

Employee Benefit Trust of Eastern PA
Monroe Career & Technical Institute Employee Benefit Plan

Plan Document

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Monroe Career & Technical Institute Employee Benefit Plan

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INTRODUCTION

We provide health and welfare benefits for the eligible employees and dependents of the Monroe Career & Technical Institute Employee Benefit Plan. Although these benefits are described in the attached Appendices, there are certain eligibility provisions and member rights that the appendices may not address.

The Monroe Career & Technical Institute Employee Benefit Plan includes the following plans:

- Medical and Prescription Drug
- Dental
- Vision

This Plan Document is written in simple, direct language and is designed to help you understand the details of the benefits available, the eligibility requirements, and general information about the benefit plans. We urge you to become familiar with the contents of this document so that you and your dependents can fully utilize, whenever necessary, the benefits that are available to eligible Participants.

PLAN AND PROGRAM BENEFITS

Important information about your health benefits can be found in the Appendices at the end of this Plan Document. Within each Appendices you will find a summary of the benefits, the services that are covered, the services that are excluded, how the plan works, how to file a claim, how to appeal a benefit determination, member rights and responsibilities, who to call if you have questions and general information.

ELIGIBILITY FOR PARTICIPATION

In order to be considered for participation with this Plan, an individual must meet certain eligibility requirements and enroll (apply) for coverage within a specific timeframe.

Employees eligible to enroll in coverage are detailed in Appendix A.

You are eligible to become a member or participant in the Monroe Career & Technical Institute Employee Benefit Plan after you satisfy all of the following:

- 1) The eligibility requirements of the included Plan(s)
- 2) The enrollment requirements of the included Plan(s)

There is a limited period of time to apply for initial enrollment and enrollment changes. Please refer to the Open Enrollment section below.

Subscriber

An individual must meet all eligibility criteria specified in Appendix A to enroll in the Plan.

Dependent - Spouse

An individual must be the lawful spouse of the subscriber to enroll in the Plan as a dependent spouse. The term spouse shall mean the covered employee's legally married spouse as recognized under Pennsylvania law.

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Dependent - Child

To enroll in the Plan as a child, an individual must be under the age of twenty-six (26) and be:

- A birth child of the subscriber or the subscriber's spouse;
- A child legally adopted by or placed for adoption with the subscriber or the subscriber's spouse;
- A ward of the subscriber or the subscriber's spouse; or
- A child for whom the subscriber or the subscriber's spouse is required to provide health care coverage pursuant to a Qualified Medical Child Support Order (QMCSO).

Dependent - Disabled Child

An individual must be an unmarried child age twenty-six (26) or older to enroll in the Plan as a disabled dependent child. The child must be:

- A birth child, adopted child, or ward of the subscriber or the subscriber's spouse;
- Mentally or physically incapable of earning a living; and
- Chiefly dependent upon the subscriber or subscriber's spouse for support and maintenance, provided that:
 - The incapacity began before age twenty-six (26);
 - The subscriber provides the district with proof of incapacity within thirty-one (31) days after the dependent disabled child reaches age twenty-six (26); and
 - The subscriber provides related information as otherwise requested by the district, but not more frequently than annually.

Note that the district may require documentation to verify dependent eligibility in the plan, including, but not limited to copies of marriage certificates, birth certificates, joint bank account statements and tax returns for any dependents that are enrolled in the plan.

ENROLLMENT

Initial Enrollment for Newly Eligible Members

"Initial" is the term used to represent eligible members enrolling for the first time. Please refer to Appendix A to determine when you are eligible to enroll initially.

Dependent - Newborns

For thirty-one (31) days following birth, your newborn child is covered under this Plan.

Eligible newborns **must** be enrolled within thirty-one (31) days of birth to have ongoing coverage. If the newborn child qualifies as a dependent, you must notify the district immediately and add the newborn child as a dependent within the required timeframes.

If the newborn child does not qualify as a dependent under the terms of this plan, the newborn child may not be enrolled in ongoing coverage.

OPEN ENROLLMENT

Prior to July 1st of each year an open enrollment period will occur. Each employee will be given an opportunity to review the benefit options that are available and make changes if desired. This open enrollment period is also an opportunity to add or delete dependents from the coverage.

Benefit choices made during the open enrollment period will become effective July 1st and remain in effect until the next July 1st unless there is a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. (see Group Health Plan Special Enrollment Rights section below).

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A Plan Participant who fails to make an election during open enrollment will automatically retain the coverage that is currently in force. At initial plan eligibility, failure to make an election will result in non-enrollment. If the Plan Participant desires to waive coverage in the Medical and Prescription Drug plans, a certificate of alternative coverage will be required.

Plan Participants will receive detailed information regarding open enrollment from the district.

Group Health Plan Special Enrollment Rights

It's important that you understand your right to apply for group health insurance coverage outside of the annual open enrollment period. The Health Insurance Portability and Accountability Act (HIPAA) requires that employees be allowed to enroll themselves and/or their dependent(s) in an employer's Group Health Plan under certain circumstances, described below, provided that the employee notified the employer within 30 days of the occurrence of any following events:

- Loss of health coverage under another employer plan (including exhaustion of COBRA coverage) or after an individual loses other minimum essential coverage;
- Acquiring a spouse through marriage; or
- Acquiring a dependent child through birth, adoption, placement for adoption or foster care placement.
- Acquiring a stepchild or becoming a legal guardian for a child
- Receiving a legal custody order, in the case of a ward;
- A change in Medicare status

Except as set forth above, coverage will begin the first day of the first calendar month beginning after the date following a life status change.

Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 creates two new special enrollment rights for employees and/or their dependents. In addition to the special enrollment rights set forth above, all group health plans must also permit eligible employees and their dependent(s) to enroll in an employer plan if the employee requests enrollment under the group health plan within 60 days of the occurrence of following events:

Loss of coverage under Medicaid or a state child health plan: If you or your dependent(s) lose coverage under Medicaid or a state child health plan, you may request to enroll yourself and/or your dependent(s) in our group health plan not later than 60 days after the date coverage ends under Medicaid or the state child health plan.

Gaining eligibility for coverage under Medicaid or a state child health plan: If you and/or your dependent(s) become eligible for financial assistance from Medicaid or a state child health plan, you may request to enroll yourself and/or your dependent(s) under our group health plan, provided that your request is made not later than 60 days after the date that Medicaid or the state child health plan determines that you and/ or your dependent(s) are eligible for such financial assistance. If you and/or your dependent(s) are currently enrolled in our group health plan, you have the option of terminating your and/or your dependent's (s') enrollment in our group health plan and enroll in Medicaid or a state child health plan.

Please note that once you terminate your enrollment in our group health plan, your dependent's (s') enrollment will be also terminated.

Failure to notify us of your loss or gain of eligibility for coverage under Medicaid or a state child health plan within 60 days, will prevent you from enrolling in our plans and/or making any changes to your coverage elections until our next open enrollment period.

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If one of these events occurs, you must notify the district immediately.

Timelines for Submission of Enrollment Applications

There is a limited period of time to apply for initial enrollment and enrollment changes as detailed above.

If you fail to apply these specific timeframes, you may not be allowed to enroll in the Plan until the next annual Open Enrollment period.

IMPORTANT DISCLOSURES

Maternity and Newborn Length of Stay

Group health plans and health insurance issuers 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 not 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, plans and issuers 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).

Coverage for Reconstructive Surgery Following Mastectomy

Group health plans and health insurance issuers that offer coverage for mastectomy, under Federal law, must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. This coverage applies to both men and women. It is to include:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas (loss of normal lymph channel drainage).

Mental Health Parity and Addiction Equity

Group health plans and health insurance issuers that offer coverage for mental health benefits (including substance use disorder benefits), under Federal law, must provide that restrictions on these benefits are no more restrictive than the most common or frequent requirements that apply to substantially all medical and surgical benefits covered under the plan including 1) inpatient, in-network; 2) inpatient, out-of-network; 3) outpatient, in-network; 4) outpatient, out-of-network; 5) emergency care; and 6) prescription drugs. This equality or parity requirement applies to:

- Financial requirements including deductibles, co-payments, co-insurance, and out-of-pocket expenses;
- Treatment limitations including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment; and
- Out-of-network benefits

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Upon request you or your provider are entitled to receive the criteria for medical necessity determinations for mental health or substance use disorder benefits. The reasons for any denial of such benefits must also be made available upon request.

Genetic Information

Group health plans and health insurance issuers generally may not, under Federal law, obtain or use genetic information when determining premium charges, coverage, benefits, or any other purpose. This rule is not violated if the plan or issuer receives the information inadvertently or for use in monitoring the effects of toxic substances in the workplace. Also, you are free to authorize the disclosure of genetic information when making a FMLA or health-related claim.

Children's Health Insurance Program

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

PENNSYLVANIA – Medicaid

Website: <http://www.dhs.state.pa.us/hipp>

Phone: 1-800-692-7462

HIPAA Notice of Privacy Practices

The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires your self-funded health plan(s) (SFHP) to keep protected health information private and to give you this notice of its legal duties and privacy practices for protected health information. The SFHP must obey the terms of this notice as now in effect. The SFHP can change the terms of this notice and the privacy practices it describes at any time. The change must agree with the Privacy Rule. Any change will apply to all protected health information held by the SFHP. If there is a change, the change will not happen until you receive a new notice describing it. You will receive your new notice either at work or at the mailing address that you gave your employer.

The Privacy Rule allows the SFHP to use and disclose your medical information in order to decide if you are eligible for benefits and to handle claims and any appeals.

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When the SFHP discloses medical information to your employer and its employees that handle SFHP matters, the information will be kept confidential. Your employer agrees not to use or disclose the information for decisions about your employment (including fitness for duty determinations) or any other benefit or employee benefit plan. If an employee does not keep your medical information private, he will be disciplined.

If someone obtains, accesses, uses, or discloses your protected health information in a way not permitted under the Privacy Rule, the event will be investigated. You will receive a report of this breach if it compromises your protected health information.

If you do not give us a written authorization, the SFHP will not make any other uses or disclosures. Without your specific authorization, we cannot sell, use, or disclose your information for marketing or any other purpose. If your spouse or adult child files a claim without you, the SFHP will not discuss the claim with you without authorization from your spouse or adult child. An authorization can be revoked in writing. A revocation will not change anything the Plan has already done based on the earlier authorization.

YOUR PROTECTED HEALTH INFORMATION RIGHTS.

- You have the right to request restrictions on the use and disclosure of medical information used for claims or Plan operations. Your spouse and dependents may ask that their medical information not be disclosed to you. The Plan is not required to agree to the restriction.
- You have the right to receive confidential communications of medical information in a different way or at a different address, if you are in danger. The Plan will agree to reasonable requests. A reasonable request: (1) is in writing; (2) identifies the information; (3) states that disclosure of all or part of this information could endanger you; (4) tells how to handle the reimbursement; and (5) gives another address or other way to contact you.
- You have the right to see and copy your medical information. You will be allowed to see this information, except for one reason. If a licensed health care professional determines this will endanger someone, you will be denied access. Your request must be in writing and can only apply to records held by the Plan. You do not have the right under these rules to see or copy health information in your employment file.
- The Plan will respond in 30 days after receipt of the request. If the information is not on-site, the Plan will tell you in 30 days and will provide the information in 60 days of the request. If this cannot be done, the Plan will explain the reasons for the delay in writing and will give you the date by which it will provide the information. It cannot delay beyond this date.
- You can see your medical information during normal business hours at a place named by the Plan Administrator. If you request copies, the Plan will charge \$0.25 per page plus the cost of mailing. If the Plan does not have the information, and it knows where to find the information, it will tell you.
- You have the right to amend your medical information. Since the Plan does not create this information, you should contact your health care provider to change your medical information and send the amended information to the Plan. However, if the creator of the medical information is not available, you may file a written amendment request with the Plan. The request must explain why you believe the information creator is not available and why the change is necessary. If the information is not a part of its records or if it determines the current information on file is accurate and complete, the Plan will deny the request.

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- The Plan will respond in 60 days after receipt of the request. If your request cannot be met in 60 days, the Plan will explain the reasons for the delay in writing and will give you the date by which it will respond. This date cannot be more than 90 days after your request. It cannot delay beyond this date.
- If the Plan agrees, in whole or in part, it will tell you, identify the affected records, and attach the amendment to them. If you tell the Plan to tell anyone else, it will make reasonable efforts to send the amendment within a reasonable time to those persons.
- If the Plan denies the request, in whole or in part, it will give you a written denial that states: (1) the reason; (2) how to send a written statement disagreeing with the denial; and (3) how to complain to the Plan or to the Secretary of the Department of Health and Human Services. If you do not send a statement of disagreement, you may ask the Plan to include your amendment request and the denial with any future disclosures of the medical information. The Plan may write a rebuttal to your statement of disagreement. If there is a rebuttal, the Plan must send you a copy.
- You have the right to receive a record of medical information disclosures that have been made within the last 6 years. This record will not include disclosures to you or any you agreed to by an authorization form. The record will exclude disclosures to your employer that were made as a part of handling a claim. If you request more than one report in the same 12-month period, the Plan will charge a fee after the first report of \$25 per report.
- You have the right to get a copy of this notice from the Plan by just asking.

