

# Welfare Benefit Plan

## Summary Plan Description

WRAP Plan

eResearch Technology, Inc.  
Health and Welfare Plans

# eResearch Technology, Inc. Health and Welfare Plans

## *Summary Plan Description*

Your Employer maintains the eResearch Technology, Inc. Health and Welfare Plans (“the Plan”) for the exclusive benefit of, and to provide health and welfare benefits to its eligible employees and their eligible dependents.

This Summary Plan Description (SPD) summarizes the important features of the Plan, including your benefits and obligations under the Plan. Read this SPD carefully so that you understand the provisions of the Plan and the benefits you will receive. These benefits are provided under various insurance contracts, as well as through self-insured plans funded by the general assets of your Employer. The Benefit Documents for each Benefit are part of this SPD only to the extent it provides detailed descriptions regarding each Benefits’ eligibility rules, benefit descriptions, claims and appeal procedures, or other substantive provisions. You should keep this SPD with the Benefit Documents provided to you upon enrollment in each Benefit. You should also share this SPD with any family members you have elected to cover under the Plan.

The Plan is required to comply with certain federal laws and regulations that may change with the passage of new or revised laws. Your Employer reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time. Any amendment, termination or other action by your Employer will be done in accordance with its normal operating procedures and any applicable laws.

Certain terms in the SPD have special meaning and are capitalized throughout the SPD. Such terms are defined in more detail in the DEFINITIONS section of the SPD. If any information in this SPD conflicts with the terms of the Plan document, the terms of the Plan document—not this SPD—will apply.

### **Plan Contacts:**

Below are the contacts you can reach out to for assistance regarding the Plan:

#### **Contact for Participant Questions about the Plan:**

Darren Kozinski  
Benefits Manager  
eResearch Technology, Inc.  
1818 Market Street Suite 2600  
Philadelphia, PA 19103  
215-972-0420  
[darren.kozinski@clario.com](mailto:darren.kozinski@clario.com)

#### **Contact for COBRA Coverage Notifications:**

Darren Kozinski  
Benefits Manager  
eResearch Technology, Inc.  
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## EMPLOYER INFORMATION

### Who established the Plan?

Your Employer who adopted the Plan is:	eResearch Technology, Inc.
Business Address:	1818 Market Street, Suite 2600 Philadelphia, PA 19103
Business Telephone Number:	215-972-0420
Federal Tax Identification Number:	22-3264604

Related Employers have adopted the Plan at the consent of eResearch Technology, Inc. to provide Benefits to their eligible employees and their eligible dependents. You may obtain additional details from your Human Resources representative.

## PLAN INFORMATION

### Establishment of New Plan

The official Name of the Plan is:	eResearch Technology, Inc. Health and Welfare Plans
Plan Number:	503
Plan Year:	January 1 through December 31 of the same calendar year.
The effective date of the Plan is	<u>January 1, 2024.</u>

## ELIGIBILITY

### Q1. Who is eligible for Benefits?

You are eligible to participate in the Plan under certain Benefits if you are a common-law employee of your Employer and are a:

- Full-time employee
- Part-time employee

and meet certain criteria, as provided in Appendix B.

### Q2. Are my Dependents eligible to be covered by the Plan?

Yes, Dependents can be covered by the Plan under certain Benefits.

If you elect coverage for your Dependent Child(ren), their coverage generally will end when they reach a Benefit's limiting age (e.g., age 26 for the Major Medical Option).

### Q3. How do I enroll in Benefits?

Once you meet the eligibility criteria, described in Appendix B you may enroll in Benefits.

To enroll, follow the procedures below:

#### **Initial Enrollment**

If you are eligible to participate in the Plan for the first time, you must submit your elections and any supporting documents, if applicable, in a timely manner in accordance with your Employer's enrollment procedures. If you miss your enrollment period, you may have to wait until the next open enrollment period or experience a qualifying life event to enroll in the Plan.

#### **Annual Open Enrollment**

You may change your coverage (or elect coverage in the Plan if you did not elect coverage when first eligible) during each annual open enrollment period. You should review the enrollment materials provided to you and follow the instructions for enrolling or re-enrolling, as applicable. If you do not properly complete enrollment materials on a timely basis, your elections for the prior Plan Year may cease or remain the same for the subsequent Plan Year.

#### **Dependents**

Coverage of Dependents may be contingent on receiving required documents, as requested by the Plan Administrator. If applicable, and you fail to provide the required documents in a timely manner and you enroll a Dependent in coverage, the Dependent may be removed retroactively to the first date of eligibility.

### Q4. Can I change Benefits throughout the year?

Maybe. In order to pay your portion of Health Care Plan premiums on a pre-tax basis, the IRS limits election changes to the annual enrollment period UNLESS you experience one of the qualifying life events defined by the IRS, such as marriage, divorce, job change, birth, or adoption of a child, or when a dependent child reaches a Plan Component's limiting age. If you experience a qualifying life event you must notify the Plan Administrator within a specified timeframe following the event.

Any election made on an after-tax basis may be changed in accordance with the Employer's policy or applicable Plan Component limitations. In addition, HIPAA special enrollment rights allow you and your eligible Dependents to enroll in a Major Medical Plan Component if 1) you or your Dependents experience a loss of coverage under another group health plan, health insurance, Medicaid, or CHIP; 2) you gain a new Dependent through marriage, birth, adoption, or placement for adoption; or 3) you or your Dependents become eligible for premium assistance through a state Medicaid or CHIP program.

**Q5. When does coverage begin and end?**

Coverage begins on the date you meet any required waiting period and, depending on the Benefit, generally ends on the date or end of the month in which you cease to satisfy the eligibility requirements. See Appendix B for additional information.

For example, coverage may end due to divorce, death, change in employment status (including termination), failure to pay Contributions, a Dependent Child reaching a Plan Component's limiting age, or a Plan amendment or termination. If you experience a divorce, you will not lose coverage, but your spouse will lose coverage. If your Dependent Child reaches a Plan Component's limiting age, you will not lose coverage, but your Child will lose coverage. If you experience a change in employment status that causes a change in Plan eligibility, you and your Dependents may lose coverage.

**Q6. What should I do if an Eligible Dependent loses eligibility status?**

You are required, under COBRA rules, to notify the Plan Administrator in writing, **within 60 days** of an Eligible Dependent's change in status. If you fail to notify the Plan Administrator when a Dependent becomes ineligible for coverage, you may be required to reimburse the Plan for costs incurred by the Plan and the Plan Administrator may take other action, as permitted by the Plan.

Please note that coverage for that Dependent will end on the date of the event, or the end of the month containing the event, as provided in the Benefit Documents. For example, if you cover a spouse as an Eligible Dependent in a Health Care Plan, the spouse's coverage will end on the date of the divorce, even if you notify the Plan much later.

## BENEFITS AND FUNDING

**Q1. What is the purpose of the Plan?**

The Plan is a welfare benefit plan that is intended to provide you with a range of Benefits to promote your health and welfare.

**Q2. What is the Plan's funding method?**

The Plan is funded through

- Insurance contracts.
- Self-insured arrangements paid through the general assets of the Employer.

**Q3. What Benefits are provided by the Plan?**

The Plan provides the Benefits listed on Appendix A to this SPD.

**Q4. What is the source of Contributions?**

Depending on the Plan Component, premium contributions are either paid by:

- Employer Contributions only;
- Employee Contributions only; and/or,
- Both Employer and Employee Contributions.

**Q5. How do I pay for Benefits?**

Depending on the Benefit, the cost of coverage may be deducted from your pay on either a pre-tax basis or a post-tax basis.

It is important to note that if you intend to enroll your Domestic Partner or civil union partner, the cost of their coverage may be added to your wages as taxable income. Consult with your tax or legal advisor for further guidance.

## COORDINATION OF BENEFITS

**Q6. What happens if I am covered by two or more health plans?**

Coordination of benefits is governed by the Benefit Document applicable to each Benefit. In general, the Plan that covers you as an employee will be the primary payor with the other health plan covering any additional costs that may remain after the primary plan's benefits have been exhausted.

If your Dependent Children are covered by this Plan and your spouse's health plan, the health plans generally will perform coordination of benefits using the "birthday rule." This means if your birthday month occurs earlier in a calendar year than your spouse's or partner's birthday month, this Plan will be the primary payor.

**Q7. What if the other health plan is Medicare?**

If the other health plan is Medicare, this Plan will be the primary payer (i.e., pay before the other coverage) unless you have chosen Medicare as your primary plan or unless otherwise required by law.

## Q8. Will the Plan be primary or secondary payer if I am covered by Medicare?

If you are covered by Medicare, the Plan intends to pay either primary or secondary as follows.

- If you are 65 or older and your Employer has less than 20 employees, Medicare will be the primary payer.
- If you are 65 or older and your Employer has more than 20 employees, Medicare is the secondary payer.
- If you are disabled and your Employer has 100 or more employees, Medicare is the secondary payer.
- If you have End Stage Renal Disease (ESRD) and you are in the first 30 months of Medicare coverage, Medicare is the secondary payer during the 30-month coordination period.
- If you have ESRD and are covered by COBRA continuation coverage and you are in your first 30 months of Medicare coverage, Medicare is the secondary payer during the 30-month coordination period.
- If you are 65 or older and are covered by Medicare and COBRA continuation coverage, Medicare is the primary payer and COBRA is the secondary payer.
- If you are disabled and covered by Medicare and COBRA, Medicare is the primary payer and COBRA is the secondary payer.

## CLAIMS AND APPEALS

### Q1. What Claims and appeal procedures apply?

You must follow the Claims submission rules and Claims appeal procedures contained in the applicable Benefit Document. Notwithstanding the foregoing, in no event shall the Claims submission rules and Claims appeal procedures contained in the applicable Benefit Document provide fewer rights to you than the rights prescribed in Labor Regulation section 2560.503-1.

If the applicable Benefit Document does not include Claims and appeals procedures, or if such document includes procedures that do not satisfy the minimum requirements of ERISA, then the Claims and/or appeals will be determined in accordance with this Section and Section Five of the Plan document.

### Q2. How do I appeal a Claim or benefit determination?

If you disagree with a benefit or Claims determination, you must submit a written request to the Claims Administrator. Please see Appendix A for contact information, including the address of the Claims Administrator for the Benefit.

## HEALTH CARE PLANS

### Q3. What types of Health Care Claims can I appeal?

You can appeal any Claim for benefits, which includes a request for coverage determination, a pre-authorization or approval of a Plan benefit, or a utilization review determination in accordance with the terms of the Plan. Depending on the type of Claim, your Claim will fall into one of the following categories:

- **Urgent Care Claims** – Claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or that could cause severe pain.
- **Pre-Service Claims** – Claims that require notification or approval prior to receiving medical care.
- **Concurrent Care Claims** – Claims that were previously approved for treatment.
- **Post-Service Claims** – Claims that are filed for payment of benefits after medical care has been received.

### Q4. After I submit a Claim, when should I expect a response?

The timeframe for a Plan Component to provide notice of a Claim determination varies based on the type of Claim filed:

CLAIM TYPE	DEADLINE FOR MAKING INITIAL DETERMINATION
Urgent care	As soon as possible, and no later than <b>72 hours</b> after receiving the Claim
Pre-service	Within a reasonable time period, and no later than <b>15 days</b> after receiving the Claim*
Post-service	Within a reasonable time period, and no later than <b>30 days</b> after receiving the Claim*

For concurrent medical care Claims, if the treatment was previously approved, the request to extend the treatment will be processed within 24 hours of the receipt of the request if the request is made 24 hours prior to the end of the approved treatment. However, if the request is not made at least 24 hours prior to the end of the approved treatment, the request will be processed as an urgent care Claim.

#### **Extension of Claim Determination Deadline**

- **Urgent Care Claims.** If the Plan Component needs more information, it must tell the Claimant within 24 hours and give the Claimant at least 48 hours to respond. Then the plan must decide the Claim within 48 hours after receiving the missing information or within 48 hours of the deadline for the Claimant to supply the missing information, whichever comes first.
- **Pre-Service Claims and Post-Service Claims.** The Plan Component may extend the time period up to 15 days more if, for reasons beyond its control, the plan cannot make the decision within the first deadline. If the Plan Component requests more information, the Claimant has at least 45 days to supply it. The Plan Component then must decide the Claim within 15 days after receiving the additional information or within 15 days of the deadline for the Claimant to supply the additional information, whichever comes first.

**Q5. If my Health Care Claim is denied, will I receive a notification?**

Yes, if your Claim is denied in full or in part, you will receive a written notice of adverse benefit determination. The notice will contain the following information:

- Information sufficient to identify the Claim.
- The specific reason for the denial.
- Reference to the specific Plan provisions on which the denial was based.
- A description of any additional material or information necessary for you to perfect the Claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under ERISA Section 502 following a denial on review, if applicable.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to you upon request.
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either a) an explanation of the scientific or clinical judgment for the determination, or b) a statement that such explanation will be provided free of charge, upon request.
- If the denial involves an urgent care Claim, the notice will also include a description of the expedited review process applicable to such Claims.

**Q6. In addition to providing the notice of adverse benefit determination, is there anything else the Claims Administrator must do if a Health Care Claim is denied?**

Yes, the Claims Administrator is required to take the following steps:

- Ensure that any notice includes information sufficient to identify the Claim, including the date of service, the health care provider, and the amount of the Claim. Moreover, the Plan must provide notice of the opportunity to request the diagnosis code, the treatment code, and its corresponding meaning;
- Ensure the notice includes the denial code and its corresponding meaning and the standard used to deny the Claim;
- Provide a description of the internal appeal and external review processes available under the Plan;
- Provide a description of how to initiate an appeal; and
- Disclose the availability of any applicable office of health insurance consumer assistance or ombudsman available to assist with internal Claims and appeals or external review processes, including contact information.

**Q7. If my Health Care Claim is denied, what should I do?**

When you receive a denial, you will have **180 days** following receipt of the notification to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The Claims Administrator will review the appeal upon receipt and will follow the terms of the Plan. An appeal decision will be made within the time frame provided by the Plan and will be reviewed even if information or documents are missing from the appeal.

A document, record, or other information is relevant to a Claim if it

- was relied upon in making the Claim determination;
- was submitted, considered, or generated in the course of making the Claim determination, even if it was not used to make the Claim determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Claim reviews follow the terms of the Plan has been applied consistently; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied Claim.

The review will take into account all comments, documents, records, and other information submitted by you relating to the Claim, even if the information was not submitted or considered in the initial Claim review. The review will not rely on the initial denial and will be performed by a fiduciary of the Plan who is neither the individual who denied the Claim nor a direct report of that individual.

**Q8. Is there an expedited process for an urgent care Claim?**

Yes, you are entitled to an expedited review process that permits you to submit your request orally or in writing and that permits all necessary information to be shared by telephone, facsimile, or other similarly expeditious method.

## Q9. If I appeal a Claim determination, what happens next?

### **First Appeal**

Once you have submitted an appeal, you will receive a written response, as follows:

- **Urgent Care Claim.** As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal by the Plan Component.
- **Pre-Service Claim.** Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal by the Plan Component.
- **Post-Service Claim.** Within a reasonable period of time, but not later than 60 days after receipt of the appeal by the Plan Component.
- **Concurrent Care Claim.** Before treatment ends or is reduced, where the adverse determination is the decision to reduce or terminate concurrent care early, or, if the Component Plan denies your request to extend treatment, within the appropriate time period based upon the type of Claim.

### **Second Appeal**

If specified in the Benefit Documents for each Plan Component or in documentation given to you by the Claims Administrator, you may be entitled to a second appeal following an adverse determination of your initial appeal. In such case, the second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal.

The appeal decision with respect to any second appeal will be made according to the following schedule:

- **Urgent Care Claim.** As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- **Pre-Service Claim.** Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- **Post-Service Claim.** Within a reasonable period of time, but not later than 30 days after receipt of the appeal.
- **Concurrent Claim.** The response will be made in the appropriate time period based upon the type of Claim: Pre-Service Urgent, Pre-Service Non-urgent or Post-Service.

## Q10. Will I receive a written notification of a claim determination on review (i.e., an appeal)?

Yes, you will receive a final notice of adverse benefit determination. The notice will include the following information:

- Information sufficient to identify the Claim.
- The specific reason for the denial.
- Reference to the specific Plan provisions on which the denial was based.
- A description of any additional material or information necessary for you to perfect the Claim and an explanation of why the material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to the procedures. This will include a statement of your right to bring a civil action under ERISA Section 502 following a denial on review, if applicable.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to you upon request.
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either (i) an explanation of the scientific or clinical judgment for the determination, or (ii) a statement that such explanation will be provided free of charge, upon request.
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

## Q11. If my appeal is denied, do I have any other rights?

Yes, you may have the right to request an independent, external review. Your external review will be conducted by an independent review organization not affiliated with the Plan. This independent review organization may overturn the Plan's decision, and the independent review organization's decision is binding on the Plan. Your appeal denial notice will include more information about your right to file a request for an external review and contact information. You must file your request for external review within four months of receiving your final internal appeal determination. Filing a request for external review will not affect your ability to bring a legal claim in court. When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

## DISABILITY PLANS

### Q12. When will I receive a Disability Claim determination?

You will receive a written or electronic notification of the Plan's Claim decision within 45 days.

### Q13. Will the Disability Claim determination period ever be extended?

Yes, the Plan may extend the review period twice, each time by 30 days, if the extension is necessary due to circumstances beyond the control of the Plan. If an extension is necessary, the Plan will notify you in writing.

### Q14. What if I did not submit all the necessary information to process my Disability Claim?

The Plan will send you a written notice and will provide a description of the required documents or information. You will then have 45 days to submit the additional information to the Plan.

### Q15. Will I receive a notice if my Disability Claim is denied?

Yes, you will receive a notice that will contain the following information:

- Information sufficient to identify the Claim.
- The specific reason for the denial.
- Reference to the specific Plan provisions on which the denial was based.
- A description of any additional material or information necessary for you to perfect the Claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under ERISA Section 502 following a denial on review, if applicable.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to you upon request.

### Q16. If my Disability Claim is denied, what should I do?

When you receive a denial, you will have **180 days** following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

### Q17. If I appeal a Disability Claim determination, what happens next?

Once you have submitted an appeal, you will receive a written response within 45 days after receipt of your request to review a Claim determination. The 45-day period may be extended by 45 days if the Plan determines that special circumstances require an extension. If an extension is required, you will receive a written notification.

## NON-HEALTH/NON-DISABILITY PLANS

### Q18. What if a Plan Component is not a Health Care or Disability Component?

Generally, any Plan Component that is not a Health Care or Disability Component will review a Claim within 90 days and provide written notification of its decision. The 90-day period may be extended by 90-days in certain circumstances. If you disagree with the Claim decision, you may file an appeal within 60 days of your receipt of the written notice of denial of a Claim. The Plan administrator will then render a decision within 60 days after receipt of the request for review. In special circumstances, the Plan may make a determination within 120 days after the receipt of your request for review. If such an extension is required, you will be notified in writing.

## LEGAL ACTIONS

### Q19. What should I do if I want to pursue a legal action against the Plan?

These claim and appeals procedures must be exhausted for all claims before you can bring any legal action. If you do not make a claim or file an appeal in the manner and within the appropriate time period discussed in this SPD or, if applicable, the Benefit Documents of a Plan Component, you may lose the right to file suit in state or federal court in the state of Pennsylvania.

