A GUIDE TO YOUR BENEFITS

HIGHMARK.

University of Delaware

Highmark Blue Choice Deductible PPO Plan

July 01, 2026

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 of Civil Rights Complaint Portal, available at 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
Phone: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html

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ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Для получения помощи позвоните по номеру, указанному на обратной стороне вашей идентификационной карты (TTY: 711).

ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero riportato sul retro della Sua tessera di identificazione (TTY: 711).

ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711) pour obtenir de l'aide.

ÀKÍYÈSÍ: Tí o bá nsọ èdè Yorùbá, àwọn iṣẹ ìtumọ ati ògbufọ èdè wà ní àrọwọtó lọ́fẹ̀ẹ́ fún ọ. Awọn iṣẹ ìtọ́jú ati ìrànlọ́wọ́ tó yẹ (bíi titẹwé nla, gbigbọ ohùn, ati ìwé afọ́jú) lati pèsè iwifúnni ni awọn ọna ìráàyè si wà pẹlu lọ́fẹ̀ẹ́. Pe nọmba tó wà lẹhin kaádì ìdánimọ rẹ (TTY: 711) fún irànlọwọ.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזויווי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל. רופט דעם נומער אויף די אנדערע זייט פון אייער אידענטיטעט קארטל (TTY: 711) פאר הילף.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقاتٍ يمكن الوصول إليها من دون أي تكلفة. اتصل على الرقم المدوّن على ظهر بطاقة هويتك (TTY: 711) للحصول على المساعدة.

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字体、音频和盲文），以便您获取无障碍格式的信息。如需帮助，请拨打您的 ID 卡背面的号码（听障人士专用号码： 711）。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિઃશુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેઇલ) પણ નિઃશુલ્ક ઉપલબ્ધ છે. મદદ માટે તમારા આઇડી કાર્ડની પાછળ આપેલા નંબર (TTY: 711) પર કૉલ કરો.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711) để được trợ giúp.

ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई निःशुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि निःशुल्क उपलब्ध छन्। मद्दतको लागि तपाईंको ID कार्डको पछाडिको नम्बरमा कल गर्नुहोस् (TTY: 711)।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ़्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फ़ॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी निःशुल्क उपलब्ध हैं। सहायता के लिए अपने पहचान कार्ड के पीछे लिखे नंबर (TTY: 711) पर कॉल करें।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용할 수 있습니다. 도움이 필요하시면 ID 카드 뒷면에 있는 번호로 전화하십시오(TTY: 711).

Table of Contents

This Booklet is not a Contract

This booklet is not a contract. It provides a description of the benefits provided under your health care plan adminstered by Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield [1] (hereafter, Highmark or Highmark Blue Cross Blue Shield), an Independent Licensee of the Blue Cross Blue Shield Association. Your health benefits are entirely funded by your employer. Highmark provides administrative and claims payment services only and does not assume any financial risk or obligation with respect to claims.

Non-Assignment

Unless otherwise required by law, Highmark is authorized by the member to make payments directly to providers furnishing Covered Services 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 herein 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 which a member may be liable for medical care, treatment, or services.

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

[1] Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield serves the state of Delaware and is an independent licensee of the Blue Cross Blue Shield Association.

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.

Please refer to your Summary of Benefits at the end of this booklet. The Summary of Benefits will tell you what services are covered by your plan, the coverage level for these services and your share of the costs.

This plan is a preferred provider organization health care program, commonly referred to as a PPO. PPO plans provide a higher level of benefits when services are received from Network Providers. In most cases, you can also receive care from Out-of-Network Providers, but your share of the cost for these services will be greater.

- ***Your health care program gives you freedom of choice.*** You are encouraged, but are not required, to select a physician of record to receive covered care. A physician of record (also called a primary care provider or PCP) is the doctor or practice that you visit for your primary and routine health care services. This could be an internal medicine physician general practitioner, family practitioner, certified registered nurse practitioner, or pediatrician.

  A physician of record is often your least costly option for getting care. Your physician of record can deliver routine services, such as physicals and immunizations, and can recommend and help you select appropriate specialist care when you need it. Physicians of record, or their covering providers, are on call 24 hours a day, seven days a week. All of our plans allow you to go directly to a specialist without a referral. This includes specialists for behavioral health and preventive care.

- You have access to a large provider network of physicians, hospitals, and other providers in the Highmark Blue Cross Blue Shield service area, as well as providers across the country that are part of the local Blue Cross and Blue Shield PPO network.

- To locate a Network Provider near you, or to learn whether your current physician is in the network, log onto your Highmark member website, www.myhighmark.com

- ***Your health care program gives you "stay healthy" care.*** You are covered for a range of preventive care, including physical examinations and selected routine tests. Preventive care is a proactive approach to health management that can help you stay on top of your health status and prevent more serious, costly care down the road.

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

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

We do not provide services. We only pay for covered services you receive from Providers. We are not liable for any act or omission of any Provider. We have no responsibility for a Provider’s failure or refusal to give services to you. Any decision to receive care is solely between you and your Provider. Any action by us pursuant to any utilization management, referral management, discharge planning, Medical Necessity and

Appropriateness determination or other functions in no way absolves the Provider of the responsibility to provide appropriate medical care to you.

Information for Non-English-Speaking Members

Non-English-speaking members 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 for benefits information. 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 is an explanation of some benefit terms that may be found on the Summary of Benefits, included at the end of this booklet. For specific cost-sharing 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.

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 (Out-of-Pocket)

Coinsurance, also referred to as “Out-of-Pocket”, 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 your Summary of Benefits for the percentage amounts paid by the program.

Copayment

The copayment for certain covered services is the specific, upfront dollar amount which will be deducted from the plan allowance and is your responsibility. See your 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 your Summary of Benefits for the deductible amount. You may be required to pay any applicable deductible at the time you receive care from a provider.

Family Deductible

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

To satisfy the family deductible, covered persons must satisfy their individual deductible specified in the Summary of Benefits. Once a family member meets their individual deductible, the program would begin to pay for that person's covered services even if the family deductible has not been met. If the family deductible is met, the program would begin to pay for eligible services for all covered family members within the Benefit Period.

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. It includes covered expenses such as deductible and coinsurance, but excludes amounts in excess of the plan allowance and charges for non-covered services. When the specified dollar amount is attained, the level of benefit increases as specified in the Summary of Benefits. See your Summary of Benefits for the out-of-pocket limit.

Family Out-of-Pocket Limit

The out-of-pocket limit refers to the specified dollar amount of expense incurred by you or your covered family members for covered services in a benefit period. It includes covered expenses such as deductible and coinsurance, but excludes amounts in excess of the plan allowance and charges for non-covered services.

When the specified dollar amount is attained, the level of benefit increases as specified in the Summary of Benefits. See your 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 medical deductible, coinsurance, and copayments incurred for network covered services 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 your Summary of Benefits for the total maximum out-of-pocket. The total maximum out-of-pocket does not include out-of-network cost-sharing, amounts in excess of the plan allowance.

Maximum

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

Covered Services - Medical Program

Your health care program provides benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate. Covered services may be rendered by a provider in person and, as appropriate, remotely or virtually via telephone, internet or other electronic form of communication. All benefit limits, deductibles and copayment amounts are described in the Summary of Benefits included in this booklet.

Ambulance Service

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

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

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

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.

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 member's 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.

Any cost sharing amounts that are included with your program (deductible/coinsurance) will apply for anesthesia for non-covered dental procedures.

Assisted Reproductive Technologies and Fertility Care Services

Coverage is provided for fertility care services and fertility preservation services for individuals diagnosed with infertility or at risk of infertility due to surgery, radiation, chemotherapy or other medical treatment.

Covered services include the following when determined to be medically necessary and appropriate:

- Intrauterine Insemination (IUI)
- Intracervical/vaginal Insemination (ICI)
- In Vitro Fertilization (IVF), including IVF where the embryo is transferred to a gestational carrier or surrogate;
- Gamete Intrafallopian Transfer (GIFT)
- Zygote Intrafallopian Transfer (ZIFT)
- Cryopreservation of cells and tissue

- Reversal of voluntary sterilization (under limited circumstances)
- Intracytoplasmic Sperm Injection (ICSI)
- Tubal Embryo Transfer (TET)
- Frozen Embryo Transfer (FET)
- Ovulation Induction Management
- Immunotherapy for Recurrent Fetal Loss

For IVF services, retrievals must be completed before the individual is 45 years old and transfers must be completed before the individual is 50 years old. The benefit is limited to six (6) completed egg retrievals per lifetime, with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine, using single embryo transfers (SET) when recommended and medically appropriate.

Autism Spectrum Disorders

Benefits are provided to members for the following:

Diagnostic Assessment of Autism Spectrum Disorders

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

Treatment of Autism Spectrum Disorders

Services must be specified in a treatment plan developed by a physician or psychologist following a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. Except for inpatient care, Highmark may review a treatment plan for autism spectrum disorders not more than once every twelve months, or as agreed upon between Highmark and the physician or psychologist developing the treatment plan.

Pursuant to the applicable state law, treatment may include the following medically necessary services:

Habilitative or Rehabilitative care

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

Pharmacy care

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

Psychiatric and psychological care

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

Therapeutic care

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

Note: Certain services for the treatment of autism spectrum disorders described above, including but not limited to diagnostic services, pharmacy care, psychiatric and psychological care, rehabilitative care, and therapeutic cares, are also described as services covered under other benefits as set forth within this Covered Services - Medical Program section. When you receive such services, they will be paid as specified in such other benefits as set forth in the

Summary of Benefits. However, any visit limitations for physical therapy, occupational therapy, and speech therapy will not apply when those services are prescribed for the treatment of autism spectrum disorders. Applied behavioral analysis for the treatment of autism spectrum disorders will be paid as set forth in the Summary of Benefits.

Dental Services Related to Congenital Defect or Accidental Injury

Dental services initially rendered by a physician which are required as a result of congenital defect or due to accidental injury to the jaws, cheeks, lips, tongue, roof or floor of the mouth. Injury as a result of chewing or biting shall not be considered an accidental injury.

Diabetes Treatment

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

- **Equipment and supplies:**
  - Blood glucose monitors, monitor supplies, injection aids, syringes, and insulin infusion devices
- **Diabetes Education Program*:**
  - When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through a diabetes education program:
    - Visits medically necessary and appropriate upon the diagnosis of diabetes
    - Subsequent visits under circumstances whereby your physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in your self-management, or b) identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to your treatment and/or management of diabetes

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

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 foods 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 foods will continue as long as it represents at least 50% of your daily caloric requirement.

