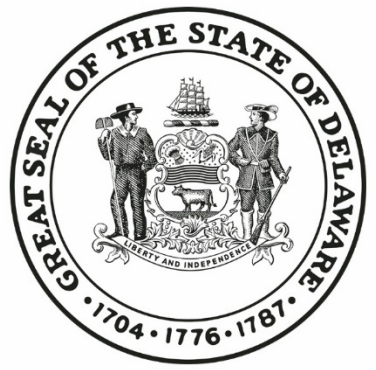

STATE OF DELAWARE
SPECIAL MEDICFILL®

This booklet provides a basic description of the principal features of your health care program administered by Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield (hereafter, Highmark or Highmark Blue Cross Blue Shield), an Independent Licensee of the Blue Cross Blue Shield Association. Medicfill is a registered trademark of Highmark Blue Cross Blue Shield.

WELCOME

This health care plan has been selected by the State Employee Benefits Committee of the State of Delaware. The plan benefits are funded by the State of Delaware and are administered by Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield (Highmark). Highmark does not assume any financial risk or obligation with respect to claims.

This booklet summarizes the benefits of the Special Medicfill Health Care Plan for eligible State of DE Medicare retirees. These benefits are designed to follow Medicare guidelines and cover both the Medicare Part A and Part B deductibles, and the Part B 20% coinsurance after original Medicare makes their full payment.

This booklet, which replaces all previous booklets, is not a contract, but was written to describe the benefits provided under your Special Medicfill Health Care Plan in effect as of January 1, 2026.

Medicare Links

This Special Medicfill booklet gives a brief description of the benefits available to you from Medicare and this plan, please see link, https://www.medicare.gov/medicare-and-you for a complete description of the medical benefits covered under Medicare. **You'll also find a list of "What's New and Important?" for Medicare on Page 2 of Medicare and You 2026.**

For more information regarding Medicare Supplement (Medigap) standardized plans, please see https://www.medicare.gov/health-drug-plans/medigap/basics/compare-plan-benefits.

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PREVENTIVE SCHEDULE OF BENEFITS

Benefits for the following preventive care and wellness programs are paid at 100% of Highmark's allowable charge if not covered by Medicare. If Medicare pays any portion, this plan will pay the balance up to 100% of the allowable charge. You pay nothing for most covered preventive services if you get the services from a doctor or other qualified health care provider who accepts assignment.
However, for some preventive services, you may have to pay a deductible, coinsurance, or both. These costs may also apply if you get a preventive service in the same visit as a non-preventive service.

ABDOMINAL AORTIC ANEURYSM SCREENING

One-time, as part of the "Welcome to Medicare" preventive visit - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

ADVANCE CARE PLANNING

Can also be covered as part of your medical treatment, 100% of allowed charges, no deductible–when this service is not part of your "Wellness" visit; the Part B deductible and coinsurance apply - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

ADVANCED PRIMARY CARE MANAGEMENT SERVICES

Medicare now pays for advanced primary care management services each month where your doctor or other health care provider coordinates and tailors care to your needs. Providers that offer these services must give you 24/7 access to your care team or provider, comprehensive care management, management of care transitions, and more. Check with your primary care provider to find out if they offer these services. You can also visit Medicare.gov/coverage/advanced-primary-care-management-services to learn more.

You pay 20% of the Medicare-approved amount for these services. The Part B deductible applies. If you have a Medicare Advantage Plan, your costs for these services might be different. Contact your plan for specific cost information.

ALCOHOL MISUSE COUNSELING

One screening, and up to 4 brief counseling sessions per year - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

BONE DENSITY SCREENING

Every 24 months - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

BREAST CANCER SCREENING (MAMMOGRAMS)

Women ages 40 and older; one baseline b/w ages 35-39 years - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

SUPPLEMENTAL BREAST CANCER SCREENINGS (BREAST MRI, BREAST ULTRASOUND, MAMMOGRAM)

Benefits are provided at 100% for the following:

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 individual's risk of breast cancer.

DIAGNOSTIC BREAST EXAMINATION

Includes coverage at 100% for one (1) annual medically necessary and clinically appropriate examination of the breast, including such examination using breast MRI, breast ultrasound, or mammogram, that is used for either: (1) to evaluate an abnormality seen or suspected from a screening examination for breast cancer; or (2) to evaluate an abnormality detected by another means of examination.

CARDIOVASCULAR DISEASE (BEHAVIOR THERPAY)

One visit per year with primary doctor - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

CARDIOVASCULAR SCREENINGS

Lab tests every 5 years - Medicare pays 100% of their allowed charges with no Medicare deductible. Please note, when Medicare pays for this service, the Special Medicfill plan covers the Medicare Part B deductible and 20% coinsurance for the associated doctor's visit and the member pays nothing for this test and the associated doctor's visit.

CERVICAL AND VAGINAL CANCER SCREENING (PAP SMEAR ONLY)

Every 24-months except for high risk, then covered annually - Medicare pays 100% of their allowed charges with no Medicare deductible for Pap smears once every 24 months for women at average risk, and once every twelve months for women at high risk. Medicare also pays 80% of allowed after the Part B deductible for the associated doctor's visit. When Pap smears for cancer screening are covered by Medicare, the Special Medical plan pays nothing as Medicare paid 100% of allowed charges. When not covered by Medicare, the Special Medicfill plan will pay 100% of our allowable charge for a Pap Smear every 12 months. The member will pay nothing for these services in these scenarios.

CERVICAL AND VAGINAL CANCER SCREENING (PAP COLLECTION, PELVIC EXAMS AND BREAST EXAMS)

100% of allowed charges, with no Part B deductible requirement, for Pap smears once every 24 months for women at average risk, and once every twelve months for women at high risk - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

COLONOSCOPY

Once every 120-months (or every 24 months if you're at high risk for colon cancer) or 48 months after a previous flexible sigmoidoscopy. A follow-up colonoscopy as a screening test is also covered if you initially have a non-invasive stool-based screening test (fecal occult blood tests or multi-target stool DNA test) and receive a positive result—Medicare pays 100% of their allowed charges with no Medicare deductible for ROUTINE colonoscopies with nothing from the Special Medicfill or the member to pay after Medicare has made their full payment. For NON-ROUTINE colonoscopies, Medicare pays 80% of allowed charges, no deductible, if polyp or other tissue is removed and the Special Medicfill plan will pay the 20% coinsurance after Medicare has made their full payment, leaving the member with nothing to pay for this service as noted.

COMPUTED TOMOGRAPHY (CT) COLONOGRAPHY

Medicare covers this screening test once every 24 months if you're 45 or older and at high risk for colorectal cancer. If you aren't at high risk, Medicare covers the test once every 60 months, or 48 months after a previous sigmoidoscopy or colonoscopy. You pay nothing if your doctor or other health care provider accepts assignment.

MULTI-TARGET STOOL DNA TEST

Ages 45-85 once every three years if meets criteria - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

BLOOD-BASED BIOMARKER TEST

Ages 45+ once every three years if meets criteria - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

FECAL OCCULT BLOOD

Age 45+ annually - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

SIGMOIDOSCOPY

Age 45+ every 48-months or 120 after previous screening colonoscopy for those not at high risk - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

BARIUM ENEMA

Age 50+ once every 48 months instead of colonoscopy or sigmoidoscopy - Medicare pays 80% of allowed charges, no deductible, the Special Medicfill plan will pay the 20% coinsurance after Medicare has made their full payment, leaving the member with nothing to pay for this service as noted.

DEPRESSION SCREENING

Annual in a primary care setting - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

DIABETES SCREENING

Limited up to twice per year - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

DIABETES SELF-MANAGEMENT TRAINING

Medicare pays 80% of their allowed charges after the Medicare deductible. Please note, when Medicare pays for this service, the Special Medicfill plan covers the Medicare Part B deductible and 20% coinsurance, and the member pays nothing.

FLU SHOTS

Provided annually - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

GLAUCOMA TESTS

Provided annually for high risk - Medicare pays 80% of their allowed charges after the Medicare deductible. Please note, when Medicare pays for this service, the Special Medicfill plan covers the Medicare Part B deductible and 20% coinsurance, and the member pays nothing.