If you believe your privacy rights have been violated, you may file a written complaint with the Contact Person. To file a complaint with the Plan hand-deliver or mail it to the address below. Please be as specific as possible and include any evidence you may have. Neither your employer nor the Plan will retaliate against you for filing a complaint.

If you do not get a response to your complaint in 30 days or if for any reason you do not feel comfortable filing your complaint with the Contact Person, contact Human Resources for your employer.

By law you can file a complaint with the Secretary of the Department of Health and Human Services. You may obtain further information regarding this option from your Office for Civil Rights (OCR) regional office or the web at <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>. OCR complaints should be filed within 180 days of the occurrence.

COBRA CONTINUATION COVERAGE UNDER GROUP HEALTH PLANS

The Consolidated Omnibus Budget Reconciliation Act (COBRA) may provide you with rights to health care continuation coverage. If you are covered by our group health plan, COBRA may give you the right to stay covered even if something happens, like losing your job, which would otherwise cause you to lose coverage. This continuation coverage under a group health plan is called "COBRA continuation coverage." COBRA continuation coverage lasts only for a limited time, and you have to pay for it.

Qualifying Beneficiaries and Qualifying Events

If you are covered by our group health plan, you, your spouse, and your dependent children may have rights under COBRA as "qualified beneficiaries" if:

- You lose or leave your job (other than by reason of your gross misconduct) (if you take an FMLA leave of absence and do not return to active employment, the qualifying event of termination of employment occurs at the end of the leave); or

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- You work less hours and our group health plan says this makes you ineligible for coverage.

Your dependent children may include any child who is born to or placed for adoption with you during a period of COBRA continuation coverage, if certain requirements are met.

Your spouse and your dependent children have the right to be qualified beneficiaries for COBRA continuation coverage following your death or divorce or legal separation if they are covered by our group health plan and would lose coverage because of the qualifying event.

COBRA gives your dependent child the right to COBRA continuation coverage for up to 36 months if he or she is covered by our group health plan and would lose coverage because he or she has reached an age or satisfied a condition that causes dependent coverage to end. If you become entitled to Medicare benefits (under Part A, Part B, or both), this would be a qualifying event for your spouse and dependent children. You are not "entitled" to Medicare until you have actually completed the Medicare enrollment and you have been notified your Medicare coverage is in effect.

Notice of the Qualifying Event and COBRA Election

Notice from Us – The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. We are required to notify the Plan Administrator of the qualifying event when you lose or leave your job, your hours are reduced, you die, we commence bankruptcy proceedings, or you become entitled to Medicare benefits.

Notice from you – In order for the COBRA rights notice and election forms to be provided, the Plan Administrator must be notified if:

- there is a divorce or legal separation;
- a child, adopted child or stepchild attains age 26;
- a grandchild (great-grandchild, etc.), sibling, step-sibling, niece, or nephew ceases to be your dependent; or
- an individual receiving COBRA continuation coverage qualifies for or loses Social Security disability benefits.

You or any qualifying beneficiary are required to give notice within 60 days of the later of:

- The date of the qualifying event; or
- The date the qualified beneficiary would lose coverage on account of the qualifying event.

Notice is to be given in writing. The group health plan may require that a specific form be completed.

COBRA Election – 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. You may elect COBRA continuation coverage on behalf of your spouse, and either you or your spouse may elect COBRA continuation coverage on behalf of your children.

If COBRA continuation coverage is desired, it must be elected within 60 days after the later of:

- The date the qualified beneficiary would lose coverage on account of the qualifying event; or

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- The date notice is provided to the qualified beneficiary of the right to elect COBRA continuation coverage.

If the Plan Administrator receives notice from you (or someone else who believes he/she is a qualified beneficiary) but determines that no COBRA continuation coverage is required, the Plan Administrator will provide you with a written explanation as to why you are not entitled to continuation coverage. This explanation will be provided within 14 days of the Plan's receipt of your notice.

Cost of Coverage - The group health plan is required to continue the same coverage. All costs of coverage are payable by you after the termination of your employment or by your spouse or child and are made on an after-tax basis. The charge would be equal to the entire cost of coverage, plus a small (2%) additional charge for administration. (If you are getting a longer period of coverage because of disability, you may have to pay more. If the coverage would not be required to be made available in the absence of a disability extension, the COBRA continuation coverage premium can be 150% of the regular cost of coverage.) COBRA continuation coverage charges can be paid in monthly installments.

Timely Payment – Coverage will cease if payment is not made timely. For the first payment, the plan must give you (or the qualified beneficiary) at least 45 days after the date of the election. Thereafter, timely payment usually means within 30 days after the first day of that coverage period. The group health plan may permit a later date; read its COBRA coverage notice. If you are receiving severance pay in connection with a termination of employment, you may choose to have your severance pay applied toward your COBRA coverage payments.

Period of Coverage - If COBRA continuation coverage is elected, coverage generally begins as of the date that coverage would otherwise have been lost. Coverage will then continue until the earliest of the following dates (unless it is terminated for cause):

- The last day of the 36-month maximum coverage period. This does not apply if the qualifying event was termination of employment or a reduction of hours of employment.
- The last day of the 18-month maximum coverage period required where the qualifying event was termination of employment or a reduction of hours of employment. This is subject to a "Disability Extension" or a "Second Qualifying Event Extension."
- You (or the qualified beneficiary) fail to make timely payment.
- The date we cease to provide any group health plan to any employee.
- The date, after the date of the election, as of which the qualified beneficiary first becomes covered under any other group health plan.
- The date, after the date of the election, as of which the qualified beneficiary first becomes entitled to Medicare benefits.

Special Medicare Related Coverage Period – If you become entitled to Medicare benefits less than 18 months before the qualifying event and the qualifying event is termination of employment or a reduction of hours of employment, COBRA continuation coverage for your spouse and your dependents (but not you) will continue until 36 months after the date of your Medicare entitlement. For example, if you become entitled to Medicare 8 months before the date you terminate employment, COBRA continuation coverage for your spouse and children will last 28 months after your termination (36 months minus 8 months).

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Disability Extension – Under certain circumstances a disabled qualified beneficiary will receive 29 months of coverage, instead of 18 months. If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. In order to qualify, the disability would have to have started at some time before the 60th day of COBRA continuation coverage.

In order for notice to be properly and timely given to the Plan, notice must be given in writing to the Plan Administrator and must be accompanied by a copy of the Social Security Administration determination. The group health plan may require that a specific form be completed. You or any qualifying beneficiary are required to give notice within 60 days of the latest of:

- The date of the disability determination by the Social Security Administration;
- The date of the qualifying event; or
- The date the qualified beneficiary would lose coverage on account of the qualifying event.

However, if the notice is not given during the first 18 months of COBRA continuation coverage, it will be too late and COBRA coverage will not be extended.

If the Social Security Administration determines that the person is no longer disabled, notice is required to be given to the Plan Administrator within 30 days of this determination. Coverage will end as of the later of: (1) 30 days after the final determination; or (2) the end of the maximum coverage period that would have applied without regard to the disability extension.

Second Qualifying Event Extension – If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to them if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if a dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused your spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

In order for notice to be properly given to the Plan, notice must be given in writing to the Plan Administrator. The group health plan may require that a specific form be completed. You or any qualifying beneficiary are required to give notice within 60 days of the later of:

- The date of the qualifying event; or
- The date the qualified beneficiary would lose coverage on account of the qualifying event.

More Information on COBRA

COBRA has a number of special rules, and the information above does not cover everything in the governing regulations. The Plan Administrator is required to answer your questions about your COBRA rights. If you have any questions about your COBRA rights or would like additional information about COBRA and your group health plan, contact the appropriate plan administrator.

If you want to know more, the Department of Labor has a booklet called "Health Benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA)." You can request this booklet free of charge by calling 1-800-998-7542. The booklet is also available on the Internet at: <http://www.dol.gov/ebsa>.

GENERAL CLAIM PROCEDURES

Claims Payment / Denial Appeals Process

If you have a claim against a particular welfare benefit program, you will need to reference that particular plan under the claim procedure set out in that plan's booklet. If you have a claim against this Plan, you may file a written claim with the Plan Administrator describing the specifics of your claim.

MEDICAL APPEAL PROCEDURES

I. INTRODUCTION

The following procedures apply to the medical plans of LEA's which are members of the Employee Benefit Trust of Eastern Pennsylvania (EBTEP) which have adopted these procedures to amend their medical plans by Board Resolution. These appeal procedures will apply except in the case of plans which have a separate pharmacy provider, in which case the appeal provisions of the pharmacy provider shall be followed.

It is the intent of these procedures to conform to the requirements of the Affordable Care Act and applicable regulations. Further, these procedures shall apply to both grandfathered and non-grandfathered plans.

II. APPEAL PROCEDURE

- A participant shall receive an adverse benefit determination (ABD) if the claims administrator determines that there is a denial, reduction, termination of, or fails to provide or make a payment (in whole or in part) for a benefit; including if a denial, reduction, termination or failure to make a payment based on the determination of a participant's eligibility to participate in a plan. A rescission or a retroactive termination of coverage is considered an adverse benefit determination, even if there is no adverse effect on any particular benefit at the time.
- An ABD shall provide the following information:
 - Specific reasons for the denial;
 - The specific rule, guideline, protocol, or other similar criterion relied upon in making the decision or a statement or copy of the rule, guideline, protocol, or other similar criterion is available upon request;
 - An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the participant's medical circumstances or a statement that such explanation will be provided free of charge upon request;
 - A description of any additional material or information needed to perfect the claim with an explanation of what is needed. This ABD is provided to the participant as an *initial benefit determination*.
- The participant may appeal the ABD by filing a written or oral request (an oral request in the case of an urgent care claim) with the claims administrator of the plan for the LEA within 180 days after the participant receives a notice of an ABD denying the initial claim for benefits. This appeal is known as the "internal appeal". The participant will be able to submit written comments, documents, records, testimony, and other information relating to the claim for benefits (regardless of whether such information was considered in the initial claim for benefits) to the claims

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administrator for review and consideration. The participant will also be entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information that is relevant to the appeal.

- The Claims Administrator Will Respond to This Internal Appeal Within the Following Time Periods:
 - *Post-Service Claim* – In the case of an appeal of a denied post-service claim, the claims administrator shall respond to participant within 60 days after receipt of the appeal unless it is necessary for the claims administrator to obtain additional information or the participant agrees to extend the time for the decision. The claims administrator may request an extension of 15 days due to matters beyond its control. The participant shall be afforded at least 45 days from receipt of a notice to submit information necessary to decide the claim to provide the specified information.
 - *Pre-Service Claim* – In the case of an appeal of a pre-service claim, the claims administrator shall respond to the participant with a decision within 30 days after receipt of the appeal unless it is necessary for the claims administrator to obtain additional information or the participant agrees to extend the time for the decision. The claims administrator may request an extension of 15 days due to matters beyond its control. The participant shall be afforded at least 45 days from receipt of a notice to submit information necessary to decide the claim to provide the specified information. .
 - *Expedited Pre-Service Claim or Urgent Claim* – In the case of an appeal of an urgent care claim, the claims administrator shall respond to the participant with a decision within 72 hours after classification of the appeal as urgent.
 - *Concurrent Care Review Claim* – In the case of a concurrent care review claim, the claims administrator shall respond to the participant before the ongoing treatment in question is reduced or terminated.
- Further Appeal from Adverse Decision of Claim Administrator's Internal Appeal to An Independent Review Organization (IRO) for Claims Concerning "Medical Judgment"*

* Questions of "medical judgment" involve the plan's requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness of a covered benefit, or whether a service is experimental or investigational as determined by the external reviewer.

- If the claims administrator denies a claim involving medical judgment in whole or in part, the claims administrator will provide the participant with written notice of the denial (although the initial notice of a denied urgent care claim may be provided to the participant orally or via facsimile or other similar expeditious means of communication). The notice will provide the legally required information, and will also state that the participant shall file a further appeal by filing a written request for review by an Independent Review Organization (IRO) within four months of the date of the claims administrator's decision, if the participant desires to appeal the decision of the IRO.
- A decision by an IRO concerning a medical judgment appeal shall be issued to the participant within 45 days of the date of the request for the appeal.
- If the decision of the IRO is to deny the participant's appeal, the participant shall have the right to elect to have the EBTEP Board of Trustees review the IRO's denial. This right of appeal to the EBTEP Board of Trustees is an elective right and is not a required appeal. For this elective appeal, the participant shall provide a written request to have the EBTEP

Monroe Career & Technical Institute Employee Benefit Plan

Board of Trustees review the IRO's decision within four months of the date of the decision. If the participant provides this notice to review the IRO's appeal at least 30 days before the next quarterly meeting of the Board of Trustees, the decision of the IRO shall be reviewed at the next quarterly board meeting of the Board of Trustees, and a decision shall be promptly provided to the participant and claims administrator within 30 days of the meeting of the Board of Trustees. If a participant's notice of appeal of the decision of the IRO is provided less than 30 days before the next quarterly meeting of the Board of Trustees, the appeal shall be reviewed at the Board of Trustees meeting in the following quarter and the written notice of the decision shall be provided to the participant within 30 days of the date of the meeting of the Board of Trustees. If the participant does not elect a further appeal to the EBTEP Board of Trustees for medical issues, the participant may seek other remedies available under state or federal law.