Coverage for enteral foods <u>excludes</u> the following:

- Blenderized food, baby food, or regular shelf food
- Milk or soy-based infant formulae with intact proteins
- Any foods, 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, rehabilitation, or therapy services
- Family counseling related to the member's terminal condition

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

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

Home Infusion and Suite Infusion Therapy Services

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

Benefits for certain infusion therapy Prescription Drugs, as identified by Highmark and which are appropriate for self-administration, will be provided only when received from an Exclusive Specialty Pharmacy Provider as described in the section, Prescription Drug Benefits.

Hospital Services

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

Inpatient Services

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

- a room with two or more beds;

- a private room. 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.

<u>Ancillary Services</u>
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;
- 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
- rehabilitative services, and therapy services.

Outpatient Services

<u>Ancillary Services</u>
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;
- 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.

<u>Emergency Care Services</u>
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.

In the event that you receive emergency care services from an Out-of-Network Provider and require an inpatient admission or observation immediately resulting from your injury or emergency medical condition, and upon stabilization:

- you are unable to travel using nonmedical transportation or nonemergency medical transportation to an available Network Provider located within a reasonable travel distance; or
- you do not consent to be transferred,

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

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

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

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

Pre-Admission Testing
Tests and studies, as indicated in the Diagnostic Services section 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.

Cost sharing amounts for medical services are in the Summary of Benefits section under Hospital and Medical/Surgical Expenses.

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.

Maternity Services

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

Abortions
Elective and non-elective abortions are covered to the extent permitted by state law. Non-elective abortions are abortions performed where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the life of the member in danger unless an abortion is performed.

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

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

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

Covered services include professional provider visits to examine the newborn child while the mother is an inpatient.

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.

Outpatient Medical Care Services (Visits and Consultations)

Medical care rendered by a professional provider when you are an outpatient for a condition not related to surgery, pregnancy or mental illness, except as specifically provided. Covered services 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 physician's (PCP) or specialist's office
- Physician's office located in an outpatient hospital/hospital satellite setting
- Urgent Care Center
- Retail site, such as in a pharmacy or other retail store

Or you can interact with a professional provider as follows:

- A virtual visit between you and a PCP or retail clinic via a real time two-way audio (including audio-only conversations if you are not able to access the appropriate broadband service or other technology necessary to establish an audio and visual connection), visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology.
- A specialist virtual visit between you and a specialist (including a behavioral health specialist) via a real time two-way audio (including audio-only conversations if you are not able to access the appropriate broadband service or other technology necessary to establish an audio and visual connection), visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology. 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.

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.

Telemedicine through a designated telemedicine provider is also covered. Check your Summary of Benefits for more information.

Chronic care management services in the Chronic Care Management Services Program, as administered by the Centers for Medicare and Medicaid Services, will not be subject to deductibles, copayments, or fees.

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.

Mental Health Care Services

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

Day, dollar and/or visit limits, if any, applicable to any other covered services do not apply to mental health treatment.

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

Inpatient Medical Services
The following services are provided for the inpatient treatment of mental illness by a professional provider:

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

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

Outpatient Mental Health Care Services
Inpatient Facility Services and inpatient medical services 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 a real time two-way audio (including audio-only conversations if you are not able to access the appropriate broadband service or other technology necessary to establish an audio and visual connection), visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology. Benefits are also provided for Mental Health Care Services received through an Intensive Outpatient Program.

Telemedicine Services through a Designated Telemedicine Provider are also covered. Check your Summary of Benefits for more information.

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.

Benefits for orthotic devices are limited to the most appropriate model that adequately meets your medical needs.

Preventive Care Services

Benefits will be provided for preventive care services in accordance with a Preventive Schedule. Recommended annual services are based on a calendar year resetting January 1 of every year. Refer to the

Summary of Benefits for your program's specific level of coverage, and to Highmark Blue Cross Blue Shield's Preventive Schedule to determine what services are appropriate for your age. The frequency and eligibility of services is subject to change.

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.

Adult Immunizations

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

Annual Behavioral Health Well Check Visit

Benefits are provided for an annual behavioral health well check Visit with a licensed mental health clinician who has at minimum a master's level degree. A behavioral health well check Visit includes a review of medical history, evaluation of adverse childhood experiences, and use of a group of developmentally appropriate mental health screening tools. A behavioral health well check may also include anticipatory behavioral health guidance congruent with stage of life.

Breast Cancer Screenings

Benefits are provided for the following:

- An annual routine mammographic screening starting at 40 years of age or older as well as additional imaging (e,g, magnetic resonance imaging (MRI), ultrasound and mammography) and pathology evaluations needed to complete the screening process for malignancies.
- Mammographic screenings for all members regardless of age when such services are prescribed by a physician.
- An annual supplemental breast screening examination starting at forty (40) years of age or older. Supplemental breast screening examination means a medically necessary and clinically appropriate examination of the breast, including such examination using breast MRI, breast ultrasound, or mammogram, that is used for either of the following: (1) to screen for breast cancer when there is no abnormality seen or suspected in the breast; or (2) based on personal or family medical history or additional factors that may increase the individiual's risk of breast cancer.

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 45 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. 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.
- Mammographic screenings for all members regardless of age when such services are prescribed by a physician.

Pediatric Immunizations
Benefits are provided 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 also provided for pediatric lead poisoning screening tests.

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

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

Tobacco Use, Counseling and Interventions
Benefits are provided for screenings for tobacco use and, for those who use tobacco products, tobacco cessation counseling sessions and covered medications.

Well Care
Benefits are provided for items and services in accordance with the Preventive Schedule based on age and subject to frequency limits, including, but not limited to, an initial physical examination to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods and counseling, including FDA-approved contraceptive drugs, devices, and other products and follow-up services related thereto, FDA-approved over-the-counter emergency contraception, contraceptives intended to last for no more than a 12-month period, voluntary female sterilization procedures, member education and counseling on

contraception, and immediate postpartum insertion of long-acting reversible contraception for all members capable of pregnancy and breastfeeding support and counseling.

Only FDA-approved contraception apps, which are not part of the 18 method categories, and are available for download to a cell phone are reimbursable through the paper claim process with a prescription. Members need to submit three documents to obtain reimbursement: 1) completed paper Claim Form: https://www.highmarkbcbs/redesign/pdfs/mhs/Medical_Claim_Form.pdf Under section DIAGNOSIS OR NATURE OF ILLNESS OR INJURY – write “contraception app purchase”; 2) receipt of payment for the FDA approved contraception app; and 3) provider prescription for the FDA approved contraception app.

Private Duty Nursing Services

Private duty nursing care by an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) is covered when you are an inpatient in an acute hospital. We may review the case in advance. We may review the case again after 80 hours of care.

Care must be:

- ordered by the attending doctor
- for the same condition you are hospitalized for, and
- approved by the hospital

This care is not covered when done in special care units of the hospital, such as:

- self-care units
- selective care units
- intensive care units

Private duty nursing care is not covered when done as a convenience even if authorized by your doctor.

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.

Some examples of prosthetics are:

- hair prostheses for hair loss caused by alopecia areata resulting from an autoimmune disease.
- limb, ear, or eye prostheses
- electro-larynx devices

The plan will also pay for hearing aids for members less than 24 years of age. Benefits are limited to one wearable hearing aid per ear every three (3) years for children less than 24 years of age.

Skilled Nursing Facility Services

You are covered for confinement in a skilled nursing facility. Highmark must approve your stay. We may review your stay concurrently. A confinement includes all admissions not separated by 180 days. Benefits renew after 180 days without inpatient skilled nursing facility care.

The plan covers:

- skilled nursing and related care as an inpatient
- rehabilitation when needed due to illness, disability or injury

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;
- for intermediate, rest or homelike care; 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.

Chiropractic supportive care, which is continuous, interval-based treatment that is medically necessary when there is a diagnosis of chronic pain or disease and which maintains function or prevents or slows deterioration.

Substance Abuse Services

Benefits are provided for Detoxification Services (withdrawal management services), individual and group counseling and psychotherapy, psychological testing, and family counseling for the diagnosis and treatment of substance abuse when rendered by a Facility Provider or Professional Provider and include the following:

- Detoxification Services rendered:
  - on an Inpatient basis; or
  - on an Outpatient basis
- Substance Abuse Treatment Facility services for non-hospital Inpatient residential treatment and rehabilitation services; Residential treatment and rehabilitation services include medically monitored high intensity Inpatient Services with twenty-four hour nursing care and Physician availability and medically managed intensive Inpatient Services with twenty-four hour nursing care and daily Physician oversight
- Outpatient services rendered in a hospital or Substance Abuse Treatment Facility or through an Intensive Outpatient Program or Partial Hospitalization Program and Outpatient Substance Abuse Treatment Facility services for rehabilitation therapy. For purposes of this benefit, a Substance Abuse Service provided on a Partial Hospitalization basis shall be deemed an Outpatient care visit subject to Outpatient care cost-sharing amounts. Benefits are also provided for Substance Abuse services rendered through an Opioid Treatment Program or Office Based Opioid Treatment Program.

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

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

Surgical Services

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

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

Assistant at Surgery
Services of a physician, or of the physician's employed physician assistant (PA), or certified registered nurse practitioner (CRNP), clinical nurse specialist (CNS), or certified nurse midwife (CNM), who actively assists the operating surgeon in the performance of covered surgery.

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

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

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

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

Special Surgery
- Oral Surgery

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

  - Extraction of impacted third molars when partially or totally covered by bone
  - Extraction of teeth in preparation for radiation therapy
  - Mandibular staple implant, provided the procedure is not done to prepare the mouth for dentures
  - Lingual frenectomy, frenotomy or frenoplasty (to correct tongue-tie)
  - Facility provider and anesthesia services rendered in a facility setting in conjunction with non-covered dental procedures when determined by Highmark to be medically necessary and appropriate due to your age and/or medical condition
  - Accidental injury to the jaw or structures contiguous to the jaw except teeth
  - The correction of a non-dental physiological condition which has resulted in a severe functional impairment
  - Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth

- Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus

  Coverage is not provided for the extraction of normal, abscessed or diseased teeth or for the removal, repair or replacement of teeth damaged due to accidental injuries or disease even if such services are necessary to correct other injuries suffered as a result of accident or disease.