The individual named below can be served with legal papers regarding the Plan.

eResearch Technology, Inc.  
Attn: General Counsel

Service of legal process also may be directed to the Plan Administrator.

## Q20. What is the time limit to bring a lawsuit?

Please refer to the applicable Benefit Document for information about the time period applicable to your Claim. If the Benefit Document does not contain any such provision, as permitted by law, you must bring a lawsuit within the following time frames:

- In the case of a Plan Component that is self-insured by your Employer, you must bring any lawsuit seeking benefits within the shorter of (i) one year from the date of the final appeal denial under the Plan's claims and appeals procedures or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; claims against nonfiduciaries; and claims for breach of fiduciary duty that are not governed by Section 413 of ERISA) must be brought within one year of the act or omission giving rise to the claim.
- In the case of a fully-insured Plan Component, the time period for bringing any lawsuit against the insurance company issuing such Plan Component or the Plan will be determined by the terms of the applicable Plan Component. If the Plan Component does not set forth such a time period, you must bring any lawsuit seeking benefits within the shorter of (i) one year from the date of the final appeal denial under the Plan's claims and appeals procedures or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits must be brought within one year of the act or omission giving rise to the claim.

## MISCELLANEOUS

### LEAVE OF ABSENCE

#### Q1. What happens to my Benefits if I take a leave of absence?

Depending on the leave policies and procedures adopted by your Employer, you may be able to continue certain Benefits while on an approved leave of absence. If you are eligible to continue certain Benefits, you may be required to complete certain forms or documents and pay towards the cost of coverage.

#### Q2. Is my Employer required to comply with the Family and Medical Leave Act (FMLA)?

Yes, your Employer is required to comply with FMLA. The Plan Administrator must continue Health Care Plan coverage while you are on leave protected by the FMLA.

#### Q3. What happens if my leave is protected by FMLA?

If your leave is protected under FMLA, you may continue your group health care coverage under the Plan (e.g. Medical, Dental, Vision, or Health FSA) for you and any covered Dependents as long as you continue to pay your portion of the cost for your Benefits during the leave, or if allowed, after the leave.

Your Employer may offer the following options for payment of Contributions:

- **Paid Leave** – Contributions will be automatically deducted from payroll.
- **Unpaid Leave** – You will be required to submit payment to your Employer for any required Contributions. If you do not pay Contributions in a timely manner, you will be provided a notice of cancellation and will have **15 days** from the date of the notice to make the required payment. If you fail to make the payment in the permitted time, your coverage will be cancelled. However, upon return to work, your coverage will be reinstated.

Any coverage that are terminated during your FMLA leave will be reinstated upon your return from leave without any evidence of good health or newly imposed waiting period so long as you make the required contributions, including any catch-up payments attributable to the period prior to your return from leave, if applicable.

#### Q4. What happens if I experience a "change in status" while on FMLA leave?

If you experience a "change in status" (e.g., change in marital status, number of Dependents, residency, or employment status), you may change your coverage election as if you were actively employed.

#### Q5. What happens if I do not return to work following my FMLA leave?

If you do not return to work following your FMLA leave, you may be entitled to COBRA continuation coverage, if applicable. You may also be required to reimburse your Employer for costs of coverage provided to you while you were on unpaid FMLA leave.

#### Q6. What happens if my leave is protected under USERRA?

If you are going into or returning from military service, your Benefits may be protected under USERRA. Under USERRA, you may elect to continue coverage under the Plan for up to 24 months. To continue coverage, you must comply with the terms of the Plan, including election and payment of coverage. Moreover, upon return from leave protected under USERRA, your coverage will be reinstated (i.e., begin again).

### OTHER IMPORTANT INFORMATION

#### Q7. Can I assign my rights under the Plan to another person or third party?

The assignment of benefits is governed by the Benefit Document. However, if the Benefit Document does not contain such a provision, the Plan will not permit the assignment of any rights under the Plan to another person or third party.

Even if an assignment is permitted under the Benefit Document, the Plan Administrator, or any delegated third-party, has the right to determine the validity of the assignment.

#### **Q8. Is this document a contract between me and my Employer?**

No, this document is an SPD and is intended to summarize general provisions of the Plan. This document does not constitute a contract of any type between you and your Employer. Nothing in this document shall give you any right of employment.

## **DEFINITIONS**

When used in this SPD with initial capital letters, the following words will have the meanings described below unless the content indicates other meanings are intended. If any defined term in this SPD conflicts with the same term contained in an insurance contract or other document, the other document shall govern.

**BENEFIT** – Each benefit available under the Plan, as identified in Appendix A.

**BENEFIT DOCUMENT** – Any policy, contract, or other document that governs the terms of the Benefit.

**CHILD(REN)** – Your child(ren) as defined in Appendix B unless defined differently under a Benefit Document.

**CLAIM** – A request for benefits made by you under the terms of the Benefit Document.

**CLAIMS ADMINISTRATOR** – The Plan Administrator or the third party appointed by the Plan Administrator to review claims submitted by you, including appeals, as applicable.

**CONTRIBUTIONS** – The amount paid by you or your Employer equal to the cost of coverage under a Benefit.

**DEPENDENT** – Your dependent as defined in Appendix B. A Dependent may also include other individuals as identified in the applicable Benefit Document.

**DISABILITY PLAN** – The Benefit that provides a Participant supplemental income during a limited or extended period of time due to the inability to work as a result of illness, injury, or accident. The Disability Plan includes a short-term disability plan, other than state-mandated benefits, and a long-term disability plan.

**DOMESTIC PARTNER** – Your Domestic Partner as defined in Appendix B. You should refer to the Benefit's insurance contract or other document for eligibility requirements.

**ELIGIBLE DEPENDENT** – A Dependent that is eligible for coverage under one or more of the Benefits.

**EMPLOYER** – Your Employer who adopted this Plan is eResearch Technology, Inc.. Your Employer will also serve as the Plan Administrator, as defined in the Employee Retirement Income Security Act (ERISA), who is responsible for the day-to-day operations and decisions regarding the Plan, unless a separate Plan Administrator is appointed for all or some of the Plan responsibilities.

**HEALTH CARE PLAN** – Any Benefit that provides medical care, including a Major Medical Option, dental, vision, flexible spending arrangement, or an employee assistance program.

**MAJOR MEDICAL OPTION** – A Benefit that provides medical benefits, other than vision or dental benefits, to eligible employees and their Eligible Dependents.

**PARTICIPANT** – An employee of your Employer who has satisfied the eligibility requirements and entered the Plan.

**PLAN** – The Plan described in this SPD is the eResearch Technology, Inc. Health and Welfare Plans.

**PLAN ADMINISTRATOR** – Your Employer is responsible for the day-to-day administration of the Plan and is the Plan Administrator unless an appointed Plan Administrator is named in the Administrative Information section of this SPD.

**PLAN SPONSOR** – The Plan Sponsor is eResearch Technology, Inc..

## **ADMINISTRATIVE INFORMATION**

#### **Q1. Who has the authority to make determinations under the Plan?**

The Plan Administrator has discretionary authority to interpret and make determinations under the Plan. The Plan Administrator may delegate its authority to third parties regarding Claims administration (e.g, the review and process of Claims), ministerial services (e.g., recordkeeping, mailing of notices, etc.), and other services, as necessary.

#### **Q2. What are some of the duties of the Plan Administrator?**

The Plan Administrator's duties include, but are not limited to, the following:

- Administering the Plan in accordance with its terms;
- Delegating to any person or entity powers, duties, and responsibilities, as necessary;
- Determining all questions of eligibility, status, and coverage under the Plan;
- Interpreting the Plan, including ambiguities, inconsistencies, omissions, and disputed terms;
- Making factual findings;
- Deciding disputes that may arise relative to a covered person's rights;

- Recommending procedures for filing a Claim for Benefits, review Claim denials, and appeals relating to them, and uphold or reverse such denials;
- Keeping and maintaining the Plan document and all other records pertaining to the Plan;
- Appointing and supervising a third-party administrator to pay Claims;
- Performing all necessary reporting, as required by ERISA, if applicable;
- Establishing and communicating procedures to determine an order's status as a qualified medical child support order; and
- Performing functions necessary for the Plan's administration.

**Q3. Can changes be made to the Plan?**

Yes. While the Employer intends to maintain the Plan indefinitely, the Employer may, in its sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part. This includes amending Benefits provided under the Plan. If an amendment, suspension, or termination is enacted, the Employer will provide notice, as required by law.

**Q4. What happens if the Plan Administrator or its delegates makes a clerical error?**

If the Plan Administrator or its delegated agent make a clerical error, the error will not invalidate coverage. Rather, coverage effective dates will be determined solely in accordance with the provisions of the Plan, including any Benefit Document. Moreover, as permitted by law, the Plan Administrator will make an equitable adjustment as a result of an error or delay.

**Q5. If the Plan receives a premium refund, will the reimbursement be paid to Participants?**

If the Plan has an insured Major Medical Option, the Plan may receive a refund of premium payments. For example, the Plan may receive a medical loss ratio rebate or an experience adjustment. If this occurs, your Employer will determine if the refund is a Plan asset. If so, the Plan Administrator will have discretion to pay the refund to Participants as follows:

- Distribute a refund to Participants within 90 days of receipt,
- Use the refund to reduce Participants' portion of future premiums under the Plan; or
- Use the refund to enhance future Benefits under the Plan.

If the Plan Administrator determines the refund does not belong to the Plan, the Employer may determine how to use the refund and the Participants will not have any right to reimbursement.

**Q6. Who is responsible for the day-to-day operations of the Plan?**

Your Employer is responsible for the Plan's day-to-day administration. To assist in operating the Plan efficiently and accurately, your Employer may appoint additional persons or organizations to act on its behalf or to perform certain functions. The Plan Administrator may provide the Claims administration through a third-party Claims Administrator.

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about the Plan. The Plan Administrator has the exclusive right to interpret the Plan's provisions. You may contact the Plan Administrator for any further information about the Plan.

**Q7. Who is responsible to administer the Plan's Claims?**

The Claims Administrator is responsible to administer the Plan's Claims. The Claims Administrator is:

- The Insurance Issuer or self-insured plan administrator appointed by the Employer.
- The Employer.

Refer to the chart in Appendix A for Claims Administrator contact information.

**Q8. How can I obtain additional information about the Plan?**

For additional information regarding the Plan, contact your Human Resources representative, or refer to the Benefit Documents. Copies of the Plan document, this SPD, and incorporated Benefit Documents are available free of charge from your Employer upon request.

**Q9. If I receive a medical child support order, what should I do?**

If you receive a medical child support order, send the order to the Plan Administrator. The Plan Administrator will then review the order to determine if it is a "qualified medical child support order" (QMCSO). If it is determined the order is a QMCSO, the Plan will automatically change your coverage to extend coverage to the Child. Coverage for the Child will begin on the date specified in the order, or if none is specified, the date of the order, as permitted under a Benefit.

You are permitted to obtain, without charge, a copy of the policy and/or procedures governing the QMCSO from the Plan Administrator.

**Q10. When can the Plan Administrator retroactively terminate coverage provided under a Health Care Plan?**

A retroactive termination of coverage is referred to as a "rescission." The Plan Administrator may retroactively terminate your coverage or the coverage of your Eligible Dependent if you commit fraud or if you intentionally misrepresent a material fact to the Plan.

**Q11. What is considered fraud or intentional misrepresentation?**

Fraud or intentional misrepresentation occurs when you obtain Benefits by fraudulently or intentionally misrepresenting a material fact to the Plan. If you fraudulently or intentionally misrepresent a fact, the Plan Administrator may take certain action, as permitted by law, at its sole discretion.

## YOUR RIGHTS UNDER ERISA

### Q1. Is the Plan subject to the Employee Retirement Income Security Act (ERISA)?

Yes, the Plan is subject to ERISA and you have certain rights summarized in this section.

### Q2. What are my legal rights and protections under the Plan?

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to the following.

#### **Receive Information About Your Plan and Benefits**

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and any collective bargaining agreements, and, if required by ERISA to be filed, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) (if required by ERISA to be prepared) and updated SPD. The administrator may charge a reasonable fee for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary Annual Report.

#### **Continue Health Care Plan Coverage**

The Plan Administrator is required to continue Health Care Plan coverage for you or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing your COBRA continuation coverage rights. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your Health Care Plan, if you have creditable coverage from another plan.

#### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

#### **Enforce Your Rights**

If your Claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan document or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's Claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

#### **Assistance With Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. For more information about this statement or your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit [www.healthcare.gov](http://www.healthcare.gov).

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. In addition, you may contact the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

## COBRA

This section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review this SPD or contact the Plan Administrator.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

## Q1. What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this Q1. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

Each qualified beneficiary is required to pay the entire cost of COBRA coverage, including both employee and employer contributions. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the Health Care Plan.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); or
- The parents become divorced or legally separated.

## Q2. Can I elect continuation for my Domestic Partner?

An individual covered under the Plan due to his or her status as an employee's Domestic Partner is not provided with federal continuation coverage rights under COBRA. However, the Plan will provide such Domestic Partners with continuation coverage that mirrors the rights and obligations of continuation coverage of the spouse of an employee under COBRA.

If you are covered under the Plan as a dependent because of your status as an employee's Domestic Partner, you will be treated as a qualified beneficiary ("Domestic Partner qualified beneficiary") if you lose your coverage under the Plan because any of the following qualifying events occurs:

- Your Domestic Partner dies;
- Your Domestic Partner's hours of employment are reduced;
- Your Domestic Partner's employment ends for any reason other than his or her gross misconduct;
- The employee- Domestic Partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- Your domestic partnership terminates.

**Notification requirements.** If you become eligible for these continuation coverage rights because of the termination of your domestic partnership, you must notify the Plan Administrator in writing within 60 days after the later of (1) the date your domestic partnership terminates; or (2) the date on which you lose (or would lose) coverage under the terms of the Plan as a result of the termination of the domestic partnership. Your notice must indicate that your domestic partnership has terminated, the date of such termination, and your name and address. You must provide this notice to the contact listed on Page i of this SPD.

**You may lose your right to elect continuation coverage if proper procedures are not followed within the time periods described.**

As a Domestic Partner qualified beneficiary, your election requirements, length of continuation coverage, cost of continuation coverage, payment obligations, and termination of the continuation coverage rights will be equivalent to those of an eligible spouse who is a qualified beneficiary under COBRA as described in this "Continuation of Coverage Rights" section.

If you have any questions about continuation coverage requirements and benefits for Domestic Partners, please contact the Plan Administrator.

### Q3. When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days, or a longer time period if permitted by the Plan, after the qualifying event occurs.**

#### **NOTICE PROCEDURES:**

Any notice must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail, fax, or hand deliver your notice to the person, department, or firm listed on Page i of this SPD.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must include:

- the Plan's name: eResearch Technology, Inc. Health and Welfare Plans
- the name and address of the Participant and any other qualified beneficiaryies, and
- the Qualifying Event and the date it happened.

If the Qualifying Event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement.

### Q4. How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

#### **Disability extension of 18-month period of COBRA continuation coverage**

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

To qualify for the disability extension, the qualified beneficiary must notify the Plan Administrator of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures described above.

#### **Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

#### **Limited COBRA Coverage Period for Health FSA Benefits**

COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the Plan Year. Health FSA COBRA coverage will only last until the end of the Plan Year during which the qualifying event occurred. The use-it-or-lose rule will continue to apply, so any unused funds (in excess of any carryover amount, if applicable) will be forfeited at the end of the Plan Year (and grace period if applicable) and the Health FSA COBRA coverage will be terminated.

If applicable, any carryover funds remaining in a Health FSA account after the end of the Plan Year in which a qualifying event occurred will continue to be available to reimburse health care expenses until the qualified beneficiary's other COBRA coverage (e.g. medical, dental, vision) ends.

### Q5. Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

**Q6. Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

**Q7. What if I have additional questions?**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

**Q8. How do I protect my COBRA rights?**

**Keep Your Plan Administrator Informed of Address Changes.** To protect your family's rights, you should keep the Plan Administrator informed of any changes in your family members' addresses. You should also keep a copy, for your records, of any notices that you send to the Plan Administrator or its designee.

**Q9. What factors should be considered when determining to elect COBRA continuation coverage?**

You may have the right to request special enrollment in another health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after Plan coverage ends because of a Qualifying Event listed above. You may also have the same special right at the end of COBRA continuation coverage if you elect COBRA continuation coverage for the maximum time available to you.

**Q10. What is the procedure for obtaining COBRA continuation coverage?**

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

**Q11. What is the election period and how long must it last?**

The election period is the time period within which the qualified beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the qualified beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of 1) the date the qualified beneficiary would lose coverage because of the Qualifying Event, or 2) the date notice is provided to the qualified beneficiary of the qualified beneficiary's right to elect COBRA continuation coverage.

**Q12. Will a waiver made before the end of the election period end a qualified beneficiary's election rights?**

If, during the election period, a qualified beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. The waiver's revocation is an election of COBRA continuation coverage. If a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

**Q13. Is COBRA continuation coverage available if a qualified beneficiary has Medicare?**

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are entitled to Medicare benefits on or before the date on which COBRA continuation coverage is elected. But a qualified beneficiary's COBRA continuation coverage will terminate automatically if, after electing COBRA continuation coverage, the qualified beneficiary becomes entitled to Medicare or becomes covered under another health Plan.

**Q14. When may a qualified beneficiary's COBRA continuation coverage be terminated?**

A qualified beneficiary may waive COBRA continuation coverage during the election period. Except for an interruption of coverage in connection with a waiver, a qualified beneficiary's COBRA continuation coverage must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates.

- The last day of the applicable maximum coverage period.
- The first day for which timely payment is not made to the Plan with respect to the qualified beneficiary.
- The date upon which your Employer ceases to provide any health Plan (including a successor Plan) to any employee.
- The date, after the date of the election, that the qualified beneficiary first becomes covered under a health Plan.
- The date, after the date of the election, that the qualified beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).
- The later of the following two dates if the qualified beneficiary is entitled to a disability extension.

1. The end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.
2. The earlier of 1) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled, or 2) 29 months after the date of the Qualifying Event.

The Plan can terminate for cause a qualified beneficiary's coverage on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries (for example, for submitting a fraudulent Claim).

If the Plan's obligation to make COBRA continuation coverage available to the qualified beneficiary ceases, and an individual who is not a qualified beneficiary receives coverage under the Plan solely because of the individual's relationship to a qualified beneficiary, the Plan is not obligated to make coverage available to the individual who is not a qualified beneficiary.

**Q15. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?**

Yes. The Plan is also permitted to allow for payment at other intervals.

**Q16. What is considered timely when paying for COBRA continuation coverage?**

Payment is made timely if made no later than 30 days after the first day of the coverage period.

The Plan does not require payment for any period of COBRA continuation coverage for a qualified beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that qualified beneficiary. Payment is considered made on the date on which it is postmarked to those providing COBRA continuation coverage.