HEPATITIS B SHOTS

Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

HEPATITIS C SCREENING TEST

Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

HIV SCREENING (ANNUALLY)

Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

LUNG CANCER SCREENING (ANNUALLY)

For adults ages 55-77 years with 30 pack/year smoking history and currently smokes or quit within the past 15 years - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

MEDICAL NUTRITION THERAPY SERVICES

Provided the diagnostic criteria is met - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

OBESITY SCREENING AND COUNSELING

For persons with a body mass index (BMI) of 30 or more - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

PNEUMOCOCCAL SHOT

Once per lifetime - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

PROSTATE CANCER SCREENINGS

Medicare pays 100% of their allowed charges with no Medicare deductible for the PSA test and the Special Medicfill plan and member pay nothing. For the digital rectal exam, Medicare pays 80% of allowed charges, no deductible, and the Special Medicfill plan will pay the 20% coinsurance after Medicare has made their full payment, leaving the member with nothing to pay for this service as noted.

SEXUALLY TRANSMITTED INFECTION (STI) SCREENING AND COUNSELING

Covered once per 12-months for individuals who are pregnant or at an increased risk for a STI. Medicare also covers up to two individual 20–30-minute counseling sessions for sexually active adults at increased risk for STI's - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

TOBACCO CESSATION

Without diagnosis of tobacco related illness - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

WELCOME TO MEDICARE PREVENTIVE VISIT

Within 12 months of enrollment - Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

YEARLY WELLNESS VISITS

Medicare pays 100% of their allowed charges with no Medicare deductible. Therefore, there is no payment from Special Medicfill or nothing for the member to pay after Medicare's made their full payment.

OVARIAN CANCER SCREENING

Includes two (2) annual ovarian cancer screening tests for women at risk for ovarian cancer using any of the following methods that are recommended by a member's physician:

a. Tumor marker tests supported by national clinical guidelines, national standards of care, or peer reviewed medical literature.
b. Transvaginal ultrasound
c. Pelvic examination
d. Other screening tests supported by national clinical guidelines, national standards of care, or peer reviewed medical literature.

At risk for ovarian cancer means any of the following:

a. Having a family history of any of the following:

   - One or more first- or second-degree relatives with ovarian cancer
   - Clusters of women relatives with breast cancer
   - Nonpolyposis colorectal cancer
   - Breast cancer in a male relative

b. Testing positive for any of the following genetic mutations:

   - BRCA1 or BRCA2
   - Lynch Syndrome

c. Having a personal history of any of the following:

   - Ovarian cancer
   - Endometriosis
   - Unexplained fertility
   - Uterine Fibroids
   - Polycystic ovarian syndrome

HOSPITAL AND OTHER FACILITY BENEFITS

INPATIENT HOSPITAL SERVICES

Benefits are provided for covered expenses for inpatient hospital care for each benefit period as follows:

- For days 1 through 60, this plan will pay the Medicare Part A deductible.
- For days 61 through 90, this plan will pay the specified daily coinsurance.
- For days 91 through 150, this plan will pay for hospital services for all admissions except for treatment of mental and nervous disorders. You may use these days before you use your 60 Medicare lifetime reserve days. If you use your Medicare lifetime reserve days, this plan will pay the coinsurance amount.
- For days 151 through 365, this plan will pay for hospital services except for treatment of mental and nervous disorders.

Covered services include:

- Semi-private room and board and ancillary services. If a private room is medically necessary, benefits are provided at the private room rate.
- Medicare limits coverage to 190 days for admissions for treatment of mental and nervous disorders. This plan will pay the Part A deductible and specified daily coinsurance for days approved by Medicare.
- When you are admitted to the hospital for dental surgical services approved by Medicare, this plan will pay the Medicare Part A deductible and the daily coinsurance amount. Dental services are limited to surgery related to the jaw or reduction of any fracture of the jaw or facial bone.

SKILLED NURSING FACILITY

When you are admitted to a Skilled Nursing Facility for a stay approved by Medicare, this plan will pay the applicable daily coinsurance for days 21 through 100.

HOSPICE

To qualify for hospice care, your doctor must certify that you're terminally ill and have 6 months or less to live. Coverage includes drugs for pain relief and symptom management, nursing, some durable medical equipment and spiritual and grief counseling.

A Medicare-approved hospice usually gives hospice care in your home or other facility where you live such as a nursing home. Hospice care doesn't pay for your stay in a facility (room and board) unless the hospice medical team determines that you need short-term inpatient stays for pain and symptom management that can't be addressed at home.

Medicare also covers inpatient respite care which is care you get in a Medicare-approved facility so that your usual caregiver can rest. You can stay up to 5 days each time you get respite care.

You can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that you're terminally ill.

This plan will pay 5% of the Medicare-approved amount for inpatient respite care.

SERVICES IN HOSPITALS OUTSIDE THE UNITED STATES

The Medicare program places certain restrictions on payments for admissions outside the United States. If Medicare approves payment for the admission, this plan will pay the Part A deductible and the daily coinsurance for the first 90 days. This plan will then pay 100% of the allowable charges for days 91-150.

If the admission does not qualify for payment under Medicare, but if it meets Medicare criteria for an inpatient admission within the United States and we approve the admission, this plan will pay for covered services as defined by Medicare law at 100% of the allowable charge for 150 days of inpatient care.

OUTPATIENT HOSPITAL SERVICES

This plan will pay the Medicare Part B deductible and then this plan will pay 20% of the reasonable charge for covered services for care in the outpatient department of the hospital. If care is rendered in a free-standing facility and Medicare pays, then this plan will pay the deductible, if any, and the coinsurance amount.

Covered services include:

- Diabetes equipment supplies and therapeutic equipment.
- Emergency Treatment that is treatment for accidental injury or for sudden and serious medical conditions. These services must be rendered within 72 hours after the accident or onset of the emergency condition.
- Minor Surgery.
- Radiation Therapy and Chemotherapy for proven malignancies and neoplastic diseases.
- Diagnostic imaging services, laboratory and machine testing.
- Physical Therapy (subject to Medicare criteria).
- Anesthesia.
- Hemodialysis.
- Clinical Services.
- Injections (not including routine immunizations except for influenza, pneumococcal and hepatitis B vaccines which are fully covered by Medicare).

- Coverage Outside the United States - In those cases where Medicare will pay, this plan will pay the deductible and coinsurance amounts. In those cases where Medicare does not pay, this plan will pay for those covered services as defined by Medicare at 100% of the allowable charge.

SURGICAL-MEDICAL BENEFITS

This plan will pay the Medicare Part B deductible, and then this plan will pay 20% of the Medicare reasonable charge for covered professional services provided or ordered by a physician.

COVERED SERVICES

Covered services are as defined by Medicare and include:

- Acupuncture for back pain
- Ambulance Services.
- Ambulatory Surgical Centers
- Anesthesia.
- Appliances and Durable Medical Equipment.
- Behavioral Health Integration Services
- Cardiac Rehabilitation
- Chiropractic Services (limited to correction of subluxation of the spine)
- Chiropractic Services limited to manual manipulation of the spine to correct a subluxation that can be demonstrated by X-ray.
- Chronic Care Management Services
- Clinic Visits.
- Clinical Research Studies
- Continuous Positive Airway Pressure (CPAP therapy)
- Defibrillator (Implantable Automatic)
- EKG (once for screening; otherwise diagnostic)
- Emergency Department Services
- Foot Exams and Treatment
- Hearing and Balance Exams
- Home and Office Visits.
- Imaging Services.
- Injections (not including routine immunizations – See *Preventive Benefits*).
- Inpatient Consultations.
- Inpatient Hospital Medical Visits.

- Inpatient Skilled Nursing Facility medical visits.
- Kidney Dialysis Services and Supplies
- Kidney Disease Education Services
- Laboratory and machine testing.
- Medical Emergency Care in the outpatient department of a hospital or other facility approved by us.
- Mental Health Care (outpatient--including intensive outpatient services)
- Occupational Therapy
- Opioid use Disorder Treatment Services
- Outpatient Medical and Surgical Services and Supplies
- Physical Therapy (subject to Medicare criteria).
- Prescription Drugs (limited)
- Prosthetic/Orthotic Items
- Pulmonary Rehabilitation
- Radiation Therapy and Chemotherapy for proven malignancies and neoplastic diseases.
- Screening, Brief Intervention & Referral to Treatment
- Second Surgical Opinions
- Speech-Language Pathology Services
- Surgery.
- Telehealth (limited) & other virtual visits—E-Visits and Virtual Check-ins
- Tobacco Use Cessation Counseling (with diagnosis of tobacco-related illness)
- Transitional Care Management Services

ACUPUNCTURE

Medicare only covers acupuncture (including dry needling) for chronic low back pain. Medicare covers up to 12 acupuncture visits in 90 days for chronic low back pain defined as:

- Lasting 12 weeks or longer

- Not having an identifiable cause (for example, not an identifiable disease like cancer that has spread, or an infectious or inflammatory disease)
- Pain that isn't associated with surgery or pregnancy.