- 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.
- For a second surgical opinion, you will be responsible for the same cost sharing that you have for a specialist office visit which can be found in the Summary of Benefits section.

Surgery Limitations

- 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, Rehabilitative Services

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

- 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 (including cognitive therapy), rehabilitative services
- Physical medicine, rehabilitative services
- Radiation therapy
- Respiratory therapy (includes Pulmonary rehabilitation)
- Speech therapy, rehabilitative
- Cardiac rehabilitation

- Chemotherapy

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

Transplant Services

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

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

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

    - Copayments, deductibles, coinsurance, and out-of-pocket maximums may apply.
    - The benefit includes all organ acquisition costs, except as limited above.

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, regulations or other directive, no benefits will be provided for services, supplies, prescription drugs or charges:

Key Word	Exclusion
Acupuncture	● For acupuncture services.
Ambulance	● For ambulance services, except as provided herein.
Assisted Reproductive Technology/techniques	● For reversal of voluntary sterilization (tuboplasty or vasoplasty) undergone after the covered individual successfully procreated with the covered individual's partner at the time the reversal is desired; ● Payment for surrogate service fees for purposes of child birth; ● Living expenses; and ● Travel expenses.
Bariatric Surgery	● For bariatric surgery including reversal, revision, repeat and staged surgery, except for the treatment of sickness or injury resulting from such bariatric surgery.
Comfort/Convenience Items	● For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider.
Cosmetic Surgery	● For a cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except: a) as otherwise provided herein, b) when required to correct a condition directly resulting from an accident; c) when necessary to correct a functional impairment which directly results from a covered disease or injury, or d) to correct a congenital birth defect.
Court Ordered Services	● For otherwise covered services ordered by a court or other tribunal unless medically necessary and appropriate or if the reimbursement of such services is required by law.
Custodial Care	● For custodial care, domiciliary care, protective and supportive care including educational services, rest cures and convalescent care.
Dental Care	● Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, anesthesia for non-covered dental procedures and except for dental expenses otherwise covered because of accidental bodily injury to sound natural teeth and for orthodontic treatment for congenital cleft palates as provided herein.
Diabetes Prevention Program	● For a diabetes prevention program offered by other than a network diabetes prevention provider.

Effective Date	●	Rendered prior to your effective date of coverage.
Employment	●	For any tests, screenings, examinations or any other services required by an employer or governmental body or agency in order to begin or to continue working or as a condition to performing the functions of any employment in a particular setting or location that do not relate to the furnishing or administration of an individual test, screening or evaluation determined by your attending professional provider as being medically appropriate.
Experimental/Investigational	●	Which are experimental/investigational in nature.
Eyeglasses/Contact Lenses	●	For eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury).
Felonies	●	For any illness or injury you suffer during your commission of a felony, as long as such illness or injuries are not the result of a medical condition or an act of domestic violence.
Foot Care	●	For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
Health Care Management program	●	For any care, treatment, prescription drug or service which has been disallowed under the provisions of Health Care Management program.
Home Health Care	●	For the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: dietitian services; homemaker services; maintenance therapy; dialysis treatment; custodial care; food or home-delivered meals.
Illegal Services	●	Services for which coverage or reimbursement is determined to be illegal by your state of residence regardless of whether you travel to a state where the service can be legally performed. In such cases, the plan will not cover such health care services. For detailed information about these excluded services, contact Member Services at the number on the back of your ID card.
Immunizations	●	For immunizations required for foreign travel or employment, except as provided herein.
Inpatient Admissions	●	For inpatient admissions which are primarily for diagnostic studies.
	●	For inpatient admissions which are primarily for physical medicine services.

Learning Disabilities/Learning Disorders	• For services that are primarily educational in nature, such as academic skills training or those for remedial education or vocational training, including tutorial services.
Legal Obligation	• For which you would have no legal obligation to pay.
Medically Necessary and Appropriate	• Which are not medically necessary and appropriate as determined by Highmark.
Medicare	• To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program. • For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage.
Military Service	• To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.
Miscellaneous	• For any type of interaction made through unsecured and unstructured services, such as, but not limited to skype and instant messaging unless such service is within the scope of practice of the provider, charges for failure to keep a scheduled visit, or charges for completion of a claim form. • For any other medical or dental service or treatment or prescription 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.
Neuropsychological/Educational Testing	• For neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment.
Nutritional Counseling	• For nutritional counseling, except as provided herein or as otherwise set forth in the Preventive Schedule.
Obesity	• For treatment of obesity, except for medical and surgical treatment of morbid obesity or as set forth in the Preventive Schedule. Please refer to the Preventive Care 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.
Public Surveillance	• For any tests, screening, examinations or any other services required by a governmental body or agency for public surveillance purposes that do not relate to the furnishing or administration of an individual test, screening or evaluation determined by your attending professional provider as being medically appropriate.
Respite Care	• For respite care except as may be provided in connection with hospice care.
School	• For any tests, screenings, examinations or any other services required by a school, college or university in order to enter onto school property or a particular location regardless of purpose that do not relate to the furnishing or administration of an individual test, screening or evaluation determined by your attending professional provider as being medically appropriate.
Skilled Nursing	• For skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness.
Smoking (nicotine) Cessation	• For nicotine cessation support programs and/or classes, except as otherwise set forth in the Preventive Schedule. Please refer to the

		Preventive Care Services section of Covered Services for more information.
Social or Environmental Change	●	For services provided primarily for social or environmental change.
Sterilization	●	For reversal of sterilization, except as provided herein.
Termination Date	●	Incurred after the date of termination of your coverage except as provided herein.
Therapy	●	For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur.
TMJ	●	For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
Vision Correction Surgery	●	For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.
War	●	For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.
Weight Reduction	●	For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
Well-Baby Care	●	For well-baby care visits, except as provided herein.
Workers' Compensation	●	For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government’s workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.

How Your Health Care Program Works

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

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

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

Network Care

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

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

To locate a Network Provider visit your member website.

Please note that Network Providers must meet quality standards to be in the network.

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 and outpatient 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 and radiologists, are in the network.

Out-of-Area Care

Your program also provides coverage for you and your eligible dependents when you receive care from providers located outside the Highmark Blue Cross Blue Shield 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 or includes any services requiring authorization 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 or service 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.

Out-of-Area Ancillary Services

There are special rules for certain ancillary services, including independent clinical laboratories, specialty pharmacy and durable medical equipment/prosthetics, when these services are obtained outside the Highmark Blue Cross Blue Shield service area.

If the ordering physician is located in Delaware, any lab provider the member uses must contract directly with Highmark Blue Cross Blue Shield for benefits to be paid at the in-network level. If the lab does not contract directly with Highmark Blue Cross Blue Shield, out-of-network benefits will apply. However, if the ordering physician is located in another state, for benefits to be paid at the in-network level, the member must use a lab provider that contracts directly with the Blue Cross Blue Shield plan in whose state the ordering physician is located.

For example, if the ordering physician is in Maryland, the lab provider must contract directly with the Maryland plan for in-network benefits to apply; if not, out-of-network benefits will apply.

Similarly, a specialty pharmacy must contract directly with the Blue Cross Blue Shield plan in whose state the ordering physician is located.

A DME provider must contract with the local Blue Cross Blue Shield plan in whose state the equipment is being shipped or delivered for benefits to be paid in-network. For example, if the DME provider is located in Delaware but is shipping to Maryland, the provider must contract directly with the Maryland plan for in-network benefits to apply; if not, out-of-network benefits will apply whether the provider contracts with Highmark Blue Cross Blue Shield or not. If a member is purchasing and picking up DME, the provider must be in-network for the Blue Cross Blue Shield service area where the retailer is located for in-network benefits to apply.

If you are unsure of the network status of a particular provider, you should contact Member Service at the number on the back of your ID card for clarification before seeking services.

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

BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this arrangement, when members access covered services outside 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 processed through the BlueCard Program will be based on the lower of the participating provider's billed charges for covered services or the negotiated price made available to Highmark by the Host Blue.

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

- an actual price - An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases, or
- an estimated price - An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives, or
- an average price - An average price is a percentage of billed charges for covered services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its 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, (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Highmark in determining your premiums.

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

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

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

In some instances, federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, Highmark will include any such surcharge, tax or other fee in determining your premium.

Non-Participating Providers Outside of the Highmark Blue Cross Blue Shield Service Area

Member Liability Calculation
When covered services are provided outside of the Highmark Blue Cross Blue Shield 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 emergency services or ambulance services when provided by air rendered by non-participating providers will be governed by applicable federal and state law.

Exceptions
In some exception cases, Highmark may pay claims from non-participating health care providers outside of the Highmark Blue Cross Blue Shield 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 for the same covered service inside the Highmark Blue Cross Blue Shield service area, as described elsewhere in this booklet. 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
General Information

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

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

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

Please note that while you or a family member can use the services, including behavioral health and well 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.myhighmark.com and click on "Find a Doctor" to start your search. Search for the physician, then click on the provider's name to view the following information:

- Name
- Location/Office Hours/Phone Numbers
- Whether the provider is accepting new patients
- Professional qualifications
- Clinical specialties
- Medical school attended
- Residency completion
- Board certification status

- Hospital affiliations
- Medical group affiliations
- Patient ratings
- Performance in 13 categories of care
- Parking and public transit nearby
- Handicap accessibility
- Languages spoken
- Gender

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:

- Associate counselor of mental health
- Associate marriage and family therapist
- Audiologist
- Behavior specialist
- Certified registered nurse*
- Chiropractor
- Clinical social worker
- Dentist
- Dietitian-nutritionist
- Doula
- Licensed practical nurse
- Marriage and family therapist
- Nurse-midwife

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

Ancillary Providers:

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

Contracting Suppliers (for the sale or lease of):

- Durable medical equipment
- Supplies
- Orthotics
- Prosthetics

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

Health Care Management

Medical Management

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

Network Care

When you use a Network Provider for inpatient care, the provider will contact Highmark for you to receive authorization for your care.

If the Network Provider is located outside the Highmark Blue Cross Blue Shield service area, you are 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.