If you make a timely payment and the payment is less than the amount the Plan requires, the Plan Administrator may consider the amount timely if 1) the amount owed is insignificant, and 2) you pay the amount owed within a reasonable period. A reasonable period is 30 days, and an insignificant amount is considered \$50 or 10% of the required amount. Please see the Plan document for additional information.

## PRIVACY RIGHTS UNDER HIPAA

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

This notice describes how your Protected Health Information (PHI) may be used or disclosed under the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). PHI or Electronic Protected Health Information (ePHI) means individually identifiable health information held by, or on behalf of, the Plan.

***Uses and Disclosures of Your Information***

The Plan Administrator on behalf of the Plan may use or disclose your PHI for the purposes of routine treatment, payment, or health care operations related to the Plan. For example, the Plan may use your PHI for management activities related to the Plan—including auditing, fraud and abuse detection, and customer service. The Plan also may use or disclose your PHI in order to pay your Claims for benefits. For example, the Plan may use your information to make eligibility determinations and for billing and Claims management purposes. Note that the Genetic Information Nondiscrimination Act (GINA) prohibits using PHI that is genetic information for underwriting purposes. In addition, the Plan may disclose your PHI to the Plan Administrator so that the Plan Administrator can perform administrative functions on behalf of the Plan, such as facilitating Claims or appeals.

The Plan also may use or disclose your PHI where required or permitted by law. The Plan Administrator on behalf of the Plan is permitted to use or disclose PHI:

- when required by law;
- for public health activities;
- to report Child or domestic abuse;
- for governmental oversight activities;
- pursuant to judicial or administrative proceedings;
- for certain law enforcement purposes;
- for a coroner, medical examiner, or funeral director in order to obtain information about a deceased individual;
- for organ, eye, or tissue donation purposes;
- for certain government-approved research activities;
- to avert a serious threat to an individual's or the public's health or safety;
- for certain government functions, such as related to military service or national security;
- to comply with workers' compensation laws;
- to a family member or close friend that you have identified and who is directly involved in your care or payment for your care; or
- to notify a family member or other individual involved in the care of your location, general condition, or death or to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notifications.

For any other uses and disclosures of your PHI, the Plan will obtain your written authorization. The Plan will obtain your written authorization to use or disclose PHI for marketing purposes where the Plan receives financial remuneration, for the sale of PHI, or with respect to psychotherapy notes, except for limited health care operations purposes. You may revoke this authorization in writing at any time, provided the Plan has not yet acted while relying on your authorization.

Stricter State Privacy Laws – Under the HIPAA privacy and security rules, the Plan is required to comply with state laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter). The Plan maintains a policy to ensure compliance with these laws.

### **Your Rights With Respect To Your Health Information**

You have several rights with respect to your PHI, which are described below. Please call the Privacy Officer listed below if you have questions about your rights.

- You have the right to request restrictions on how your PHI may be used or disclosed. The Plan generally is not required to agree to your requested restriction, except in limited circumstances.
- You have the right to receive your PHI confidentially, such as at a location other than your home, if you state in writing that disclosing the information through normal means could endanger you.
- You have the right to inspect and copy your PHI that is maintained by the Plan in a designated record set or to request an electronic copy. The Plan may charge a reasonable, cost-based fee for such copies.
- You have the right to request an amendment to your PHI that the Plan maintains in a designated record set. The Plan may deny your request for an amendment if it believes your information is accurate and complete, or if the information was created by a party other than the Plan.
- You have a right to request an accounting of disclosures that the Plan has made of your PHI during the six years before your request, except for disclosures that you have authorized or for disclosures related to routine treatment, payment, or health care operations of the Plan.
- You have a right to request a paper copy of this notice, even if you have agreed to receive this notice electronically.

### **Our Duties With Respect To Your Individually Identifiable Health Information**

The Plan is required by law to maintain the privacy of your PHI and to provide you with a notice of its legal duties and privacy practices with respect to your PHI.

### **Questions?**

If you have questions or would like more information about the Plan's privacy policies, you may contact the Privacy Officer. The Privacy Officer is responsible for developing and implementing the Plan's privacy policies and procedures.

If you believe your privacy rights have been violated, you may file a complaint with the Plan or the Secretary of the U.S. Department of Health and Human Services. You cannot be retaliated against for filing such a complaint.

## **OTHER LEGAL NOTICES**

### **Q1. Do I have any other legal rights and protections under the Plan?**

Yes, the Plan is required to comply with other federal regulations, which guarantee certain legal rights and protections, as follows.

#### **Your Rights Under the Patient Protection and Affordable Care Act**

The Patient Protection and Affordable Care Act (PPACA or ACA) provides certain consumer protections, including the elimination of annual and lifetime limits on benefits, the provision of preventive services without cost sharing, the limitation of out-of-pocket annual costs, the coverage of essential health benefits, the elimination of waiting periods of more than 90 days for coverage to begin, the elimination of pre-existing conditions, and the guarantee of issue and renewal of coverage. As applicable, these provisions are contained within the Benefit Document of the Major Medical Option.

#### **Your Rights Under the Americans With Disabilities Act**

The Americans with Disabilities Act (ADA) provides that your Employer may not discriminate against you on the basis of disability. In addition, it generally restricts your Employer from obtaining medical information from you but permits your Employer to obtain medical information or request medical examinations as part of a voluntary Wellness Program. Your Employer may not deny you the right to access the Wellness Program on the basis of disability. If you have a disability, your Employer is required to provide a reasonable accommodation or adjustment that allows you to participate in the Wellness Program. Any information provided to your Employer due to participation in the Wellness Program must remain confidential. To request an accommodation, please contact the Plan Administrator or follow the instructions contained in the "Notice Regarding Wellness Program."

#### **Your Rights Under the Family and Medical Leave Act**

The Family and Medical Leave Act (FMLA) provides that Health Care must be maintained during any period of unpaid leave covered by FMLA under the same conditions as if you continued to work. Moreover, FMLA requires that you be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA. If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse your Employer for its share of health care premiums or Contributions paid on your behalf during your FMLA leave.

#### **Your Rights Under the Genetic Information Nondiscrimination Act of 2008**

The Genetic Information Nondiscrimination Act of 2008 (GINA) provides that your Employer may not discriminate against you on the basis of genetic information, including adjusting premiums and contribution amounts.

#### **Your Rights Under the Health Insurance Portability and Accountability Act (Special Enrollment)**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides certain special enrollment rights if you decline coverage in the Major Medical Option for yourself or your Eligible Dependents because of other coverage. If you or your Eligible Dependents lose eligibility for that other coverage or if your Employer stops contributing toward your or your Dependent's other coverage, you may be able to enroll yourself and your Eligible Dependent in the Major Medical Option. Generally, you must request enrollment within 30 days after your or your Eligible Dependent's other coverage ends or after your Employer stops contributing toward the other coverage.

If the other coverage is Medicaid or the Children's Health Insurance Program (CHIP), you must request enrollment within 60 days after your or your Eligible Dependent's Medicaid or CHIP coverage ends. Finally, if you have a new Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Eligible Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

**Your Rights Under the Health Insurance Portability and Accountability Act (Health Factors)**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits the Major Medical Option from discriminating against you or your Eligible Dependents based on a health factor. Health factors include your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. Compliance with this provision is not determinative of compliance with any other federal or state laws, including COBRA or ADA.

**Your Rights Under the Mental Health Parity and Addiction Equity Act of 2008**

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) provides that if any Major Medical Option under the Plan 1) provides for both medical and surgical benefits and mental health or substance use disorder benefits, and 2) is not subject to increased cost exemption (within the meaning of the MHPAEA), the following conditions apply:

- The Major Medical Option may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- The Major Medical Option may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.
- The criteria for medical necessity determinations made under any health insurance option with respect to mental health or substance use disorder benefits will be made available by the Plan Administrator (in accordance with the MHPAEA) to any current or potential Participant upon request.
- The reason for any denial under the Plan for reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any Participant will, on request or as otherwise required under the MHPAEA, be made available by the Plan Administrator to the Participant in accordance with the Claims procedures applicable to the group medical coverage feature.
- The Plan will be operated and constructed in all respects in compliance with the MHPAEA.

“Mental health benefits” and “substance use disorder benefits” are defined in the Major Medical Option applicable to the health insurance option, pursuant to applicable state and federal law, and consistent with generally recognized standards of current medical practice.

**Your Rights Under Michelle’s Law**

Michelle’s Law provides that a Major Medical Option of the Plan that requires a certification of student status for any period of coverage of an Eligible Dependent will comply with Public Law No. 110-381 (2008), as amended from time to time. Eligibility for such coverage for an Eligible Dependent who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence will be extended if the leave normally would cause the Eligible Dependent to lose eligibility for coverage under any Major Medical Option’s coverage due to loss of student status. This eligibility extension shall last up to one year beginning on the first day of the medically necessary leave of absence or the date the coverage would otherwise terminate due to loss of student status, whichever is earlier.

**Your Rights Under Newborns’ and Mothers’ Health Protection Act**

The Newborns’ and Mothers’ Health Protection Act (NHPA) provides that the Major Medical Option of the Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, the Major Medical Option may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Your Rights Under Title VII of the Civil Rights Act of 1964**

Title VII of the Civil Rights Act of 1964 (Title VII) provides that your Employer cannot discriminate against you on the basis of religion. Title VII permits you to request an accommodation to participate in a Wellness Program Plan due to a sincerely-held religious belief, practice, or observance and requires your Employer to provide the reasonable accommodation or adjustment unless the request imposes an undue hardship.

**Your Rights Under USERRA**

The Uniformed Services Employment and Reemployment Rights Act (USERRA) provides for continuation of Health Care Plan coverage if you are called for active-duty military service. The maximum length of extended coverage under USERRA is the lesser of

- 24 months beginning on the date that the military leave begins, or
- A period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional two-percent administration fee. If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the U.S. Department of Veterans Affairs) incurred as a result of the military service.

**Your Rights Under Women’s Health and Cancer Rights Act**

The Women’s Health and Cancer Rights Act (WHCRA) requires that a Major Medical Option that provides medical and surgical benefits with respect to a mastectomy provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedema.

These services must be provided in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles, copays, and coinsurance provisions applicable to other such medical and surgical benefits provided under the

applicable medical option. Please refer to the Major Medical Option's summary of benefits coverage for additional information. If you have other questions, please contact the Plan Administrator.

**Your Rights Under Consolidated Appropriations Act 2021**

The Consolidated Appropriations Act 2021 (CAA) provides for:

- Certain disclosures, including insurance ID cards with stated in-network and out-of-network deductibles and out-of-pocket costs; and provider directories that are current and accurate.
- Notification of the ability to receive transitional care for an ongoing course of treatment when an in-network facility transitions to an out-of-network facility during a course of treatment.
- Protections from surprise medical bills from out-of-network providers for emergency services and out-of-network services at in-network facilities.

Contact your Plan Administrator for this information as it pertains to a particular Benefit.

**Q2. Is there anything else I should know if I want to enroll my Domestic Partner?**

Yes. Unless otherwise provided by the Plan Documents, you must be aware of the following:

**Imputed Income:** Under current federal income tax laws, the value of providing medical benefits to a Domestic Partner or civil union partner and the partner's Eligible Dependent Children is considered taxable to you—unless they are considered your Dependents for purposes of federal income taxes. This means you will pay federal, state, and local income taxes, as well as employment taxes, on the full value of the coverage provided to your Domestic Partner or civil union partner and the partner's Dependents. This type of taxable income is known as imputed income, and your Employer will report it on your Form W-2 at the end of each year. It is important for you to understand the tax implications of covering a Domestic Partner or civil union partner and the partner's Eligible Dependent Children. Please consult a tax advisor to determine the full tax and financial effect of electing this coverage.

**COBRA:** An individual covered under the Plan due to their status as an Employee's Domestic Partner or civil union partner is not provided with federal continuation coverage rights under COBRA. However, the Plan may, at the consent of the applicable Plan Component(s), provide such partners with continuation coverage that mirrors the rights and obligations of continuation coverage of the Spouse of an Employee under COBRA. If you have any questions about continuation coverage requirements and benefits for Domestic Partner or civil union partner, please contact Human Resources.

**Appendix A**  
**eResearch Technology, Inc. Health and Welfare Plans**

**Plan Components and Claims Administrators**

Benefit Documents are part of this SPD. Any update to the Benefit Document will replace any earlier versions for the period defined in the updated Benefit Document.

Fully-Insured Benefits	Policy/Group No.	Type of Benefit	Claims Administrator <i>(Use the address &amp; phone number on your ID Card if different)</i>	
<b>Cigna Health and Life Insurance Company</b> 900 Cottage Grove Road Bloomfield, CT 06002	AI110207	Voluntary Accident	Cigna PO Box 188028 Chattanooga, TN 37422	800-754-3207  <a href="http://www.suphealthclaims.com">www.suphealthclaims.com</a>
	CI110202	Voluntary Critical Illness		
	HC110168	Voluntary Hospital Indemnity (High and Low Plans)		
<b>GeoBlue</b> 933 1st Avenue King of Prussia, PA 19406	4EL-6617-23	Business Travel Accident (BTA)	GeoBlue PO Box 1748 Southeastern, PA 19399-1748	888-412-6403  <a href="http://www.geo-blue.com">www.geo-blue.com</a>
<b>LegalEase, A Legal Access Company</b> 5151 San Felipe Street, Suite 2300 Houston, TX 77056	2000723	Prepaid Legal	LegalEase 5151 San Felipe Street, Suite 2300 Houston, TX 77056	800-562-2929  <a href="http://www.legaleaseplan.com">www.legaleaseplan.com</a>
<b>Prudential Insurance Company of America</b> 751 Broad Street Newark, NJ 07102	70960	Basic Life (with EAP)/AD&D Voluntary Life	Prudential PO Box 70182 Philadelphia, PA 19176	800-524-0542  <a href="http://www.prudential.com/mybenefits">www.prudential.com/mybenefits</a>
		Long-Term Disability Short-Term Disability	Prudential PO Box 13480 Philadelphia, PA 19176	800-842-1718  <a href="http://www.prudential.com/mybenefits">www.prudential.com/mybenefits</a>
<b>Vision Service Plan (VSP)</b> 3333 Quality Drive Rancho Cordova, CA 95670	30107687	Vision	VSP PO Box 495907 Cincinnati, OH 45249-5907	800-877-7195  <a href="http://www.vsp.com/faqs/claims-reimbursements">www.vsp.com/faqs/claims-reimbursements</a>

Self-Insured Benefits	Contract No.	Type of Benefit	Claims Administrator <i>(Use the address &amp; phone number on your ID Card if different)</i>	
<b>Baker Tilly Vantagen</b> 1200 Abington Executive Park Clarks Summit, PA 18411	485	General-Purpose Health FSA  Limited-Purpose Health FSA	Baker Tilly 1200 Abington Executive Park Clarks Summit, PA 18411	800-307-0230  <a href="http://www.bakertillyvantagen.com">www.bakertillyvantagen.com</a>
<b>CVS/Caremark</b> 1 CVS Drive Woonsocket, RI 02895	23HX	Prescription Drugs	CVS/Caremark PO Box 52136 Phoenix, AZ 85072	800-334-8134  <a href="http://www.caremark.com">www.caremark.com</a>
<b>Delta Dental of Pennsylvania</b> One Delta Drive Mechanicsburg, PA 17055	18131	Dental – PPO (Basic and Enhanced Plans)	Delta Dental of PA PO Box 2105 Mechanicsburg, PA 17055-2105	800-932-0783  <a href="http://www.deltadental.com">www.deltadental.com</a>

Self-Insured Benefits	Contract No.	Type of Benefit	<b>Claims Administrator</b> <i>(Use the address &amp; phone number on your ID Card if different)</i>	
<b>Highmark Blue Cross Blue Shield</b> 120 Fifth Avenue Pittsburgh, PA 15222	302203	Medical – HDHP Medical – PPO Well360 Virtual Health	Highmark BCBS PO Box 890173 Camp Hill, PA 17089-0173	800-241-5704 <a href="http://www.highmark.com">www.highmark.com</a>
<b>Quantum Health Solutions Group</b> 9777 South Yosemite Street, Suite 220 Lone Tree, CO 80124	—	Health Care Coordination	Quantum Health Solutions Group 9777 South Yosemite Street, Suite 220 Lone Tree, CO 80124	800-257-2038 <a href="http://lookup.quantum-health.com">lookup.quantum-health.com</a>

**Non-ERISA Benefits** In addition to the above Component Plans, eligible employees are offered non-ERISA welfare benefits. Such non-ERISA benefits are not governed by ERISA and include the following benefit plan(s):

Insurer/Provider	Type of Benefit
<b>Baker Tilly Vantagen</b>	HSA, Dependent Care FSA, Commuter Benefits Program, COBRA Administration
<b>ID Theft Assist</b>	Identity Theft Protection
<b>Nationwide</b>	Pet Insurance
<b>Prudential Insurance Company of America</b>	New York State Mandated Disability and Paid Family Leave (NY DBL/PFL, Hawaii State Mandated Disability (HI TDI), Absence Management, ADA Accommodation Management

## Appendix B eResearch Technology, Inc. Health and Welfare Plans

### Eligibility and Participation Requirements

An employee who is determined to be benefit-eligible as of his or her start date shall be able to participate in the Plan as of the Coverage Date specified below.

Employee Class	Working Hours Minimum	Benefits Offered	Date Coverage Begins	Date Coverage Ends
<b>Full-Time Employees</b>	40 hours per week	All Benefits listed on Appendix A	Date of Hire	Medical, EAP, Dental, Vision, FSA: End of the month following termination date, unless COBRA is available and is elected.
<b>Part-Time Employees</b>	30 hours per week	All Benefits listed on Appendix A	Date of Hire	Life/AD&D, Voluntary Life, BTA: Date of termination, may be eligible to convert of port life benefit when coverage ends.  All Other Coverages: Date of termination.

#### **Dependent Eligibility**

Unless specified otherwise under the applicable Plan Component's benefit documents, coverage for dependents, if elected, begins on the date the Employee's coverage begins (provided the Employee timely enroll them in coverage). Mid-Plan Year elections for newly acquired Dependents may also be permitted under certain circumstances.

Dependent Definitions. For purposes of eligibility and participation in this Plan, Dependent definitions shall have the same meaning set forth in each applicable Plan Component's benefit documents which are incorporated by reference herein. Unless otherwise defined in the Plan Component's benefit documents, your eligible dependents include:

- Your lawful same- or opposite-sex spouse under applicable law unless legally separated by court decree; or,
  - Your Domestic Partner or civil union partner with whom you have lawfully registered into a partnership in a state or municipality that provides for such registration.
- Your child(ren) under age 26 (regardless of financial dependency, residency with you, marital status, or student status), or if older, your unmarried child who is principally supported by you and who you can certify (on a periodic basis) is not capable of self-support due to a physical or mental disability that either began while the child was covered under the Plan or occurred prior to attaining age 26. For purposes of the Plan, a child includes:
  - Your (or your spouse's/Domestic Partner's) biological child, stepchild, legally adopted child (including any child lawfully placed for adoption with you by a court of competent jurisdiction);
  - A foster child who has been placed with you by an authorized placement agency or by judgment, decree, or other court order of any court of competent jurisdiction;
  - Your court-appointed legal ward under a Component Plan's limiting age provided he or she legally resides with you in a parent-child relationship and qualifies as your dependent for tax purposes.

An eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order or a National Medical Support Notice, including a judgment, decree, or order issued by a court of competent jurisdiction, or an order issued through an administrative process that has the force and effect of law under applicable state law.

#### **Rehire Rule**

Unless otherwise specified to the contrary in the Benefit Documents for a Component Plan, an employee who is rehired prior to the end of a 13-consecutive week period of time after date of termination will be credited with hours of service met towards the eligibility waiting period during his or her preceding period of employment. Otherwise, a terminated employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and participation requirements for his or her employment class.

#### **Special Eligibility Rules for Variable Hour, Part-Time and Seasonal Employees**

Certain employees who are hired into positions that are not initially benefit-eligible may become participants in the Plan by achieving Full-Time Status ("ACAFT") under special eligibility rules for variable hour, part-time, and seasonal employees. In the event your Employer adopts such rules, it intends to administer them in a manner consistent with the final regulations issued by the Department of Treasury related to the "Shared Responsibility" provisions of the ACA.

For purposes of these special eligibility rules (known as either the "Look-Back Measurement Method" or "Monthly Measurement Method"), a variable hour, part-time or seasonal employee will achieve ACA-FT status after averaging 130 or more hours of service per month (or 30 or more hours of service per week) during a period of time spanning a specific number of consecutive months ("Measurement Period"). Eligibility or ineligibility for benefits will last for a future specific number of consecutive months referred to as the "Stability Period." The maximum length of any Measurement Period or Stability Period shall not exceed 12-consecutive months.

If applicable, details regarding the Look-Back Measurement Method and/or Monthly Measurement Method adopted by your Employer (e.g. the classes of employees it applies to, a description of each type of measurement period, breaks-in-services rules, and procedures used to count hours of service) are available upon request from to the Plan Administrator.

**APPENDIX C**  
**eResearch Technology, Inc. Health and Welfare Plans**

**Premium Assistance under Medicaid and CHIP**

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility.

<b>ALABAMA – Medicaid</b>	<b>ALASKA – Medicaid</b>
Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="https://health.alaska.gov/dpa/Pages/default.aspx">https://health.alaska.gov/dpa/Pages/default.aspx</a>
<b>ARKANSAS – Medicaid</b>	<b>CALIFORNIA – Medicaid</b>
Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a> Phone: 916-445-8322 Fax: 916-440-5676 Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>
<b>COLORADO – Medicaid and CHIP+</b>	<b>FLORIDA – Medicaid</b>
Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHIP+: <a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus</a> CHIP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): <a href="https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program">https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program</a> HIBI Customer Service: 1-855-692-6442	Website: <a href="https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html">https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html</a> Phone: 1-877-357-3268
<b>GEORGIA – Medicaid</b>	<b>INDIANA – Medicaid</b>
GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162, Press 1 GA CHIPRA Website: <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a> Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a> Phone 1-800-457-4584
<b>IOWA – Medicaid and CHIP (Hawki)</b>	<b>KANSAS – Medicaid</b>
Medicaid Website: <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a> Medicaid Phone: 1-800-338-8366 Hawki Website: <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a> Hawki Phone: 1-800-257-8563 HIPP Website: <a href="https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a> HIPP Phone: 1-888-346-9562	Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a> Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012

<p align="center"><b>KENTUCKY – Medicaid</b></p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a>  Phone: 1-855-459-6328  Email: <a href="mailto:KIHIPP.PROGRAM@ky.gov">KIHIPP.PROGRAM@ky.gov</a>  KCHIP Website: <a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a>  Phone: 1-877-524-4718  Kentucky Medicaid Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a></p>	<p align="center"><b>LOUISIANA – Medicaid</b></p> <p>Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a>  Phone: 1-888-342-6207 (Medicaid hotline) or  1-855-618-5488 (LaHIPP)</p>
<p align="center"><b>MAINE – Medicaid</b></p> <p>Enrollment Website: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a>  Phone: 1-800-442-6003  TTY: Maine relay 711  Private Health Insurance Premium Webpage:  <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a>  Phone: -800-977-6740.  TTY: Maine relay 711</p>	<p align="center"><b>MASSACHUSETTS – Medicaid and CHIP</b></p> <p>Website: <a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a>  Phone: 1-800-862-4840  TTY: (617) 886-8102</p>
<p align="center"><b>MINNESOTA – Medicaid</b></p> <p>Website:  <a href="https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a>  Phone: 1-800-657-3739</p>	<p align="center"><b>MISSOURI – Medicaid</b></p> <p>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a>  Phone: 573-751-2005</p>
<p align="center"><b>MONTANA – Medicaid</b></p> <p>Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a>  Phone: 1-800-694-3084  Email: <a href="mailto:HSHIPPProgram@mt.gov">HSHIPPProgram@mt.gov</a></p>	<p align="center"><b>NEBRASKA – Medicaid</b></p> <p>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a>  Phone: 1-855-632-7633  Lincoln: 402-473-7000  Omaha: 402-595-1178</p>
<p align="center"><b>NEVADA – Medicaid</b></p> <p>Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a>  Medicaid Phone: 1-800-992-0900</p>	<p align="center"><b>NEW HAMPSHIRE – Medicaid</b></p> <p>Website: <a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a>  Phone: 603-271-5218  Toll free number for the HIPP program:  1-800-852-3345, ext 5218</p>
<p align="center"><b>NEW JERSEY – Medicaid and CHIP</b></p> <p>Medicaid Website:  <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>  Medicaid Phone: 609-631-2392  CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>  CHIP Phone: 1-800-701-0710</p>	<p align="center"><b>NEW YORK – Medicaid</b></p> <p>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a>  Phone: 1-800-541-2831</p>
<p align="center"><b>NORTH CAROLINA – Medicaid</b></p> <p>Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a>  Phone: 919-855-4100</p>	<p align="center"><b>NORTH DAKOTA – Medicaid</b></p> <p>Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a>  Phone: 1-844-854-4825</p>
<p align="center"><b>OKLAHOMA – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>  Phone: 1-888-365-3742</p>	<p align="center"><b>OREGON – Medicaid</b></p> <p>Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a>  <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a>  Phone: 1-800-699-9075</p>
<p align="center"><b>PENNSYLVANIA – Medicaid and CHIP</b></p> <p>Website:  <a href="https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx">https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx</a>  Phone: 1-800-692-7462  CHIP Website: Children’s Health Insurance Program (CHIP) (pa.gov)  CHIP Phone: 1-800-986-KIDS (5437)</p>	<p align="center"><b>RHODE ISLAND – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a>  Phone: 1-855-697-4347, or 401-462-0311  (Direct Rlte Share Line)</p>
<p align="center"><b>SOUTH CAROLINA – Medicaid</b></p> <p>Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a>  Phone: 1-888-549-0820</p>	<p align="center"><b>SOUTH DAKOTA – Medicaid</b></p> <p>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a>  Phone: 1-888-828-0059</p>
<p align="center"><b>TEXAS – Medicaid</b></p> <p>Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a>  Phone: 1-800-440-0493</p>	<p align="center"><b>UTAH – Medicaid and CHIP</b></p> <p>Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a></p>

	CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a> Phone: 1-877-543-7669
<b>VERMONT – Medicaid</b>	<b>VIRGINIA – Medicaid and CHIP</b>
Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a> Phone: 1-800-250-8427	Website: <a href="https://www.coverva.org/en/famis-select">https://www.coverva.org/en/famis-select</a> <a href="https://www.coverva.org/en/hipp">https://www.coverva.org/en/hipp</a> Medicaid/CHIP Phone: 1-800-432-5924
<b>WASHINGTON – Medicaid</b>	<b>WEST VIRGINIA – Medicaid and CHIP</b>
Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a> Phone: 1-800-562-3022	Website: <a href="https://dhr.wv.gov/bms/">https://dhr.wv.gov/bms/</a> <a href="http://mywhipp.com/">http://mywhipp.com/</a> Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
<b>WISCONSIN – Medicaid and CHIP</b>	<b>WYOMING – Medicaid</b>
Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a> Phone: 1-800-362-3002	Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a> Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)  
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

# PPO BLUE

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*PPO Program*

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

**Clario, Inc. HDHP Family Active  
Group 10775300, 01, 03, 70, 71, 72, 73  
Effective January 01, 2024**



## **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 languagesIf 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](mailto: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 المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

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

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

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

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

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

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

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

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

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## **Disclosure**

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

## **Non-Assignment**

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

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

# Introduction to Your Health Care Program

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

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

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

- ***Your health care program gives you freedom of choice.*** You are not required to select a primary care provider to receive covered care. You have access to a large provider network of physicians, hospitals, and other providers in Pennsylvania, as well as providers across the country who are part of the local PPO network. For a higher level of coverage, you need to receive care from a network provider. However, you can go outside the network and still receive care at the lower level of coverage. To locate a network provider near you, or to learn whether your current physician is in the network, log onto your Highmark member website, [www.myhighmark.com](http://www.myhighmark.com).
- ***Your health care program gives you "stay healthy" care.*** You are covered for a range of preventive care, including physical examinations and selected diagnostic tests. Preventive care is a proactive approach to health management that can help you stay on top of your health status and prevent more serious, costly care down the road.

You can review your health care program's 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.

# How Your Benefits Are Applied

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

## **Benefit Period**

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

## **Medical Cost-Sharing Provisions**

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

### ***Coinsurance***

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

### ***Copayment***

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

### ***Deductible***

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

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

### ***Family Deductible***

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

For a family with several covered dependents, the deductible you pay for all covered family members, regardless of family size, is specified under family deductible. To reach this total, the entire family deductible must be satisfied in one benefit period by one or more family members. Benefits for any individual member of the family will not be payable until the family deductible has been satisfied. Once the family deductible is met, no further deductible amounts must be satisfied by any covered family member.

### ***Out-of-Pocket Limit***

The out-of-pocket limit refers to the specified dollar amount of expense incurred for covered services in a benefit period. When the specified dollar amount is attained, the level of benefit increases as specified in the

Summary of Benefits. See the Summary of Benefits for the out-of-pocket limit. The out-of-pocket limit does not include amounts in excess of the plan allowance. All out-of-pocket amounts are based on the plan allowance.

### ***Total Maximum Out-of-Pocket***

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

However, if any covered family member has incurred an amount equal to the individual total maximum out-of-pocket, the benefits payable for covered services for that particular individual family member will be payable at 100% of the plan allowance during the remainder of the benefit period.

### **Maximum**

The greatest amount of benefits that the program will provide for covered services within a prescribed period of time. This could be expressed in dollars, number of days or number of services. In connection with such day and/or visit limits, all services received by you during a benefit period will reduce the remaining number of days and/or visits available under that benefit, regardless of whether you have satisfied your deductible.

# Covered Services - Medical Program

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

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

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

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

## **Outpatient Medical Care Services (Visits and Consultations)**

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

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

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

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

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

Professional providers may also request consultations from another professional provider for an advisory opinion regarding a diagnosis or management of your medical problem. These are called "provider-to-provider" consultations or "interprofessional consultations". ***Interprofessional consultations do not include provider interaction with you.***

Different types of providers, their services and their locations may require different payment amounts and result in different charges. You may be responsible for a facility fee, clinic charge or similar fee (in addition to any professional fees) if your office visit or service is provided at a hospital, facility provider, ancillary provider,

retail clinic or urgent care center. You may also be responsible for a charge for an interprofessional consultation, which may occur during your office visit or at a different time.

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

#### ***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;

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

- ii. personal history of BRCA1 or BRCA2 gene mutations;
  - iii. a first-degree relative with a BRCA1 or BRCA2 gene mutation;
  - iv. prior therapeutic thoracic radiation therapy between 10 and 30 years of age; or
  - v. personal history of Li-Fraumeni syndrome, Cowden syndrome or Bannayan-Riley-Ruvalcaba syndrome or a first-degree relative with one of these syndromes; or
6. extremely dense breast tissue based on breast composition categories;

one (1) supplemental breast screening every year using standard or abbreviated magnetic resonance imaging (MRI) or, if such imaging is not possible, ultrasound if recommended by the treating physician to screen for breast cancer when there is no abnormality seen or suspected in the breast.

- Mammographic screenings for all members regardless of age when such services are prescribed by a physician.

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

### ***Diabetes Prevention Program***

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

### ***Tobacco Use, Counseling and Interventions***

Benefits are provided for screenings for tobacco use and, for those who use tobacco products, two tobacco cessation attempts per year. A tobacco cessation attempt includes four tobacco cessation counseling sessions and preventive 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, coverage for contraceptive methods and counseling for all members capable of pregnancy and breastfeeding support and counseling.

### ***Preventive Prescription Drugs (Outpatient)***

Coverage will be provided for prescription and over-the-counter drugs that are prescribed for preventive purposes.

## **Pediatric Care**

### ***Routine Physical Examinations***

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

### ***Pediatric Immunizations***

Benefits are provided to members under 21 years of age and dependent children for those pediatric immunizations, including the immunizing agents, which as determined by the Pennsylvania Department of

Health conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services. Coinsurance must not be more restrictive than coinsurance levels for all other benefits.

### ***Preventive Prescription Drugs (Outpatient)***

Coverage will be provided for prescription and over-the-counter drugs that are prescribed for preventive purposes.

### ***Virtual Physical Care Program***

Virtual Physical Care Program powered by Sword is a clinical-grade, digital musculoskeletal care platform pairs expert, licensed physical therapists with technology that gives real-time feedback. This virtual solution treats all the major joints issues, including lower back, shoulder, neck, knee, hip, ankle, and wrist, and can accommodate all phases of the spectrum from acute, chronic, pre-surgery and post-surgery rehab.

### ***Kidney Care Management***

Kidney Care Management by Healthmap provides coordinated case management services for members with chronic kidney disease in stages 3-5 and end stage renal disease (ESRD).

### ***Mental Well-Being***

Mental Well-Being by Spring Health offers an expanded network of behavioral health providers in addition to a digital experience where members can access self-guided interventions, dedicated Care Navigators, Health and Wellness Coaching, clinical therapy visits, and medication management to support all mental and behavioral health needs for members throughout the from low to high acuity needs.

### ***CHF and COPD Management***

CHF and COPD Management powered by Vida is a whole person, virtual care solution that offers members Congestive Heart Failure (CHF) and/or Chronic Obstructive Pulmonary Disease (COPD) health coaching, self-management education, fitness tracking, meal planning, clinical visits, and medication management.

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

### **Outpatient Evaluation and Management Services**

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

### **Surgery**

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

## **Maternity Services**

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

### ***Complications of Pregnancy***

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

### ***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. This coverage 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.

## **Medical Services**

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

### **Concurrent Care**

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

### **Consultation**

Consultation services rendered to an inpatient by another professional provider at the request of the attending professional provider. Consultation does not include staff consultations which are required by facility provider rules and regulations. Benefits are limited to one (1) consultation per consultant per admission.

### **Inpatient Medical Care Visits**

Benefits are provided for inpatient medical care visits.

### **Intensive Medical Care**

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

### **Routine Newborn Care**

Professional provider visits to examine the newborn infant.

## **Surgical Services**

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

### ***Anesthesia***

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

### ***Assistant at Surgery***

Services of a physician or of the physician's employed physician assistant (PA), or certified registered nurse practitioner (CRNP) or certified nurse midwife (CNM), who actively assists the operating surgeon in the performance of covered surgery. Benefits will be provided for an assistant at surgery only if a house staff member, intern or resident is not available.

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

### ***Mastectomy and Breast Cancer Reconstruction***

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

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

### ***Special Surgery***

- Oral Surgery

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

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

### ***Second Surgical Opinion***

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

#### **Keep in mind that:**

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

consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

## ***Surgery***

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

## **Emergency Care Services**

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

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

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

- a. you are unable to travel using non-medical transportation or non-emergency medical transportation; or
- b. you do not consent to be transferred,

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

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

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

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

## **Ambulance Service**

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

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

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

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

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

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

Under the No Surprises Act only Air Ambulance falls under no balance billing. Balance Billing can occur for non air ambulance services.

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

Local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured from a hospital to your home, or from a skilled nursing facility to your home.

## **Therapy and Rehabilitation Services**

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

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

## **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.

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

### ***Inpatient Facility Services***

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

### ***Inpatient Medical Services***

Covered inpatient medical services provided by a professional provider:

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

### ***Partial Hospitalization Program***

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

### ***Outpatient Mental Health Care Services***

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

A specialist virtual visit between you and a specialist (including a behavioral health specialist) via audio and video telecommunications. Benefits are provided for a specialist virtual visit when you communicate with the specialist from any location, such as your home, office, or another mobile location, or if you travel to a provider-based location referred to as a provider originating site. If you communicate with the specialist from a provider originating site, you will be responsible for the specialist virtual visit provider originating site fee.

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.

## **Other Services**

### **Acupuncture Therapy Services**

Benefits will be provided for acupuncture therapy services rendered by a professional provider which are determined to be medically necessary and appropriate. This benefit includes acupuncture therapy services when used to treat nausea associated with surgery, chemotherapy or pregnancy. Acupuncture therapy services are also covered as an adjunct to standard conservative therapy for the following chronic conditions when other conservative methods of treatment have failed: chronic low back pain and chronic headaches or migraine headaches. Coverage does not include acupuncture therapy services for the treatment of pain or maintenance treatment where the patient's symptoms are neither regressing nor improving.

### **Allergy Extract/Injections**

Benefits are provided for allergy extract and allergy injections.

### **Anesthesia for Non-Covered Dental Procedures (Limited)**

Benefits will be provided for general anesthesia and associated hospital and medical services normally related to the administration of general anesthesia which are rendered in connection with non-covered dental procedures or non-covered oral surgery. Benefits are provided for members age seven or under and for

developmentally disabled members when determined by Highmark to be medically necessary and appropriate and when a successful result cannot be expected for treatment under local anesthesia, or when a superior result can be expected from treatment under general anesthesia.

## **Artificial Insemination**

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

## **Assisted Fertilization Treatment**

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

## **Blue Distinction Specialty Care**

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

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

## **Transplants**

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

## **Dental Services Related to Accidental Injury**

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

## **Diabetes Treatment**

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

- 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).

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

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

## **Diagnostic Services**

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

### ***Advanced Imaging Services***

Include, but are not limited to, computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET scan), positron emission tomography/computed tomography (PET/CT scan).

### ***Basic Diagnostic Services***

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

## **Durable Medical Equipment**

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

## **Hearing Care Services**

Benefits include coverage for diagnostic testing and an audiometric examination and purchase 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 supplier who is a network provider.

## **Home Infusion and Suite Infusion Therapy Services**

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

## **Home Health Care Services/Hospice Care Services**

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

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

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

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

## **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.

## **Therapeutic Injections**

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

## **Transplant Services**

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

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

- when both the recipient and the donor are members, each is entitled to the benefits of their program;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this program. Benefits provided to the donor will be charged against the recipient's coverage under this program to the extent that benefits remain and are available under this program after benefits for the recipient's own expenses have been paid;

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

## **Prescription Drugs (Outpatient)**

Coverage will be provided for prescription and over-the-counter drugs that are set forth within a predefined schedule\* and that are prescribed for preventive purposes. Benefits will be provided for prescription drugs in the amounts specified in the Summary of Benefits of this booklet.

