programs and other events designed to promote the Member's health, injury prevention and other healthy daily living habits."

II. Add the following new definition to the **Terms You Should Know** Section:

"**PARTICIPATING FITNESS CENTER** - a gym or other facility designed for the purpose of providing individuals with the opportunity to exercise for the purpose of improving and maintaining personal fitness that has an agreement, either directly or indirectly, with the Plan pertaining to the payment for fitness programs available to Members under this Contract."

Except as stated in this Amendatory Rider, the Certificate remains unchanged.

This Amendatory Rider is effective from 07/01/2024.

HIGHMARK INC., d/b/a
HIGHMARK BLUE SHIELD,