- Elective Appeal from Adverse Decision of Claim Administrator's Internal Appeal to EBTEP Board of Trustees Concerning Claims Involving "Non-Medical Judgment"
 - If the internal appeal decision of the claims administrator involves **non-medical judgment**, then the participant shall have the right to a further appeal to the EBTEP Board of Trustees. This right of appeal to the EBTEP Board of Trustees is an elective right and is not a required appeal. If the participant elects to have their non-medical claim reviewed by the EBTEP Board of Trustees, they shall submit their appeal in writing within four months of the date of receipt of the denial of their internal appeal. If the participant does not elect a further appeal to the EBTEP Board of Trustees for non-medical issues, the participant may seek other remedies available under state or federal law.
 - In the case of a further elective non-medical judgment appeal to the EBTEP Board of Trustees, the decision shall be made at the next quarterly board meeting of the Board of Trustees if the participant provides his/her notice of appeal at least 30 days before the next quarterly meeting of the Board of Trustees. If the appeal is provided less than 30 days before the next quarterly meeting of the Board of Trustees, the appeal shall be reviewed at the following quarterly meeting of the EBTEP Board of Trustees, and a decision shall be promptly provided to the participant and claims administrator within 30 days of the date of the meeting of the Board of Trustees.
- Remedies After Adverse Decision of EBTEP Board of Trustees

If the EBTEP Board of Trustees denies a participant's further elective non-medical appeal or if the EBTEP Board of Trustees denies a participant's elective appeal from a determination of the IRO, the participant shall receive a written notice of the denial which includes information required by law and also provides that the participant may seek other remedies available under state or federal law.

TERMINATION OF COVERAGE

You may elect to terminate coverage as provided under the individual included plans and programs. We may terminate a plan or program for all employees, at our discretion. Coverage will terminate with your termination of employment unless the plan specifically provides for retiree benefits. Coverage will also terminate if you fail to pay your required part of the premium.

Monroe Career & Technical Institute Employee Benefit Plan

Medicare or Medicaid Coverage

If you become (or your spouse or your dependent becomes) entitled to Medicare or Medicaid coverage, you may make a prospective election to cancel or reduce coverage for the affected person under your health plan. In addition, if you lose (or your spouse or your dependent loses) eligibility for such coverage, you may make a prospective election to begin or increase coverage for the affected person under your health plan.

Family Medical Leave Act

Regardless of the established leave policies, this Plan shall at all times comply with the Family and Medical Leave Act (FMLA) of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Military Leave - If you take an unpaid leave of absence due to military service that is protected by the Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA), special rules will apply. If you are employed in Pennsylvania, we will pay your group health plan premiums for the first 30 days. If you are absent for 31 days or more, you will need to arrange to pay for your full premium costs. We will not pay any portion of the premium. You may pay to continue your coverage for up to 24 months. If you are not employed in Pennsylvania, your cost will include a small (2%) additional charge for administration.

If You Leave

If you terminate your employment with us, you will no longer be a participant under most of the included plans and programs. However, you may be able to elect COBRA Continuation Coverage under the group health plan you have chosen. You will need to pay for any continuing coverage directly.

If You Die

If you die while you are actively employed, your spouse or estate can file claims for benefits. If no COBRA Continuation Coverage is elected, the claims must have been incurred before the termination of coverage due to your death.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about eligibility or other general information, contact your Human Resources office. For information about claims payment, you should contact the Claims Administrator:

Medical and Prescription Drug

Highmark Blue Shield
P.O. Box 890062
Camp Hill, PA 17089
www.highmark.com
(800) 241-5704

Dental

United Concordia Dental
P.O. Box 69421
Harrisburg, PA 17106
www.unitedconcordia.com
(800) 332-0366

Vision

Vision Benefits of America
400 Lydia Street
Suite 300
Carnegie, PA 15106
www.vbaplans.com
(800) 432-4966

Monroe Career & Technical Institute Employee Benefit Plan

GENERAL INFORMATION

Plan Name	Monroe Career & Technical Institute Employee Benefit Plan
Plan Type	Self-funded health & welfare plans including: Medical and Prescription Drug plan, Dental Plan, and Vision Plan
Employer Identification Number	23-1715511
Plan Number	501
Plan Dates	July 1 st through June 30 th
Plan Sponsor	Monroe Career & Technical Institute 194 Laurel Lake Rd Bartonsville, PA 18321
Plan Administrator	Employee Benefit Trust of Eastern PA 6 Danforth Dr. Easton, PA 18045
Named Fiduciary	Employee Benefit Trust of Eastern PA 6 Danforth Dr. Easton, PA 18045
Agent for Service of Legal Process	If, for any reason, you want to seek legal action against the Plan, you can serve legal process on the Plan Administrator for the Plan.
Claims Administrator	<u>Medical and Prescription Drug</u> Highmark Blue Shield P.O. Box 890062 Camp Hill, PA 17089 <u>Dental</u> United Concordia Dental P.O. Box 69421 Harrisburg, PA 17106 <u>Vision</u> Vision Benefits of America 400 Lydia Street Suite 300 Carnegie, PA 15106

APPENDIX A

Eligibility Requirements for Monroe Career & Technical Institute Employee Benefit Plan

Medical and Prescription Drug Plan

Eligible Classes of Employees:

- Full-time Employees

If you are in an eligible class of employees, you are eligible to enroll in medical, prescription drug, dental and vision benefits on the first day of employment.

Dependent Eligibility

Medical and Prescription Drug Plan - Eligible dependents may remain on the plan, as determined by the Affordable Care Act, until the age of 26 regardless of marital status and employment status.

Spousal Rule applies to all employees. If your spouse is offered coverage through his or her own employer and does not enroll, a surcharge will be assessed.

Dental Plan – Eligible dependents may remain on the plan until age 19. If he or she is a full-time student, he or she may remain on the plan through age 23, or he or she graduates college, whichever is earlier.

Vision Plan – Eligible dependents may remain on the plan until age 19. If he or she is a full-time student, he or she may remain on the plan through age 25, or he or she graduates college, whichever is earlier.

Retiree Eligibility

If you are an eligible retiree, as determined by state law, you may be eligible to participate in the plan until you are eligible for Medicare. Your eligible spouse may be able to remain on the plan, as well, until eligible for Medicare. Your eligible dependents may be able to remain on the plan, as well, until you are ineligible.

APPENDIX B – PPO PLAN

Monroe Career & Technical Institute

Highmark PPO Medical & Prescription Drug Benefits

In addition to the following Benefit Booklet Coverage provided by Highmark, the following items are incorporated by reference into this Medical & Prescription Drug Plan:

Please consult the Appeal Process contained in the Plan Document which shall control the appeal procedure. The information contained in Appendix B regarding Appeals does not control how appeals will be handled for your Employer.

PPO BLUE

PPO PROGRAM

**Monroe Career And Technical Institute
Group 10213470, 71, 72, 73
Effective July 1, 2019**

Discrimination is Against the Law

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

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

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

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

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

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

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

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga lib्रेng 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 Blue Cross Blue Shield provides administrative and claims payment services only.

Non-Assignment

Highmark is authorized by the member to make payments directly to providers furnishing Covered Services provided under the program described in this benefit booklet; however, Highmark reserves the right to make these payments directly to the

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

Introduction to Your Health Care Program

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

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

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 physician to receive covered care. You have access to a large provider network of physicians, hospitals, and other providers in the Highmark service area, as well as providers across the country. For a higher level of coverage, you need to receive care from one of the network providers in the Highmark service area. However, you can go outside the local 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.highmarkbcbs.com.
- ***Your health care program gives you "stay healthy" care.*** You are covered for a range of preventive care, including physical examinations and selected diagnostic tests. Preventive care is a proactive approach to health management that can help you stay on top of your health status and prevent more serious, costly care down the road.

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

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

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

Information for Non-English-Speaking Members

Non-English-speaking members have access to clear benefits information. They can call the toll-free Member Service telephone number on the back of their ID card to be

connected to a language services interpreter line. Highmark Member Service representatives are trained to make the connection.

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

How Your Benefits Are Applied

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

Benefit Period

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

Medical and Prescription Drug Cost-Sharing Provisions

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

Coinsurance

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

Minimum/Maximum Member Liability for Drug Coinsurance

You are responsible for a percentage of the provider's allowable price of every covered prescription drug. However, your program includes a maximum member liability amount for each covered prescription drug to limit your liability on very expensive prescription drugs, and a minimum member liability amount for each covered prescription drug that will establish your responsibility on less expensive prescription drugs. Your minimum coinsurance obligation is the amount specified in the Summary of Benefits, or the cost of the covered prescription drug, whichever is lower.

Here is how it works. Consider a 20% coinsurance with a \$15 minimum and a \$50 maximum. If your prescription costs less than \$15, you will pay the actual cost of the prescription. If your prescription costs between \$15 and \$75, you will pay \$15 since 20% of \$75 is \$15 and that is the minimum coinsurance. If your prescription costs between \$75 and \$250, you will pay 20% of the actual prescription cost.

The maximum member liability amount for coinsurance is the highest coinsurance amount that is your responsibility. Therefore, if your prescription costs more than

\$250, you will pay \$50 (since 20% of \$250 is \$50 and that is a maximum amount you will pay for coinsurance for each prescription drug).

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.

If your group changes group health care expense coverage during your benefit period, the amount you paid toward your deductible during the last partial benefit period for services covered under your prior coverage will be applied to the network and out-of-network deductible of the initial benefit period under this program.

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 three individual deductibles per family, as specified under family deductible. After each of the three covered persons meets the individual deductible specified in the Summary of Benefits, the deductible for the entire family is met. If one family member meets the deductible and needs to use benefits, the program would begin to pay for that person's covered services even if the deductible for the entire family 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.

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.

Out-of-Pocket Credit

If your group changes group health care expense coverage during your benefit period, the amount you paid toward your out-of-pocket limit during the last partial benefit period for services covered under your prior coverage will be applied to the network and out-of-network (combined) out-of-pocket limit of the initial benefit period under this program. This credit is similarly applied toward your total maximum out-of-pocket for network covered services.

Maximum

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

Covered Services - Medical Program

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

Network care is covered at a higher level of benefits than out-of-network care. For the lowest out-of-pocket costs, use a network provider. To make sure that a provider is in the network, call Member Service at the number on the back of your member ID card. Or visit www.highmarkbcbs.com.

Ambulance Service

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

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

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

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

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

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

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

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.

Dental Services Related to Accidental Injury

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

Diabetes Treatment

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

- Equipment and supplies: Blood glucose monitors, monitor supplies, 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).

Diagnostic Services

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

Advanced Imaging Services

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

Basic Diagnostic Services

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

Durable Medical Equipment

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

Enteral Foods

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

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

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

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

Coverage for enteral formulae excludes the following:

- Blenderized food, baby food, or regular shelf food
- Milk or soy-based infant formulae with intact proteins
- Any formulae, when used for the convenience of you or your family members
- Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance
- Semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally

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

Home Health Care/Hospice Care Services

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

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

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

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

Home Infusion and Suite Infusion Therapy Services

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

Hospital Services

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

Inpatient Services

Bed and Board

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

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

Ancillary Services

Hospital services and supplies including, but not restricted to:

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

Outpatient Services

Ancillary Services

Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms and equipment;
- drugs and medicines provided to you while you are an outpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives;

- anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;
- medical and surgical dressings, supplies, casts and splints.

Emergency Care Services

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

Emergency care services are services and supplies, including drugs and medicines, for the outpatient emergency treatment of bodily injuries resulting from an accident or a medical condition. 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.

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

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

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

Pre-Admission Testing

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

Surgery

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

Inpatient Medical Services

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

Concurrent Care

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

Consultation

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

Inpatient Medical Care Visits

Benefits are provided for inpatient medical care visits.

Intensive Medical Care

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

Routine Newborn Care

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

Maternity Services

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

Complications of Pregnancy

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

Maternity Home Health Care Visit

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

network provider. The visit is subject to all the terms of this program and is exempt from any copayment, coinsurance or deductible amounts.

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

Normal Pregnancy

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

Nursery Care

Covered services provided to the newborn child from the moment of birth, including care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Routine nursery care includes inpatient medical visits by a professional provider. Benefits will continue for a maximum of 31 days. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within such period. Refer to the General Information section for further eligibility information.

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

Mental Health Care Services

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

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

Inpatient hospital services provided by a facility provider or residential treatment facility provider that satisfies the criteria established by the plan for the treatment of mental illness.

Inpatient Medical Services

Covered inpatient medical services provided by a professional provider:

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

Partial Hospitalization Mental Health Care Services

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

Outpatient Mental Health Care Services

Inpatient facility service and inpatient medical benefits (except room and board) provided by a facility provider or professional provider as previously described, are also available when you are an outpatient, including a virtual visit between you and a specialist via an audio and video telecommunications system.