Medicare covers an additional 8 sessions if you show improvement. You can get a maximum of 20 acupuncture treatments in a 12-month period. The Part B deductible and coinsurance apply. If you aren't showing improvement, Medicare won't cover the 8 additional treatments.

OVARIAN CANCER MONITORING TESTS

Includes coverage at 100% for two (2) annual ovarian cancer monitoring tests which are tests and examinations subsequent to treatment for ovarian cancer using any of the following methods that are recommended by a member's physician:

- Tumor marker tests supported by national clinical guidelines, national standards of care, or peer reviewed medical literature.
- Transvaginal ultrasound
- Pelvic examination
- Other screening tests supported by national clinical guidelines, national standards of care, or peer reviewed medical literature.

OUTPATIENT TREATMENT FOR MENTAL AND NERVOUS DISORDERS

This plan will pay the Medicare Part B deductible and then 20% of the reasonable charge for mental health care services in an outpatient setting. If you receive outpatient care in a partial hospitalization program or in the outpatient department of a hospital, this plan will pay 20% of the reasonable charge.

Mental health care (outpatient) Medicare covers mental health care services to help with conditions like depression and anxiety. These visits are often called counseling or psychotherapy, and can be done individually, in group psychotherapy or family settings, and in crisis situations. Coverage includes services generally provided in an outpatient setting (like a doctor's or other health care provider's office, hospital outpatient department, or by telehealth), including visits with a psychiatrist or other doctor, clinical psychologist, clinical nurse specialist, clinical social worker, nurse practitioner, or physician assistant. Medicare-covered mental health care includes:

- Services provided by marriage & family therapists and mental health counselors.
- Partial hospitalization services that are given by a Community Mental Health Center or by a hospital to outpatients. This structured day program offers outpatient psychiatric services as an alternative to inpatient psychiatric care.
- Intensive outpatient program services that include intensive psychiatric care, counseling, and therapy. These services may be given in hospitals, Community Mental Health Centers, Federally Qualified Health Centers, Rural Health Clinics, and Opioid Treatment Programs (when services are for the treatment of Opioid Use Disorder).

SERVICES OUTSIDE THE UNITED STATES

- For services outside of the United States, in those cases where Medicare will pay, this plan will pay the Part B deductible and coinsurance amounts.
- In those cases where Medicare will not pay, benefits for services outside the United States are provided at 20% of Medicare's Resource-Based Relative Value Scale (RBRVS).
- Travel (health care needed when traveling outside the United States) facility. Medicare generally does not cover medical care while you are traveling outside the U.S. or its territories and possessions. If emergency care is needed and covered, payment is 80% of allowed charges after the deductible.
- Out of country Surgical medical benefits for services outside the U.S. which are covered by Medicare BCBSD will pay the Medicare Part B deductible and 20% coinsurance. Benefits for services outside the U.S. not paid by Medicare are covered at 20% of the Highmark DE traditional RBRVS allowable, if these services are defined as coverable under Medicare policy guidelines.
- Nothing for services covered by Medicare, 80% for services not covered by Medicare, but defined as coverable under Medicare policy guidelines.

OTHER COVERED BENEFITS

The following benefits are provided in addition to those in the Hospital and Surgical-Medical Benefits section of this booklet. Covered services include:

ABORTION

This plan will cover elective and non-elective abortions 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. Coverage includes services related to the termination of pregnancy to the extent permitted by state law.

Medicare generally does not cover abortions except:

- If the pregnancy is the result of an act of rape or incest; or
- In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

OUTPATIENT PRESCRIPTION DRUGS

Medicare Part B covers 80% of the reasonable charges for a **very limited number of drugs** (for example, cancer and immunosuppressive drugs) after the Medicare Part B deductible. See https://www.medicare.gov/medicare-and-you for more information.

PRIVATE DUTY NURSING - INPATIENT

When you are an inpatient in an acute hospital ('hospital' is defined in the Definitions section of this booklet), benefits are provided for the medically necessary services of a Registered Professional Nurse (R.N.) at 80% of Highmark's allowable charge, up to a maximum of 240 hours during a 12-month period.

This benefit is provided only when all of the following conditions are met:

- The nursing service is available;
- The service is prescribed by the attending doctor;
- The service is connected with the condition for which hospital care and treatment are being rendered;
- The service is medically necessary; and
- The service is approved by the hospital.

Private duty nursing is not covered when it is provided as a convenience for you, whether or not prescribed by your doctor, or when it is provided at your request or your family's request.

If an R.N. is not available, then at our discretion, benefits may be provided for a Licensed Practical Nurse (L.P.N.) at 80% of Highmark's allowable charge.

HUMAN ORGAN TRANSPLANT BENEFIT

The benefits listed in this section are only available for services related to medically necessary human organ transplants. If Medicare covers these services, services related to kidney, cornea and bone marrow transplants are covered on the same basis and at the same level as other surgical benefits under this benefit plan and are not subject to the benefits and limitations of this section.

Benefits for human organ transplants are available only when Medicare pays for an organ transplant.

Benefits Available

Subject to all the terms and conditions of this benefit plan, when a human organ transplant is medically necessary, the following benefits are available for that transplant:

- If Medicare covers these services, covered Hospital and Surgical-Medical services as specified under this benefit plan. Benefits are payable on the same basis and at the same level as other similar benefits under this benefit plan.

- If Medicare covers these services, surgical, storage and transportation costs incurred and directly related to the donation of a human organ used in a covered transplant procedure. The maximum amount payable for this benefit is $10,000 for each cadaveric organ and up to $45,000 for each organ procured from a living donor (including harvesting).

- If Medicare covers these services, transportation to and from the site of the covered transplant procedure is covered for the transplant recipient and one other person. If the recipient is a minor, transportation costs for two other persons accompanying the recipient are covered.

- If Medicare covers these services, reasonable and necessary lodging and meal expenses incurred, up to a daily maximum of $150, by those individuals accompanying the recipient.

Benefit Limitations

- The benefits for transportation, lodging and meal expenses are subject to an aggregate maximum of $10,000 per covered transplant procedure. All covered transportation costs, lodging and meal expenses incurred are paid at the same level as outpatient doctor's visits.

- The organ transplant benefits specified in this section are available only during the applicable benefit period. For purposes of this Human Organ Transplant Benefit, the Benefit Period shall mean 5 days immediately prior to and one year immediately following a covered Organ Transplant Procedure.

- Benefits under this section are payable only for those services that Medicare will pay, with the exception of those non-Medicare covered services specified in the *Other Covered Benefits* section of this booklet.

EXCLUSIONS

The following services and other items are excluded from your coverage under this Medicfill plan:

- Services and supplies covered by Medicare Part A and Part B benefits, except those items and services expressly provided in this plan.
- Unless otherwise specified in this health care plan, charges for covered services that are over the Medicare allowable charge for that service.
- Any service or benefit provided or available, to any extent, to you under federal, state or local Workers' Compensation laws, occupational disease laws or other laws concerning job related injuries or conditions.
- Unless federal law requires otherwise, any services or supplies furnished by the Veterans' Administration or by any institution owned or operated by the United States, any corporation, agency or bureau thereof, or any state, county or municipal government; services or supplies available, in whole or in part under the laws of the United States (including Medicare) or under the laws of any state or political subdivision thereof or furnished or available pursuant to any law hereinafter enacted.
- Any service necessitated by an act of war declared or undeclared which occurs after the effective date of this plan, or by service in the armed forces of any country, or by any criminal act in which you conspired or took part.
- Services rendered by any member of your immediate family or any person living with you. For purpose of this paragraph only, family includes parents, spouses, siblings, and natural or adopted children of whatever age.
- Services for which no charge would normally be made in the absence of insurance.
- Rest cures, custodial care or homelike care, whether or not recommended by your doctor.
- Dental X-rays and appliances and the services of a dentist, except Medicare covered surgery involving the bone of the jaw or facial bone.
- Eyeglasses, contact lenses, the examination, prescription or fitting of same, and all procedures for refractive correction.
- Hearing aids and the examination, prescription or fitting of same,
- All procedures for refractive correction.
- Orthotics, including all equipment, devices, foot inserts, arch supports, lifts and corrective shoes.
- Routine foot care.
- Blood or blood donor services, including blood components.
- Supplies or services for cosmetic purposes, including routine treatment of acne and treatment for hair loss restoration.