Injectable insulin and drugs that under Federal law may only be dispensed by written prescription and are approved for general use by the FDA. The drugs must be dispensed for your outpatient use by a pharmacy provider on or after your effective date.

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\* 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.

# What Is Not Covered

Except as specifically provided in this booklet 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
Allergy Testing	<ul style="list-style-type: none"><li>For allergy testing, except as provided herein.</li></ul>
Ambulance	<ul style="list-style-type: none"><li>For ambulance services, except as provided herein.</li></ul>
Comfort/Convenience Items	<ul style="list-style-type: none"><li>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.</li></ul>
Compounded Medications	<ul style="list-style-type: none"><li>For compounded medications.</li></ul>
Cosmetic Surgery	<ul style="list-style-type: none"><li>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.</li></ul>
Court Ordered Services	<ul style="list-style-type: none"><li>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.</li></ul>
Custodial Care	<ul style="list-style-type: none"><li>For custodial care, domiciliary care, protective and supportive care including educational services, rest cures and convalescent care.</li></ul>
Dental Care	<ul style="list-style-type: none"><li>Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease except for dental expenses otherwise covered because of accidental bodily injury to sound natural teeth and for orthodontic treatment for congenital cleft palates as provided herein.</li></ul>
Diabetes Prevention Program	<ul style="list-style-type: none"><li>For a diabetes prevention program offered by other than a network diabetes prevention provider.</li></ul>
Effective Date	<ul style="list-style-type: none"><li>Rendered prior to your effective date of coverage.</li></ul>
Enteral Foods	<ul style="list-style-type: none"><li>For the following services associated with the additional enteral foods benefits provided under your program: blenderized food, baby food, or regular shelf food; milk or soy-based infant formulae with intact proteins; any formulae, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for</li></ul>

caloric supplementation, limitation or maintenance; semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally; normal food products used in the dietary management of the disorders provided herein.

- Experimental/ Investigative
  - Which are experimental/investigative in nature, except as provided herein for routine patient costs incurred in connection with an approved clinical trial.
- Eyeglasses/Contact Lenses
  - For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury).
- Felonies
  - For any illness or injury you suffer during your commission of a felony, as long as such illness or injuries are not the result of a medical condition or an act of domestic violence.
- Foot Care
  - For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
- Health Care Management program
  - For any care, treatment, prescription drug or service which has been disallowed under the provisions of Health Care Management program.
- Immunizations
  - For immunizations required for foreign travel or employment, except as provided herein.
- Inpatient Admissions
  - For inpatient admissions which are primarily for diagnostic studies.
  - For inpatient admissions which are primarily for physical medicine services.
- Learning Disabilities
  - For any care that is related to conditions such as learning disabilities, behavioral problems, or intellectual disabilities, but not including care related to autism spectrum disorders, which extends beyond traditional medical management or medically necessary and appropriate inpatient confinement. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services related to the treatment of learning disorders or learning disabilities;

and d) services provided primarily for social or environmental change; or for respite care.

- For any care that is related to autism spectrum disorders which extends beyond traditional medical management, except as otherwise provided herein. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement, and aptitude testing); except for specific evaluation purposes directly related to medical treatment; and c) services provided primarily for respite care.

Legal Obligation

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

Medically Necessary and Appropriate

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

Medicare

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

Military Service

- To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.

Miscellaneous

- For any other medical or dental service or treatment except as provided herein.
- For any tests, screenings, examinations or any other services required by: (a) an employer or governmental body or agency in order to begin or to continue working or as a condition to performing the functions of any employment in a particular setting; (b) a school, college or university in order to enter onto school property or a particular location regardless of purpose, or; (c) a governmental body or agency for public surveillance purposes; and that does not relate to the furnishing or administration of an individualized test, screening or evaluation determined by the member's attending professional provider as being medically appropriate.
- Services for which coverage or reimbursement is determined to be illegal by your state of residence regardless of whether you travel to a state where the service can be legally performed.

Motor Vehicle Accident

- For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law,

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

- Nutritional Counseling
  - For nutritional counseling except as provided herein, or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
- Obesity
  - For the treatment of obesity, except for medical and surgical treatment of morbid obesity, or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
- Oral Surgery
  - For oral surgery procedures, except as provided herein.
- Physical Examinations
  - For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein.
- Preventive Care Services
  - For preventive care services, wellness services or programs, except as provided herein.
- Provider of Service
  - Which are not prescribed by or performed by or upon the direction of a professional provider.
  - Rendered by other than providers.
  - Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.
  - Which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same member.
  - Rendered by a provider who is a member of your immediate family.
  - Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
- Respite Care
  - For respite care.
- Smoking (nicotine) Cessation
  - For nicotine cessation support programs and/or classes, except as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
- Sterilization
  - For reversal of sterilization.

Termination Date	<ul style="list-style-type: none"> <li>● Incurred after the date of termination of your coverage except as provided herein.</li> </ul>
Therapy	<ul style="list-style-type: none"> <li>● 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.</li> </ul>
TMJ	<ul style="list-style-type: none"> <li>● 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.</li> </ul>
Vision Correction Surgery	<ul style="list-style-type: none"> <li>● For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.</li> </ul>
War	<ul style="list-style-type: none"> <li>● For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.</li> </ul>
Weight Reduction	<ul style="list-style-type: none"> <li>● For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.</li> </ul>
Workers' Compensation	<ul style="list-style-type: none"> <li>● For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.</li> </ul>

# How Your Health Care Program Works

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

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

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

## **Network Care**

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

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

## **Out-of-Network Care**

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

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

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

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

## **Provider Reimbursement and Member Liability**

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

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

responsibility. The member's total cost-sharing liability is the sum of the coinsurance plus any deductible and/or copayment obligations.

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

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

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

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

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

***No Prior Approval Requirement or Pre-Certification Requirement Applies When Members Receive Emergency Care services.***

## **Out-of-Area Care**

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

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

## **Inter-Plan Arrangements**

### **Out-of-Area Services**

Highmark has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "inter-plan arrangements." These inter-plan arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association. Whenever members access health care services outside 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, (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Highmark in determining the member's premiums.

### **Special Cases: Value-Based Programs**

If members receive covered services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Highmark through average pricing or fee schedule adjustments.

### **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](http://www.bcbsglobalcore.com). If members need assistance with their claim submissions, they should call the service center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

## **Your Provider Network**

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

To determine if your physician is in the network, call the Member Service toll-free telephone number on the back of your ID card, or log to [www.myhighmark.com](http://www.myhighmark.com).

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

Please note that while you or a family member can use the services, including behavioral health and well woman care, of any network physician or specialist without a referral and receive the maximum coverage under your benefit program, you are encouraged to select a personal or primary care provider. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal provider can help you select an appropriate specialist and work closely with that specialist when the need arises. In addition, primary care providers or their covering physicians are on call 24/7.

### **Remember:**

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

## **How to Obtain Information Regarding Your Physician**

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

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

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

## **Eligible Providers**

Eligible network providers include facilities, general practitioners, internists, obstetricians/gynecologists and a wide range of specialists all licensed where required and performing within the scope of such licensure. Eligible Providers include:

### ***Facility Providers:***

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

### ***Professional Providers:***

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

### ***Ancillary Providers:***

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

### ***Contracting Suppliers (for the sale or lease of):***

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

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

### ***Blue Distinction Centers***

The Blue Cross Blue Shield Association recognizes health care facilities located nationwide that demonstrate expertise in delivering quality specialty care safely, effectively and cost-efficiently. Those facilities are designated as Blue Distinction Centers (BDC) or Blue Distinction Centers+ (BDC+).

BDC are hospitals recognized for their expertise in delivering specialty care. They meet quality-focused criteria that emphasizes patient safety and outcomes. BDC+ are hospitals recognized for their expertise and efficiency in delivering specialty care. To qualify as a BDC+, the facility must first meet quality-focused criteria that emphasizes patient safety and outcomes, as well as cost of care measures.

Selection criteria are unique for each Blue Distinction Specialty Care Program reflecting that particular area of specialized care. A facility with proven expertise in one specialty area may or may not meet thresholds in other areas. For example, a BDC for one specialty may not necessarily meet the criteria for becoming a BDC for another specialty. A facility that has a BDC or BDC+ designation in multiple areas of care has met detailed criteria in each area.

# Health Care Management

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## Medical Management

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

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

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

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

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

## Benefits after Provider Termination from the Network

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

anticipated outcomes; or (vi) treatment for a terminal illness. If, however, the network provider is terminated for cause and you continue to seek treatment from that provider, then your plan will not cover payment for health care services provided to you following the date of termination. Any Services authorized under this section will be covered in accordance with the same terms and conditions as applicable to a network provider. Nothing in this section shall require payment of benefits for health care services that are not otherwise provided under the terms and conditions of your plan.

### ***Pre-Admission Certification***

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

#### **In-Area Network Care**

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

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

#### **Out-of-Area Network Care**

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

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

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

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

#### **Out-of-Network Care**

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

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

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

## **Care Utilization Review Process**

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

### ***Prospective Review***

Prospective review, also known as precertification or pre-service review, begins upon receipt of treatment information. Upon receipt and review of a precertification request from a provider, if Highmark determines that information is missing that is needed in order to make a decision, Highmark will notify the requesting provider that the information is missing. Highmark will identify the missing information with enough specificity so that the provider can submit the information needed to Highmark.

After receiving the request for care, Highmark:

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

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

### ***Concurrent Review***

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

### ***Discharge Planning***

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

## ***Outpatient Procedure or Covered Service Precertification***

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

### **In-Area Network Care**

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

### **Out-of-Area Care**

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

### **Out-of-Network Care**

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

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

## ***Retrospective Review***

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

## ***Case Management Services***

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

## ***Individual Case Management***

Case Management is the process by which Highmark, in its sole discretion, identifies alternative treatment modalities commensurate with your diagnosis profile and consults with the patient and attending professional

provider(s). Notwithstanding the foregoing, all decisions regarding the treatment to be provided to you shall remain the responsibility of the treating professional provider(s) and you working with Highmark.

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

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

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

### ***Health Improvement Services and Support***

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

### ***Selection of Providers***

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

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

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

### ***Wellness Programs***

Highmark offers you the opportunity to participate in programs of health promotion and/or disease prevention. When offered, these programs will be available to you without regard to health status. Whether or not you

decide to participate in such programs will not affect your continued eligibility, benefits, premiums, or cost-sharing obligations.

## **Precertification, Preauthorization and Pre-Service Claims Review Processes**

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

### ***Authorized Representatives***

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

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

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

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

### ***Decisions Involving Urgent Care Claims***

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

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

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

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

### ***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 Appeal Procedure subsection in the How to File a Claim section of this benefit booklet.

# General Information

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## Who is Eligible for Coverage

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

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

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

You may enroll your:

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

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

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

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.

Your newborn child will be covered under your program for 31 days from the moment of birth and without having to enroll the child. However, to be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within the 31-day period.

## **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.

## **Termination of Your Coverage Under the Group Contract**

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

## **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.

## **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**

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

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

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

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

The Plan will provide eligible benefits when needed, but you may be asked to show, execute and/or deliver documents, or take other necessary actions to support the Plan in any subrogation efforts. Neither you nor any of your dependents shall do anything to prejudice the right given to the Plan by this Subrogation section without the Plan's consent.

# A Recognized Identification Card

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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, 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 (when applicable)
- Member Service toll-free number (on back of card)
- Member website (on back of card)
- Toll-free telephone number for out-of-network facility admissions (on back of card)
- Suitcase symbol

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

# How to File a Claim

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## 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 twenty (20) days or as soon as reasonably possible after you have received covered services. Notice given by you or on your behalf to Highmark that includes information sufficient to identify you shall constitute sufficient notice of a claim to Highmark. You can give notice to Highmark by writing to the Member Service Department. The address of the Member Service Department can be found on your ID card. A charge shall be considered incurred on the date 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 fifteen (15) days following the date a notice of a claim is received, furnish you with claim forms for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of such notice, you shall be deemed to have complied with the requirements of this subsection as to filing a proof of loss upon submitting, within the time fixed in this subsection for filing proofs of loss, itemized 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 ninety (90) days after the date of such loss. Proof of loss must include all data necessary for Highmark to determine benefits. Failure to submit a proof of loss to Highmark within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will Highmark be required to accept a proof of loss later than 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 of the information and evidence of payment required on the claim form has been submitted in the manner described above. Highmark reserves the right to require additional information and documents as needed to support a claim that a covered service has been rendered.

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

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

#### **Time of Payment of Claims**

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

#### **Authorized Representative**

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

### **Limitation on Legal Actions**

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

### **Physical Examinations and Autopsy**

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

### **Your Explanation of Benefits Statement**

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

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

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

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

## **How to Voice a Complaint**

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

Highmark  
One Valley Square  
512 Township Line Road  
Blue Bell, PA 19422

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

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

## **Fraud or Provider Abuse**

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

## **Additional Information on How to File a Claim**

### **Member Inquiries**

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

### **Filing Benefit Claims**

- ***Authorized Representatives***  
You have the right to designate an authorized representative to file or pursue a request for

reimbursement or other post-service claim on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

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

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

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

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

## **Determinations on Benefit Claims**

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

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

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

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

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

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

## **Appeal Procedure**

Your benefit program maintains an appeal process involving two levels of review with the exception of urgent care claims (which involve a single level of review). At any time during the appeal process, you may choose to

designate a representative to participate in the appeal process on your behalf. You or your representative shall notify Highmark in writing of the designation.

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

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

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

### ***Initial Review***

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

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

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

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

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

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

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

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

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

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

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

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

### ***Second Level Review***

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

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

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

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

In rendering a decision on a second level appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care

professional will be a person who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the matter under review.

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

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

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

### ***External Review***

You have four (4) months from the date you receive notice of a final Highmark adverse benefit determination to file a request for an external review with Highmark. Note that for pre-service claims, the four (4) month period begins to run from the date you received Highmark's first-level adverse benefit determination.

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

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

### **Preliminary Review**

Highmark will conduct a preliminary review of your external review request within five (5) business days following the date on which Highmark receives the request. Highmark's preliminary review will determine whether:

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

Highmark will notify you of the results of its preliminary review within one (1) business day following its completion of the review. This will include our reasons regarding the ineligibility of your request, if applicable, and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not complete, Highmark's notification will describe the information or materials needed to make the

request complete. You will then have the balance of the four (4) month filing period or, if later, forty-eight (48) hours from receipt of the notice, to perfect your request for external review; whichever is later.

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

### **Referral to an Independent Review Organization (IRO)**

Highmark will, randomly or by rotation, select an IRO to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Within five (5) business days thereafter, Highmark will provide the IRO with documents and information we considered when making our final adverse benefit determination. The IRO may reverse Highmark's final adverse benefit determination if the documents and information are not provided to the IRO within the five-day time frame.

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

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

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

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

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

### **Expedited External Review (Applies to Urgent Care Claims Only)**

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

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

item or service for which you received emergency services, but you have not been discharged from the facility rendering the emergency services.

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

### **Referral to an Independent Review Organization (IRO)**

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

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

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

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

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

# Member Service

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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](http://www.myhighmark.com). For TTY/TDD hearing impaired service, please dial 711 and the number on the back of your ID card.

As a Highmark member, you have access to a wide range of readily available health education tools and support services.

## **Blues On Call<sup>sm</sup> - 24/7 Health Decision Support**

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

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

### ***Help with common illnesses, injuries and questions***

Health coaches can address any health topic that concerns you:

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

You do not have to be ill to talk to a health coach. Call to learn about programs and other resources available to help you manage:

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

### ***Help with chronic conditions***

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

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

## **Highmark Website**

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

Go to [www.myhighmark.com](http://www.myhighmark.com). Then click on the Members tab and log in to your home page to take advantage of all kinds of programs and resources to help you understand your health status, including an online wellness profile. Then, take steps toward real health improvement.

## **Baby Blueprints®**

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

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

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

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

### **Easy Enrollment**

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

# Member Rights and Responsibilities

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

## ***You have the right to:***

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

## ***You have a responsibility to:***

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

## **How We Protect Your Right to Confidentiality**

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

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

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

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

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

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

# Terms You Should Know

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

**Acupuncturist** - A licensed acupuncturist performing within the scope of such licensure. Where there is no licensure law, the acupuncturist must be certified by the appropriate professional body.

**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.

Ambulance Service  
Clinical Laboratory  
Diabetes Prevention Provider  
Home Infusion Therapy Provider

Independent Diagnostic Testing Facility (IDTF)  
Suite Infusion Therapy Provider  
Suppliers

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

**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.

**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.

**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.

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

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

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

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

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

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

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

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

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

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

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

**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.

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

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

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

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

**Dentist** - A person who is a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.), licensed where required and performing services within the scope of such licensure.

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

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

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

**Detoxification Services (Withdrawal Management Services)** - Inpatient and outpatient services for the treatment of withdrawal from alcohol or drugs. Inpatient services must include twenty-four hour nursing care and physician oversight.

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

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

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

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

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

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

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

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

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

**Effective Date** - The date when your coverage begins.

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

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

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

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

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

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

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

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

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

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

**Family Deductible** - The sum of the individual deductible amounts for a specified number of family members, who are covered, and the point at which no further deductible amounts must be satisfied by any covered family member.

**Family Deductible** - A specified dollar amount of liability for covered services that must be incurred by members covered under one (1) family coverage before Highmark will assume liability for all or part of the remaining covered service incurred by any individual member under that family coverage 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.

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

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

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

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

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

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

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

**Highmark Managed Care Network Service Area** - The geographic area consisting of the following counties in western Pennsylvania:

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

**Highmark Managed Care Facility Provider** - A facility provider, licensed where required and performing within the scope of its license, that has entered into a Highmark Managed Care Network agreement, either directly or indirectly, with Highmark Inc. pertaining to payment as a participant in a managed care network for covered services rendered to you.

**Highmark Managed Care Network** - All Highmark managed care facility providers and professional providers, approved as a network by the Pennsylvania Department of Health, that have entered into a network agreement, either directly or indirectly, with Highmark Inc. pertaining to payment as a participant in a managed care network for covered services rendered to you.

**Highmark Managed Care Professional Provider** - A professional provider, licensed where required and performing within the scope of its license, that has entered into a Highmark Managed Care Network agreement, either directly or indirectly, with Highmark Inc. pertaining to payment as a participant in a managed care network for covered services rendered to you.

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

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

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

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

**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 you receive the service or supply for which the charge is made.

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

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

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

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

**Intensive Outpatient Program** - A time-limited, separate and distinct outpatient program that includes individual therapy, family therapy, group therapy and medication management following an individualized treatment plan. Participation in an Intensive Outpatient Program may involve two (2) or more hours of programming a week. The program may be offered during the day or evening hours and can be a step-down from a higher level of care or a step-up to prevent the need for a higher level of care. The goals of an Intensive Outpatient Program are to prevent or reduce the need for inpatient hospitalization and to reduce or stabilize symptoms and functional impairment of a psychiatric or co-occurring substance use disorder. Medically necessary treatment is provided within a structured therapeutic milieu.

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

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

**Maximum** - The greatest amount for which your program 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.

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

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

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

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

Notwithstanding the above when you receive outpatient prescription drugs the network is designated by the Plan.