Orthotic Devices

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

Outpatient Medical Care Services (Office Visits)

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

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

Or you can interact with a professional provider as follows:

- A virtual visit between you and a PCP or retail clinic via an audio and video telecommunications system
- A virtual visit between you and a specialist via the internet or similar electronic communications for the treatment of skin conditions or diseases
- A specialist virtual visit between you and a 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. Benefits will not be provided for a specialist virtual visit if the visit is related to the treatment of mental illness or substance abuse.

Different types of providers and their locations may require different payment amounts. The specific amounts you are responsible for paying depend on your particular Highmark benefits.

Allergy Extract/Injections

Benefits are provided for allergy extract and allergy injections.

Therapeutic Injections

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

Preventive Care Services

Benefits will be provided for covered services. Refer to the Summary of Benefits for your program's specific level of coverage.

Adult and Pediatric Care

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

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

Adult Immunizations

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

Colorectal Cancer Screenings

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

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

Benefits are provided for members 50 years of age or older as follows, or more frequently and regardless of age when prescribed by a physician:

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

If you are determined to be at high or increased risk, regardless of age, benefits are provided for a colonoscopy or any other combination of covered services related to colorectal cancer screening when prescribed by a physician and in accordance with the American Cancer Society guidelines on screening for colorectal cancer as of January 1, 2008.

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

Diabetes Prevention Program

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

Mammographic Screening

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

Benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified by the Pennsylvania Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

Pediatric Immunizations

Benefits are provided to members under 21 years of age and dependent children for those pediatric immunizations, including the immunizing agents, which conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services. Benefits are not subject to the program deductibles or dollar limits.

Routine Gynecological Examination and Pap Test

Benefits are provided for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine Papanicolaou smear (pap test) per calendar year. Benefits are not subject to program deductibles or maximums.

Routine Screening Tests and Procedures

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

Tobacco Use, Counseling and Interventions

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

Private Duty Nursing Services

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

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

- If you are at home only when Highmark determines that the nursing services require the skills of an RN or an LPN.

Prosthetic Appliances

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

Skilled Nursing Facility Services

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

No benefits are payable:

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

Spinal Manipulations

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

Substance Abuse Services

Benefits are provided for 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:

- Inpatient hospital or substance abuse treatment facility services for detoxification
- Substance abuse treatment facility services for non-hospital inpatient residential treatment and rehabilitation services
- Outpatient hospital or substance abuse treatment facility or 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.

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 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.

Mastectomy and Breast Cancer Reconstruction

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

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

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

Special Surgery

- Oral Surgery

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

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

Second Surgical Opinion

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

Keep in mind that:

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

eligible for a maximum of two such consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

Surgery

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

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

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

Transplant Services

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

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

- when both the recipient and the donor are members, each is entitled to the benefits of their program;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this program subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Cross or Blue Shield coverage or any government program; and 2) 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.

Covered Services - Prescription Drug Program

Prescription drugs are covered when you purchase them through the pharmacy network applicable to your program. For convenience and choice, these pharmacies include both major chains and independent stores. To locate a network pharmacy, go to your member website, log in and choose **Prescriptions**. Or call Member Service at the number on the back of your ID card.

Your program may also include a formulary. The formulary is a list of FDA-approved prescription drugs. It covers products in every major treatment category. The formulary is on your member website. You can also call Member Service for more information.

A drug formulary may restrict coverage of some drugs. To help manage costs, coverage will be for the generic drug if it is available. Generic drugs have the same active ingredient as brand names. Generic drugs must also meet the same FDA requirements.

Your program may also include a mandatory generic penalty (MGP) provision. The MGP provision provides that if you receive a brand name drug when a generic equivalent is available you must pay the price difference between the brand and generic prices in addition to the applicable copayment or coinsurance amount.

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

Should you purchase or should your physician prescribe a brand name drug when a generic is available, you must pay the price difference between the brand and generic prices in addition to the applicable copayment or coinsurance amount.

Covered Drugs

Covered drugs include:

- those which, under Federal law, are required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription;"
- legend drugs under applicable state law and dispensed by a licensed pharmacist;
- preventive drugs that are offered in accordance with a predefined schedule and are prescribed for preventive purposes. Highmark periodically reviews the schedule based on legislative requirements and the advice of the American Academy of Pediatrics, the U.S. Preventive Services Task Force, the Blue Cross Blue Shield Association and medical consultants. Therefore, the

frequency and eligibility of services is subject to change. For a current schedule of covered preventive drugs, log onto your member website, or call Member Service at the toll-free telephone number listed on the back of your ID card;

- prescribed injectable insulin;
- diabetic supplies, including needles and syringes; and
- certain drugs that may require prior authorization

What Is Not Covered

Except as specifically provided in this program or as Highmark is mandated or required to provide based on state or federal law, no benefits will be provided for services, supplies, prescription drugs or charges:

<u>Key Word</u>	<u>Exclusion</u>
Abortion	<ul style="list-style-type: none"> For elective abortions except those abortions necessary to avert the death of the mother or terminate pregnancies caused by rape or incest.
Acupuncture	<ul style="list-style-type: none"> For acupuncture services.
Allergy Testing	<ul style="list-style-type: none"> For allergy testing, except as provided herein.
Ambulance	<ul style="list-style-type: none"> For ambulance services, except as provided herein.
Assisted Fertilization	<ul style="list-style-type: none"> For all in-vitro fertilization.
Comfort/Convenience Items	<ul style="list-style-type: none"> For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider.
Cosmetic Surgery	<ul style="list-style-type: none"> For a cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except: a) as otherwise provided herein, b) when required to correct a condition directly resulting from an accident; c) when necessary to correct a functional impairment which directly results from a covered disease or injury, or d) to correct a congenital birth defect.
Court Ordered Services	<ul style="list-style-type: none"> For otherwise covered services ordered by a court or other tribunal unless medically necessary and appropriate or if the reimbursement of such services is required by law..
Custodial Care	<ul style="list-style-type: none"> For custodial care, domiciliary care, protective and supportive care including educational services, rest cures and convalescent care.
Dental Care	<ul style="list-style-type: none"> 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 related to accidental injury, anesthesia for non-covered dental procedures and orthodontic treatment for congenital cleft palates as provided herein.

- Diabetes Prevention Program
 - For a diabetes prevention program offered by other than a network diabetes prevention provider or a YMCA diabetes prevention eligible provider.
- Effective Date
 - Rendered prior to your effective date of coverage.
- Enteral Foods
 - For the following services associated with the additional enteral foods benefits provided under your program: blenderized food, baby food, or regular shelf food; milk or soy-based infant formulae with intact proteins; any formulae, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance; semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally; normal food products used in the dietary management of the disorders provided herein.
- Experimental/ Investigative
 - Which are experimental/investigative in nature.
- 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.

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| Health Care Management program | <ul style="list-style-type: none">• For any care, treatment, prescription drug or service which has been disallowed under the provisions of Health Care Management program. |
| Hearing Care Services | <ul style="list-style-type: none">• For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids. |
| Home Health Care | <ul style="list-style-type: none">• For the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: dietitian services; homemaker services; maintenance therapy; dialysis treatment; custodial care; food or home-delivered meals. |
| Immunizations | <ul style="list-style-type: none">• For immunizations required for foreign travel or employment, except as provided herein. |
| Inpatient Admissions | <ul style="list-style-type: none">• For inpatient admissions which are primarily for diagnostic studies.• For inpatient admissions which are primarily for physical medicine services. |
| Learning Disabilities | <ul style="list-style-type: none">• For any care that is related to conditions such as autism spectrum disorders, learning disabilities, behavioral problems or intellectual disabilities, which extends beyond traditional medical management or medically necessary 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; d) services provided primarily for social or environmental change or for respite care. |
| Legal Obligation | <ul style="list-style-type: none">• For which you would have no legal obligation to pay. |

- Medically Necessary and Appropriate

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

 - To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program.
 - For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage.
- Methadone Hydrochloride

 - For methadone hydrochloride treatment for which no additional functional progress is expected to occur.
- 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 telephone consultations , charges for failure to keep a scheduled visit, or charges for completion of a claim form.
 - For any other medical or dental service or treatment or prescription drug except as provided herein.
- 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
Obesity

 - For nutritional counseling, except as provided herein.
 - For treatment of obesity, except for medical and surgical treatment of morbid obesity or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
- Oral Surgery

 - For oral surgery procedures, except as provided herein.
- Physical Examinations

 - For routine or periodic physical examinations, the completion of forms, and the preparation of specialized

reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein.

Prescription Drugs
(Medical Program)

- For prescription drugs which were paid or are payable under a freestanding prescription drug program.

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 ancillary providers, facility providers or professional 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.

Sexual Dysfunction

- For treatment of sexual dysfunction that is not related to organic disease or injury.

Skilled Nursing

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

Smoking (nicotine) Cessation	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • For reversal of sterilization.
Termination Date	<ul style="list-style-type: none"> • Incurred after the date of termination of your coverage except as provided herein.
Therapy	<ul style="list-style-type: none"> • For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur.
TMJ	<ul style="list-style-type: none"> • For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
Vision Correction Surgery	<ul style="list-style-type: none"> • For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.
War	<ul style="list-style-type: none"> • For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.
Weight Reduction	<ul style="list-style-type: none"> • For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
Well-Baby Care	<ul style="list-style-type: none"> • For well-baby care visits, except as provided herein.
Workers' Compensation	<ul style="list-style-type: none"> • For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.

In addition, under your Prescription Drug benefits, except as specifically provided in this program or as Highmark is mandated or required to provide based on state or federal law, no benefits will be provided for:

- Antihemophilia drugs.
- Antitussives (cough/cold products).
- Any amounts above the deductible, coinsurance, copayment or other cost-sharing amounts for each prescription order or refill that are your responsibility.
- Any amounts you are required to pay directly to the pharmacy for each prescription or refill.
- Any charges by any pharmacy provider or pharmacist except as provided herein.
- Any drug or medication except as provided herein.
- Any drug or medication which does not meet the definition of covered maintenance prescription drug, except those set forth in the predefined preventive schedule. Please refer to the Covered Drugs section for more information.
- Any drugs and supplies which can be purchased without a prescription order, including, but not limited to blood glucose monitors and injection aids, except as provided herein.
- Any drugs prescribed for cosmetic purposes only.
- Any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes.
- Any drugs used to abort a pregnancy.
- Any drugs which are experimental/investigative.
- Any prescription drug purchased through mail order but not dispensed by a designated mail order pharmacy provider.
- Any prescription drug which has been disallowed under the Prescription Drug Management section of this booklet.
- Any prescription drugs or supplies purchased at a non-participating pharmacy provider, except in connection

with emergency care described herein.

- Any prescription for more than the retail days supply or mail-service days supply as outlined in the Summary of Benefits.
- Any selected diagnostic agents.
- Blood products.
- Charges for a prescription drug when such drug or medication is used for unlabeled or unapproved indications and where such use has not been approved by the Food and Drug Administration (FDA).
- Charges for administration of prescription drugs and/or injectable insulin, whether by a physician or other person.
- Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances).
- Compounded medications.
- Drugs and supplies that are not medically necessary and appropriate or otherwise excluded herein.
- Food supplements.
- Hair growth stimulants.
- Immunizations/biologicals.
- Over-the-counter drugs, except those set forth in the predefined preventive schedule. Please refer to the Covered Drugs section for more information.
- Prescription drugs dispensed for treatment of an illness or an injury for which the group is required by law to furnish hospital care in whole or in part-including, but not limited to-state or federal workers' compensation laws, occupational disease laws and other employer liability laws.
- Prescription drugs to which you are entitled, with or without charge, under a plan or program of any government or governmental body.
- Services of your attending physician, surgeon or other medical attendant.

- Topical antifungals.
- Weight control drugs.

How Your Health Care Program Works

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

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

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

For further information, please refer to the Consent Decree Addendum provided at the end of this benefit booklet.

Network Care

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

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

Out-of-Network Care

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

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

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

Even though a hospital may be in our network, not every doctor providing services in that hospital is in the network. For example: If you are having

surgery, make sure that all of your providers, including surgeons, anesthesiologists and radiologists, are in the network.

YMCA Diabetes Prevention Eligible Providers

When provided by a YMCA Diabetes Prevention Eligible Provider, the Diabetes Prevention Program shall be available at the network level of benefits.

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 a member receives covered services from an out-of-network provider, in addition to the member's cost-share liability described above, the member is responsible for the difference between Highmark's payment and the provider's billed charge. If a member receives services which are not covered under this plan, the member is responsible for all charges associated with those services.

Out-of-Area Care

Your program also provides coverage for you and your eligible dependents when you receive care from providers located outside the Plan Service Area. 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 the geographic area Highmark serves, the claim for those services may be processed through one of these inter-plan arrangements, as described generally below.

Typically, when accessing care outside the geographic area Highmark serves, members obtain care from health care 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 health care 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 the geographic area Highmark serves, 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 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 health care 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, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices, (ie, prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Highmark in determining your 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, audits/health care 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.