- Unless specified otherwise, services for routine physical examinations or other examinations or treatments including, but not limited to, those procured by you to satisfy requirements of any third party including those required or ordered by a potential employer, licensing authority, insurer, educational institution, court, or legal representative, unless specified otherwise. School, camp, and pre-marital physicals are also excluded.

- Services not directly related to or medically necessary for the diagnosis or treatment of an illness or injury. Medical necessity is defined by us as: medically necessary services or supplies provided by a hospital, doctor or other provider to identify or treat an illness or injury and which, as determined by us are:

  - Consistent with the symptom or diagnosis and treatment of a condition, disease or injury;
  - Appropriate with regard to standards of accepted professional practice;
  - Not solely for your convenience, your doctor's convenience or any other provider's convenience; and,
  - The most appropriate supply or level of service which can safely be provided to you. When applied to an inpatient it further means that your medical symptoms or condition require that the service or supplies cannot be safely provided to you as an outpatient.

  We may base payment upon Medicare's determination of medical necessity.

- Computerized gait analysis or electrodynographic testing.

- Services and supplies for or related to visual therapy or orthoptics.

- Services by a medical department maintained by your employer.

- Services and supplies which are experimental or investigational in nature meaning any treatment, procedure, facility, equipment, drugs, drug usage, devices or supplies not recognized as accepted medical practice and any of such items requiring federal or other government agency approval not granted at the time services were rendered.

- Any service or supply specified as an exclusion under the Medicare program or denied by Medicare except any service or supply expressly covered as a benefit by this plan.

- Services, supplies, or drugs obtained in violation of applicable law.

- Prescription drugs (except for the limited number of drugs covered by Medicare Part B) for use outside the hospital, even if your doctor writes you a prescription. Medicare Part D Prescription Drug Coverage is provided through the State of Delaware's CVS Caremark/Silver Scripts Medicare Retiree Prescription Plan. Please contact the following offices for additional information:
  State of Delaware Office of Pensions, Phone: 1-800-722-7300, https://open.omb.delaware.gov or
  Statewide Benefits Office, Phone: 1-800-489-8933, https://dhr.delaware.gov/benefits/

VALUE ADDED FEATURES

Highmark offers Value Added Features. They are described below.

DISCOUNT PROGRAMS

Savings on a variety of product and services are available to Highmark members, including:

- Fitness clubs
- Alternative health services (i.e., acupuncture, chiropractic care)
- Laser vision corrective surgery
- Fitness gear
- Weight loss programs and healthy eating options
- Hearing aids

For a full listing of our discounts go to www.myhighmark.com or call us at 844-459-6452.

HOW TO CLAIM BENEFITS

Claims must be filed within 2 years from the time you receive care. Claims filed beyond 2 years will not be paid.

HOW TO CLAIM HOSPITAL AND SURGICAL-MEDICAL BENEFITS

Since this program supplements Medicare benefits, claims for benefits must first be submitted for coverage through Medicare.

A *Request for Medicare Payment Form*, must be filled out and submitted in order for Medicare to pay for services of doctors and suppliers which are covered by your medical insurance. All Social Security offices, and most doctors' offices, have copies of this form. Instructions on how to fill it out are on the back of the form.

When Medicare has paid for the services of doctors and suppliers that are covered by your medical insurance, you will receive an *Explanation of Benefits* notice explaining what coverage has been provided.

INSIDE DELAWARE

When you receive care inside Delaware, put your Highmark Identification Number on your *Request for Medicare Payment Form* *CMS-1490S.pdf* Payment will be made to the provider of services.

OUTSIDE DELAWARE

Medicare Part A Hospital Services

If you are hospitalized outside of Delaware, supply the hospital with your Highmark Identification Number. The hospital or Skilled Nursing Facility that provides you service will submit a Medicare Claim Form to the Medicare Part A Intermediary in the area where you receive care. Payment will be made to the provider of services.

Medicare Part B Doctor's Services

If you receive surgical-medical care outside of Delaware, supply the doctor or provider with your Highmark Identification Number. The doctor or provider will submit the claim to Medicare in the area where you receive care. Payment will be made to the provider of services.

OUTSIDE THE UNITED STATES

For claims incurred while on a cruise ship:

Send a copy of the *Explanation of Benefits* form you received from Medicare to:

Highmark Blue Cross Blue Shield
P.O. Box 8831
Wilmington, DE 19899-8831

Highmark will pay you directly for benefits in accordance with this health care plan.

For all other international claims:

Use the BlueCard Worldwide® International Claim Form available at www.myhighmark.com, and send the form to:

BlueCard Worldwide Service Center
P.O. Box 72017
Richmond, VA 23255-2017 USA

HOW TO CLAIM OTHER COVERED BENEFITS

PRIVATE DUTY NURSING

For private duty nursing inpatient benefits, please submit the following information to us:

- Name of the hospital.
- Date of admission to the hospital.
- Date of discharge from the hospital.
- Diagnosis.
- Attending physician's signature.
- Either a completed Claim Form CL-65, which may be obtained in any Delaware hospital, or the nurse's receipt showing the nurse's registration number. If the nurse's receipt is submitted without Form CL-65, you must also include the signed authorization of the attending physician.
- Your name, address, and Highmark Identification Number (referred to in some cases as 'contract' or 'certificate' Identification Number).

Highmark Blue Cross Blue Shield (Highmark)
HEALTH PLAN APPEAL PROCESS

For State of Delaware's Highmark
Special Medicfill® Medicare Complement Plan

The Highmark Special Medicfill plan benefits are designed to follow Medicare guidelines and cover both the Medicare Part A and B deductibles, and the Part B 20% coinsurance after original Medicare makes their full payment.

In instances when the claim is denied by Medicare, Highmark will also deny the claim for payment. Members with claims denied by Medicare should appeal directly to Medicare. Medicare appeal information is found in the Handbook on Medicare.gov/medicare-and-you.

In instances when the claim is not covered by Medicare, but services are covered by the Highmark Special Medicfill plan (such as coverage for services outside the United States, private duty nursing, and some routine services as outlined in the Highmark Delaware Special Medicfill plan benefit booklet) and are denied, follow the appeal process noted below:

INITIAL SERVICE

Member receives service and a claim is filed by the member (or by provider on member's behalf) with Highmark.

IF DENIED and member has potential liability to provider,

LEVEL I APPEAL – ADMINISTERED BY HIGHMARK

To appeal a Highmark decision, member must file an appeal with Highmark within 180 days from receipt of the notice of denial to request a review of the initial claim decision.

- Highmark will review the appeal and provide a written decision to the member
  - Within 15 days for Pre-Service requests
  - Within 30 days for Post-Service requests

IF DENIAL IS UPHELD,

LEVEL II APPEAL – ADMINISTERED BY HIGHMARK

To appeal a Level I decision, member must file a Level II appeal within 60 days from receipt of the Level I appeal decision.
Note: If denial is related to urgent care, member would skip the Level II appeal and move directly to a Level III Appeal.

Highmark Delaware will review the appeal and provide a written decision to the member

a) Within 15 days for Pre-Service requests
b) Within 30 days for Post-Service requests

IF DENIAL IS UPHELD,

LEVEL III APPEAL – ADMINISTERED BY THE STATE OF DELAWARE STATEWIDE BENEFITS OFFICE (SBO)

For medical judgment or medical necessity denials, including care that is cosmetic or experimental, the member may choose to file a Level III voluntary appeal to the SBO.