Out-of-Network Care

If you are planning on being admitted to an out-of-network facility provider, ***you are responsible*** for notifying Highmark or its designated agent of your planned admission, and, except for emergency services, ambulance services when provided by air, or as otherwise set forth herein in this booklet, ***you will be solely responsible for the costs of all services provided by Out-of-Network Providers***. You should call 7 to 10 days prior to your planned admission if you are unsure whether the facility that you will be admitted to is a network facility provider or an out-of-network facility provider. When you receive emergency ambulance services by ground or water, from an out-of-network volunteer fire company or emergency medical services provider agency certified by the Delaware State Fire Prevention Commission, the provider may bill you for the difference between the provider's billed amount and the Plan's payment. This is in addition to any member coinsurance, deductible, and/or copayment obligations.

For emergency admissions, call Highmark or its designated agent within 48 hours of the admission, or as soon as reasonably possible. You can contact Highmark via the toll-free Member Service telephone number located on the back of your ID card.

The following covered services when received from an Out-of-Network Provider will be provided at the network services level of benefits and you will not be subject to any balance billing amounts:

1. Emergency care services; and

2. Ambulance services when provided by air.

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

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

Benefits provided for the diagnosis and medically necessary treatment, including in-patient treatment, of drug and alcohol dependencies are not subject to prospective review.

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.

Benefits provided in inpatient or residential settings for the diagnosis and treatment of substance abuse are not subject to concurrent utilization review for the first 14 days of an admission, provided the facility provider notifies Highmark of both the admission and the initial treatment plan within forty-eight (48) hours of the admission.

The facility must perform daily clinical review and periodically consult with Highmark to ensure that the facility is using the evidence-based and peer reviewed clinical review tool used by Highmark and designated by the American Society of Addiction Medicine (ASAM) or, if applicable, any state-specific ASAM criteria, and appropriate to the age of the patient to ensure that the inpatient treatment is medically necessary for the patient.

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 (including certain covered medications) as determined by Highmark. Whenever a Member utilizes an Out-of-Network Provider, it is the responsibility of the Member to first contact Highmark to confirm the Medical Necessity and Appropriateness of such procedures or Covered Services. Precertification is not required for an emergency or the treatment of substance abuse.

In-Area Network Care
Network Providers in the Highmark Blue Cross Blue Shield service area are responsible for the precertification of such procedures or covered services, for other than emergency, 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 Network Care
Whenever you utilize a Network Provider located in another Blue Cross Blue Shield service area for other than an emergency, 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.

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

Emergency Care Services – No Prior Approval Requirement
No prior approval or Precertification is required for you to receive Emergency Care Services.

1. Emergency Care Services

   When you require Emergency Care Services, all benefits for such covered services will be provided at the network services benefit levels even if the covered services are not received from a Network Provider. In the event of an inpatient admission, either you, your provider, or a family member must notify Highmark within forty-eight (48) hours of the admission, or as soon as reasonably possible. Once you are stabilized, Highmark may offer to transfer your care from an Out-of-Network Provider to a Network Provider. In connection with such transfer, Highmark will arrange for transport to the Network Provider without cost to you.

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

For admissions for the treatment of substance abuse, Highmark may deny coverage for any portion of the initial 14-day inpatient or residential treatment on the basis that the treatment was not medically necessary only if the treatment was contrary to the evidence-based and peer reviewed clinical review tool used by Highmark and designated by ASAM or any state-specific ASAM criteria.

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.

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.

Care Management Programs
Care management programs are designed to help you maintain good health and to work with you to manage chronic conditions or special health care needs and reduce health risk factors.

You may be offered care and disease management and prescription drug management services as deemed appropriate from time to time by Highmark.

You may also be offered an opportunity to participate in certain care management programs which may include, but are not limited to, disease or other health condition monitoring, consultations with health care providers or other health care professionals participating in the care management program, health coaching, medication management and optimization. In some instances, consultations, remote monitoring equipment devices and/or durable equipment are provided as part of the program.

Participation in such programs will not affect your continued eligibility, your premium, or reduce your benefits. Highmark reserves the right to modify or discontinue any such program at any time.

Health Improvement Services and Support
From time to time, Highmark may directly or indirectly make available to you information and access to non-medical items, services and support programs designed to address underlying social and environmental factors that may impact your health status. The provision of such information, items, services and support programs shall not alter your benefits under this plan.

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.

Continuous Glucose Monitoring (CGM)
CGM devices are available from a retail participating pharmacy provider or a designated mail-order pharmacy provider. Receiver kits are limited to one (1) per benefit period. Sensor kits are limited to one (1) refill every thirty (30) days. Transmitter kits are limited to one (1) refill every ninety (90) days.

Market Watch Prescription Drug

Coverage is not provided for Market Watch Prescription Drugs, unless an exception has been granted by Highmark pursuant to the Step Therapy Program described above. Your prescribing physician must obtain authorization from Highmark prior to prescribing certain covered medications, including medications that would otherwise be excluded without an exception or non-formulary 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.

- You, your authorized representative or your doctor may request coverage of a Prescription Drug not appearing on the formulary. We will review the exception request and notify you of our determination within two (2) business days of receiving the request.

- If you are suffering from a health condition that may seriously jeopardize the your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a non-formulary drug, you (or representative or doctor) may request an expedited review based on exigent circumstances. In such cases we will notify you, you representative, or doctor of our coverage determination within twenty-four (24) hours of receiving the request.

- In the event that Highmark denies a request for exception, you, your representative or your doctor may request that the exception request and denial be reviewed by an independent review organization. We will make our determination on the external exception request and notify you, your representative or your doctor of our coverage determination within 2 business days following our receipt of the request, or if the request was an expedited exception request, no later than twenty-four (24) hours following our receipt of the request.

- If Highmark grants the request for an exception, the Prescription Drug will be covered for the duration of the prescription, or if pursuant to an expedited exception request, for the duration of the exigency not to exceed one (1) year. Coverage will be provided in accordance with the Schedule of Benefits.

Contraceptive Exceptions

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

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, unless a shorter timeframe is required by law.

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, unless a shorter timeframe is required by law.

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 Process subsection in the How to File a Claim section of this benefit booklet.

Benefits After Provider Termination from the Network

If, at the time you are receiving medical care from a Network Provider, notice is received from Highmark that:

1. Highmark intends to terminate or has terminated all or portions of the contract of that Network Provider for reasons other than cause; or

2. The contract of that Network Provider will not be renewed, or the participation status of that Network Provider is changing;

you may, at your option, continue an active course of treatment with that network provider until the treatment is complete or for a period of up to ninety (90) days from the date the notification of the termination or pending termination is received, whichever is shorter. For purposes of this section, active course of treatment means:

1. an ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;

2. an ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring specialized medical treatment to avoid the reasonable possibility of death or permanent harm or complex ongoing care which you are currently receiving, such as chemotherapy, radiation therapy or post-operative visits;

3. confirmed pregnancy, through the postpartum period;

4. scheduled nonelective surgery, through postoperative care;

5. an ongoing course of treatment for a health condition that is life-threatening, degenerative, potentially disabling or congenital and that requires specialized medical care over a prolonged period of time or for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes;

6. treatment for a terminal illness; or

7. undergoing a course of institutional or inpatient care from the provider or facility provider.

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

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

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 member or the member'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, as medically certified by a Physician, 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.

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

Changes in Membership Status

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

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.

Termination of Your Coverage Under the Group Contract

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

No Benefits After Termination of Coverage

Your Program does not pay for charges incurred after termination of coverage regardless of whether you are an inpatient receiving facility services on the day your coverage terminates.

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. Highmark has the right to decide when to apply the below coordination of benefits provisions and shall not be required to determine the existence of any other health care program providing coverage to you or your dependents. In order to administer these provisions, Highmark may need to obtain information related to other health care coverage and may release such information to any organization or person as necessary. You must provide information related to other health care coverage through the completion of any questionnaires, surveys or other methods as requested by Highmark. Failure to timely provide the required information may result in claims processing delays or the denial of payment for covered services. You must also timely notify Highmark of any changes to any other health care coverage.

1. **Definitions**

In addition to the Definitions section of this document, the following definitions apply to this section:

a. Other Agreement - any individual, group or group-type coverage, whether insured or uninsured, providing health care benefits or services, other than school/student accident-type coverage, or a group or group-type hospital indemnity Agreement of one hundred dollars ($100) per day or less, including:

   i. Blue Cross, Blue Shield, health maintenance organization and other prepayment coverage;

   ii. coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and

   iii. coverage under any tax-supported or government program to the extent permitted by law.

   "Other Agreement" shall be applied separately with respect to each arrangement for benefits or services and separately with respect to that portion of any arrangement which reserves the right to take the benefits or services of Other Agreements into consideration in determining its benefits and that portion which does not.

b. Dependent - for any Other Agreement, any person who qualifies as a Dependent under that Agreement.

c. Allowable Expense - a health care expense, including any coinsurance for a service or supply specified in this plan, to the extent that such service or supply is covered by this plan and/or the Other Agreement. When benefits are provided in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by this and/or the Other Agreement is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a member is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

   i. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless this or the Other Agreement provides coverage for private hospital room expenses.

   ii. If a member is covered by this plan and one (1) or more Other Agreements that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

   iii. If a member is covered by this and one (1) or more Other Agreements that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   iv. If a member is covered by this and an Other Agreement, one (1) of which calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and the other of which provides its benefits or services on the basis of negotiated fees, the payment arrangement of the Primary Agreement will be deemed the Allowable Expense. However, if a provider under the Secondary Agreement provides benefits or services for a specific negotiated fee or payment amount that is different than the payment arrangement under the Primary Agreement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Agreement to determine its benefits.

v. The amount of any benefit reduction under the Primary Agreement because a member has failed to comply with the plan provisions is not an Allowable Expense. Examples of these types of provisions include, but are not limited to, second surgical opinions, precertification of admissions, and preferred provider arrangements.

d. Primary/Secondary Agreement - the order of benefit determination rules state whether this plan (hereinafter, "this Agreement") is a Primary Agreement or a Secondary Agreement.

i. When this Agreement is a Primary Agreement, its benefits are determined before those of the Other Agreement and without considering the Other Agreement's benefits.

ii. When this Agreement is a Secondary Agreement, its benefits are determined after those of the Other Agreement and may be reduced because of the benefits of the Other Agreement.

iii. When there are more than two (2) Other Agreements covering the person, this Agreement may be a Primary Agreement as to one (1) or more Other Agreements, and may be a Secondary Agreement as to a different agreement or agreements.