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

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

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

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

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

Cross Blue Shield Association located in a service area other than a Highmark or Highmark affiliate service area, pertaining to payment as a participant in your network for covered services rendered to a member.

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

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

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

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

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

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

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

**Out-of-Network Provider** - An ancillary provider, professional provider or facility provider who has not entered into an agreement, either directly or indirectly, with Highmark or a Highmark affiliate, or with any licensee of the Blue Cross Blue Shield Association located in a service area other than a Highmark or Highmark affiliate service area, pertaining to payment as a participant in your network for covered services rendered to a member.

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

**Out-of-Pocket Limit** - The out-of-pocket limit refers to the specified dollar amount of expense incurred for covered services in a benefit period. When the specified dollar amount is attained, the level of benefit increases as specified in the Summary of Benefits. See the Summary of Benefits for the out-of-pocket limit.

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

**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.

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

#### In-Network Benefits

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

#### Out-of-Network Benefits

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

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

For non-emergency covered medical services received at certain in-network facilities from out-of-network physicians when such services are either ancillary, or non-ancillary that have not satisfied the notice and consent criteria required by federal law, the plan allowance may be based on the (i) the reference price (as defined below) if out of area; (ii) the recognized amount (as defined below); (iii) the amount agreed to by the out-of-network provider and Highmark; or (iv) the amount determined by Independent Dispute Resolution (IDR).

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

#### Emergency Services Provided by an Out-of-Network Provider

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

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

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

### In All Other Cases

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

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

When covered medical services are received from an out-of-network provider outside of the Highmark service area, the plan allowance may be determined on the basis of the reference price (as defined below) or on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your health care program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

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

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

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

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

Bucks                      Chester                      Delaware                      Montgomery                      Philadelphia

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

**Preferred Provider Organization (PPO) Program** - A program that does not require the selection of a primary care provider, but is based on a provider network made up of physicians, hospitals and other health

care facilities. Using this provider network helps assure that you receive maximum coverage for eligible services.

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

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

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

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

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

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

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

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

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

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

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

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

A residential treatment program must provide the following:

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

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

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

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

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

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

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

- minimal care, custodial care, ambulatory care, or part-time care services; or
- 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:

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

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

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

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

**State-Owned Psychiatric Hospital** - A facility provider, that is owned and operated by the Commonwealth of Pennsylvania, which is primarily engaged in providing treatment and/or care for the Inpatient

treatment of mental illness for individuals aged eighteen and older whose hospitalization is ordered by a court of competent jurisdiction through a civil commitment proceeding.

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

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

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

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

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

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

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

- a. **Cardiac Rehabilitation** - the physiological and psychological rehabilitation of patients with cardiac conditions through regulated exercise programs.
- b. **Chemotherapy** - the treatment of malignant disease by chemical or biological antineoplastic agents.
- c. **Dialysis Treatments** - the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body through hemodialysis or peritoneal dialysis. Dialysis treatment includes home dialysis.
- d. **Infusion Therapy** - the treatment by the administration of medically necessary and appropriate fluid or medication via a central or peripheral vein when performed, furnished, and billed by a facility provider or ancillary provider in accordance with accepted medical practice.

- e. **Occupational Therapy** - the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational.
- f. **Physical Medicine** - the treatment by physical means or modalities such as, but not limited to, mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities, and rehabilitative procedures, performed to relieve pain and restore level of function following disease, illness, or injury.
- g. **Radiation Therapy** - the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.
- h. **Respiratory Therapy** - the introduction of dry or moist gases into the lungs for treatment purposes.
- i. **Speech Therapy** - the treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

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

**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.

Highmark is a registered mark of Highmark Inc.

Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association.

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

The Blue Cross Blue Shield Association is an independent company that does not provide Highmark Blue Shield products and services. It is solely responsible for the services described in this booklet.

You are hereby notified that Highmark Blue Shield provides administrative services only on behalf of your self-funded group health plan. Highmark 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 Shield to use the familiar Blue Cross and Blue Shield words and symbols. Highmark Blue Shield is neither the insurer nor the guarantor of benefits under your group health plan. Your Group remains fully responsible for the payment of group health plan benefits.

## Summary of HDHP Benefits

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.

### eResearch Technology, Inc. (Clario) QHDHP Plan

Effective 01/01/2024

Benefit	Network	Out-of-Network
<b>General Provisions</b>		
<b>Benefit Period</b> (1)	Contract Year	
<b>Deductible</b> (per benefit period) (non-embedded)		
Employee only	\$2,000	\$2,500
Family	\$4,000	\$5,000
<b>Plan Pays</b> – payment based on the plan allowance	90% after deductible	80% after deductible
<b>Out-of-Pocket Maximums</b> (Once met, plan pays 100% for the rest of the benefit period) (embedded)		
Employee only	\$3,000	\$6,000
Individual member within a Family	\$4,000	\$6,000
Family	\$6,000	\$12,000
<b>Office/Clinic/Urgent Care Visits</b>		
<b>Retail Clinic Visits</b>	90% after deductible	80% after deductible
<b>Primary Care Provider Office Visits &amp; Virtual Visits</b>	90% after deductible	80% after deductible
<b>Specialist Office Visits &amp; Virtual Visits</b>	90% after deductible	80% after deductible
<b>Urgent Care Center Visits</b>	90% after deductible	80% after deductible
<b>Telemedicine</b> (3)	90% after deductible	Not Covered
<b>Preventive Care</b>		
<b>Routine Adult</b>		
Physical exams	100% (deductible does not apply)	80% after deductible
Adult immunizations	100% (deductible does not apply)	80% after deductible
Colorectal cancer screening (includes colonoscopy; sigmoidoscopy; barium enema; blood occult)	100% (deductible does not apply)	80% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	80% after deductible
Mammograms, annual routine	100% (deductible does not apply)	80% after deductible
<b>Routine Pediatric</b>		
Physical exams	100% (deductible does not apply)	80% after deductible
Pediatric immunizations	100% (deductible does not apply)	80% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
<b>Hospital and Medical/Surgical Expenses (including maternity)</b>		
<b>Hospital Inpatient</b>	90% after deductible	80% after deductible Limit: 70 days per benefit period
<b>Hospital Outpatient</b>	90% after deductible	80% after deductible
<b>Maternity</b> (non-preventive facility & professional services)	90% after deductible	80% after deductible
<b>Medical/Surgical</b> (except office visits)	90% after deductible	80% after deductible
<b>Emergency Services</b>		
<b>Emergency Room Services</b> (includes emergency medical and emergency accident)	90% after In-Network deductible	
<b>Ambulance – Emergency</b>	90% after In-Network deductible	
<b>Therapy and Rehabilitation Services</b>		
<b>Physical Medicine</b>	90% after deductible	80% after deductible
	Limit: 30 visits per benefit period, combined with Occupational Therapy. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
<b>Occupational Therapy</b>	90% after deductible	80% after deductible
	Limit: 30 visits per benefit period, combined with Physical Medicine. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
<b>Speech Therapy</b>	90% after deductible	80% after deductible
	Limit: 20 visits per benefit period. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
<b>Spinal Manipulations</b>	90% after deductible	80% after deductible
	Limit: 20 visits per benefit period.	
<b>Cardiac Rehabilitation</b>	90% after deductible	80% after deductible

Benefit	Network	Out-of-Network
Respiratory Therapy	90% after deductible	80% after deductible
	Limit: 36 visits per benefit period	
Other Therapy Services (Infusion Therapy, Chemotherapy, Radiation Therapy, and Dialysis)	90% after deductible	80% after deductible
<b>Mental Health/Substance Abuse</b>		
Inpatient	90% after deductible	80% after deductible
Inpatient Detoxification/Rehabilitation		
Outpatient	90% after deductible	80% after deductible
Autism (includes ABA Therapy)	90% after deductible	80% after deductible
<b>Other Services</b>		
Acupuncture	90% after deductible	80% after deductible
	Limit: 18 visits per calendar year	
Allergy Extracts and Injections	90% after deductible	80% after deductible
Assisted Fertilization Procedures	90% after deductible	80% after deductible
Bariatric Surgery	90% after deductible Limit: \$10,000 per lifetime for surgeon's charges	Not Covered
Dental Services Related to Accidental Injury	90% after deductible	80% after deductible
Diagnostic Services <i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	90% after deductible (applies for all places of service)	80% after deductible
	<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing, ECG, EEG, echocardiogram, pulmonary study, stress test, audiology test, etc.)	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	80% after deductible
Wigs	90% after deductible	90% after deductible
	Limit: \$500 per benefit period	
Hearing Aids and/or exams	90% after deductible Limit: 2 devices every 3 years	Not Covered
Home Health Care/Visiting Nurse	90% after deductible	80% after deductible
Hospice	90% after deductible	80% after deductible
Injection	90% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment (4)	90% after deductible	80% after deductible
Private Duty Nursing	Not Covered	
Skilled Nursing Facility Care	90% after deductible	80% after deductible
	Limit: 120 days per benefit period	
Transplant Services	<u>When Performed in a BDC/BDC+</u> 100% after deductible	80% after deductible Limit: surgeon's benefit maximum per organ Bone Marrow - \$130,000 Heart - \$150,000 Heart/Lung - \$185,000 Kidney - \$80,000 Kidney/Pancreas - \$80,000 Liver - \$230,000 Lung - \$185,000 Pancreas - \$50,000
	<u>When Performed in a Non-BDC</u> 90% after deductible	
Travel Limit for Transplants performed at BDC/BDC+ only	Limit: \$10,000 per transplant	N/A
Precertification Requirements (5)	Yes	N/A

- (1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
- (2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, prescription drug cost share and any qualified medical expense.
- (3) Services must be performed by a Blue Shield approved telemedicine provider.
- (4) 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.
- (5) Blue Shield Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (6) Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. To obtain a prescription medication that is not included on this formulary, your provider must complete the 'Prescription Drug Medication Request Form' and return it to the Pharmacy Affairs Department for clinical review. Under the mandatory generic provision, you are responsible for the payment differential when a generic drug is available, and you or your provider specifies a brand name drug. Your payment is the price difference between the brand name drug and the generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

**HIGHMARK INC.  
NOTICE OF PRIVACY PRACTICES**

**PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)**

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**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.**

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**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 practically 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



# PPO BLUE

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*PPO Program*

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

**Clario, Inc. Core Family Active  
Group 10775304, 05, 06, 07, 70, 71, 75, 76, 77  
Effective January 01, 2024**



## **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 languagesIf 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](mailto: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 المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

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

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

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

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

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

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

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

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

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**Disclosure**

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

**Non-Assignment**

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

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

# Introduction to Your Health Care Program

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

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

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

- ***Your health care program gives you freedom of choice.*** You are not required to select a primary care provider to receive covered care. You have access to a large provider network of physicians, hospitals, and other providers in Pennsylvania, as well as providers across the country who are part of the local PPO network. For a higher level of coverage, you need to receive care from a network provider. However, you can go outside the network and still receive care at the lower level of coverage. To locate a network provider near you, or to learn whether your current physician is in the network, log onto your Highmark member website, [www.myhighmark.com](http://www.myhighmark.com).
- ***Your health care program gives you "stay healthy" care.*** You are covered for a range of preventive care, including physical examinations and selected diagnostic tests. Preventive care is a proactive approach to health management that can help you stay on top of your health status and prevent more serious, costly care down the road.

You can review your health care program's 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.

# How Your Benefits Are Applied

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

## **Benefit Period**

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

## **Medical Cost-Sharing Provisions**

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

### ***Coinsurance***

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

### ***Copayment***

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

### ***Deductible***

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

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

### ***Family Deductible***

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

For a family with several covered dependents, you pay no more than two individual deductibles per family, as specified under family deductible. After each of the two 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 has not been met.

### ***Out-of-Pocket Limit***

The out-of-pocket limit refers to the specified dollar amount of expense incurred for covered services in a benefit period. When the specified dollar amount is attained, the level of benefit increases as specified in the

Summary of Benefits. See the Summary of Benefits for the out-of-pocket limit. The out-of-pocket limit does not include amounts in excess of the plan allowance. All out-of-pocket amounts are based on the plan allowance.

### ***Total Maximum Out-of-Pocket***

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

### **Maximum**

The greatest amount of benefits that the program will provide for covered services within a prescribed period of time. This could be expressed in dollars, number of days or number of services. In connection with such day and/or visit limits, all services received by you during a benefit period will reduce the remaining number of days and/or visits available under that benefit, regardless of whether you have satisfied your deductible.

# Covered Services - Medical Program

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

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

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

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

## **Outpatient Medical Care Services (Visits and Consultations)**

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

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

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

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

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

Professional providers may also request consultations from another professional provider for an advisory opinion regarding a diagnosis or management of your medical problem. These are called "provider-to-provider" consultations or "interprofessional consultations". ***Interprofessional consultations do not include provider interaction with you.***

Different types of providers, their services and their locations may require different payment amounts and result in different charges. You may be responsible for a facility fee, clinic charge or similar fee (in addition to any professional fees) if your office visit or service is provided at a hospital, facility provider, ancillary provider,

retail clinic or urgent care center. You may also be responsible for a charge for an interprofessional consultation, which may occur during your office visit or at a different time.

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

#### ***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;

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

- ii. personal history of BRCA1 or BRCA2 gene mutations;
  - iii. a first-degree relative with a BRCA1 or BRCA2 gene mutation;
  - iv. prior therapeutic thoracic radiation therapy between 10 and 30 years of age; or
  - v. personal history of Li-Fraumeni syndrome, Cowden syndrome or Bannayan-Riley-Ruvalcaba syndrome or a first-degree relative with one of these syndromes; or
6. extremely dense breast tissue based on breast composition categories;

one (1) supplemental breast screening every year using standard or abbreviated magnetic resonance imaging (MRI) or, if such imaging is not possible, ultrasound if recommended by the treating physician to screen for breast cancer when there is no abnormality seen or suspected in the breast.

- Mammographic screenings for all members regardless of age when such services are prescribed by a physician.

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

### ***Diabetes Prevention Program***

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

### ***Tobacco Use, Counseling and Interventions***

Benefits are provided for screenings for tobacco use and, for those who use tobacco products, two tobacco cessation attempts per year. A tobacco cessation attempt includes four tobacco cessation counseling sessions and preventive 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, coverage for contraceptive methods and counseling for all members capable of pregnancy and breastfeeding support and counseling.

### ***Preventive Prescription Drugs (Outpatient)***

Coverage will be provided for prescription and over-the-counter drugs that are prescribed for preventive purposes.

## **Pediatric Care**

### ***Routine Physical Examinations***

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

### ***Pediatric Immunizations***

Benefits are provided to members under 21 years of age and dependent children for those pediatric immunizations, including the immunizing agents, which as determined by the Pennsylvania Department of

Health conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services. Coinsurance must not be more restrictive than coinsurance levels for all other benefits.

### ***Preventive Prescription Drugs (Outpatient)***

Coverage will be provided for prescription and over-the-counter drugs that are prescribed for preventive purposes.

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

### **Outpatient Evaluation and Management Services**

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

### **Surgery**

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

## **Maternity Services**

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

### ***Complications of Pregnancy***

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

### ***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. This coverage 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.

## **Medical Services**

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

### **Concurrent Care**

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

### **Consultation**

Consultation services rendered to an inpatient by another professional provider at the request of the attending professional provider. Consultation does not include staff consultations which are required by facility provider rules and regulations. Benefits are limited to one (1) consultation per consultant per admission.

### **Inpatient Medical Care Visits**

Benefits are provided for inpatient medical care visits.

### **Intensive Medical Care**

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

### **Routine Newborn Care**

Professional provider visits to examine the newborn infant.

## **Surgical Services**

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

### ***Anesthesia***

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

### ***Assistant at Surgery***

Services of a physician or of the physician's employed physician assistant (PA), or certified registered nurse practitioner (CRNP) or certified nurse midwife (CNM), who actively assists the operating surgeon in the performance of covered surgery. Benefits will be provided for an assistant at surgery only if a house staff member, intern or resident is not available.

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

### ***Mastectomy and Breast Cancer Reconstruction***

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

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

### ***Special Surgery***

- Oral Surgery

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

- Extraction of impacted third molars when partially or totally covered by bone
- Extraction of teeth in preparation for radiation therapy
- Mandibular staple implant, provided the procedure is not done to prepare the mouth for dentures
- Lingual frenectomy, frenotomy or frenoplasty (to correct tongue-tie)

- Facility provider and anesthesia services rendered in a facility setting in conjunction with non-covered dental procedures when determined by Highmark to be medically necessary and appropriate due to your age and/or medical condition
  - Accidental injury to the jaw or structures contiguous to the jaw except teeth
  - The correction of a non-dental physiological condition which has resulted in a severe functional impairment
  - Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth
  - Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus
- Sterilization
    - Sterilization regardless of medical necessity and appropriateness.

### ***Second Surgical Opinion***

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

#### **Keep in mind that:**

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

### ***Surgery***

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

### **Emergency Care Services**

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

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

ancillary services necessary to evaluate such injury or emergency medical condition and further medical examination and treatment as required to stabilize the patient.

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

- a. you are unable to travel using non-medical transportation or non-emergency medical transportation;  
or
- b. you do not consent to be transferred,

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

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

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

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

## **Ambulance Service**

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

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

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

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

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

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

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

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

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

## **Therapy and Rehabilitation Services**

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

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

## **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.

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

### ***Inpatient Facility Services***

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

### ***Inpatient Medical Services***

Covered inpatient medical services provided by a professional provider:

- Individual psychotherapy

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

### ***Partial Hospitalization Program***

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

### ***Outpatient Mental Health Care Services***

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

A specialist virtual visit between you and a specialist (including a behavioral health specialist) via audio and video telecommunications. Benefits are provided for a specialist virtual visit when you communicate with the specialist from any location, such as your home, office, or another mobile location, or if you travel to a provider-based location referred to as a provider originating site. If you communicate with the specialist from a provider originating site, you will be responsible for the specialist virtual visit provider originating site fee.

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.

## **Other Services**

### **Acupuncture Therapy Services**

Benefits will be provided for acupuncture therapy services rendered by a professional provider which are determined to be medically necessary and appropriate. This benefit includes acupuncture therapy services when used to treat nausea associated with surgery, chemotherapy or pregnancy. Acupuncture therapy services are also covered as an adjunct to standard conservative therapy for the following chronic conditions when other conservative methods of treatment have failed: chronic low back pain and chronic headaches or migraine headaches. Coverage does not include acupuncture therapy services for the treatment of pain or maintenance treatment where the patient's symptoms are neither regressing nor improving.

### **Allergy Extract/Injections**

Benefits are provided for allergy extract and allergy injections.

### **Anesthesia for Non-Covered Dental Procedures (Limited)**

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

### **Artificial Insemination**

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

### **Assisted Fertilization Treatment**

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

### **Blue Distinction Specialty Care**

The Blue Distinction Specialty Care Program is a nationwide quality designation program, awarded by the Blue Cross Blue Shield Association, recognizing health care providers that demonstrate expertise in delivering quality specialty care safely, effectively and cost-efficiently. The Blue Distinction Specialty Care Program

offered by your group focuses on the following areas of specialty care provided at the designated health care providers.