VOLUNTARY APPEAL TO THE STATEWIDE BENEFITS OFFICE

a) Member may file an appeal of the denial in writing to SBO within 20 days of the postmark date of the notice of denial of the Level II appeal (or within 20 days of the postmark date of the notice of denial of an expedited Level I appeal). The appeal must contain member contact information (mailing address, telephone number, etc.), a written summary of events, applicable Explanations of Benefits (EOBs), a copy of the member's Identification Card or the plan name and member's identification number (as on Identification Card), any additional documentation member desires to provide to support his/her position. Additionally, member must sign and submit with the appeal, the State of Delaware's Authorization for Release of Protected Health Information Form to provide authorization to the Statewide Benefits Office to obtain applicable information from Highmark and the SBO's Health Plan Appeal Form and Checklist, both of which are available at **https://dhr.delaware.gov/benefits/medical/highmark/appeal.shtml.**

Members submitting an appeal without a signed Authorization Form and/or completed Health Plan Appeal Form and Checklist will be requested, in writing, to submit the forms. Statewide Benefits Office will not begin to review the appeal until the Authorization Form and the Appeal Form and Checklist are received. The Appeals Administrator from the Statewide Benefits Office (or his/her designee) will conduct an internal review of the appeal and provide a written notice of the decision to the member and Highmark with 30 days of receiving the appeal. The request for appeal should be sent to:

Appeals Administrator
RE: APPEAL
Statewide Benefits Office
841 Silver Lake Blvd.
Suite 100
Dover, DE 19904
Tel: (302) 739-8331/ Fax: (302) 739-8339
Email: Benefits@delaware.gov

The Appeals Administrator from the Statewide Benefits Office (or his/her designee) will conduct an internal review of the appeal and provide a written notice of the decision to the member and Highmark Delaware within 30 days of receiving the appeal.

IF DENIAL IS UPHELD,

LEVEL IV (FINAL) APPEAL – ADMINISTERED BY THE STATE OF DELAWARE STATE EMPLOYEE BENEFITS COMMITTEE (SEBC)

Member may file a written appeal to the State Employee Benefits Committee (SEBC) within 20 days of the postmark date of the notice of denial from the Level III Appeal.

Co-Chair, State Employee Benefits Committee (SEBC)
RE: APPEAL
Department of Human Resources
841 Silver Lake Blvd.
Suite 100
Dover, DE 19901
Email: SEBC@delaware.gov

The SEBC receives the appeal and:

a) Identifies a Hearing Officer (Division Director, Statewide Benefits Office). The Hearing Officer conducts a hearing and submits a report to the SEBC within 60 days of the date of the hearing. The SEBC accepts or modifies the report, and notice of the decision is postmarked to the member within 60 days; **OR**

b) Hears the appeal and notice of the decision is postmarked to the member within 60 days of the hearing.

COORDINATION OF BENEFITS

We reserve the right to coordinate available benefits for you so that duplication of payment of the same benefits will not occur and so that all parties having responsibility for payment for covered services perform in accordance with their benefit plan obligations. If you are entitled to benefits under any other plan as defined herein, to which you are a party or beneficiary, the amount of benefits payable under this plan and any other plan will be coordinated so that the aggregate amount paid will not exceed one hundred percent of the Allowable Expenses.

DEFINITIONS

For the purpose of interpretation of this provision, the following definitions will apply:

Allowable Expenses means a necessary, reasonable and customary health care expense when the expense is covered at least in part by one or more health benefit plans covering the individual for whom the claim is made.

Coordination of Benefits Provision means any provision of any plan that establishes the order in which plans pay benefits when an individual is insured under two or more plans.

Other Plan means any arrangement providing health care benefits or services, including but not limited to benefits or services through:

- Any form of health or other insurance, including nonprofit health service, or any other form of prepayment of insurance coverage including individual, group, blanket, franchise, fraternal, no-fault insurance or personal injury protection coverage;
- Any health maintenance organization or similar coverage;
- Coverage under any labor management trusteed plan, union welfare plan, or employee benefit organization plan;
- Coverage under any governmental or tax supported program; or
- Coverage required by statute to be offered to or procured potentially by you whether or not you have the option of declining such coverage or of purchasing such coverage subject to mandatory or optional deductibles, including but not limited to personal injury protection coverage, no-fault coverage or similar provisions of state or other statutes.

Primary Plan means the plan under which benefits are determined before those of the other plan and without considering the other plan's benefits.

Secondary Plan means the plan under which benefits are determined after those of the other plan. Benefits under a secondary plan may be reduced because of the other plan's benefits.

ORDER OF BENEFITS DETERMINATION

The primary and secondary plan responsibility is determined according to the following rules as they apply to your Medicfill health care plan:

- A plan with no provision for coordination of benefits is primary over a plan that contains such provision.

- A plan that covers you as an employee is primary over a plan that covers you as a dependent.
- A plan that covers you as an active employee (or as that employee's dependent) is primary over a plan that covers you as a laid off or retired employee (or that employee's dependent).
- If two or more plans cover a dependent child of parents not divorced or separated, the plan of the parent whose birthday occurs earlier in the calendar year is primary. If both parents have the same birthday, the plan that covered one parent longer is primary.
- If the other plan's Coordination of Benefits provision determines primary or secondary plan responsibility based upon the parent's gender rather than upon the parent's birthday, the gender rule will control. As a result, the plan covering the dependent child of the male parent will be primary.
- If two or more plans cover a dependent child of divorced or separated parents, benefits for the child are determined in the following order:
  - First, the plan of the parent with custody of the child;
  - Then, the plan of the spouse of the parent with the custody of the child; and
  - Finally, the plan of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the organization providing benefits has actual knowledge of the decree, the plan of that parent is primary.
- If the above rules do not establish which plan is primary, the plan that has covered the individual for the longer time-period is primary.
- When there are two or more secondary plans, this order of benefit determination will be repeated until this plan's responsibility for benefits has been determined.

EFFECT ON BENEFITS

- When this plan is primary, the benefits of the secondary plan will be ignored for the purpose of determining the benefits under this plan.
- When this plan is secondary, we will coordinate payments with those of the other plan(s) so that payments made by both (or all) plans will not exceed Allowable Expenses for covered services. In no event will we pay more than would have been paid had there been no other plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

To determine the applicability of and to implement the terms of this provision, we may release to or obtain from any organization or individual any information deemed necessary.

You, personally, are obligated to provide information necessary to implement this provision. If you refuse to cooperate with us in providing necessary information or in securing payment, then coverage under this plan for that incident is null and void and we may, at our discretion, terminate the coverage and take any other action necessary to protect our rights hereunder.

FACILITY OF PAYMENT

When this plan is determined to be primary but payment was made under another plan, we have the right to reimburse the organization making such payments the amount that we determine is the plan's liability in accordance with this provision. By making such payment, we will have satisfied the obligation under this plan.

RIGHT OF RECOVERY

When we make payments that exceed the maximum amount of covered benefits that we must pay under the coordination of benefits rules, we have the right to recover the excess from any one of the following:

- Any person to or for whom such payments were made;
- Any insurance companies;
- Other organizations; or
- You.

ELIGIBILITY INFORMATION

WHO IS ELIGIBLE

This Health Care Plan is made available through the State of Delaware who elected to provide Medicare supplementary coverage for:

- Retired employees and their spouses
- Disabled employees, spouses and dependent children
- Employees, spouses and dependent children who have permanent kidney failure End State Renal Disease (ESRD).

You must be enrolled in Part A and Part B of the Medicare program. You must provide evidence of enrollment in Part and and Part B to the Office of Pensions upon request. You must also continue to be covered under both Part A and Part B to keep coverage in this plan.

WHEN YOUR COVERAGE ENDS

DEATH

Coverage for your surviving spouse and any eligible dependents ends as of the last day of the month of your death.

LOSS OF BENEFITS

You can lose coverage under this plan if you do not retain coverage under both Part A and Part B of Medicare.

Also, persons under 65 can lose their Medicare eligibility by losing their Social Security disability classification. This occurs when the disabled or blind person becomes gainfully employed or, in the case of the dialysis patient, three years after a successful kidney transplant or one year after termination of dialysis.

Contact your State of Delaware Office of Pensions for information regarding other coverage that may be available.

STATE OF DELAWARE DROPS COVERAGE

Your coverage (and your dependents coverage) ends on the date on which the State of Delaware's contract with Highmark for the administration of benefits ends.

BENEFITS AFTER YOUR COVERAGE ENDS

If you are an inpatient in a hospital, skilled nursing facility or specialized care facility on the date your coverage terminates because the State's contract with Highmark terminated, the plan will continue to provide the benefits described in this booklet for the facility and professional charges related to that admission for up to 10 days after the coverage termination date or until the day you are discharged from the hospital, skilled nursing facility or specialized care facility, whichever occurs first.