Non-Participating Providers Outside of the Plan Service Area

Member Liability Calculation

When covered services are provided outside of the Plan service area 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 out-of-network emergency services are governed by applicable federal and state law.

Exceptions

In some exception cases, Highmark may pay claims from non-participating health care providers outside of the Plan service area 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 inside the Plan service area. 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 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 health care 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 service center for assistance, hospitals will not require members to pay for inpatient covered services, except for their cost-sharing amounts. In such cases, the 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 for non-emergency inpatient services.**

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

When members pay for covered services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional

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

Your Provider Network

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

To determine if your physician is in the network, call the Member Service toll-free telephone number on the back of your ID card, or log onto www.highmarkbcbs.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 physician. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal physician 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.highmarkbcbs.com and click on "Find a Doctor" to start your search. Search for the physician, then click on the provider's name to view the following information:

- Name, address, telephone numbers
- Professional qualifications
- Specialty

- Medical school attended
- Residency completion
- Board certification status
- Hospital affiliations

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

Eligible Providers

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

Facility Providers

- Hospital
- Psychiatric hospital
- Rehabilitation hospital
- Ambulatory surgical facility
- Birthing facility
- Day/night psychiatric 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

- Audiologist
- Certified registered nurse*
- Chiropractor
- Clinical social worker
- Dentist
- Dietician-nutritionist
- Licensed practical nurse
- Marriage and family therapist
- Nurse-midwife

- Occupational therapist
- Optometrist
- Physical therapist
- Physician
- Podiatrist
- Professional counselor
- Psychologist
- Registered nurse
- Respiratory therapist
- Speech-language pathologist
- Teacher of hearing impaired

Ancillary Providers:

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

Contracting Suppliers (for the sale or lease of):

- Durable medical equipment
- Supplies
- Orthotics
- Prosthetics

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

Prescription Drug Providers

You must purchase drugs from a network pharmacy to be eligible for benefits under this program. *No benefits are available if drugs are purchased from a non-network pharmacy.*

- **Network Pharmacy:** Network pharmacies have an arrangement with Highmark to provide prescription drugs to you at an agreed upon price. When you purchase covered drugs from a pharmacy in the network applicable to your program, present your prescription and ID card to the pharmacist. (Prescriptions that the pharmacy receives by phone from your physician or dentist may also be covered.) You should request and retain a receipt for any amounts you have paid if needed for income tax or any other purpose.

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

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

To start using mail order:

1. Ask your doctor to write a prescription for up to a 90-day supply, plus refills for up to one year, if appropriate.
2. Complete the Pharmacy Mail Order Form and Health, Allergy & Medication Questionnaire. You can get these forms by calling Member Service or from your member website. After logging in, click on the "Prescriptions" tab. Scroll down the page to "Forms to Manage Your Plan" and click on "Mail order form and health questionnaire (PDF)".
3. Send the completed forms and your payment to the address listed on the mail order form. It usually takes about five days to get your prescription after it has been processed.

Your mail order will include directions for ordering refills.

- **Exclusive Pharmacy Provider:** The exclusive pharmacy provider has an agreement, either directly or indirectly, with Highmark pertaining to the payment and exclusive dispensing of selected prescription drugs provided to you. Please refer to the Covered Services - Prescription Drug Program section for a list of the selected prescription drug categories.

Health Care Management

Medical Management

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

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

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

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

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

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

Care Utilization Review Process

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

Prospective Review

Prospective review, also known as precertification or pre-service review, begins upon receipt of treatment information.

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;
- authorizes care and assigns an appropriate length of stay for inpatient admissions

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.

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.

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 procedures or covered services and you will be held harmless whenever certification for such procedures or covered services is not obtained. If the procedure or covered service is deemed not to be medically necessary and appropriate, you will be held harmless, 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 an out-of-area provider, it is your responsibility to first contact Highmark to confirm the medical necessity and appropriateness of such procedures or covered services. If you do not contact Highmark for certification, those procedures or covered services may be reviewed after they are 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 out-of-area provider's charge.

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 of such procedures or covered services. If you do not contact Highmark for certification, those procedures or covered services may be reviewed after they are 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 Highmark's determination of 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.

Retrospective Review

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

Case Management Services

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

Individual Case Management

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

Highmark case managers are a free resource to all Highmark members. If you have an inpatient hospital admission, you may be contacted as part of our Outreach program. If your claims history indicates that your needs appear to be more complex, you may be contacted by a case manager from our Complex program. In either case, you are always free to 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.

Selection of Providers

You have the option of choosing where and whom to go to for 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. .

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.

Prescription Drug Management

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

Early Refill Authorization

Unexpected Event

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

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

Traveling Abroad

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

Individual Case Management

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

Quantity Level Limits

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

Managed Prescription Drug Coverage

A prescription order or refill which may exceed the manufacturer's recommended dosage over a specified period of time may be denied by Highmark when presented to the pharmacy provider. Highmark may contact the prescribing physician to determine if the covered medication is medically necessary and appropriate. The covered medication will be dispensed if it is determined by Highmark to be medically necessary and appropriate.

Preauthorization

Certain prescription drugs may require preauthorization to ensure the medical necessity and appropriateness of the prescription order. The prescribing physician

must obtain authorization from Highmark prior to prescribing certain covered medications. The specific drugs or drug classifications which require preauthorization may be obtained by calling the toll-free Member Service telephone number appearing on your ID card.

Precertification, Preauthorization and Pre-Service Claims Review Processes

The precertification, preauthorization and pre-service claims review processes information described below applies to both medical and prescription drug management.

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 15 days from the date Highmark receives the claim.

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 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 24 hours following Highmark receipt of the claim of the specific information needed to complete your claim. Your physician will then be given not less than 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 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 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 24 hours following receipt of the request.

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

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

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

General Information

Who is Eligible for Coverage

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

You may enroll your:

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

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

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

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

age for a period equal to the duration of their service on active duty or active state duty.

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

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

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

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

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

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

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

Changes in Membership Status

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

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

Medicare

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

Covered Active Employees Age 65 or Over

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

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

- or -

Non-Covered Active Employees Age 65 or Over

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

Spouses Age 65 or Over of Active Employees

If you are actively employed in a group with 20 or more employees, your spouse has the same choices for benefit coverage as indicated above for the employee age 65 and over.

Regardless of the choice made by you or your spouse, each one of you should apply for Medicare Part A coverage about three months prior to becoming age 65. If you

elect to be covered under the program, you may wait to enroll for Medicare Part B. You will be able to enroll for Part B later during special enrollment periods without penalty.

Leave of Absence or Layoff

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

Continuation of Coverage

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

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

Conversion

If your employer does not offer continuation of coverage, or if you do not wish to continue coverage through your employer's program, you may be able to enroll in an individual conversion program available from Highmark. Also, conversion is available to anyone who has elected continued coverage through your employer's program and the term of that coverage has expired.

If your coverage through your employer is discontinued for any reason, except as specified below, you may be able to convert to a direct payment program.

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

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

Termination of Your Coverage Under the Employer 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 totally disabled at the time your coverage terminates due to termination of active employment, benefits will be continued for covered services directly related to the condition causing such total disability. This benefit extension does not apply to covered services relating to other conditions, illnesses, diseases or injuries and is not available if your termination was due to fraud or intentional misrepresentation of a material fact. This total disability extension of benefits will be provided as long as you remain so disabled as follows:
 - Up to a maximum period of 12 consecutive months; or
 - Until the maximum amount of benefits has been paid; or
 - Until the total disability ends; or
 - Until you become covered without limitation as to the disabling condition under other group coverage, whichever occurs first.
- If you are required to pay any premium, your benefits will not be continued if your coverage is terminated because you failed to pay the required premium.

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, the contract covering the parent whose birthday falls earlier in the calendar year pays first. 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 separated or divorced, the following applies:
 - The parent with custody of the child pays first.

- The coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody.
- Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.
- When 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 disregarded.

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

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

Subrogation

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

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

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

The Plan shall have a first priority lien on the proceeds of any payment, settlement or award you receive in connection with an injury caused by a person or organization. The lien shall be in the amount of benefits paid on your behalf regardless of whether

you are made-whole for your loss or because you have incurred attorney fees or costs.

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

A Recognized Identification Card

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

If your card is lost or stolen, please contact Highmark Member Service immediately. You can also request additional or replacement cards online by logging onto www.highmarkbcbs.com.

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

- Your name and your dependent's name, if applicable
- Identification number
- Group number
- Copayment for physician office visits and emergency room visits
- Pharmacy network logo (when applicable)
- Member Service toll-free number (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

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

If you receive medications from a network pharmacy and present your ID card, you will not have to file a claim. If you forget your ID card when you go to a network pharmacy, the pharmacy may ask you to pay in full for the prescription.

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

- **Know Your Benefits.** Review this information to see if the services you received are eligible under your medical program.
- **Get an Itemized Bill.** Itemized bills must include:
 - The name and address of the service or pharmacy provider
 - The patient's full name
 - The date of service or supply or purchase
 - A description of the service or medication/supply
 - The amount charged
 - For a medical service, the diagnosis or nature of illness
 - For durable medical equipment, the doctor's certification
 - For private duty nursing, the nurse's license number, charge per day and shift worked, and signature of provider prescribing the service;
 - For ambulance services, the total mileage
 - Drug and medicine bills must show the prescription name and number and the prescribing provider's name.

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

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

- **Attach Itemized Bills to the Claim Form and Mail.** After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the back of your ID card.

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

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

Your Explanation of Benefits Statement

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

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

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

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

How to Voice a Complaint

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

Highmark Blue Cross Blue Shield
P.O. Box 535095
Pittsburgh, PA 15253

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

If the informal dissatisfaction process is not successful and does not meet your needs, you have the right to have your objection reviewed by our Member Grievance and Appeals Department. For details about how this process works, please refer to the Appeal Procedure section of this 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 30 days from the date your claim was received. However, this 30-day period of time may be extended one time by Highmark for an additional 15 days, provided that Highmark determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day post-service claim determination period. If an extension of time is necessary because you failed to submit information necessary for Highmark to make a decision on your post-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your post-service claim.

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

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

Appeal Procedure

Your benefit program maintains an appeal process involving one 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.

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

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

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

not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal.

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

- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of the appeal;
- When the appeal involves an urgent care claim, as soon as possible taking into account the medical exigencies involved but not later than 72 hours following receipt of the appeal; or
- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 60 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 a statement regarding your right to request an external review or pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

External Review

You have four months from the date you receive notice of a final Highmark adverse benefit determination to file a request for an external review with Highmark. 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; or (ii) a determination made by your plan administrator to rescind your coverage.

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

Preliminary Review

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

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

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

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

Referral to an Independent Review Organization (IRO)

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

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

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

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

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

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

Expedited External Review (Applies to Urgent Care Claims Only)

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

- If the final adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or your health or would jeopardize your ability to regain maximum function and you filed a request for an expedited internal appeal; or
- Following a final internal adverse benefit determination, if you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from the facility rendering the emergency services.

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

Referral to an Independent Review Organization (IRO)

Highmark will, randomly or by rotation, select an IRO to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will

be accredited by a nationally-recognized accrediting organization. Thereafter, Highmark will immediately provide the IRO with documents and information we considered when making our final adverse benefit determination via the most expeditious method (e.g., electronic, facsimile, etc.).

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

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

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

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

Member Service

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

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

Blues On Callsm - 24/7 Health Decision Support

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

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

Help with common illnesses, injuries and questions

Health Coaches can address any health topic that concerns you:

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

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

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

Help with chronic conditions

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

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

myCare Navigatorsm - 24/7 Health Advocate Support

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

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

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

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

Highmark Website

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

Go to www.highmarkbcbs.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 nurse health coach available to you throughout your pregnancy.

Easy Enrollment

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

Member Rights and Responsibilities

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

You have the right to:

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

You have a responsibility to:

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

How We Protect Your Right to Confidentiality

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

health care needs, even targeting certain individuals for quality improvement programs, such as health, wellness and disease management programs.

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

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

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

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

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

Terms You Should Know

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

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.

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.

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

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.

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

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.

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

Custodial Care - Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting the activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition.

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.

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

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

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

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

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

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

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

Medical researchers constantly experiment with new medical equipment, drugs and other technologies. In turn, health care plans must evaluate these technologies.

Decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. That is why a panel of more than 400 medical professionals work with a nationally recognized Medical Affairs Committee to review new technologies and new applications for existing technologies for medical and behavioral health procedures and devices. To stay current and patient-responsive, these reviews are ongoing and all-encompassing, considering factors such as product efficiency, safety and effectiveness. If the technology passes the test, the Medical Affairs Committee recommends it be considered as acceptable medical practice and a covered benefit. Technology that does not merit this status is usually considered "experimental/investigative" and is not generally covered. However, it may be re-evaluated in the future.