2. **Effect On Benefits**

a. This section shall apply in determining the benefits payable under this Agreement if, for the covered services received, the sum of the benefits payable under this Agreement and the benefits payable under Other Agreements would exceed the total Allowable Expense.

b. Except as provided in Paragraph 2c. of this section, when this Agreement is a Secondary Agreement, benefits will be calculated based on what the plan would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under this Agreement that is unpaid under the Primary Agreement. The plan may reduce its payment by the amount so that, when combined with the amount paid under the Primary Agreement, the total benefits paid or provided under all agreements for the claim do not exceed the total Allowable Expense for that claim. [In addition, the plan shall credit to the applicable deductible any amounts it would have credited to that deductible in the absence of other health care coverage.] Benefits payable under Other Agreements include the benefits that would have been payable had claim been made.

c. If,

i. an Other Agreement contains a provision coordinating its benefits with those of this Agreement and its rules require the benefits of this Agreement to be determined first, and

ii. the rules set forth in Paragraph 2.d. of this section require the benefits of this Agreement to be determined first, then the benefits of the Other Agreement will be ignored in determining the benefits under this Agreement.

d. In accordance with the National Association of Insurance Commissioners, this Agreement determines its order of benefits using the first of the following rules which apply:

i. The benefits of an agreement which covers the person as other than a Dependent shall be determined first,

ii. When this Agreement and an Other Agreement cover the person as a Dependent child whose parents are married or are living together, whether or not they have ever been married:

(a) the benefits of the agreement which covers the person as a Dependent of the parent whose birthday (month and day) falls earliest in the year shall be determined first; but,

(b) if both parents have the same birthday, the benefits of the agreement which covered the parent longer are determined before those of the Agreement which covered the other parent for a shorter period of time.

iii. when this Agreement and an Other Agreement cover the person as a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(a) if a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage, that agreement is the Primary Agreement;

(b) if a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of d. ii) (a) above shall determine the order of benefits;

(c) if a court decree states that parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of d. ii) (a) above shall determine the order of benefits; or

(d) if there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(i) the agreement covering the custodial parent;

(ii) the agreement covering the spouse of the custodial parent;

(iii) the agreement covering the non-custodial parent; and then

(iv) the agreement covering the spouse of the non-custodial parent.

iv. The benefits of the agreement covering the person as an employee other than a laid-off or retired employee or as a Dependent of such person shall be determined before the benefits of the agreement covering the same person as a laid-off or retired employee or as a Dependent of such person. If an Other Agreement does not have this provision regarding laid-off or retired employees and, as a result, the agreements do not agree on the order of benefits, then this rule is ignored.

v. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under an Other Agreement, the contract covering the person as an employee, member, subscriber or retiree or covering the person as a Dependent of an employee, member, subscriber or retiree is the Primacy Agreement and the COBRA or state or other federal continuation coverage is the Secondary Agreement. If an Other Agreement does not have this rule, and as a result, the agreements do not agree on the order of benefits, then this rule is ignored. This rule does not apply if the rule set forth in d. i) above can determine the order of benefits.

vi. If none of the above rules determines the order of benefits, the benefits of the agreement which has covered the person for the longest period of time shall be determined first.

e. If an Other Agreement does not contain provisions establishing the same order of benefit determination rules, the benefits under that agreement will be determined before the benefits under this Agreement.

3. **Facility of Payment**

Whenever payments should have been made under this Agreement in accordance with this section, but the payments have been made under any Other Agreement, the plan has the right to pay to any organization that has made such payment any amount it determines to be warranted to satisfy the intent of this section. Amounts so paid shall be deemed to be benefits paid under this Agreement and, to the extent of the payments for Covered Services, the plan shall be fully discharged from liability under this Agreement.

4. **Right of Recovery**

a. Whenever payments have been made by the plan for covered services in excess of the maximum amount of payment necessary at that time to satisfy the intent of this section, irrespective of to whom paid, the plan shall have the right to recover the excess from among the following, as the plan shall determine: any person to or for whom such payments were made, any insurance company, or any other organization.

b. The member and the plan will cooperate fully to make every reasonable effort under the circumstances, to help secure the plan’s rights to recover these excess payments.

5. **Benefits Payable**

The plan shall not be required to determine the existence of any Other Agreement or amount of benefits payable under any Other Agreement except this Agreement. The payment of benefits under this Agreement shall be affected by the benefits payable under any and all Other Agreements only to the extent that the plan is furnished with information relative to such Other Agreements by the member or any other insurance company or organization or person.

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

Subrogation

When we pay a claim, we are subrogated to all rights of reimbursement you have against any third party. A third party includes, but is not limited to, another person, legal entity (such as a corporation or self-insured plan), or insurer (providing you uninsured or underinsured automobile coverage, other automobile coverage, workers compensation, malpractice, or other liability coverage). We will have the sole right to interpret all rights and duties created by this section.

Some examples of Highmark Blue Cross Blue Shield's rights include:

- **Constructive trust.** Accepting benefits from Highmark makes you and your agents a constructive trustee of any funds recovered from any third party. This constructive trust will continue until Highmark receives payment. Failure to pay funds to Highmark will be considered a breach of your duty to the health care plan. No settlement can be made without Highmark's written permission.

- **Subrogation lien.** Accepting benefits from Highmark will result in an automatic lien by Highmark against any recovery from any third party. This means Highmark has the right to first dollar recovery of those funds, whether or not those funds make you whole. First dollar means that Highmark has first priority to recover from any and all payments made by the third party. Recovery means any judgment, settlement or other obligation to pay money. Highmark is entitled to recovery from any party possessing the funds.

- **Recovery from a third party.** Highmark is entitled to be paid from any recovery, no matter how the recovery is categorized. Some examples include recovery for lost wages only or pain and suffering only. You will be responsible for any attorney's fee and costs of litigation.

Some examples of your responsibilities include:

- **Notifying Highmark.** If you are involved in an accident or incident that results in both Highmark paying a claim and you having a claim against any third party, you must notify Highmark in writing within 30 days.

- **Cooperating with Highmark.** You are required to cooperate with Highmark and assist in the recovery from the third party.

A Recognized Identification Card

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

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

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

- Member name
- Member Identification number
- Group number
- Copayment for physician office visits and emergency room visits (if applicable)
- Plan Deductible (if applicable)
- Out-of-Pocket Limit (if applicable)
- Total Maximum Out-of-Pocket (if applicable)
- Pharmacy network logo (if applicable)
- Member Service toll-free number (on back of card)
- Member website (on back of card)
- Toll-free telephone number for Out-of-network facility admissions (on back of card)

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 provider 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 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 have 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.

Proof of Loss
Claims cannot be paid until a written proof of loss is submitted to Highmark. Written proof of loss must be provided to Highmark within fifteen (15) months after the date of such loss. Proof of loss must include all data necessary for Highmark to determine benefits. Failure to submit a proof of loss to Highmark within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will Highmark be required to accept a proof of loss later than 1 year from the time proof is otherwise required.

Submission of Claim Forms

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

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.

If you prefer, you may also write to:

Member Services
Highmark Blue Cross Blue Shield
P. O. Box 1991
Wilmington, DE 19899-1991

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 Process 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 Process subsection below.

How to Appeal a Claim Decision

You have the right to a full and fair review of all claim decisions. Here is how the appeal process works:

Highmark's Appeal Process

- To appeal a Highmark decision, you or your representative must contact Highmark Member Service ***within 180 days*** from receipt of a claim denial or notification that the claim is not subject to the legal prohibitions against balance billing. If you fail to submit your appeal within the 180-day timeframe, your appeal will be rejected and the initial decision will be upheld. You may call us or you may use the Highmark *Appeal/External Review Form*, available at myhighmark.com/downloads/AppealForm.pdf. There is no cost to appeal. Please explain why you believe the decision was wrong and provide any additional relevant information.
- You should use the *Designation of Personal Representative for Appeal Purposes* form (available at myhighmark.com/downloads/PersonalRepDesignationAppeal.pdf) to designate a personal representative. If you consent to the filing of an appeal by your authorized representative, you cannot file a separate appeal.
- You may submit any comments, documents, records and other information relevant to your appeal. In addition, you have the right to request copies of any documents, records or other information relevant to the claim decision including but not limited to copies of any plan rule, guideline or protocol used in making the decision and diagnostic and treatment codes and explanations of these codes for the services referenced in the denial.
- Standard Appeals will be reviewed and you will be notified with 30 to 60 days of your appeal request.
- Expedited Appeals are available if waiting the 30 to 60 days for a standard appeal decision could seriously jeopardize your life, ability to regain maximum function or, in the opinion of your physician, would subject you to severe pain that cannot be managed without the care or treatment that is the subject of you appeal. If you receive an expedited appeal, we will notify you and your provider of our decision within 72 hours of your appeal request. To request an expedited appeal, call the Highmark Member Service Department.

External Review Options

- If you have completed the Highmark appeal process and are not satisfied with the outcome, or if you have requested an expedited Highmark appeal, you may be eligible for an external review.
- To be eligible for external review, the decision of the Plan must involve:
    - A claim that was denied involving medical judgment, including application of the Plan's requirements as to medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered services or a determination that the treatment is experimental or investigational;
    - A claim that the Plan has concluded is not subject to legal prohibition against balance billing; or
    - A determination made by the Plan to rescind a Member's coverage.

      To exercise this appeal, you or your authorized representative must contact Highmark in writing within four months from the date that you received the Highmark appeal decision.

Other Important Information

If your health plan is subject to the Employee Retirement Income Security Act (ERISA), and you have exhausted all appeal options, you have the right to file a civil action under Section 502 (a) of ERISA. To determine your ERISA status, please contact your employer or plan administrator.

Questions

If you have any questions about your appeal rights, please contact the Highmark Member Service.

Contact Information

Highmark Blue Cross Blue Shield Member Service

Phone: 800.633.2563

Mail/In-Person: 800 Delaware Avenue, P.O. Box 8832, Wilmington, DE 19899-8832

Online Member Self-Service: www.myhighmark.com

Member Service

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

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

Blues On Call℠ - 24/7 Health Decision Support

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

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

Help with common illnesses, injuries and questions

Health Coaches can address any health topic that concerns you:

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

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

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

Help with chronic conditions

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

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

Highmark Website

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

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

Baby Blueprints®

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

If you are expecting a baby, this is an exciting time for you. It is 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.