If you lose coverage for any reason other than because the State's contract with Highmark terminated, all health care benefits under this health care plan terminate on the date your group coverage terminates.

GENERAL CONDITIONS

IMPORTANT PAYMENT INFORMATION:

PAYMENT OF BENEFITS

If your provider accepts Medicare assignment, payment will be made directly to the provider. They cannot bill you for any balance over the Medicare reasonable charge. However, if your provider does not accept Medicare assignment and you have not assigned benefits under this plan to your doctor in accordance with Medicare program requirements, payment will be made directly to you and you may be responsible for any balance remaining. If you have assigned benefits under this plan to your doctor according to Medicare guidelines, this plan will pay benefits under this plan directly to your doctor, as required. In all other cases where benefits are payable to you, such payments shall not be assignable without our written approval.

MEDICARE AMENDMENTS

If there are changes to the Medicare Law or any other applicable law that either increase or decrease the amount of benefits or provide services not previously covered, benefits under this plan will be adjusted accordingly.

RELEASING NECESSARY INFORMATION

Hospitals, doctors, pharmacies and other providers have information we need to determine your eligibility for both enrollment and benefits under this plan. By applying for coverage you agree to let any doctor, hospital, pharmacy or provider give us and our agents all the medical information we may need. This may include the diagnosis and history of any illness, disease, condition or symptom you have had, or for which coverage is sought; or other information. We will keep this information confidential to the extent permitted by law. However, by applying for coverage you authorize us to furnish any and all records including complete diagnosis and medical information to an appropriate medical review board, utilization review board, utilization review organization and/or to any other insurance carrier or administrator or health maintenance organization for purposes of administration of this health benefits plan. If such information relates to fraud or other misrepresentation, we may disclose it to legal authorities or use it in legal proceedings. We reserve the right to charge a fee for the reproduction of claims records requested from us.

TIME LIMITS

Requests for benefits must be received by us within 2 years from the date you received the service.

DENIAL OF LIABILITY

We are not responsible for the quality of care received from any institution or individual. Your coverage does not give you any claim, right or cause of action against us based on an act of omission or commission of a hospital, nursing home, doctor or other provider of care or service.

RECEIPT OF BENEFITS

In order for you to receive benefits, you must identify yourself as our customer as soon as possible. When you receive services, you must show the current membership card.

DUPLICATE COVERAGE

If you have two or more benefit plans through Blue Cross Blue Shield corporations, benefits will be coordinated.

SUBROGATION AND RIGHT OF REIMBURSEMENT:

When we pay a claim, we are subrogated to all rights 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 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'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.

LEGAL ACTION

No legal action may be brought against Highmark for failure to provide benefits under this plan unless brought within 3 years from the date the service in question was rendered.

CANCELLATION FOR MISREPRESENTATION, FRAUD OR OTHER INTENTIONAL ACTS

We may cancel your coverage at any time if we learn:

- That the statements you made at the time you applied for coverage were untrue or incomplete; or
- That you received or attempted to receive benefits under this plan under circumstances indicating fraud or other intentional misconduct; or
- You assisted another person as specified above.

HOW HIGHMARK PROTECTS YOUR CONFIDENTIAL INFORMATION

It is necessary for Highmark to receive information about you and your health to properly administer your plan benefits. This information is called "Personal Identifiable Health Information" and includes items such as your

- provider's name,
- tests that were done,
- diagnosis, or
- costs of treatment.

The following explains how Highmark protects the confidentiality of your Personal Identifiable Health Information.

YOUR RIGHT TO CONSENT OR DENY RELEASE OF INFORMATION

By enrolling with Highmark, you agree that we can receive information from your providers about care that you received. You also permit Highmark to release your Personal Identifiable Health Information to business associates outside Highmark, such as

- organizations that process claims,
- people who help coordinate services, or
- auditors.

We may need to release your Personal Identifiable Health Information to:

- process and pay claims,
- coordinate benefits when you're covered under another health plan,
- monitor care,
- help manage a chronic illness, such as diabetes or congestive heart failure,
- measure satisfaction through customer surveys, or
- conduct studies to measure our performance and providers' performance.

In situations other than our routine business practice, Highmark will only release Personal Identifiable Health Information if you sign the *Notice of Specific Consent* form. The form will contain information such as what is being released, who is getting the information and why the information is needed.

WITHDRAWING CONSENT

If you signed a *Notice of Specific Consent* form, you may withdraw that consent by calling or writing Highmark's Customer Service Department. When you call, please specify which information indicated on the *Notice of Specific Consent* form you don't want released. However, if you withdraw that consent, the withdrawal will not affect any Personal Identifiable Health Information that Highmark has already released based on your signing the *Notice of Specific Consent* form.

SHARING YOUR INFORMATION WITH THE PLAN

At times it may be necessary for Highmark to provide the plan with information such as

- medical cost experience
- claims volume
- cost savings.

We do not release your Personal Identifiable Health Information to the plan without your signing a *Notice of Specific Consent* form, unless we are required to do so by law. The consent form will contain information such as what is being released, who is getting the information and why the information is needed.

YOUR RIGHT TO ACCESS MEDICAL RECORDS

You have the right to access the medical records that were originated by Highmark. Some examples of such records are the *Explanation of Benefits* and authorization of service forms. You can request your records by either writing or calling Highmark's Customer Service Department.

HOW HIGHMARK PROTECTS YOUR PRIVACY

All Highmark Employees are required to sign confidentiality statements when they're hired. Employees are then trained to follow certain guidelines to protect your confidential information. However, employees need to discuss your information with other employees when performing routine business practices, such as when they

- process claims,
- resolve disputes,
- answer inquiries, or
- coordinate care or benefits.

Much of your Personal Identifiable Health Information is on our computer network. Our employees are granted access to the network only on a need-to-know basis. Highmark's management determines the level of access that employees need to perform their job. Our systems are password protected. Passwords are periodically changed to prevent unauthorized access.

Highmark also requires that your providers follow confidentiality policies. We periodically audit providers to ensure that your medical records are kept private and that their staff has received confidentiality training.

USE OF MEASUREMENT DATA

We conduct surveys and health studies to measure customer satisfaction to help us improve our services. Health studies help us measure our performance and providers' performance. Information collected during these studies is reported for the entire group rather than for one person. Your Personal Identifiable Health Information is not identified.

Highmark sometimes uses outside agencies to conduct surveys and studies. Highmark requires these agencies to sign a confidentiality agreement and to train their employees about confidentiality.

COMPLAINTS AND QUESTIONS

You have the right to file a complaint with us at anytime you feel that we have not maintained your privacy. You also have the right to ask questions about our confidential policy. To do either, please call Highmark's Customer Service Department at 844-459-6452.

SUGGESTIONS AND COMPLAINTS

Highmark welcomes questions, suggestions, and complaints. We study your comments to see how we can improve our service. Call or write Customer Service anytime you have a concern about Highmark's services, procedures or policies. We'll make every attempt to answer your questions and resolve any problems within 30 working days.

So that we can learn about our panel providers, you may also call or write us when you have a concern about:

- access to your PCP or other provider
- the care you received

Highmark's Address

Customer Service
Highmark Blue Cross Blue Shield
P.O. Box 8799
Wilmington, DE 19899-8799

Highmark's Customer Service Telephone Numbers

To talk to a Customer Service Representative, call 8:00 AM to 8:00 PM Eastern Standard Time (EST), Monday through Friday.

Phone: 844-459-6452

Highmark's Internet Address:

www.myhighmark.com

To learn how to appeal benefits, see "Benefits Appeal" in the section, *A Guide to Claims.*

DEFINITIONS

Accident means accidental bodily injury that is sustained as the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while this plan is in force.

Admission means the period from the time you enter a hospital or skilled nursing facility as an inpatient until discharge.

Allowable Charge means the fee or price Highmark Blue Cross Blue Shield determines to be reasonable for services and supplies.

Benefit Period means the period beginning with the first day of admission to a hospital or Skilled Nursing Facility and ending when you have gone 60 consecutive days without admission to either a hospital or Skilled Nursing Facility.

Coinsurance means the portion of covered charges for services that, under Medicare, is your responsibility to pay. The coinsurance is the amount remaining after Medicare payment is made.