A similar process is followed for evaluating new pharmaceuticals. The Pharmacy and Therapeutics (P & T) Committee assesses new pharmaceuticals based on national and international data, research that is currently underway and expert opinion from leading clinicians. The P & T Committee consists of at least one Highmark-employed pharmacist and/or medical director, five board-certified, actively practicing network physicians and two Doctors of Pharmacy currently providing clinical pharmacy services within the Highmark service area. At the committee's discretion, advice, support and consultation may also be sought from physician subcommittees in the following specialties: cardiology, dermatology, endocrinology, hematology/oncology, obstetrics/gynecology, ophthalmology, psychiatry, infectious disease, neurology, gastroenterology and urology. Issues that are addressed during the review process include clinical efficacy, unique value, safety, patient compliance, local physician and specialist input and pharmacoeconomic impact. After the review is complete, the P & T Committee makes recommendations.

Situations may occur when you elect to pursue experimental/investigative treatment. If you have a concern that a service you will receive may be experimental/investigational, you or the hospital and/or professional provider may contact Highmark's Member Service to determine coverage.

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

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

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

Adams	Franklin	Mifflin	Snyder
Berks	Fulton	Monroe	Sullivan
Bradford	Juniata	Montour	Susquehanna
Carbon	Lackawanna	Northampton	Tioga
Centre (part)	Lancaster	Northumberland	Union
Clinton	Lebanon	Perry	Wayne
Columbia	Lehigh	Pike	Wyoming
Cumberland	Luzerne	Schuylkill	York
Dauphin	Lycoming		

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.

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

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

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

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

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

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

Medically Necessary and Appropriate (Medical Necessity and Appropriateness) - Services, supplies or covered medications that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (iii) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Highmark reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply or covered medication is medically necessary and appropriate. No benefits will be provided unless Highmark determines that the service, supply or covered medication is medically necessary and appropriate.

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

Multi-Source Brand Drug - A recognized trade name drug product that does not have patent protection and for which a generic equivalent exists.

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

- **Highmark Blue Cross Blue Shield Participating Facility Provider Network** - all Highmark Blue Cross Blue Shield participating facility providers that have entered directly or indirectly, with Highmark Blue Cross Blue Shield.

- **Highmark Blue Shield Participating Facility Provider Network** - all Highmark Blue Shield participating facility providers that have entered into an agreement, either directly or indirectly, with Highmark.
- **PremierBlue Shield Preferred Professional Provider Network** - all PremierBlue Shield Preferred Professional providers who have an agreement, either directly or indirectly, with Highmark.
- **Highmark Managed Care Network** - all Highmark managed care facility providers and professional providers who have an agreement, either directly or indirectly, with Highmark Inc.

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

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

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.

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. The plan allowance for an in area out-of-network provider 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 provider is determined based 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.

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

In some cases, an allowance may be negotiated with an out-of-area non-participating provider. The negotiated reimbursement amount will be based on prevailing market reimbursement amounts. In the event the negotiations with a non-participating out-of-

area provider are unsuccessful, the plan allowance will be based on pricing determined by a national database. For facility claims, the pricing will be determined on the basis of detailed data reflecting actual reported billings and payments over the preceding 24 months and includes an inflation factor. For professional claims, pricing will be determined on median-based cost of care that is adjusted for geography.

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

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

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

Preferred Provider Organization (PPO) Program - A program that does not require the selection of a primary care physician, 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.

Prescription Drugs - Any drugs or medications ordered by a professional provider by means of a valid prescription order, bearing the federal legend: "Caution: Federal law prohibits dispensing without a prescription," or legend drugs under applicable state law and dispensed by a licensed pharmacist. Also included are prescribed injectable insulin and disposable insulin syringes, as well as compounded medications, consisting of the mixture of at least two ingredients other than water, one of which must be a legend drug.

Primary Care Physician (PCP) - A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics and who may supervise, coordinate and provide specific basic medical services and maintain continuity of patient care.

Provider's Allowable Price - The amount at which a participating pharmacy provider has agreed, either directly or indirectly, with the health plan to provide covered medications to you under this program.

Single Source Brand Drug - A recognized brand drug under patent protection which prohibits the manufacturing of generic equivalent products.

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

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

Highmark is a registered mark of Highmark Inc.

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

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield, First Priority Life Insurance Company or First Priority Health, all of which are independent licensees of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4106.

The information in this benefit booklet is for plans offered through First Priority Life Insurance Company, a licensed affiliate of Highmark Blue Cross Shield.

Highmark Blue Cross Blue Shield and First Priority Life Insurance Company are independent licensees of the Blue Cross Blue Shield Association.

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

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

Express Scripts is a registered trademark of Express Scripts Holding Company.

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

Summary of Benefits

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

Benefit	In Network	Out of Network
General Provisions		
Effective Date	July 1, 2019	
Benefit Period(1)	Calendar Year	
Deductible (per benefit period)		
Individual	\$250	\$500
Family	\$750	\$1,500
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	none	\$2,000
Family	none	\$4,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$7,900	not applicable
Family	\$15,800	not applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$20 copay	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after \$20 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after \$35 copay	80% after deductible
Virtual Visit Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after \$35 copay	80% after deductible
Telemedicine Services (3)	not covered	not covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	80% after deductible
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, Medically Necessary	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Nutritional Therapy	100% (deductible does not apply)	80% after deductible
	Limit: 6 visits per benefit period. Covered for any diagnosis	
Prostate Cancer Screening	100% (deductible does not apply)	80% (deductible does not apply)
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	80% after deductible
Pediatric Immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services	100% after \$100 copay (waived if admitted)	

Benefit	In Network	Out of Network
Ambulance - Emergency and Non-Emergency	80% after deductible up to a \$400 coinsurance maximum for emergencies; 80% after deductible for non-emergencies	80% after in-network deductible up to a \$400 coinsurance maximum for emergencies; 80% after out of network deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after deductible	80% after deductible
	limit: 36 visits/benefit period aggregate with speech therapy and occupational therapy	
Respiratory Therapy	100% after deductible	80% after deductible
Speech Therapy	100% after deductible	80% after deductible
	limit: 36 visits/benefit period aggregate with occupational therapy and physical medicine	
Occupational Therapy	100% after deductible	80% after deductible
	limit: 36 visits/benefit period aggregate with speech therapy and physical medicine	
Spinal Manipulations	100% after deductible	80% after deductible
	limit: 18 visits/benefit period	
Cardiac Rehabilitation Therapy	100% after deductible	80% after deductible
	limit: 36 visits/benefit period	
Infusion Therapy	100% after deductible	80% after deductible
Chemotherapy	100% after deductible	80% after deductible
Radiation Therapy	100% after deductible	80% after deductible
Dialysis	100% after deductible	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	80% after deductible
Inpatient Substance Abuse Detoxification	100% after deductible	80% after deductible
Inpatient Substance Abuse Rehabilitation	100% after deductible	80% after deductible
	limit: 45 days/benefit period	
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after deductible	80% after deductible
Outpatient Substance Abuse Services	100% after deductible	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Assisted Fertilization Procedures (Limited to Artificial Insemination - 3 attempts per lifetime)	100% after deductible	80% after deductible
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics, Prosthetics, and Ostomy Supplies	100% after deductible	80% after deductible
	limit: \$5,000 dollars/benefit period	
Home Health Care	100% after deductible	80% after deductible
Hospice	100% after deductible	80% after deductible
	limit: 180 days/ lifetime and respite care maximum of 5 days for every 3 months	

Benefit	In Network	Out of Network
Infertility Counseling, Testing	100% after deductible	80% after deductible
	Testing to determine infertility only.	
Private Duty Nursing	100% after deductible	80% after deductible
	limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after deductible	80% after deductible
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements (5)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	
Prescription Drug Program (6) Hard Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Open Benefit Design Exclude High Cost Low Value Drugs – NO Excludes New to Market Drugs - NO Exclude RX Drugs with OTC Equivalents – NO	Retail Drugs (30-day Supply) Plan Pays 80% \$15 minimum /\$100 maximum drug copay per prescription Maintenance Drugs through Mail Order (90-day Supply) Plan Pays 80% \$30 minimum/\$200 maximum drug copay per prescription	

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

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

(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.

(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit

(4) Services are limited to those listed on the Highmark Preventive Schedule with enhancements (Women's Health Preventive Schedule may apply).

(5) Highmark 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 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) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. This formulary covers all FDA-approved generic and brand-name drugs. Under the hard mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs.

Consent Decree Addendum to Your Benefit Booklet

On June 27, 2014, Highmark and UPMC entered into a Consent Decree that was designed to protect your access to UPMC providers.

The terms of this Addendum are effective through June 30, 2019 and are not applicable after that date.

Please be aware that certain UPMC providers may still continue to participate in the network for your plan only when they render certain covered services. Likewise, certain UPMC health care providers may be network providers only when they provide covered services at certain locations. Members should call the Member Service Department telephone number appearing on their Identification Card in order to determine whether a UPMC health care provider is a network provider when rendering specific covered services at a specific location.

Under the Consent Decree, covered services may be available at the network level of benefits from out-of-network UPMC providers under your plan but only in the circumstances described below:

Continued Care

If you are in a continuing course of treatment as described in this addendum, from an out-of-network UPMC provider, you may opt to continue treatment with that UPMC provider. Covered services will be available at the network level of benefits.

The need for a continuing course of treatment with a UPMC provider shall be determined, in the first instance, by your treating physician acting in consultation with you and in accordance with your wishes or your authorized representative. If you are pregnant, and your pregnancy was confirmed before December 31, 2015, or if you started a continuing course of treatment for a chronic or persistent medical condition with a UPMC provider in calendar years 2013, 2014 or 2015 (or on or before June 30, 2016 for UPMC Mercy), you may continue treatment with that UPMC provider through the period of delivery and post-partum care for that pregnancy or completed treatment of the chronic or persistent medical condition. Notwithstanding the above, if you were treated at UPMC Mercy and by a UPMC Mercy physician for a confirmed pregnancy on or before June 30, 2016, you may continue to receive treatment at UPMC Mercy through the period of delivery and post-partum care for that pregnancy or completed treatment of the chronic or persistent medical condition.

Services such as routine wellness care and routine preventive care are not considered to be continued care for purposes of this addendum. Furthermore, benefits will not be provided for purposes of this addendum when the course of treatment for a chronic or persistent medical condition started before January 1, 2013, but for which no treatment

was subsequently received from a UPMC provider, unless the UPMC provider can demonstrate that the member was receiving ongoing care in accordance with recognized medical protocols and/or standards.

While undergoing a continuing course of treatment with such UPMC provider, benefits will include all covered services reasonably related to the treatment including, but not limited to, testing and follow-up care. In the event that Highmark disputes the opinion of the treating physician that a continuation of care is medically necessary and appropriate, or disputes the scope of that care, the Pennsylvania Department of Health or its designated representative will review that matter and make a final non-appealable determination.

Oncology Services (Cancer Care)

If you have been diagnosed with cancer and your treating physician determines that you should be treated by an out-of-network UPMC provider that renders oncology services, you may choose to request treatment from that UPMC provider. Covered services will be available at the network level of benefits. Treatment includes care for illnesses resulting from the cancer treatment such as, but not limited to, mental health, endocrinology, orthopedics and cardiology. The need for a treatment of a resulting illness shall be determined, in the first instance, by your treating physician acting in consultation with and in accordance with your wishes or your authorized representative.

Local Community Needs

If your treating physician believes that you require certain medical services and the Pennsylvania Department of Health has determined that such services are not available from another source locally other than from an out-of-network UPMC provider, you may receive covered services from that UPMC provider. Covered services will be available at the network level of benefits.

Emergency Care Services

When emergency care services are received from an out-of-network UPMC provider, hospital and medical benefits are provided as described in the Covered Services section. This also includes other services and supplies necessary to continue your treatment, including:

- any resulting inpatient admission through the period of discharge.

Covered services will be available at the network level of benefits.

Other Out-of-Network Services

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

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

HIGHMARK INC. NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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

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

Our Legal Duties

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

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

We will inform you of these practices the first time you become a Highmark customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice became 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 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 health services to our members.

(i) Business Associates.

In connection with our payment and health care operations activities, we contract with individuals and entities (called “business associates”) to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation, or pharmacy benefit management). To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

(ii) Other Covered Entities.

In addition, we may use or disclose your protected health information to assist health care providers in connection with *their* treatment or payment activities, or to assist other covered entities in connection with certain of *their* health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

II. Other Possible Uses and Disclosures of Protected Health Information

In addition to uses and disclosures for payment, and health care operations, we may use and/or disclose your protected health information for the following purposes:

A. To Plan Sponsors

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

plan or to decide whether to modify, amend or terminate your group health plan.

B. Required by Law

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

C. Public Health Activities

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

D. Health Oversight Activities

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

E. Abuse or Neglect

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

F. Legal Proceedings

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

G. Law Enforcement

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

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

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

I. Research

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

J. To Prevent a Serious Threat to Health or Safety

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

K. Military Activity and National Security, Protective Services

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

L. Inmates

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

M. Workers' Compensation

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

N. Others Involved in Your Health Care

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

O. Underwriting

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

P. Health Information Exchange

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

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

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

All participating providers who provide services to you will have the ability to access your information. Providers that do not provide services to you will not have access to your information. Information may be provided to others as necessary for referral, consultation, treatment or the provision of other healthcare services, such as pharmacy or laboratory services. All participating providers have agreed to a set of standards relating to their

use and disclosure of the information available through the HIE. Your health information shall be available to all participating providers through the HIE.