Value-Added Programs and Services

From time to time, Highmark offers members access to various lifestyle, health and/or value-added programs and services. Contact your group or call Member Service at the toll-free number on your member ID card for eligibility requirements and other information. Eligibility requirements for these programs and services are applied in a uniform, non-discriminatory manner to all members. Highmark reserves the right to modify or discontinue any such program at any time.

Wellness Programs

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

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

Highmark reserves the right to modify or discontinue any such program at any time.

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 health care program, 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. Your health care program 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 your health care program or the care provided and receive a reply within a reasonable period of time.

6. Make recommendations regarding the 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, member 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 is 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.*

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

Assisted Fertilization - Any method used to enhance the possibility of conception through retrieval or manipulation of the sperm or ovum. This includes, but is not limited to, Artificial Insemination, In Vitro Fertilization (IVF), Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), Tubal Embryo Transfer (TET), Peritoneal Ovum Sperm Transfer, Zona Drilling, and sperm microinjection.

Autism Spectrum Disorders - Any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

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.

Designated Telemedicine Provider - A physician, licensed where required and performing within the scope of such licensure, who has an agreement with a vendor that has contracted with the Plan to provide Telemedicine Services.

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

Diabetes 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 based on an in-person/onsite or digital model and that has an agreement with Highmark.

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.

Mental Health and Substance Abuse Emergencies
An emergency mental health or substance abuse condition is one which requires voluntary or involuntary hospitalization because the individual patient is a danger to self, or to others.

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

Exclusive Specialty Pharmacy Provider - A Specialty Pharmacy Provider performing within the scope of its license that has an agreement, either directly or indirectly, with Highmark pertaining to the payment and exclusive dispensing of selected Specialty Drugs.

Experimental/Investigational - 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/investigational 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/investigational 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/investigational" 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 Blue Cross Blue Shield 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/investigational 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 will receive from Highmark after your claim is processed. It lists: the provider’s charge, allowable amount, copayment, deductible and coinsurance amounts, if any, you are 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.

Habilitative and Rehabilitative Services - The following services or supplies when ordered by a professional provider to promote the restoration, maintenance or improvement in the level of function following disease, illness or injury are Rehabilitative Services. The following services or supplies when ordered by a professional provider to achieve functions or skills never acquired due to congenital and developmental anomalies are Habilitative Services. Habilitative and Rehabilitative Services are covered to the extent specified in the Covered Services - Medical Program and the Summary of Benefits sections within this booklet.

- **Cardiac Rehabilitation –** the physiological rehabilitation of patients with cardiac conditions through regulated exercise, diet and other lifestyle modification programs. (Cardiac Rehabilitation does not include services provided for habilitative purposes).

- **Occupational Therapy –** the treatment by means of constructive activities designed and adapted to promote the ability to satisfactorily accomplish the ordinary tasks of daily living and those required by a particular occupational role.

- **Physical Medicine –** the treatment by physical means or modalities such as, but not limited to, mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities.

- **Speech Therapy –** the treatment for the correction of a speech impairment.

Immediate Family - Your spouse, child, parent, brother or sister or persons who ordinarily reside in your household.

Infertility - A disease or condition that results in impaired function of the reproductive system whereby an individual is unable to procreate or to carry a pregnancy to live birth.

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

Intensive Outpatient Program - A time-limited, separate and distinct Outpatient program that includes individual therapy, family therapy, group therapy and medication management following an individualized treatment plan. Participation in an Intensive Outpatient Program may involve two (2) or more hours of programming a week. The program may be offered during the day or evening hours and can be a step-down from a higher level of care or a step-up to prevent the need for a higher level of care. The goals of an Intensive Outpatient Program are to prevent or reduce the need for Inpatient hospitalization and to reduce or stabilize symptoms and functional impairment of a psychiatric or co-occurring substance use disorder. Medically necessary treatment is provided within a structured therapeutic milieu.

Maintenance Prescription Drug - A prescription drug prescribed for the control of a chronic long-term condition and taken on a regular, recurring basis.

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

- having an over-the-counter drug equivalent.
- having relatively low value with respect to the cost in light of available alternative covered medications.
- being newly approved by the Food and Drug Administration for treating a condition for which there are existing covered medications have previously been approved.

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. In connection with such day and/or visit limits, all services received by a member during a benefit period will reduce the remaining number of days and/or visits available under that benefit, regardless of whether the member has satisfied the deductible. There are two types of maximums:

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

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

Medically Necessary and Appropriate (Medical Necessity and Appropriateness) – Services, medications or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are:

a. in accordance with generally accepted standards of medical practice;

b. clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and

c. not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service, sequence of services or site of service at least as likely to produce equivalent therapeutic or diagnostic results given the nature of the patient's diagnosis, treatment, illness, injury, or disease, the severity of the patient's symptoms, or other clinical criteria.

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

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

Mental Illness - An emotional or mental disorder as found within the most current edition of the Diagnostic Statistical Manual of Mental Disorders.

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

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

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

Office Based Opioid Treatment Program (OBOT) - An Outpatient treatment program for the treatment of opioid use disorder. This program is also known as medication assisted treatment.

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

Out-of-Network Provider - An ancillary provider, professional provider or facility provider who has not entered into an agreement, either directly or indirectly, with Highmark or a Highmark affiliate, or with any licensee of the Blue Cross Blue Shield Association located in a service area other than Highmark or a Highmark affiliate service area, pertaining to payment as a participant in your network for covered services rendered to a member.

Outpatient - A Member who receives Services or supplies while not an Inpatient.

Outpatient Psychiatric Facility - A Facility Provider which, for compensation from its patients, is primarily engaged in providing Diagnostic and Therapeutic Services for the treatment of Mental Illness on an Outpatient basis.

Outpatient Substance Abuse Treatment Facility - A Facility Provider which, for compensation from its patients, is primarily engaged in providing Detoxification Services (withdrawal management services) and/or rehabilitative counseling services for the treatment of Substance Abuse and Diagnostic and Therapeutic Services for the treatment of Substance Abuse on an Outpatient basis. This facility must also meet the minimum standards set by the Delaware Department of Health and Social Services, Division of Substance Abuse and Mental Health, or another appropriate governmental agency.

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

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

Plan - Refers to your health benefit plan administered by Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield which serves the state of Delaware and is an independent licensee of the Blue Cross Blue Shield Association. Any reference to the plan may also include the plan's designated agent as defined herein and with whom the plan has contracted, either directly or indirectly, to perform a function or service in the administration of this program.

Plan Allowance - The amount used to determine payment by your health care 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 a Network Provider is the contractual allowance for covered services rendered by a Network Provider in a specific geographical region. The plan allowance for an Out-of-Network Provider located in-area is based on an adjusted contractual allowance for like services rendered by a Network Provider in the same geographic region, or as required by law. The plan allowance for a Network Provider located out-of-area 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, or as required by law. The plan allowance for an Out-of-Network Provider located out-of-area is determined based on one of the following: (i) an amount negotiated with the provider; (ii) a database; (iii) 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; (iv) the reference price as defined in the **Terms You Should Know** section of this booklet); or (v) as required by law.

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

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.

Preventive Schedule - The The document provided to you by your program that details covered preventive services. Your program reviews and updates the Preventive Schedule periodically as required by law, the Blue Cross Blue Shield Association, and medical consultants. Accordingly, the frequency and eligibility of services listed on the Preventive Schedule are subject to change.

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.

Psychiatric Hospital - a Facility Provider approved by the Joint Commission, the American Osteopathic Hospital Association, the Council on Accreditation, or the Commission on Accreditation of Rehabilitation Facilities, which for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness. Continuous nursing services are provided under the supervision of a Registered Nurse.

Reference Price - A percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market. When a rate is not published by CMS for the service, Claims will utilize pricing from the local Blue Cross/Blue Shield licensee or if no such price is available, then fifty percent (50%) off billed charges.

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

A Residential Treatment Program must provide the following:

a. Awake adult supervision twenty-four hours per day;

b. Clinical assessment at least once a day;

c. Individual, group, or family therapy at least three times per week;

d. Medical history and physical examination of patient within six months prior to admission or within thirty days after admission;

e. Review of patient’s current medication(s) initiated within twenty-four hours;

f. Initiation of a multidisciplinary treatment plan within one week;

g. Nursing staff on-site or on-call twenty-four hours per day;

h. Parent training for patient's parents/guardians or family if return to family is expected;

i. Discharge planning initiated with twenty-four hours;

j. Psychiatric evaluation/updated (initial within one business day, updates at least once a week);

k. Psychosocial assessment and substance evaluation within forty-eight hours;

l. School or vocational program as per the clinical needs and/or age of the patient; and

m. Toxicology screen, quantitative drug analysis, self-help, 12-step, or education group as needed.

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

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.

Specialty Prescription Drugs - Selected prescription drugs which are either listed as a specialty drug on the medical assistance fee-for-service specialty pharmacy drug list; or have a cost that meets or exceeds the high-cost drug threshold set by the Centers for Medicare and Medicaid Services and which meet three or more of the following criteria:

- require specialized product handling or administration by a pharmacy provider;
- requires specialized clinical care, including, but not limited to, frequent dosing adjustments, clinical monitoring or expanded patient service, intensive patient counseling and ongoing clinical support, such as individualized disease or therapy management to support patient outcomes;
- is prescribed for a member with a rare medical condition,, complex or chronic medical condition of life-threatening medical condition; or
- has a limited or exclusive distribution and is not typically stocked or dispensed by a retail pharmacy provider.

State-Owned Psychiatric Hospital - a Facility Provider, that is owned and operated by the State of Delaware, which is primarily engaged in providing treatment and/or care for the Inpatient treatment of Mental

Illness for individuals aged eighteen (18) and older whose hospitalization is ordered by a court of competent jurisdiction through a civil commitment proceeding.

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

Substance Abuse Treatment Facility - a Facility Provider licensed by the state and approved by an external accreditation body (i.e. The Joint Commission on Accreditation of Rehabilitation Facilities, Council on Accreditation), which for compensation from its patients, is primarily engaged in providing Detoxification (withdrawal management) and/or rehabilitation treatment for alcohol and/or drug use/misuse. This facility must also meet the minimum standards set by the Delaware Department of Health & Social Services, Division of Substance Abuse and Mental Health, or another appropriate governmental agency.

Telemedicine Service - An interaction between you and a Designated Telemedicine Provider conducted by means of real time two-way audio (including audio-only conversations if the member is not able to access the appropriate broadband service or other technology necessary to establish an audio and visual connection), visual or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology for the purpose of providing specific outpatient covered services.