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

## **Transplants**

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

## **Dental Services Related to Accidental Injury**

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

## **Diabetes Treatment**

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

- 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).

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

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

## **Diagnostic Services**

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

### ***Advanced Imaging Services***

Include, but are not limited to, computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET scan), positron emission tomography/computed tomography (PET/CT scan).

### ***Basic Diagnostic Services***

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

## **Durable Medical Equipment**

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

## **Hearing Care Services**

Benefits include coverage for diagnostic testing and an audiometric examination and purchase 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 supplier who is a network provider.

## **Home Infusion and Suite Infusion Therapy Services**

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

## **Home Health Care Services/Hospice Care Services**

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

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

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

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

## **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.

## **Therapeutic Injections**

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

## **Transplant Services**

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

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

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

## **Prescription Drugs (Outpatient)**

Coverage will be provided for prescription and over-the-counter drugs that are set forth within a predefined schedule\* and that are prescribed for preventive purposes. Benefits will be provided for prescription drugs in the amounts specified in the Summary of Benefits of this booklet.

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\* 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.

Injectable insulin and drugs that under Federal law may only be dispensed by written prescription and are approved for general use by the FDA. The drugs must be dispensed for your outpatient use by a pharmacy provider on or after your effective date.

# What Is Not Covered

Except as specifically provided in this booklet 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
Allergy Testing	<ul style="list-style-type: none"> <li>For allergy testing, except as provided herein.</li> </ul>
Ambulance	<ul style="list-style-type: none"> <li>For ambulance services, except as provided herein.</li> </ul>
Comfort/Convenience Items	<ul style="list-style-type: none"> <li>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.</li> </ul>
Compounded Medications	<ul style="list-style-type: none"> <li>For compounded medications.</li> </ul>
Cosmetic Surgery	<ul style="list-style-type: none"> <li>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.</li> </ul>
Court Ordered Services	<ul style="list-style-type: none"> <li>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.</li> </ul>
Custodial Care	<ul style="list-style-type: none"> <li>For custodial care, domiciliary care, protective and supportive care including educational services, rest cures and convalescent care.</li> </ul>
Dental Care	<ul style="list-style-type: none"> <li>Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease except for dental expenses otherwise covered because of accidental bodily injury to sound natural teeth and for orthodontic treatment for congenital cleft palates as provided herein.</li> </ul>
Diabetes Prevention Program	<ul style="list-style-type: none"> <li>For a diabetes prevention program offered by other than a network diabetes prevention provider.</li> </ul>
Effective Date	<ul style="list-style-type: none"> <li>Rendered prior to your effective date of coverage.</li> </ul>
Enteral Foods	<ul style="list-style-type: none"> <li>For the following services associated with the additional enteral foods benefits provided under your program: blenderized food, baby food, or regular shelf food; milk or soy-based infant formulae with intact proteins; any formulae, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for</li> </ul>

caloric supplementation, limitation or maintenance; semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally; normal food products used in the dietary management of the disorders provided herein.

- Experimental/ Investigative
  - Which are experimental/investigative in nature, except as provided herein for routine patient costs incurred in connection with an approved clinical trial.
- Eyeglasses/Contact Lenses
  - For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury).
- Felonies
  - For any illness or injury you suffer during your commission of a felony, as long as such illness or injuries are not the result of a medical condition or an act of domestic violence.
- Foot Care
  - For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
- Health Care Management program
  - For any care, treatment, prescription drug or service which has been disallowed under the provisions of Health Care Management program.
- Immunizations
  - For immunizations required for foreign travel or employment, except as provided herein.
- Inpatient Admissions
  - For inpatient admissions which are primarily for diagnostic studies.
  - For inpatient admissions which are primarily for physical medicine services.
- Learning Disabilities
  - For any care that is related to conditions such as learning disabilities, behavioral problems, or intellectual disabilities, but not including care related to autism spectrum disorders, which extends beyond traditional medical management or medically necessary and appropriate inpatient confinement. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services related to the treatment of learning disorders or learning disabilities;

and d) services provided primarily for social or environmental change; or for respite care.

- For any care that is related to autism spectrum disorders which extends beyond traditional medical management, except as otherwise provided herein. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement, and aptitude testing); except for specific evaluation purposes directly related to medical treatment; and c) services provided primarily for respite care.

Legal Obligation

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

Medically Necessary and Appropriate

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

Medicare

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

Military Service

- To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.

Miscellaneous

- For any other medical or dental service or treatment except as provided herein.
- For any tests, screenings, examinations or any other services required by: (a) an employer or governmental body or agency in order to begin or to continue working or as a condition to performing the functions of any employment in a particular setting; (b) a school, college or university in order to enter onto school property or a particular location regardless of purpose, or; (c) a governmental body or agency for public surveillance purposes; and that does not relate to the furnishing or administration of an individualized test, screening or evaluation determined by the member's attending professional provider as being medically appropriate.
- Services for which coverage or reimbursement is determined to be illegal by your state of residence regardless of whether you travel to a state where the service can be legally performed.

Motor Vehicle Accident

- For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law,

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

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|------------------------------|---|
| Nutritional Counseling       | <ul style="list-style-type: none"><li>● For nutritional counseling except as provided herein, or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.</li></ul>  |
| Obesity                      | <ul style="list-style-type: none"><li>● For the treatment of obesity, except for medical and surgical treatment of morbid obesity, or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.</li></ul>   |
| Oral Surgery                 | <ul style="list-style-type: none"><li>● For oral surgery procedures, except as provided herein.</li></ul>   |
| Physical Examinations        | <ul style="list-style-type: none"><li>● 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.</li></ul>  |
| Preventive Care Services     | <ul style="list-style-type: none"><li>● For preventive care services, wellness services or programs, except as provided herein.</li></ul>   |
| Provider of Service          | <ul style="list-style-type: none"><li>● Which are not prescribed by or performed by or upon the direction of a professional provider.</li><li>● Rendered by other than providers.</li><li>● Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.</li><li>● 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.</li><li>● Rendered by a provider who is a member of your immediate family.</li><li>● Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.</li></ul> |
| Respite Care                 | <ul style="list-style-type: none"><li>● For respite care.</li></ul>   |
| Smoking (nicotine) Cessation | <ul style="list-style-type: none"><li>● For nicotine cessation support programs and/or classes, except as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.</li></ul>  |
| Sterilization                | <ul style="list-style-type: none"><li>● For reversal of sterilization.</li></ul>  |

Termination Date	<ul style="list-style-type: none"> <li>Incurred after the date of termination of your coverage except as provided herein.</li> </ul>
Therapy	<ul style="list-style-type: none"> <li>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.</li> </ul>
TMJ	<ul style="list-style-type: none"> <li>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.</li> </ul>
Vision Correction Surgery	<ul style="list-style-type: none"> <li>For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.</li> </ul>
War	<ul style="list-style-type: none"> <li>For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.</li> </ul>
Weight Reduction	<ul style="list-style-type: none"> <li>For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.</li> </ul>
Workers' Compensation	<ul style="list-style-type: none"> <li>For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.</li> </ul>

# How Your Health Care Program Works

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

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

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

## **Network Care**

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

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

## **Out-of-Network Care**

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

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

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

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

## **Provider Reimbursement and Member Liability**

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

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

responsibility. The member's total cost-sharing liability is the sum of the coinsurance plus any deductible and/or copayment obligations.

When you receive covered services from an out-of-network provider, in addition to your cost-sharing liability described above, you will be responsible for the difference between your plan's payment and the provider's billed charge. If you receive services which are not covered under your plan, you are responsible for all charges associated with those services. However, the following covered services when received from an out-of-network provider will be provided at the applicable network level of benefits and you will not be responsible for such difference:

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

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

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

***No Prior Approval Requirement or Pre-Certification Requirement Applies When Members Receive Emergency Care services.***

## **Out-of-Area Care**

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

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

## **Inter-Plan Arrangements**

### **Out-of-Area Services**

Highmark has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "inter-plan arrangements." These inter-plan arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association. Whenever members access health care services outside 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, (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Highmark in determining the member's premiums.

### **Special Cases: Value-Based Programs**

If members receive covered services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Highmark through average pricing or fee schedule adjustments.

### **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](http://www.bcbsglobalcore.com). If members need assistance with their claim submissions, they should call the service center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

## **Your Provider Network**

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

To determine if your physician is in the network, call the Member Service toll-free telephone number on the back of your ID card, or log to [www.myhighmark.com](http://www.myhighmark.com).

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

Please note that while you or a family member can use the services, including behavioral health and well woman care, of any network physician or specialist without a referral and receive the maximum coverage under your benefit program, you are encouraged to select a personal or primary care provider. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal provider can help you select an appropriate specialist and work closely with that specialist when the need arises. In addition, primary care providers or their covering physicians are on call 24/7.

### **Remember:**

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

## **How to Obtain Information Regarding Your Physician**

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

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

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

## **Eligible Providers**

Eligible network providers include facilities, general practitioners, internists, obstetricians/gynecologists and a wide range of specialists all licensed where required and performing within the scope of such licensure. Eligible Providers include:

### ***Facility Providers:***

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

### ***Professional Providers:***

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

### ***Ancillary Providers:***

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

### ***Contracting Suppliers (for the sale or lease of):***

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

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

### ***Blue Distinction Centers***

The Blue Cross Blue Shield Association recognizes health care facilities located nationwide that demonstrate expertise in delivering quality specialty care safely, effectively and cost-efficiently. Those facilities are designated as Blue Distinction Centers (BDC) or Blue Distinction Centers+ (BDC+).

BDC are hospitals recognized for their expertise in delivering specialty care. They meet quality-focused criteria that emphasizes patient safety and outcomes. BDC+ are hospitals recognized for their expertise and efficiency in delivering specialty care. To qualify as a BDC+, the facility must first meet quality-focused criteria that emphasizes patient safety and outcomes, as well as cost of care measures.

Selection criteria are unique for each Blue Distinction Specialty Care Program reflecting that particular area of specialized care. A facility with proven expertise in one specialty area may or may not meet thresholds in other areas. For example, a BDC for one specialty may not necessarily meet the criteria for becoming a BDC for another specialty. A facility that has a BDC or BDC+ designation in multiple areas of care has met detailed criteria in each area.

# Health Care Management

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## Medical Management

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

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

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

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

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

## Benefits after Provider Termination from the Network

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

anticipated outcomes; or (vi) treatment for a terminal illness. If, however, the network provider is terminated for cause and you continue to seek treatment from that provider, then your plan will not cover payment for health care services provided to you following the date of termination. Any Services authorized under this section will be covered in accordance with the same terms and conditions as applicable to a network provider. Nothing in this section shall require payment of benefits for health care services that are not otherwise provided under the terms and conditions of your plan.

### ***Pre-Admission Certification***

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

#### **In-Area Network Care**

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

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

#### **Out-of-Area Network Care**

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

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

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

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

#### **Out-of-Network Care**

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

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

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

## **Care Utilization Review Process**

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

### ***Prospective Review***

Prospective review, also known as precertification or pre-service review, begins upon receipt of treatment information. Upon receipt and review of a precertification request from a provider, if Highmark determines that information is missing that is needed in order to make a decision, Highmark will notify the requesting provider that the information is missing. Highmark will identify the missing information with enough specificity so that the provider can submit the information needed to Highmark.

After receiving the request for care, Highmark:

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

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

### ***Concurrent Review***

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

### ***Discharge Planning***

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

## ***Outpatient Procedure or Covered Service Precertification***

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

### **In-Area Network Care**

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

### **Out-of-Area Care**

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

### **Out-of-Network Care**

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

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

## ***Retrospective Review***

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

## ***Case Management Services***

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

## ***Individual Case Management***

Case Management is the process by which Highmark, in its sole discretion, identifies alternative treatment modalities commensurate with your diagnosis profile and consults with the patient and attending professional

provider(s). Notwithstanding the foregoing, all decisions regarding the treatment to be provided to you shall remain the responsibility of the treating professional provider(s) and you working with Highmark.

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

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

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

### ***Health Improvement Services and Support***

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

### ***Selection of Providers***

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

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

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

### ***Wellness Programs***

Highmark offers you the opportunity to participate in programs of health promotion and/or disease prevention. When offered, these programs will be available to you without regard to health status. Whether or not you

decide to participate in such programs will not affect your continued eligibility, benefits, premiums, or cost-sharing obligations.

## **Precertification, Preauthorization and Pre-Service Claims Review Processes**

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

### ***Authorized Representatives***

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

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

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

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

### ***Decisions Involving Urgent Care Claims***

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

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

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

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

### ***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 Appeal Procedure subsection in the How to File a Claim section of this benefit booklet.

# General Information

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## Who is Eligible for Coverage

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

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

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

You may enroll your:

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

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

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

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.

Your newborn child will be covered under your program for 31 days from the moment of birth and without having to enroll the child. However, to be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within the 31-day period.

## **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.

## **Termination of Your Coverage Under the Group Contract**

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

## **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.

## **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**

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

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

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

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

The Plan will provide eligible benefits when needed, but you may be asked to show, execute and/or deliver documents, or take other necessary actions to support the Plan in any subrogation efforts. Neither you nor any of your dependents shall do anything to prejudice the right given to the Plan by this Subrogation section without the Plan's consent.

# A Recognized Identification Card

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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, 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 (when applicable)
- Member Service toll-free number (on back of card)
- Member website (on back of card)
- Toll-free telephone number for out-of-network facility admissions (on back of card)
- Suitcase symbol

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

# How to File a Claim

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## **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 twenty (20) days or as soon as reasonably possible after you have received covered services. Notice given by you or on your behalf to Highmark that includes information sufficient to identify you shall constitute sufficient notice of a claim to Highmark. You can give notice to Highmark by writing to the Member Service Department. The address of the Member Service Department can be found on your ID card. A charge shall be considered incurred on the date 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 fifteen (15) days following the date a notice of a claim is received, furnish you with claim forms for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of such notice, you shall be deemed to have complied with the requirements of this subsection as to filing a proof of loss upon submitting, within the time fixed in this subsection for filing proofs of loss, itemized 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 ninety (90) days after the date of such loss. Proof of loss must include all data necessary for Highmark to determine benefits. Failure to submit a proof of loss to Highmark within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will Highmark be required to accept a proof of loss later than 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 of the information and evidence of payment required on the claim form has been submitted in the manner described above. Highmark reserves the right to require additional information and documents as needed to support a claim that a covered service has been rendered.

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

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

#### **Time of Payment of Claims**

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

#### **Authorized Representative**

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

### **Limitation on Legal Actions**

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

### **Physical Examinations and Autopsy**

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

### **Your Explanation of Benefits Statement**

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

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

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

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

## **How to Voice a Complaint**

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

Highmark  
One Valley Square  
512 Township Line Road  
Blue Bell, PA 19422

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

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

## **Fraud or Provider Abuse**

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

## **Additional Information on How to File a Claim**

### **Member Inquiries**

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

### **Filing Benefit Claims**

- ***Authorized Representatives***  
You have the right to designate an authorized representative to file or pursue a request for

reimbursement or other post-service claim on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

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

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

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

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

## **Determinations on Benefit Claims**

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

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

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

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

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

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

## **Appeal Procedure**

Your benefit program maintains an appeal process involving two levels of review with the exception of urgent care claims (which involve a single level of review). At any time during the appeal process, you may choose to

designate a representative to participate in the appeal process on your behalf. You or your representative shall notify Highmark in writing of the designation.

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

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

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

### ***Initial Review***

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

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

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

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

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

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

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

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

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

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

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

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

### ***Second Level Review***

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

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

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

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

In rendering a decision on a second level appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care

professional will be a person who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the matter under review.

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

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

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

### ***External Review***

You have four (4) months from the date you receive notice of a final Highmark adverse benefit determination to file a request for an external review with Highmark. Note that for pre-service claims, the four (4) month period begins to run from the date you received Highmark's first-level adverse benefit determination.

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

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

### **Preliminary Review**

Highmark will conduct a preliminary review of your external review request within five (5) business days following the date on which Highmark receives the request. Highmark's preliminary review will determine whether:

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

Highmark will notify you of the results of its preliminary review within one (1) business day following its completion of the review. This will include our reasons regarding the ineligibility of your request, if applicable, and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not complete, Highmark's notification will describe the information or materials needed to make the

request complete. You will then have the balance of the four (4) month filing period or, if later, forty-eight (48) hours from receipt of the notice, to perfect your request for external review; whichever is later.

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

### **Referral to an Independent Review Organization (IRO)**

Highmark will, randomly or by rotation, select an IRO to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Within five (5) business days thereafter, Highmark will provide the IRO with documents and information we considered when making our final adverse benefit determination. The IRO may reverse Highmark's final adverse benefit determination if the documents and information are not provided to the IRO within the five-day time frame.

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

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

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

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

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

### **Expedited External Review (Applies to Urgent Care Claims Only)**

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

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

item or service for which you received emergency services, but you have not been discharged from the facility rendering the emergency services.

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

### **Referral to an Independent Review Organization (IRO)**

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

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

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

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

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

# Member Service

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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](http://www.myhighmark.com). For TTY/TDD hearing impaired service, please dial 711 and the number on the back of your ID card.

As a Highmark member, you have access to a wide range of readily available health education tools and support services.

## **Blues On Call<sup>sm</sup> - 24/7 Health Decision Support**

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

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

### ***Help with common illnesses, injuries and questions***

Health coaches can address any health topic that concerns you:

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

You do not have to be ill to talk to a health coach. Call to learn about programs and other resources available to help you manage:

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

### ***Help with chronic conditions***

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

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

## **Highmark Website**

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

Go to [www.myhighmark.com](http://www.myhighmark.com). Then click on the Members tab and log in to your home page to take advantage of all kinds of programs and resources to help you understand your health status, including an online wellness profile. Then, take steps toward real health improvement.

## **Baby Blueprints®**

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

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

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

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

### **Easy Enrollment**

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

# Member Rights and Responsibilities

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

## ***You have the right to:***

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

## ***You have a responsibility to:***

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

## **How We Protect Your Right to Confidentiality**

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

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

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

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

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

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

# Terms You Should Know

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

**Acupuncturist** - A licensed acupuncturist performing within the scope of such licensure. Where there is no licensure law, the acupuncturist must be certified by the appropriate professional body.

**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.

Ambulance Service  
Clinical Laboratory  
Diabetes Prevention Provider  
Home Infusion Therapy Provider

Independent Diagnostic Testing Facility (IDTF)  
Suite Infusion Therapy Provider  
Suppliers

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

**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.

**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.

**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.

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

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

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

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

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

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

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

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

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

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

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

**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.

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

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

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

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

**Dentist** - A person who is a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.), licensed where required and performing services within the scope of such licensure.

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

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

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

**Detoxification Services (Withdrawal Management Services)** - Inpatient and outpatient services for the treatment of withdrawal from alcohol or drugs. Inpatient services must include twenty-four hour nursing care and physician oversight.

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

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

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

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

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

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

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

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

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

**Effective Date** - The date when your coverage begins.

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

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

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

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

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

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

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

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

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

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

**Family Deductible** - The sum of the individual deductible amounts for a specified number of family members, who are covered, and the point at which no further deductible amounts must be satisfied by any covered family member.