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

In order to opt-out, you must complete an opt-out Form, which is available at highmark.com or by calling 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 provider 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 see your PHI

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

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

V. Your Individual Rights

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

A. Right to Access

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

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

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

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

B. Right to an Accounting

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

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

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

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

C. Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing. We have a right to terminate this restriction, however if we do so, we must inform you of this restriction.

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

D. Right to Request Confidential Communications

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

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

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

E. Right to Request Amendment

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

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

F. Right to a Paper Copy of this Notice

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

VI. Questions and Complaints

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

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

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

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

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

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

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

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

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

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

Information we may disclose and the purpose: We do not sell any personal information about our members or former members for marketing purposes. We use and disclose the personal information we collect (as described above) only

as necessary to deliver health care products and services to our members or to comply with legal requirements. Some examples are:

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

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

For questions about this Privacy Notice, please contact:

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

APPENDIX C

Monroe Career & Technical Institute

Dental Benefits

In addition to the following Summary of Coverage provided by United Concordia Dental, the following items are incorporated by reference into this Dental Plan:

1. Consult the following sections in the Plan Document: Member Enrollment and Eligibility, HIPAA Notice of Privacy Practices, COBRA Continuation, and Claims and Appeals Process.
2. The Claims and Appeals Process outlined starting on page 11 as "Medical Appeal Procedures" is applicable to the Dental benefits.

UNITED CONCORDIA[®] DENTAL

Summary of Dental Coverage



Plan Name: Monroe Career and Technical Institute

Print Date: April 10, 2017

Summary of Coverage

Schedule of Benefits

Concordia Flexsm

Group Name: Monroe Career and Technical Institute

Group Number: 256107000

Effective Date: July 1, 2017

	<u>Plan Pays</u>
Class I Services	
• Exams	100%
• All X-Rays	100%
• Cleanings & Fluoride Treatments	100%
• Sealants	100%
• Palliative Treatment (Emergency)	100%
• Space Maintainers	100%
Class II Services	
• Basic Restorative (Fillings, etc.)	100%
• Endodontics	100%
• Simple Extractions	100%
• Complex Oral Surgery	100%
• General Anesthesia and/or Nitrous Oxide and/or IV Sedation	100%
• Non-surgical Periodontics	50%
• Surgical Periodontics	50%
Class III Services	
• Repairs of Crowns, Inlays, Onlays	50%
• Repairs of Bridges	50%
• Denture Repair	50%
• Inlays, Onlays, Crowns	50%
• Prosthetics (Bridges, Dentures)	50%
Orthodontics	
• Diagnostic, Active, Retention Treatment	50%
• Limited to Dependent children under the age of 19	

Deductibles & Maximums

- \$0 Program Dollar Deductible
- \$1000 per Calendar Year Maximum per Member
- \$800 Lifetime Maximum per Member for Orthodontics

All services on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations.

Summary of Coverage



Participating Dentists accept the Maximum Allowable Charge as payment in full.

Contact United Concordia

Phone 1-866-851-7564 *Customer service representatives are available from 8 a.m. - 6 p.m. ET. Assistance can also be received outside normal customer service hours through our Interactive Voice Recognition (IVR) system. Use the system 24/7 to access claim status, benefits and coverage information in 150 languages.*

Web [**www.UnitedConcordia.com**](http://www.UnitedConcordia.com)
Once enrolled, register to use My Dental Benefits for 24/7, secure access to benefit information including eligibility, claim status, procedure history, ID card requests and more.

Summary of Coverage

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

THIS PLAN DOES NOT MEET THE MINIMUM ESSENTIAL HEALTH BENEFIT REQUIREMENTS FOR PEDIATRIC ORAL HEALTH AS REQUIRED UNDER THE FEDERAL AFFORDABLE CARE ACT.

Exclusions and limitations may differ by state as specified below. Only American Dental Association procedure codes are covered.

EXCLUSIONS – The following services, supplies or charges are excluded:

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under the Group Policy (for example but not limitation, multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
2. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).
3. That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third-party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.

For Group Policies issued and delivered in Georgia, Missouri and Virginia, only services that are the responsibility of Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

For Group Policies issued and delivered in North Carolina, services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act are excluded only to the extent such services or supplies are the liability of the employee according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

For Group Policies issued and delivered in Maryland, this exclusion does not apply.

4. For prescription and non-prescription drugs, vitamins or dietary supplements.

For Group Policies issued and delivered in Arizona and New Mexico, this exclusion does not apply.

5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.

For Group Policies issued and delivered in Washington, this exclusion does not apply when required dental services and procedures are performed in a dental office for covered persons under the age of seven (7) or physically or developmentally disabled.

For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

6. Which are Cosmetic in nature as determined by the Company (for example but not limitation, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

For Group Policies issued and delivered in New Jersey, this exclusion does not apply for Cosmetic services for newly born children of Members.

For Group Policies issued and delivered in Washington, this exclusion does not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.

7. Elective procedures (for example but not limitation, the prophylactic extraction of third molars).

Summary of Coverage



8. For congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).

For Group Policies issued and delivered in Kentucky, Minnesota and Pennsylvania, this exclusion shall not apply to newly born children of Members including newly adoptive children, regardless of age.

For Group Policies issued and delivered in Colorado, Hawaii, Indiana, Missouri, New Jersey and Virginia, this exclusion shall not apply to newly born children of Members.

For Group Policies issued and delivered in Florida, this exclusion shall not apply for diagnostic or surgical dental (not medical) procedures rendered to a Member of any age.

For Group Policies issued and delivered in Washington, this exclusion shall not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.

9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the Schedule of Benefits or a Rider.
10. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

For Group Policies issued and delivered in New York, diagnostic services and treatment of jaw joint problems related to a medical condition are excluded unless specifically covered under the Certificate. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

For Group Policies issued and delivered in Florida, this exclusion does not apply to diagnostic or surgical dental (not medical) procedures for treatment of temporomandibular joint disorder (TMD) rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease or injury and such procedures are covered under the Certificate or the Schedule of Benefits.

For Group Policies issued and delivered in Minnesota, this exclusion does not apply.

11. For treatment of fractures and dislocations of the jaw.

For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.
12. For treatment of malignancies or neoplasms.
13. Services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
14. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
15. Preventive restorations.
16. Periodontal splinting of teeth by any method.
17. For duplicate dentures, prosthetic devices or any other duplicative device.
18. For which in the absence of insurance the Member would incur no charge.
19. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
20. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

For Group Policies issued and delivered in Oklahoma, this exclusion does not apply.

21. For treatment and appliances for bruxism (night grinding of teeth).

Summary of Coverage



22. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.

For Group Policies issued and delivered in Maryland, failure to furnish the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the required time, if the claim is furnished as soon as reasonably possible, and, except in the absence of legal capacity of the Member, not later than one (1) year from the time the claim is otherwise required.
23. Incomplete treatment (for example but not limitation, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).
24. Procedures that are:
 - part of a service but are reported as separate services; or
 - reported in a treatment sequence that is not appropriate; or
 - misreported or that represent a procedure other than the one reported.
25. Specialized procedures and techniques (for example but not limitation, precision attachments, copings and intentional root canal treatment).
26. Fees for broken appointments.
27. Those specifically listed on the Schedule of Benefits as “Not Covered” or “Plan Pays 0%”.
28. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Company will apply.

Summary of Coverage



LIMITATIONS – Covered services are limited as detailed below. Services are covered until 12:01 a.m. of the birthday when the patient reaches any stated age:

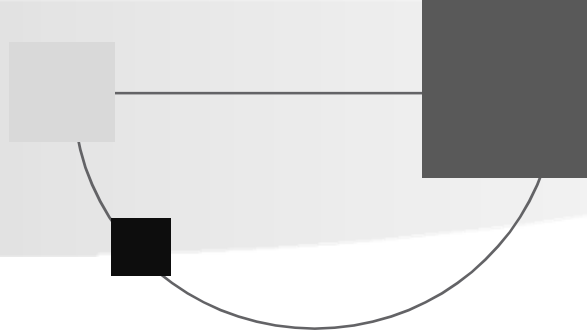
1. Full mouth x-rays – one (1) every 5 year(s).
2. Bitewing x-rays – one (1) set(s) per 6 months under age nineteen (19) and one (1) set(s) per 12 months age nineteen (19) and older.
3. Oral Evaluations:
 - Comprehensive and periodic – one (1) of these services per 6 months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
 - Limited problem focused – one (1) per dentist per patient per 12 months
4. Prophylaxis – one (1) per 6 months in combination with periodontal maintenance.
5. Fluoride treatment – one (1) per 6 months under age nineteen (19).
6. Space maintainers – one (1) per three (3) year period for Members under age nineteen (19) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.
7. Sealants – one (1) per tooth per 3 year(s) under age eleven (11) on permanent first molars and under age sixteen (16) on permanent second molars.
8. Prefabricated stainless steel crowns – one (1) per tooth per lifetime for Members under age fourteen (14).
9. Periodontal Services:
 - Periodontal maintenance following active periodontal therapy – four (4) per 12 months in combination with routine prophylaxis.
 - Periodontal scaling and root planing – one (1) per 24 months per area of the mouth.
 - Surgical periodontal procedures – one (1) per 24 months per area of the mouth.
 - Guided tissue regeneration – one (1) per tooth per lifetime.
10. Replacement of restorative services only when they are not, and cannot be made, serviceable:
 - Basic restorations – not within 12 months of previous placement of any basic restoration.
 - Single crowns, inlays, onlays – not within 5 year(s) of previous placement of any of the procedures in this category.
 - Buildups and post and cores – not within 5 year(s) of previous placement of any of the procedures in this category.
 - Replacement of natural tooth/teeth in an arch – not within 5 year(s) of a fixed partial denture, full denture or partial removable denture.
11. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of insertion by the same dentist. Subsequent denture relining or rebasing limited to one (1) every 36 month(s) thereafter.
12. Pulpal therapy – one (1) per primary tooth per lifetime.
13. Root canal retreatment – one (1) per tooth per lifetime.
14. Recementation – one (1) per 12 months. Recementation during the first 12 following insertion any preventive, restorative or prosthodontic service by the same dentist is included in the preventive, restorative or prosthodontic service benefit.
15. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.

Summary of Coverage



16. Payment for orthodontic services, if covered, shall cease at the end of the month after termination by the Company.
This limitation does not apply to Group Policies issued and delivered in Maryland.
17. Intraoral films:
 - Occlusal – two (2) per 24 months under age eight (8).

Summary of Coverage



Choice of Dentist

You may choose any licensed dentist for services to be covered by the Plan. However, you will limit your out-of-pocket cost if you choose a United Concordia participating dentist. Participating dentists accept the Plan's allowance as payment in full for covered benefits. Your out-of-pocket cost will be limited to any applicable coinsurance, deductibles or amounts exceeding the program maximum.

Participating dentists will also complete and send claims directly to United Concordia. If you go to a dentist who is not a United Concordia participating dentist, you may have to pay the dentist at the time of service. You will also have to pay the difference between the dentist's charge and the amount that the Plan allows, in addition to any coinsurance or deductible. You may have to submit the claim and wait for United Concordia to reimburse you.

To find a participating dentist, visit Find a Dentist on United Concordia's website at www.UnitedConcordia.com or telephone United Concordia's Interactive Voice Response System at 1-866-851-7564.

When you visit the dental office, let your dentist know that you are covered under a United Concordia dental program. If your dentist has questions about your eligibility or benefits, instruct the office to call United Concordia's Interactive Voice Response System at 1-866-851-7564 or visit Dental Inquiry at www.UnitedConcordia.com/dental-insurance/dentist.

Claims Submission and Payment

Upon completion of treatment, a claim form needs to be filed with United Concordia. If you visit a United Concordia participating dentist, the dental office will submit claims forms for you and your dependents. United Concordia will pay covered benefits directly to the participating dentist. Both you and the dentist will receive an explanation of benefits.

Most dental offices submit claim forms for patients. However, if you do not receive treatment from a participating dentist, you may have to complete and send a claim form to United Concordia in the event the dental office will not do this for you. Send the claim form to the address on the claim form.

Coordination of Benefits

If you or your dependents are covered by any other dental benefits plan and receive a service covered by this Plan and the other, benefits will be coordinated. This means that one plan will be primary and determine its benefits before those of the other plan and without considering the other plan's benefits.

The other plan will be secondary and determine its benefits after the other plan. The secondary plan's benefits may be reduced because of the primary plan's payment. Each plan will provide only that portion of its benefit that is required to cover expenses. This prevents duplicate payments and overpayments. Upon determination of primary or secondary liability, this Plan will determine payment.

Changes to the Plan

The Plan Sponsor reserves the right, at any time, to amend or terminate the Plan or amend or eliminate benefits under the Plan for any reason. All changes will be communicated in writing. If the Plan is discontinued, benefits, if any, will be paid for all charges incurred for covered services prior to the termination date.