Deductible means a portion of covered charges for services which is payable before Medicare begins paying. The deductible amount is determined by Medicare.

Durable Medical Equipment means medically necessary equipment, prosthetic devices (artificial devices replacing body parts) and orthopedic braces used only during an illness or injury. It does not include disposable items.

Explanation of Benefits (EOB): A written statement issued to a member that provides detail concerning processing and payment of a claim for benefits, including the member's financial responsibility for services rendered.

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

Hospital means any institution accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA), and which operates pursuant to state law and which provides diagnostic and therapeutic facilities for services performed mostly on an inpatient basis. Such services must at a minimum include: surgical and medical diagnosis and treatment; and twenty-four hour a day nursing service under the direction or supervision of registered professional nurses. Hospital services must be supervised and rendered by a staff of physicians.

Inpatient means a person admitted to a hospital or skilled nursing facility for an overnight stay.

Licensed Practical Nurse means a person licensed as such by the state in which they practice nursing.

Medically Necessary means those services or supplies which are provided by a hospital, physician or other provider that are required to identify or treat an illness or injury and which, as determined by us, are:

- Consistent with the symptom or diagnosis and treatment of the condition, disease or injury;
- Appropriate with regard to standards of accepted professional practice;
- Not solely for your convenience, the doctor's convenience, or any other provider's convenience; and,

- The most appropriate supply or level of service that can safely be provided. When applied to an inpatient, it further means that the medical symptoms or condition require that the services or supplies cannot be safely provided as an outpatient.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended. Medicare includes Part A Hospital Insurance Benefits; Part B Supplementary Medical Benefits; and includes rules, regulations, directives and interpretations about these programs issued by the Secretary of Health and Human Services.

Medicare Approved Amount means the payment amount that Original Medicare sets for a covered service or item. When your provider accepts assignment, Medicare pays its share and your Medicfill plan pays the applicable Medicare deductible and coinsurance after Medicare's payment.

Medicare Assignment means a provider has agreed to be paid directly by Medicare and to accept the Medicare Reasonable Charge set by Medicare as payment in full for the services.

Medicare Eligible Expenses means the health care expenses of the kinds covered by Medicare and to the extent recognized as reasonable by Medicare.

Medicare Part A means the Hospital Insurance Benefits provided by the United States Government under Public Law 89-97, Title XVIII of the Social Security Act as amended from time to time.

Medicare Part B means the Supplementary Medical Insurance Benefits provided by the United States Government under Public Law 89-97, Title XVIII of the Social Security Act as amended from time to time.

Medicare Part D means the Voluntary Prescription Drug Benefit Program provided by the United States Government under Public Law 108-173, Title XVIII of the Social Security Act as amended from time to time.

Outpatient means a person who is receiving services or supplies while not an inpatient in a hospital or skilled nursing facility.

Physician or Doctor means any person who is licensed to practice medicine and surgery, osteopathy, podiatry, chiropractic or dentistry and who is acting within the scope of that license.

Prescription Drugs means a substance which is used in the cure, treatment, or prevention of a disease or illness which can only be obtained upon a physician's prescription.

Provider means any person eligible to provide services or supplies under Medicare Part B such as a licensed Doctor of Medicine, doctor of osteopathy, doctor of dental surgery, doctor of pediatric medicine, doctor of podiatric medicine, doctor of optometry, doctor of chiropractic, psychologist, audiologist, independent Clinical Lab, physical therapist, speech-language pathologist, nurse-midwife or Certified Registered Nurse acting within the authority of their license.

Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare Program.

Registered Professional Nurse means a person licensed as such by the state in which he or she practices nursing.

Resource Based Relative Value Scale – a schedule established by the federal government to standardize physician payments as determined by the resource costs needed to provide them. The cost of providing each service is divided into three components: physician work, practice expense and professional liability insurance, each of which is resource-based. Payments are adjusted for geographical differences in resource costs.

Skilled Nursing Facility means extended care facilities, convalescent hospitals or rehabilitation centers providing skilled nursing care or rehabilitation services and approved by Medicare. Medicare's approval is based on the facility's guarantee of safety to the patient and effectiveness of the care rendered to the patients. These facilities provide:

- Skilled nursing and related services on an inpatient basis for patients who require continuous, 24 hour a day medical or nursing care.
- Rehabilitation for patients who require such care because of illness, disability or injury.

We, Us or Our refers to Highmark Blue Cross Blue Shield.

You and Your refers to the member or any eligible dependents you have enrolled for coverage. You must be eligible for enrollment in the Medicare program and enroll with the State for supplementary coverage

State Health Insurance Assistance Programs (SHIPs)

For free, personalized help with questions about appeals, buying other insurance, choosing a health plan, buying a Medigap policy, and Medicare rights and protections.

Alabama

State Health Insurance Assistance Program (SHIP)
1-800-243-5463

Alaska

Medicare Information Office
1-800-478-6065
TTY: 1-800-770-8973

Arizona

Arizona State Health Insurance Assistance Program (SHIP)
1-800-432-4040

Arkansas

Senior Health Insurance Information Program (SHIIP)
1-800-224-6330

California

California Health Insurance Counseling & Advocacy Program (HICAP)
1-800-434-0222

Colorado

State Health Insurance Assistance Program (SHIP)
1-888-696-7213

Connecticut

Connecticut's Program for Health Insurance Assistance, Outreach, Information and Referral, Counseling, Eligibility Screening (CHOICES)
1-800-994-9422

Delaware

Delaware Medicare Assistance Bureau (DMAB)
DMAB@delaware.gov
1-800-336-9500 | toll-free in Delaware or (302) 674-7364

Florida

Serving Health Insurance Needs of Elders (SHINE)
1-800-963-5337
TTY: 1-800-955-8770

Georgia

Georgia State Health Insurance Assistance Program (SHIP)
1-866-552-4464 (option 4)

Guam

Guam Medicare Assistance Program (GUAM MAP)
1-671-735-7415

Hawaii

Hawaii SHIP
1-888-875-9229
TTY: 1-866-810-4379

Idaho

Senior Health Insurance Benefits Advisors (SHIBA)
1-800-247-4422

Illinois

Senior Health Insurance Program (SHIP)
1-800-252-8966
TTY: 1-888-206-1327

Indiana

State Health Insurance Assistance Program (SHIP)
1-800-452-4800
TTY: 1-866-846-0139

Iowa

Senior Health Insurance Information Program (SHIIP)
1-800-351-4664
TTY: 1-800-735-2942

Kansas

Senior Health Insurance Counseling for Kansas (SHICK)
1-800-860-5260

Kentucky

State Health Insurance Assistance Program (SHIP)
1-877-293-7447

Louisiana

Senior Health Insurance Information Program (SHIIP)
1-800-259-5300

Maine

Maine State Health Insurance Assistance Program (SHIP)
1-800-262-2232

Maryland

State Health Insurance Assistance Program (SHIP)
1-800-243-3425

Massachusetts

Serving Health Insurance Needs of Everyone (SHINE)
1-800-243-4636
TTY: 1-877-610-0241

Michigan

MMAP, Inc.
1-800-803-7174

Minnesota

Minnesota State Health Insurance Assistance Program/ Senior LinkAge Line
1-800-333-2433

Mississippi

MS State Health Insurance Assistance Program (SHIP)
844-822-4622

Missouri

Missouri SHIP
1-800-390-3330

Montana

Montana State Health Insurance Assistance Program (SHIP)
1-800-551-3191

Nebraska

Nebraska SHIP
1-800-234-7119

Nevada

Nevada Medicare Assistance Program (MAP)
1-800-307-4444

New Hampshire

NH SHIP – ServiceLink Resource Center
1-866-634-9412

New Jersey

State Health Insurance Assistance Program (SHIP)
1-800-792-8820

New Mexico

New Mexico ADRC-SHIP
1-800-432-2080

New York

Health Insurance Information Counseling and Assistance Program (HIICAP) 1-800-701-0501

North Carolina

Seniors' Health Insurance Information Program (SHIIP)
1-855-408-1212

North Dakota

State Health Insurance Counseling (SHIC)
1-888-575-6611
TTY: 1-800-366-6888

Ohio

Ohio Senior Health Insurance Information Program (OSHIIP)
1-800-686-1578
TTY: 1-614-644-3745