Therapy Services - The following services or supplies ordered by a professional provider to promote the recovery of the member. Therapy services are covered to the extent specified in the Covered Services – Medical Program and the Summary of Benefits sections within this booklet.

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

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

c. **Infusion Therapy** - the treatment by the administration of medically necessary and appropriate fluid or medication via a central or peripheral vein.

d. **Pulmonary Therapy** – the treatment of chronic pulmonary diseases through a multidisciplinary program which combines Physical Medicine with an educational process directed towards the stabilization of pulmonary diseases and the improvement of functional status.

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

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

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

HIGHMARK DELAWARE

University of Delaware July 2025 - Blue Choice Deductible PPO Plan

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

Benefit	In Network	Out of Network
General Provisions		
Effective Date	July 1, 2025	
Benefit Period (1)	July Contract Year	
Deductible (per benefit period) (All services are credited to both in-network and out-of-network deductibles.) Individual Family	 $500 $1,000	 $1,000 $2,000
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) (All services are credited to both in-network and out-of-network out-of-pocket limits.) Individual Family	 $1,500 $3,000	 $3,000 $6,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $2,000 $4,000	 $4,000 $8,000
Office/Clinic/Urgent Care Visits		
Primary Care Provider (PCP) Office Visits & Virtual Visits	90% after deductible	70% after deductible
Specialist Office Visits & Virtual Visits	90% after deductible	70% after deductible
Virtual Visit Provider Originating Site Fee	90% after deductible	70% after deductible
Urgent Care Center Visits	100% after $25 copay	100% after $25 copay
Telemedicine Services - Vendor (3)	90% after deductible	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 70% (deductible does not apply)
Adult Immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	70% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	70% (deductible does not apply)
Colorectal Cancer Screening	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	70% (deductible does not apply)
Vision Exam	not covered	not covered
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 70% (deductible does not apply)
Pediatric Immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	70% (deductible does not apply)
Vision Exam	not covered	not covered
Emergency Services		
Emergency Room Facility – Acute Hospital (5)	90% after deductible	90% after in-network deductible
Medical Emergency Care (Doctor's care in an emergency facility (5)	90% after deductible	90% after in-network deductible
Ambulance - Emergency and Non-Emergency (6)	90% after deductible	90% after in-network deductible
Ambulance - Emergency and Non-Emergency (6) (air ambulance)	90% after deductible	90% after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	90% after deductible	70% after deductible

Benefit	In Network	Out of Network
Outpatient Surgery (facility)	90% after deductible	70% after deductible
Surgical Services (professional)	90% after deductible	70% after deductible
Maternity (non-preventive professional services) including dependent daughter	90% after deductible	70% after deductible
Medical Care (including inpatient visits and consultations)	90% after deductible	70% after deductible
Therapy Services		
Physical Therapy	90% after deductible services related to treatment of back pain are excluded from visit limits	70% after deductible services related to treatment of back pain are excluded from visit limits
Speech Therapy	90% after deductible	70% after deductible
Occupational Therapy	90% after deductible services related to treatment of back pain are excluded from visit limits	70% after deductible services related to treatment of back pain are excluded from visit limits
Respiratory Therapy	90% after deductible	70% after deductible
Spinal Manipulations	90% after deductible	75% after deductible
	limit: 30 visits/benefit period; services related to treatment of back pain are excluded from visit limits	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	90% after deductible	70% after deductible
Inpatient Detoxification / Rehabilitation	90% after deductible	70% after deductible
Intensive Inpatient Mental Health (Partial Hospitalization/Outpatient) visits	90% after deductible	70% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	90% after deductible	70% after deductible
Outpatient Substance Abuse Services	90% after deductible	70% after deductible
Other Services		
Allergy Extracts and Injections	90% after deductible	70% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	90% after deductible	70% after deductible
Assisted Fertilization Procedures	90% after deductible (coinsurance does not accrue toward the TMOOP)	70% after deductible (coinsurance does not accrue toward the TMOOP)
	limit: $30,000/lifetime	
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
Mammograms, Medically Necessary	90% after deductible	70% after deductible
Durable Medical Equipment and Supplies	90% after deductible; 100% (deductible does not apply) for insulin infusion pumps	70% after deductible
Foot Orthotics	not covered	not covered
Prosthetic Devices	90% after deductible	70% after deductible
Home Health Care	90% after deductible	70% after deductible
	limit: 240 visits/benefit period aggregate with visiting nurse	
Hospice	90% after deductible	70% after deductible
	Covered for up to 365 days	
Infertility Counseling, Testing and Treatment (8)	90% after deductible	70% after deductible
Inpatient Private Duty Nursing	90% after deductible	70% after deductible
	Limit: 240 hours/12 month period	
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	limit: 120 days/confinement; benefits renew after 180 days without care	
Transplant Services	90% after deductible for services received at BDCT (Blue Distinction Center for Transplant); 70% after deductible for non-BDCT facilities	70% after deductible
Precertification/Authorization Requirements (9)	Yes	Yes

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

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.

(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays and any qualified medical expense. Prescription drug expenses are subject to a separate prescription drug TMOOP.
(3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
(4) Services are limited to those listed on the University of Delaware Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
(6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
(7) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist, or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant, or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services-Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g., speech therapy, diagnostic services). Services for the treatment of Autism Spectrum Disorders do not reduce visit/day limits.
(8) Treatment includes coverage for the correction of a physical or medical problem associated with infertility.
(9) Precertification or preauthorization requirements may apply to certain inpatient admissions, outpatient procedures, or covered services (including covered medications).

NOTICE OF PRIVACY PRACTICES

Highmark Inc.

HIGHMARK®

Your Information. Your Rights. Our Responsibilities.

THIS NOTICE DESCRIBES HOW HEALTH AND FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Our responsibilities

At Highmark Inc., including its wholly-owned health plan subsidiaries and affiliates (Highmark), we value your privacy. When it comes to managing your information, we are required by law to maintain the privacy and security of your health and non-public personal (financial) information and to provide you with notice of your rights and our duties to keep your information safe and confidential. This Notice of Privacy Practices ("Notice") combines two required privacy notices:

- Health Insurance Portability and Accountability Act (HIPAA) notice of privacy practices
- Gramm Leach Bliley Act (GLBA) privacy notice

In the normal course of doing business, we collect information as necessary to provide you with health insurance products, help manage the treatment you receive, pay for your health services, and to run our business. The information we collect is called Protected Health Information ("PHI"). PHI is health and financial information that identifies you, or could be used to identify you, and was created or received by a health care provider, a health plan, a health care clearinghouse, or vendor performing activities on behalf of one of these organizations, or your employer (if a group health plan), and is related to one of the following:

- Your past, present, or future physical or mental health or condition;
- Providing you with health care; and,
- The past, present, or future payment for providing you with health care.

This Notice describes our privacy practices, which includes how we use, disclose (share), collect, manage, and protect your PHI and other non-public personal information. This Notice applies to all electronic and paper records we create, obtain, or maintain about you as a member, as well as all forms of communication (oral, written, and electronic) of this information. This Notice does not apply to Highmark in the context of being an employer.

How we protect your privacy

We understand the importance of protecting the confidentiality of your information. We restrict access to your PHI and personal information to those employees, agents, consultants, and health care providers who need to know the information to provide products or services. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to protect personal information against unauthorized use, access, and disclosure. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI or non-public personal information.

How we use and share your information

We use and share PHI and other non-public personal information we collect only as necessary to deliver products and services to our members, to operate our business, or to comply with legal requirements. For example, we may use your PHI and non-public personal information internally to manage enrollment, process claims, or audit our operations. We share PHI and non-public personal information with our affiliated companies and non-affiliated third parties, as permitted by law, who assist us in administering our programs, coordinating care, and delivering products and services to our members. We may also share PHI and non-public personal information with other third-party service providers that cooperate with us to jointly promote or administer health insurance products or services. Our contracts with all such service providers require them to protect the confidentiality of our members' information.

Please be advised that once information is shared with a third party other than a health care provider, health plan, or other person subject to federal privacy laws – for example, if you fill out an authorization form directing us to share your PHI with a life insurance carrier – the information may no longer be subject to privacy and security protections, and the recipient may use or share that information for other purposes.

Uses of PHI without your authorization.

We have the right to collect, use, and share your PHI, if needed, without your written authorization while providing your health benefits. We have listed a few examples of how we use your information without authorization.

- **Help manage the health care you receive:** To manage the health care you receive, we can use your PHI and share it with health care professionals that are treating you. For example, a doctor sends us information about your diagnosis and treatment plan so we can arrange additional services or assess the quality of your care.
- **Pay for your health services:** We may use and share your PHI as we pay for your health services. For example, we share information about you with your health care provider to coordinate payment for your particular treatment.
- **Run our business:** We may use and share your PHI to run our business and contact you when necessary. For example, we use information about you to develop and enhance products and services offered to our members, and we may share your information among our subsidiaries and affiliated entities for purposes permitted by applicable law.
- **Administer your benefits:** We may share your PHI with your group health plan administrator to perform administrative functions for the benefit plan in which you participate. For example, your employer contracts with us to administer health coverage, and we provide your employer's plan administrator with certain information to explain the premiums we charge, or to enroll or disenroll members in the benefit plan.

We may collect, use, and share your information in other ways without your authorization. We must meet certain conditions in the law before we can share your information for these purposes. The following are some of those examples.

- **As required by law:** We may share your PHI if federal or state law requires the use or disclosure. For example, we must share your PHI with the U.S. Department of Health and Human Services if they want to see that we are following federal privacy laws.
- **Help with public health and safety issues:** We can share your PHI for certain situations such as:
  - Preventing or controlling disease, injury, or disability;
  - Reporting abuse, neglect, or domestic violence;
  - Helping with product recalls;
  - Reporting adverse reactions to medications;
  - Preventing or reducing a serious threat to anyone's health or safety.
- **Respond to lawsuits and legal actions:** We may share your PHI in response to certain legal requests. For example, we may share your PHI in response to a court order, administrative order, or subpoena that complies with applicable law.
- **Respond to requests from coroners, medical examiners, funeral directors, and organ donation agencies:** We may share PHI with a coroner or medical examiner to identify deceased persons and the cause of death. If necessary, we will share PHI with funeral directors. Further, we may share PHI with organizations that handle organ, eye, or tissue donation and transplantation.
- **Do research:** We can use or share your information for health research purposes, subject to certain criteria.