Predetermination

A predetermination confirms services you are about to receive are covered under your dental plan. It helps you estimate any out-of-pocket expenses you may incur by calculating the total amount you owe and what your plan will cover based on your coinsurance amounts. It also notifies you of alternate treatment options covered by your dental plan. We encourage you to ask your dentist to submit a pre-determination to United Concordia for any procedure that exceeds \$500. A predetermination is not a guarantee of payment—it is only an estimate of what you can expect to owe.

My Dental Benefits and Online Tools

Once enrolled, register to use My Dental Benefits for 24/7, secure access to benefit information including eligibility, claim status, procedure history, ID card requests and more at www.UnitedConcordia.com. Additionally, you can Find a Dentist, access valuable member resources and download member apps from the website.

APPENDIX D

Monroe Career & Technical Institute

Vision Benefits of America Vision Benefits

In addition to the following Certificate of Coverage provided by VBA, the following items are incorporated by reference into this Vision Plan:

Please consult the Appeal Process contained in the Plan Document which shall control the appeal procedure. The information contained in Appendix D regarding Appeals does not control how appeals will be handled for your Employer.



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**SUMMARY PLAN DESCRIPTION
SUPPLEMENTAL INFORMATION SECTION**

Plan Name: Employee Benefit Trust of Eastern PA

Type of Plan: This plan provides vision care benefits to participating employees and their dependents (if dependent coverage was selected).

Employer/
Plan Administrator: Employee Benefit Trust of Eastern PA

Insurance Carrier: Vision Benefits of America
400 Lydia Street, Suite 300
Carnegie, PA 15106

Customer Service: (800) 432-4966
VBA Group #: **2520**

Effective: 7/1/16 – 6/30/19

Plan Continuation: The Employer intends to continue this plan indefinitely. Since future changes and conditions cannot be foreseen, we do reserve the right to change, suspend, or terminate the plan at any time within the parameters of the agreement with the carrier. To the extent a claim has been incurred prior to the amendment or termination, the claim will be honored in accordance with the terms and conditions which were previously in effect.

THE PRECEDING PAGES SET FORTH THE ELIGIBILITY REQUIREMENTS AND BENEFITS PROVIDED FOR YOU UNDER THIS PLAN.



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To the Employees of Employee Benefit Trust of Eastern PA:

Vision Benefits of America is pleased to provide you and your dependents with a vision care plan, as part of your total Health and Welfare Program.

The purpose of the vision care plan is to provide you and your family with complete vision care services, to maintain visual efficiency, and to prevent the development of conditions which might result in serious loss of sight.

This booklet is written in layman's language for your convenience. It is not intended to interpret, extend, or change the rules and regulations of the plan. Should any differences arise in the interpretation between the plan and this booklet, the plan shall govern.

WHAT IS VISION BENEFITS OF AMERICA?

Professional services and materials are provided by contractual arrangement with VBA, a non-profit organization head quartered in Pittsburgh, Pennsylvania. VBA maintains a network of more than 22,000 Participating Doctors of Optometry and Ophthalmology nationwide to provide professional vision care for persons covered under this plan. All materials are provided through approved laboratories, thus assuring that only the finest quality professional care and materials are provided to you.

The plan is administered directly by the Plan Administrator with benefits provided in accordance with provision of the group insurance policies issued by Vision Benefits of America.

WHO IS ELIGIBLE?

EMPLOYEES: Eligibility under this vision care plan is the same as the eligibility under your Health and Welfare plan.

DEPENDENTS: The term "dependents" includes the employee's spouse and unmarried children up to their 19th birthday. Such children include (1) a blood descendant of the first degree, (2) a legally adopted child (including a child living with the adopting parents during a period of probation), (3) a stepchild residing in the employee's household, or (4) a child permanently residing in the household of which the employee is head and actually being supported solely by the employee, providing the employee is related to the child by blood or marriage or is the child's legal guardian.

Children, between their 19th birthday and their 25th birthday, are also considered eligible dependents provided they are enrolled as full-time students in an accredited school, college, or university and are solely dependent upon the employee for support.

Also eligible are unmarried, disabled children past their 19th birthday, who are incapable of self-sustaining employment by reason of intellectual disability or mental disability, as defined by Pennsylvania's Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4101 *et seq.*) or a physical handicap, and who became so incapable prior to attainment of nineteen (19) years of age.

PROVIDED HOWEVER, proof of such incapacity and dependency is furnished to the Subscriber or VBA by the participant within thirty-one (31) days of the request for such information by VBA to the Subscriber. Subsequently additional information may be required by VBA or Subscriber but not more frequently than annually after the two-year period following the child's attainment of the limiting age.



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WHAT ARE THE BENEFITS?

VISION EXAMINATION - A complete analysis of the eyes and related structures to determine the presence of vision problems.

***LENSES** - The VBA Participating Doctor will order the proper lenses. The program provides the finest quality lenses fabricated to exacting standards. The doctor also verifies the accuracy of the finished lenses.

Through a VBA Participating Provider only, Polycarbonate Lenses for children under age 19 and 1 Year Scratch Protection are covered in full.

***FRAMES** - The plan offers a wide selection of frames; however, if you select a frame which costs more than the amount allowed by your plan, there will be an additional charge. Allowance equates to a \$25 wholesale frame (approximately \$62 to \$75 retail).

***CONTACTS SELECTED IN LIEU OF GLASSES** - When contact lenses are selected in lieu of glasses, they are considered cosmetic in nature. Your plan will provide an allowance of \$80 towards the purchase of cosmetic contact lenses. This is in lieu of all other benefits (including the vision exam) for the benefit period.

MEDICALLY NECESSARY CONTACT LENSES - Contact lenses are covered when a VBA Participating Doctor received prior approval for one of the following services related to eye disease or injury.

- a. Following cataract surgery
- b. To correct extreme visual acuity problems not correctable with spectacle lenses.
- c. To correct for significant anisometropia
- d. Keratoconus

* See Extra Cost and Non-Covered Items.

HOW OFTEN ARE THESE SERVICES AVAILABLE?

EXAMINATION - Once every 24 months
Developing Child (up to their 19th birthday) every 12 months

LENSES - Once every 24 months, if needed
Developing Child (up to their 19th birthday) every 12 months

FRAMES - Once every 24 months, if needed

- OR -

CONTACT LENSES - *(In lieu of all other benefits for the benefit period and includes vision exam).*

Elective - *(In lieu of Glasses)* - Once every 24 months

Medically Necessary - Once every 24 months

Developing Child (up to their 19th birthday) - Once every 12 months for either type



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HOW DO I USE THIS PLAN?

SELECT A VBA PARTICIPATING PROVIDER IN YOUR AREA. WHEN SCHEDULING AN APPOINTMENT, PLEASE NOTIFY THE VBA PARTICIPATING PROVIDER THAT YOUR VISION COVERAGE IS ADMINISTERED BY VBA. A LIST OF PARTICIPATING PROVIDERS IS AVAILABLE ON OUR WEBSITE AT VBAPLANS.COM. THE PROVIDER SELECTED WILL CONTACT VBA TO VERIFY ELIGIBILITY VIA ON-LINE SYSTEM AND WILL PROCESS SERVICES RECEIVED ELECTRONICALLY.

Please Note: The Participating Provider location will access benefits through VBA's secure web portal and download an electronic claim. This personalized electronic claim will contain an expiration date allowing 60 days to begin services. If services are not rendered within the 60 day time period, the provider will need to secure a new authorization.

If You Choose To See An Optometrist, Ophthalmologist Or Dispensing Optician Who Is Not a VBA Participating Doctor

1. Make an appointment and receive the necessary services from the provider. Pay the doctor his full fee and obtain an itemized receipt which must contain the following information.
 - a. Patient's Name
 - b. Date service began
 - c. The services and materials you received
 - d. The type of lenses you received (Single vision, Bifocal, Trifocal, etc.)

2. Download/Print Out-of-Network Reimbursement Form from VBA's website at vbaplans.com

3. Mail your vision care reimbursement form and receipts to:

VISION BENEFITS OF AMERICA
400 Lydia Street, Suite 300
Carnegie, PA 15106

4. You will then be reimbursed directly according to the "Non-Participating Reimbursement Schedule" (see schedule herein).

If You Choose To See A Non-Participating Doctor For An Examination And Have A VBA Participating Doctor Fill Your Prescription

1. After receiving an examination from the doctor, pay the doctor his exam fee. Obtain a receipt for the exam and prescription for your lenses.
2. Contact one of the VBA Participating Providers listed on our website who has an asterisk beside his/her name (this means the doctor is willing to fill another doctor's prescription) and make an appointment to have your prescription filled. You must inform the VBA Participating Provider office that VBA is your insurance carrier.
3. Take your prescription to the VBA Participating Provider. The VBA Provider will access the material benefits via web portal (electronically). He/She will fit you with your new glasses/contacts.
4. You will be paid directly according to the Non-Participating Reimbursement Schedule for exam, and the VBA Participating Provider will be paid for the dispensing of your glasses/contacts.

If any problems arise with your glasses or contacts due to an inaccurate prescription written by a Non-Participating Doctor, VBA and the Participating Doctor assume no responsibility.



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HOW MUCH DO I PAY?

When you select a Doctor from our VBA list, your plan covers the visual care described at no cost to you other than a \$25 copayment which applies to the total cost of the lenses and/or frames selected through a VBA Participating Provider only. The copayment does not apply to the routine vision examination or the contacts. This care includes visual examination, fitting and dispensing services, clear lenses, and an allowance towards the wholesale cost of a frame. Any additional care, service and/or materials not covered by your plan must be arranged between you and the doctor at your expense.

NOTE: Charges for vision services or materials not covered under the service contract must be paid by the beneficiary when materials are delivered.

EXTRAS

EXTRA COST - This plan is designed to cover your visual needs rather than cosmetic materials. There will be extra cost involved if you select:

- a. Tinted Lenses
- b. Photochromic Lenses
- c. Polycarbonate (Covered if under 19)
- d. Hi-Index Lenses
- e. Progressive (available starting at \$45)
- f. The coating of the lens or lenses (except 1 year scratch coating)
- g. A frame that costs more than the plan allowance
- h. Contact lenses in excess of the plan allowance
- i. Rimless frames

NOT COVERED ITEMS - There are no benefits for professional services or materials connected with:

- a. Orthoptics or vision training
- b. Plano lenses (non-prescription)
- c. Two pair of glasses in lieu of bifocals
- d. Medical or surgical treatment of the eyes
- e. Any eye examination, or corrective eyewear, required by an employer as a condition of employment
- f. Services or materials provided as a result of any Worker's Compensation Law or similar regulation
- g. Glasses and contacts during the same eligibility period

Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.



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REIMBURSEMENT SCHEDULE IF I VISIT A NON-PARTICIPATING DOCTOR

PROFESSIONAL FEES

Vision Examination, up to	\$ 32.00
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MATERIALS

Single Vision Lenses, up to	24.00
Blended Bifocal Lenses, up to	36.00
Bifocal Lenses, up to	36.00
Trifocal Lenses, up to	46.00
Progressive Lenses, up to	46.00
Lenticular Lenses, up to	72.00
Frames, up to	\$ 24.00

- OR -

CONTACT LENSES (In lieu of all other benefits for the benefit period and includes the vision exam).

Elective (In lieu of Glasses)	\$ 80.00
Medically Necessary	80.00

THERE IS NO ASSURANCE THE NON-PARTICIPATING REIMBURSEMENT SCHEDULE WILL COVER THE ENTIRE COST OF THE EXAMINATION, GLASSES OR CONTACTS.

WHAT IS THE CLAIMS APPEAL PROCESS?

If a request for benefits is denied, claimants will be notified in writing as to specific reasons for the denial. This notice will include the name and address of the person to whom written request, including additional information, documents, data, etc., may be submitted for review of the denial. This appeal must be made within 180 days of the denial. VBA and the client will review all the facts of the case and provide you with a final decision in writing within 45 days of receipt of your appeal. None of these steps precludes you from taking your case to court if not satisfied.

COMPLAINTS REGARDING PROFESSIONAL SERVICES

The patient's complaint must be in writing and referred to VBA for action. The complaint will be evaluated and, if deemed appropriate, the original examining doctor will be contacted. If the complaint can be resolved within 15 days, the disposition of the complaint will be forwarded to the complainant. Otherwise, a notice of receipt of the complaint will be forwarded to the complainant advising of the time for resolution, which in any event should not be more than 45 days.

Grievance procedures and complaint forms will be maintained in VBA's Corporate Offices and all complaints will be retained by VBA for one year after the expiration of this agreement.



Expert Solutions. Exceptional Service.

WHEN MAY THE PLAN TERMINATE?

The Plan Administrator may change or eliminate benefits under the plan and may terminate the entire plan or any portion of it within the parameters of the agreement with the carrier. Your individual coverage terminates on the day you leave active service, when you are no longer in an eligible class or when the Plan Administrator terminates the plan, whichever occurs first. Claim forms issued and received by the employee prior to the termination date will be honored.