**Family Deductible** - A specified dollar amount of liability for covered services that must be incurred by members covered under one (1) family coverage before Highmark will assume liability for all or part of the remaining covered service incurred by any individual member under that family coverage 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.

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

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

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

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

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

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

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

**Highmark Managed Care Network Service Area** - The geographic area consisting of the following counties in western Pennsylvania:

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

**Highmark Managed Care Facility Provider** - A facility provider, licensed where required and performing within the scope of its license, that has entered into a Highmark Managed Care Network agreement, either directly or indirectly, with Highmark Inc. pertaining to payment as a participant in a managed care network for covered services rendered to you.

**Highmark Managed Care Network** - All Highmark managed care facility providers and professional providers, approved as a network by the Pennsylvania Department of Health, that have entered into a network agreement, either directly or indirectly, with Highmark Inc. pertaining to payment as a participant in a managed care network for covered services rendered to you.

**Highmark Managed Care Professional Provider** - A professional provider, licensed where required and performing within the scope of its license, that has entered into a Highmark Managed Care Network agreement, either directly or indirectly, with Highmark Inc. pertaining to payment as a participant in a managed care network for covered services rendered to you.

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

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

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

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

**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 you receive the service or supply for which the charge is made.

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

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

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

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

**Intensive Outpatient Program** - A time-limited, separate and distinct outpatient program that includes individual therapy, family therapy, group therapy and medication management following an individualized treatment plan. Participation in an Intensive Outpatient Program may involve two (2) or more hours of programming a week. The program may be offered during the day or evening hours and can be a step-down from a higher level of care or a step-up to prevent the need for a higher level of care. The goals of an Intensive Outpatient Program are to prevent or reduce the need for inpatient hospitalization and to reduce or stabilize symptoms and functional impairment of a psychiatric or co-occurring substance use disorder. Medically necessary treatment is provided within a structured therapeutic milieu.

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

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

**Maximum** - The greatest amount for which your program 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.

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

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

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

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

Notwithstanding the above when you receive outpatient prescription drugs the network is designated by the Plan.

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

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

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

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

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

Cross Blue Shield Association located in a service area other than a Highmark or Highmark affiliate service area, pertaining to payment as a participant in your network for covered services rendered to a member.

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

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

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

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

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

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

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

**Out-of-Network Provider** - An ancillary provider, professional provider or facility provider who has not entered into an agreement, either directly or indirectly, with Highmark or a Highmark affiliate, or with any licensee of the Blue Cross Blue Shield Association located in a service area other than a Highmark or Highmark affiliate service area, pertaining to payment as a participant in your network for covered services rendered to a member.

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

**Out-of-Pocket Limit** - The out-of-pocket limit refers to the specified dollar amount of expense incurred for covered services in a benefit period. When the specified dollar amount is attained, the level of benefit increases as specified in the Summary of Benefits. See the Summary of Benefits for the out-of-pocket limit.

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

**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.

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

#### In-Network Benefits

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

#### Out-of-Network Benefits

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

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

For non-emergency covered medical services received at certain in-network facilities from out-of-network physicians when such services are either ancillary, or non-ancillary that have not satisfied the notice and consent criteria required by federal law, the plan allowance may be based on the (i) the reference price (as defined below) if out of area; (ii) the recognized amount (as defined below); (iii) the amount agreed to by the out-of-network provider and Highmark; or (iv) the amount determined by Independent Dispute Resolution (IDR).

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

#### Emergency Services Provided by an Out-of-Network Provider

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

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

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

### In All Other Cases

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

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

When covered medical services are received from an out-of-network provider outside of the Highmark service area, the plan allowance may be determined on the basis of the reference price (as defined below) or on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your health care program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

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

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

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

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

Bucks                      Chester                      Delaware                      Montgomery                      Philadelphia

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

**Preferred Provider Organization (PPO) Program** - A program that does not require the selection of a primary care provider, but is based on a provider network made up of physicians, hospitals and other health

care facilities. Using this provider network helps assure that you receive maximum coverage for eligible services.

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

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

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

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

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

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

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

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

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

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

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

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

A residential treatment program must provide the following:

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

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

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

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

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

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

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

- minimal care, custodial care, ambulatory care, or part-time care services; or
- 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:

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

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

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

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

**State-Owned Psychiatric Hospital** - A facility provider, that is owned and operated by the Commonwealth of Pennsylvania, which is primarily engaged in providing treatment and/or care for the Inpatient

treatment of mental illness for individuals aged eighteen and older whose hospitalization is ordered by a court of competent jurisdiction through a civil commitment proceeding.

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

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

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

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

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

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

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

- a. **Cardiac Rehabilitation** - the physiological and psychological rehabilitation of patients with cardiac conditions through regulated exercise programs.
- b. **Chemotherapy** - the treatment of malignant disease by chemical or biological antineoplastic agents.
- c. **Dialysis Treatments** - the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body through hemodialysis or peritoneal dialysis. Dialysis treatment includes home dialysis.
- d. **Infusion Therapy** - the treatment by the administration of medically necessary and appropriate fluid or medication via a central or peripheral vein when performed, furnished, and billed by a facility provider or ancillary provider in accordance with accepted medical practice.

- e. **Occupational Therapy** - the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational.
- f. **Physical Medicine** - the treatment by physical means or modalities such as, but not limited to, mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities, and rehabilitative procedures, performed to relieve pain and restore level of function following disease, illness, or injury.
- g. **Radiation Therapy** - the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.
- h. **Respiratory Therapy** - the introduction of dry or moist gases into the lungs for treatment purposes.
- i. **Speech Therapy** - the treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

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

**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.

Highmark is a registered mark of Highmark Inc.

Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association.

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

The Blue Cross Blue Shield Association is an independent company that does not provide Highmark Blue Shield products and services. It is solely responsible for the services described in this booklet.

You are hereby notified that Highmark Blue Shield provides administrative services only on behalf of your self-funded group health plan. Highmark 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 Shield to use the familiar Blue Cross and Blue Shield words and symbols. Highmark Blue Shield is neither the insurer nor the guarantor of benefits under your group health plan. Your Group remains fully responsible for the payment of group health plan benefits.

## Summary of PPO Benefits

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.

### eResearch Technology, Inc. (Clario) PPO Core Plan

Effective 01/01/2024

Benefit	Network	Out-of-Network
<b>General Provisions</b>		
<b>Benefit Period</b> (1)	Calendar	
<b>Deductible</b> (per benefit period) (non-embedded)		
Individual	\$1,000	\$2,500
Family	\$2,000	\$5,000
<b>Plan Pays</b> – payment based on the plan allowance	80% after deductible	50% after deductible
<b>Out-of-Pocket Maximums</b> (Once met, plan pays 100% for the rest of the benefit period) (non-embedded)		
Individual	\$3,500	\$10,000
Family	\$7,000	\$20,000
<b>Office/Clinic/Urgent Care Visits</b>		
<b>Retail Clinic Visits</b>	100% after \$20 copayment	50% after deductible
<b>Primary Care Provider Office Visits &amp; Virtual Visits</b>	100% after \$20 copayment	50% after deductible
<b>Specialist Office Visits &amp; Virtual Visits</b>	100% after \$35 copayment	50% after deductible
<b>Urgent Care Center Visits</b>	100% after \$70 copayment	50% after deductible
	Copayment, if any, does not apply to Urgent Care Center Visits prescribed for the treatment of Mental Health or Substance Abuse	
<b>Telemedicine</b> (3)	100% (deductible does not apply)	Not Covered
<b>Preventive Care</b>		
<b>Routine Adult</b>		
Physical exams	100% (deductible does not apply)	50% after deductible
Adult immunizations	100% (deductible does not apply)	50% after deductible
Colorectal cancer screening (includes colonoscopy; sigmoidoscopy; barium enema; blood occult)	100% (deductible does not apply)	50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	50% after deductible
Mammograms, annual routine	100% (deductible does not apply)	50% after deductible
<b>Routine Pediatric</b>		
Physical exams	100% (deductible does not apply)	50% after deductible
Pediatric immunizations	100% (deductible does not apply)	50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
<b>Hospital and Medical/Surgical Expenses (including maternity)</b>		
<b>Hospital Inpatient</b>	80% after deductible	50% after deductible Limit: 70 days per benefit period
<b>Hospital Outpatient</b>	80% after deductible	50% after deductible
<b>Maternity</b> (non-preventive facility & professional services)	80% after deductible	50% after deductible
<b>Medical/Surgical</b> (except office visits)	80% after deductible	50% after deductible
<b>Emergency Services</b>		
<b>Emergency Room Services</b> (includes emergency medical and emergency accident)	100% after \$150 copayment (waived if admitted)	
<b>Ambulance</b>	80% after Network deductible	
<b>Therapy and Rehabilitation Services</b>		
<b>Physical Medicine</b>	100% after \$35 copayment	50% after deductible
	Limit: 30 visits per benefit period, combined with Occupational Therapy. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
<b>Occupational Therapy</b>	100% after \$35 copayment	50% after deductible
	Limit: 30 visits per benefit period, combined with Physical Medicine. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
<b>Speech Therapy</b>	100% after \$35 copayment	50% after deductible
	Limit: 20 visits per benefit period. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Spinal Manipulations</b>	100% after \$35 copayment Limit: 20 visits per benefit period.	50% after deductible
<b>Cardiac Rehabilitation</b>	100% after \$35 copayment	50% after deductible
<b>Respiratory Therapy</b>	100% after \$35 copayment Limit: 36 visits per benefit period	50% after deductible
<b>Dialysis</b>	80% after deductible	Not Covered
<b>Other Therapy Services</b> (Chemotherapy, Radiation Therapy, and Dialysis)	80% after deductible	50% after deductible
<b>Mental Health/Substance Abuse</b>		
<b>Inpatient</b>	80% after deductible	50% after deductible
<b>Inpatient Detoxification/Rehabilitation</b>		
<b>Outpatient</b>	100% after \$35 copayment for office visit, otherwise 100% (deductible does not apply)	50% after deductible
<b>Autism (includes ABA Therapy)</b>	80% after deductible	50% after deductible
<b>Other Services</b>		
<b>Acupuncture</b>	100% after \$20 copay physician office 100% after \$35 copay specialist office Limit: 18 visits per calendar year	50% after deductible
<b>Allergy Extracts and injections</b> ( <i>copayment does not apply if only serum is provided</i> )	100% after \$20 copayment	50% after deductible
<b>Assisted Fertilization Procedures</b>	100% after \$35 copayment for specialist office visits, 100% after \$20 copayment for physician office visits, otherwise 80% after deductible	50% after deductible
<b>Bariatric Surgery</b>	80% after deductible Limit: \$10,000 per lifetime for surgeon's charges	Not Covered
<b>Dental Services Related to Accidental Injury</b>	80% after deductible	50% after deductible
<b>Diagnostic Services</b> <i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	Outpatient Facility: 100% after \$50 copayment per scan  Inpatient Facility: 80% after deductible  Primary Care Provider's Office: \$50 per scan copay, plus \$20 office visit copay, then 100%  Specialist's Office: \$50 per scan copay, plus \$35 office visit copay, then 100%	50% after deductible
<i>Basic Diagnostic Services</i> (ECG, EEG, echocardiogram, pulmonary study, stress test, audiology test, etc.)	80% after deductible	50% after deductible
<i>Standard Imaging</i>	100% after \$30 copayment, if in conjunction with an office visit, otherwise 20%	50% after deductible
<i>Lab/Pathology</i>	100% (deductible does not apply), outpatient facility or freestanding lab, if in conjunction with an office visit, otherwise 20%	50% after deductible
<i>Allergy Testing</i>	100% after \$20 copay in physician office; 100% after \$35 copay in specialist office if in conjunction with an office visit, otherwise 20%	50% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	80% after deductible	50% after deductible
<b>Wigs</b>	80% after deductible Limit: \$500 per benefit period	80% after deductible

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Hearing Aids and/or exams</b>	80% after deductible Limit: 2 devices every 3 years	Not Covered
<b>Home Health Care/Visiting Nurse</b>	80% after deductible	50% after deductible
<b>Hospice</b>	80% after deductible	50% after deductible
<b>Infertility Counseling, Testing and Treatment</b> (4)	80% after deductible	50% after deductible
<b>Injection/Infusion Therapy</b>	100% after \$100 copayment	50% after deductible
<b>Private Duty Nursing</b>	Not Covered	
<b>Skilled Nursing Facility Care</b>	80% after deductible	50% after deductible
	Limit: 120 days per benefit period	
<b>Transplant Services</b>	<u>When Performed in a BDC/BDC+</u> 100% (deductible does not apply)  <u>When Performed in a Non-BDC</u> 80% after deductible	50% after deductible Limit: surgeon's benefit maximum per organ Bone Marrow - \$130,000 Heart - \$150,000 Heart/Lung - \$185,000 Kidney - \$80,000 Kidney/Pancreas - \$80,000 Liver - \$230,000 Lung - \$185,000 Pancreas - \$50,000
<b>Travel Limit for Transplants</b> When performed in a BDC/BDC+ only	Limit: \$10,000 per transplant	N/A
<b>Precertification Requirements</b> (5)	Yes	N/A

(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, prescription drug cost share and any qualified medical expense.

(3) Services must be performed by a Highmark BS approved telemedicine provider.

(4) 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.

(5) Highmark BS Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

(6) Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. To obtain a prescription medication that is not included on this formulary, your provider must complete the 'Prescription Drug Medication Request Form' and return it to the Pharmacy Affairs Department for clinical review. Under the mandatory generic provision, you are responsible for the payment differential when a generic drug is available, and you or your provider specifies a brand name drug. Your payment is the price difference between the brand name drug and the generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

**HIGHMARK INC.  
NOTICE OF PRIVACY PRACTICES**

**PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)**

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**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.**

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**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 practically 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 COMMERCIAL MEDICAL POLICY - PENNSYLVANIA

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<b>Medical Policy:</b>	A-1-024
<b>Topic:</b>	Anesthesia Provided in Conjunction with Non-Covered Services
<b>Section:</b>	Anesthesia
<b>Effective Date:</b>	December 31, 2022
<b>Issued Date:</b>	December 31, 2022
<b>Last Revision Date:</b>	November 2022
<b>Annual Review:</b>	February 2022

Anesthesia is used to create a loss of sensation and consciousness through the administration of one or more agents that block the transmittal of pain impulses along nerve pathways to the brain.

## Policy Position

Effective July 5, 2012, P.L. 916, Pennsylvania Act 94, Children and Developmentally Disabled Patient Access to Quality Dental Care Act, required insurance coverage for general anesthesia and associated medical costs when provided for eligible dental patients.

Eligible dental patient - a patient who is seven years of age or younger or developmentally disabled for whom a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected for treatment under general anesthesia.

Coverage under this act shall be subject to deductible, copayment or coinsurance provisions and any other general exclusions, limitations or requirements of a health insurance policy.

Anesthesia services may be considered medically necessary when performed in conjunction with other covered services.

When a claim is received for anesthesia services which are provided in conjunction with non-covered services, the physician's charge for the anesthesia service is not covered, except for the following criteria:

- Anesthesia services rendered in conjunction with routine non-covered dental procedures and bony impacted wisdom teeth may be considered medically necessary for children and special needs individuals for **EITHER** of the following criteria which must be verified by appropriate medical documentation:
  - The individual is seven (7) years of age or younger or is developmentally disabled; **and**
    - A successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition; **and**
    - A superior result can be expected from dental care provided under general anesthesia; **or**
  - The individual is twelve years of age or younger; **and**
    - Has documented phobias; **or**
    - Documented mental illness; **and**
    - Has dental needs of such magnitude that treatment should not be delayed or deferred; **and**
    - Lack of treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity; **and**
    - A successful result cannot be expected from dental care provided under local anesthesia because of such condition; **and**

- A superior result can be expected from dental care provided under general anesthesia.
- Monitored anesthesia care (MAC)/general anesthesia and associated facility charges may be considered medically necessary in conjunction with dental surgery or procedures performed by a dentist, oral surgeon or oral maxillofacial surgeon when it meets the above criteria and there is an appropriately trained and licensed professional to both administer and monitor MAC/general anesthesia in **EITHER** of the following locations:
  - A properly-equipped and staffed office or clinic; **or**
  - A hospital or outpatient surgery center.

Anesthesia services for any other indication or when the above criteria are not met are considered not medically necessary.

Medical documentation must be part of the medical record and available upon request.

Procedure Codes						
00170	D9222	D9223	D9239	D9243	D9248	G0330

### Related Policies

Refer to Medical Policy D-6, Dental Services, for additional information.

Diagnosis Codes						
F23	F28	F29	F30.10	F30.11	F30.12	F30.13
F30.2	F30.3	F30.4	F30.8	F40.232	F40.298	F40.8
F40.9	F41.0	F41.1	F41.3	F41.8	F41.9	F43.0
F44.89	F44.9	F68.11	F68.13	F68A	F70	F71
F72	F73	F78	F79	F90.1	F90.2	F90.8
F90.9	F93.8	F93.9	G80.0	G80.1	G80.2	G80.4
G80.8						

### Place of Service: Outpatient

Anesthesia provided in conjunction with non-covered services is typically an outpatient procedure which is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, the presence of a co-morbid condition that would require monitoring in a more controlled environment such as the inpatient setting.

### The policy position applies to all commercial lines of business

### Links

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This policy is designed to address medical guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Each person's unique clinical or other circumstances may warrant individual consideration, based on review of applicable medical records, as well as other regulatory, contractual and/or legal requirements.

Medical policies do not constitute medical advice, nor are they intended to govern the practice of medicine. They are intended to reflect Highmark's reimbursement and coverage guidelines. Coverage for services may vary for individual members, based on the terms of the benefit contract.

Highmark retains the right to review and update its medical policy guidelines at its sole discretion. These guidelines are the proprietary information of Highmark. Any sale, copying or dissemination of the medical policies is prohibited; however, limited copying of medical policies is permitted for individual use.

#### **Discrimination is Against the Law**

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator/ Insurer:

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

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

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: [CivilRightsCoordinator@highmarkhealth.org](mailto:CivilRightsCoordinator@highmarkhealth.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

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

This information is issued by Highmark Blue Shield on behalf of its affiliated Blue companies, which are independent licensees of the Blue Cross Blue Shield Association. Highmark Inc. d/b/a Highmark Blue Shield and certain of its affiliated Blue companies serve Blue Shield members in the 21 counties of central Pennsylvania. As a partner in joint operating agreements, Highmark Blue Shield also provides services in conjunction with a separate health plan in southeastern Pennsylvania. Highmark Inc. or certain of its affiliated Blue companies also serve Blue Cross Blue Shield members in 29 counties in western Pennsylvania, 13 counties in northeastern Pennsylvania, the state of West Virginia plus Washington County, Ohio, the state of Delaware and [8] counties in western New York and Blue Shield members in [13] counties in northeastern New York. All references to Highmark in this document are references to Highmark Inc. d/b/a Highmark Blue Shield and/or to one or more of its affiliated Blue companies.

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 المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

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

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

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

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

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

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

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

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

## DISCOVER

## SHOP

## ADDITIONAL LINKS

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HIPAA

**FIND A DOCTOR OR RX**

**MEDICARE**

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