- **Address workers' compensation, law enforcement, health oversight activities, and other government requests:** We can use or share your PHI when needed:
  - For workers' compensation claims;
  - For law enforcement purposes or with a law enforcement official;
  - With health oversight agencies for activities authorized by law;
  - For special government functions such as military, national security, and presidential protective services.
- **Cookies and Online Services:** We may collect information obtained when you visit and utilize Highmark websites (including the Highmark Member Portal or other online benefit sites) or mobile device applications. Through the use of cookies, pixels, and other digital tracking technologies, we may collect and share information about your use of these digital services, pursuant to applicable laws, to operate our business and improve our product and service offerings.

- **Underwriting Purposes:** We may use or disclose PHI for underwriting purposes, but we are prohibited from pricing your coverage or denying you coverage based on genetic information.

- **Business Associates:** We may contract with outside entities that perform business services for us that may require them to use or access your PHI. These entities are called business associates. We will have a written contract in place with the business associate requiring protection of the privacy and security of your health information. For example, we may share your PHI with a business associate to analyze your use of our websites and mobile device applications including, but not limited to, access times, pages viewed, etc. We may also use your PHI to develop, operate, and improve machine learning and other artificial intelligence solutions, for example, to support transcription of customer service calls or claims processing. You should review our Digital Privacy Policy (available on our website) and any applicable Terms of Use for supplemental details regarding our online services, the information we collect, and the terms associated with a particular website or application.

- **Health Information Exchange (HIE)**: We may participate in certain Health Information Exchanges (HIEs), which may be an opt-in or opt-out model. An HIE is a secure electronic data sharing network which allows us to share health information electronically with other healthcare entities, such as insurers, health systems, hospitals, and physicians participating in your care for the purposes of treatment, payment, and healthcare operations. The health information we may share includes your claims, medical history, diagnosis, notes, test results, current medications, allergies, immunizations, and other vital information needed for your care. All providers who participate in an HIE have agreed to privacy and security rules to protect your health information from unauthorized access, use or disclosure.

  You cannot choose to have only certain providers access your information. If you do not want your health information to be accessed through an HIE, you may choose not to participate or "opt-out" where applicable. Even if you opt-out, this will not prevent your health information from being shared in other ways as authorized or allowed by law for purposes such as managing your health care, paying claims for services you received, or administering your benefits.

- **Organized Health Care Arrangement (OHCA):** Highmark and its affiliated system of healthcare providers, Allegheny Health Network (AHN), participate in an OHCA to conduct analysis for quality assessment and improvement activities, utilization review and related activities to facilitate more effective and efficient health care services for our members and patients. Individual PHI may be accessed, used and/or disclosed as necessary to carry out treatment, payment, or health care operations relating to the OHCA.

- **Inmates**. If you are an inmate of a correctional institution, we may share your PHI with the correctional institution to provide you with health care, or to protect your health and safety or the health and safety of others.

Uses of PHI that require your authorization. Sometimes we are required to obtain your written authorization for the use and disclosure of your PHI. For example, we would need your authorization:

- To use your PHI for certain marketing purposes;
- To sell your information;

- To share your substance use disorder counseling notes; and
- To share your psychotherapy notes.

Withdrawal. We will not use or share your information other than as described in this Notice, or as permitted or required by applicable law, unless you tell us we can in writing. You may change your mind at any time by letting us know in writing. Any change or withdrawal of authorization will be effective for future uses and disclosures of PHI. It will not impact use of information or disclosures that we have already made while your previous authorization was in effect.

Compliance with State and Federal laws. We are required to comply with federal and state laws when they offer greater privacy protection for certain types of PHI. Where such laws apply, we will follow the stricter laws related to the use and sharing of sensitive PHI, such as:

- Genetic information;
- HIV/AIDS testing, diagnosis, or treatment;
- Venereal or communicable disease testing, diagnosis, or treatment;
- Alcohol or drug abuse prevention, treatment, and referral;
- Psychotherapy notes.

Your personal information

We may also collect, use, and share other non-public personal information to administer our health and benefit programs. Personal information identifies you and may include such items as your name, address, telephone number, date of birth and Social Security number, or it may relate to health care services or premium payment history. We collect your personal information either directly from you or from others such as doctors, hospitals, or other insurers, as applicable. In some cases, we may also share your personal information with third parties and without your authorization as permitted or required by law. If sharing your personal information for a specific reason requires us to give you a chance to opt-out, we will give you that opportunity.

Your choices

For certain health information, you can tell us your choices about what we share. We may use and share your information in the situations described below but you have the right to limit or object to sharing information for these reasons.

- Under certain circumstances, we may share your PHI with your family or close friends that you have identified as being involved in your health care or payment for your health care, unless you tell us not to do so. If you are unable to provide us permission, then we may provide the information we determine is in your best interest based on our professional judgement.

- We may share your information in a disaster relief situation.

- We may use or share your name, address, phone number, and the dates you received services to contact you to support our fundraising efforts, consistent with applicable laws.

Your individual rights

When it comes to your health information, you have certain rights. The following is a description of those rights. Any request must be in writing and signed by you or your authorized representative. You can obtain more information about how to submit your request by calling the Customer Service phone number on the back of your identification card. You may also request more information or submit your request in writing to the contact listed at the end of this Notice.

- **Get a copy of your health and claims records:** You can ask to review or receive copies of your health and claims records that we have about you in a designated record set. We will provide a copy or summary of your health and claims records. We may charge a reasonable cost-based fee.

- **Get a list of those with whom we have shared information:** You can ask for a list (an "accounting") of the times we have shared your PHI that are for reasons other than treatment, payment, health care operations, or those which you authorized. You may request the date range you want to review; however, this is limited to 6 years before the date of your request.
- **Ask us to limit what we use or share:** You can ask us not to use or share certain health information about you for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it is not consistent with the law, our policies, or our business operations.
- **Request confidential communications:** You can ask us to contact you in a specific way, or at a different address, if you believe that sharing your PHI could place you in danger. For example, you may ask that we contact you only at your work address or your work email.
- **Ask us to correct or amend health and claims records:** You can ask us to correct, or amend, your health and claims records if you believe they are incorrect or incomplete. Your request must explain why you believe the information needs to be corrected. We may say "no" to your request, but we will tell you why in writing.
- **Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian or other authorized representative, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **Get a paper copy of this Notice:** You can ask for a paper copy of this Notice, even if you have agreed to receive the Notice electronically.

Changes to the terms of this Notice

On an ongoing basis, it may become necessary to revise the terms of this Notice. Any changes will apply to all information we have about you. If the Notice significantly changes, the new Notice will be available upon request, on our website, and we will mail a copy to you in our annual mailing.

Complaints

If you want more information about our privacy practices or are concerned that we may have violated your privacy rights, you can complain to us using the following contact information:

Privacy Operations
120 Fifth Avenue Place, Suite 2114
Pittsburgh, PA 15222
Toll free: 1.800.985.2050
HighmarkHealthPrivacy@highmarkhealth.org
You may also file a complaint with the U.S. Department of Health and Human Services by using the following contact information:

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
Toll free: 1.877.696.6775
www.hhs.gov/ocr/privacy/hipaa/complaints.

We support your right to protect the privacy of your PHI. 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.

Effective date

We must follow the privacy practices described in this Notice while it is in effect. This Notice is revised and effective as of September 2025 and will remain in effect unless we replace it.

ADDITIONAL PROVISIONS: PRIVACY PRACTICES RELATED TO SUBSTANCE USE DISORDER (SUD) RECORDS

These additional provisions to this Notice apply only to federally regulated SUD records. Your SUD records will be protected by federal and state privacy laws. Unless specifically indicated in these additional provisions, your SUD records will have the same protections and you will have the same rights as described elsewhere in this Notice. The following provisions identify added protections for SUD records, as required by law.

When we can use and share your SUD records

For PHI collected by a SUD program governed by federal regulations, your consent will be obtained for all future uses or disclosures for treatment, payment, and healthcare operations before sharing such information consistent with applicable privacy laws. We may also obtain your consent to disclose SUD records to prevent multiple enrollments in withdrawal management or maintenance treatment programs, or to persons within the criminal justice system who have made participation in the substance use disorder program a condition of the disposition of any criminal proceedings against you or of your parole, or other release from custody, provided the disclosure is permitted by applicable privacy laws. In most cases, your consent is obtained for this when you begin treatment with a program covered under federal regulations. Except as described in these additional provisions, any other uses or disclosures of your SUD records will require your written consent.

Records that we share with your consent to a third party regulated by federal privacy laws may be further disclosed, without your written consent, by the third party, to the extent permitted by federal privacy laws.

We may use and share SUD records without your consent for the following reasons when all conditions required by federal law are met: medical emergencies, scientific research, management audits, financial audits, program evaluation, and disclosures to public health authorities when the health records are de-identified.

Prohibition on sharing records in civil, criminal, administrative or legislative proceedings

We will not use or share your SUD records (or provide testimony based on such information) in any civil, criminal, administrative, or legislative proceedings against you, unless you have provided your written consent, or a special type of court order has been obtained and you have had the opportunity to object.

Opt-out for fundraising

We will only use or share records to fundraise for the benefit of a SUD treatment program if you are first provided with an option to elect not to receive fundraising communications.

You can request to no longer receive fundraising communications following your participation in a SUD program, even if you initially permitted us to send such communications.

Disclosures:

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association:

Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life, Highmark Senior Health Company, Highmark Care Benefits Inc., or Gateway Health Plan, Inc. d/b/a Highmark Wholecare.

Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company, Highmark Senior Health Company, or Gateway Health Plan, Inc. d/b/a Highmark Wholecare.

PA: Your plan may not cover all your health care expenses. Read your plan materials carefully to determine which health care services are covered. For more information, call the number on the back of your member ID card or, if not a member, call 866-459-4418.

Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield or Highmark BCBSD Health Options Inc. d/b/a Highmark Health Options.

West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company, Highmark Senior Solutions Company, or Highmark Health Options West Virginia Inc. d/b/a Highmark Health Options and Highmark Blue Cross Blue Shield. Visit https://www.highmarkbcbswv.com/networkaccessplan to view the Access Plan required by the Health Benefit Plan Network Access and Adequacy Act. You may also request a copy by contacting us at the number on the back of your ID card.

Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield.

Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.