Oklahoma

Oklahoma Medicare Assistance Program (MAP)
1-800-763-2828

Oregon

Senior Health Insurance Benefits Assistance (SHIBA)
1-800-722-4134

Pennsylvania

Pennsylvania Medicare Education and Decision Insight (PA MEDI)
1-800-783-7067

Puerto Rico

State Health Insurance Assistance Program (SHIP)
1-877-725-4300
TTY: 1-878-919-7291

Rhode Island

Senior Health Insurance Program (SHIP)
1-888-884-8721
TTY: 401-462-0740

South Carolina

(I-CARE) Insurance Counseling Assistance and Referrals for Elders
1-800-868-9095

South Dakota

Senior Health Information & Insurance Education (SHIINE)
1-800-536-8197

Tennessee

TN SHIP
1-877-801-0044
TTY: 1-800-848-0299

Texas

Health Information Counseling and Advocacy Program (HICAP)
1-800-252-9240

Utah

Senior Health Insurance Information Program (SHIP)
1-800-541-7735

Vermont

Vermont State Health Insurance Assistance Program
1-800-642-5119

Virgin Islands

Virgin Islands State Health Insurance Assistance Program (VISHIP)
1-340-772-7368 St. Croix area;
1-340-714-4354 St. Thomas area

Virginia

Virginia Insurance Counseling and Assistance Program (VICAP)
1-800-552-3402

Washington

Statewide Health Insurance Benefits Advisors (SHIBA)
1-800-562-6900
TTY: 1-360-586-0241

Washington D.C.

DC SHIP
202-727-8370

West Virginia

West Virginia State Health Insurance Assistance Program (WV SHIP)
1-877-987-4463

Wisconsin

WI State Health Insurance Assistance Program (SHIP)
1-800-242-1060
TTY: 711

Wyoming

Wyoming State Health Insurance Information Program (WSHIIP)
1-800-856-4398

Discrimination is Against the Law

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

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

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

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

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

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

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

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。

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

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

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

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

אכטונג: אויב איר רעדט אידיש, זענען שפראך הילף סערוויסעס, פריי פון אפצאל, אוועילעבל פאר אייך. רופט די נומער וואס איז אויף די פארקערטע זייט פון אייער ID קארטל (TTY:711).

মনোযোগ দিন: আপনি যদি বাংলা ভাষায় কথা বলেন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ রয়েছে। আপনার আইডি কার্ডের (TTY:711) পিছনে থাকা নম্বরে ফোন করুন।

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

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

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

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711).

Effective Date:December

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

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ΠΡΟΣΟΧΗ: Σε περίπτωση που μιλάτε Ελληνικά, οι διαθέσιμες υπηρεσίες γλωσσικής βοήθειας σας παρέχονται δωρεάν. Καλέστε τον αριθμό στο πίσω μέρος της ταυτότητας σας (TTY:711).

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

HIGHMARK INC.
NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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

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

Our Legal Duties

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

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

We will inform you of these practices the first time you become a Highmark customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice becomes effective September 23, 2013, and will remain in effect unless we replace it.

On an ongoing basis, we will review and monitor our privacy practices to ensure the privacy of our members' protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this Notice. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will become effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. Before we make a material change in our privacy practices, we will change this Notice and notify all affected members in writing in advance of the change. Any change to this notice will be posted on our website and we will further notify you of any changes in our annual mailing.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. Uses and Disclosures of Protected Health Information

In order to administer our health benefit programs effectively, we will collect, use and disclose protected health information for certain of our activities, including payment and health care operations.

A. Uses and Disclosures of Protected Health Information for Payment and Health Care Operations

The following is a description of how we may use and/or disclose protected health information about you for payment and health care operations:

Payment

We may use and disclose your protected health information for all activities that are included within the definition of "payment" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "payment," so please refer to 45 C.F.R. § 164.501 for a complete list.

►For example:

We may use and disclose your protected health information to pay claims from doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and/or to issue explanations of benefits/payments to the person who subscribes to the health plan in which you participate.

Health Care Operations

We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "health care operations," so please refer to 45 C.F.R. § 164.501 for a complete list.

►For example:

We may use and disclose your protected health information to rate our risk and determine the premium for your health plan, to conduct quality assessment and improvement activities, to credential health care providers, to engage in care coordination or case management, and/or to manage our business.

B. Uses and Disclosures of Protected Health Information To Other Entities

We also may use and disclose protected health information to other covered entities, business associates, or other individuals (as permitted by the HIPAA Privacy Rule) who assist us in administering our programs and delivering services to our members.

- Business Associates.

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

- Other Covered Entities.

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

II. Other Possible Uses and Disclosures of Protected Health Information

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

(i) **To Plan Sponsors**

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

(ii) **Required by Law**

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

(iii) **Public Health Activities**

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

(iv) **Health Oversight Activities**

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

(v) **Abuse or Neglect**

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

(vi) **Legal Proceedings**

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

(vii) **Law Enforcement**

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

(viii) **Coroners, Medical Examiners, Funeral Directors, and Organ Donation**

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

(ix) **Research**

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

(x) **To Prevent a Serious Threat to Health or Safety**

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

(xi) **Military Activity and National Security, Protective Services**

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

(xii) **Inmates**

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

(xiii) **Workers' Compensation**

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

(xiv) **Others Involved in Your Health Care**

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

(xv) **Underwriting**

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

(xvi) **Health Information Exchange**

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

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

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

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

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

In order to opt-out, you must call the customer service number located on the back of your membership card. You should be aware, if you choose to opt-out, your health care providers will not be able to access your health information through the HIE. Even if you chose to opt-out, your information will be sent to the HIE, but providers will not be able to access this information. Additionally, your opt-out does not affect the ability of participating providers to access health information entered into the HIE prior to your opt-out submission.

III. Required Disclosures of Your Protected Health Information

The following is a description of disclosures that we are required by law to make:

A. Disclosures to the Secretary of the U.S. Department of Health and Human Services

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

B. Disclosures to You

We are required to disclose to you most of your protected health information that is in a "designated record set" (defined below) when you request access to this information. We also are required to provide, upon your request, an accounting of many disclosures of your protected health information that are for reasons other than payment and health care operations.

IV. Other Uses and Disclosures of Your Protected Health Information

Sometimes we are required to obtain your written authorization for use or disclosure of your health information. The uses and disclosures that require an authorization under 45 C.F.R. § 164.508(a) are:

1. For marketing purposes
2. If we intend to sell your PHI
3. For use of Psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. An Authorization for use of psychotherapy notes is required unless:

a. Used by the person who created the psychotherapy note for treatment purposes, or

b. Used or disclosed for the following purposes:

A. the provider's own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;

B. for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;

C. if required for enforcement purposes;

D. if mandated by law;

E. if permitted for oversight of the provider that created the note,

F. to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or

(vi) if needed to avert a serious and imminent threat to health or safety.

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

V. Your Individual Rights

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

(i) **Right to Access**

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

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

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

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

(ii) **Right to an Accounting**

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

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

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

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

(iii) **Right to Request a Restriction**

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

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

(iv) **Right to Request Confidential Communications**

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

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

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

(v) **Right to Request Amendment**

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

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

(vi) **Right to a Paper Copy of this Notice**

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

VI. Questions and Complaints

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

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

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

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

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

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

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

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

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

A. We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of
birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.

B. We collect and create information about our members' transactions with Highmark, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits/payments (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

Information we may disclose and the purpose: We do not sell any personal information about our members or former members for marketing purposes. We use and disclose the personal information we collect (as described above) only as necessary to deliver health care products and services to our members or to comply with legal requirements. Some examples are:

C. We use personal information internally to manage enrollment, process claims, monitor the quality of the health services provided to our members, prevent fraud, audit our own performance or to respond to members' requests for information, products or services.

D. We share personal information with our affiliated companies, health care providers, agents, other insurers, peer review organizations, auditors, attorneys or consultants who assist us in administering our programs and delivering health services to our
members. Our contracts with all such service providers require them to protect the confidentiality of our members' personal information.

E. We may share personal information with other insurers that cooperate with us to jointly market or administer health insurance products
or services. All contracts with other insurers for this purpose require them to protect the confidentiality of our members personal information.

F. We may disclose information under order of a court of law in connection with a legal proceeding.

G. We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.

H. We may disclose information under a subpoena or summons to government agencies that investigate fraud or other violations of law.

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

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

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