Pennsylvania State Police

Benefits Handbook 2010

pennsylvania

We are pleased to offer you this handbook describing your health benefits as an enlisted member of the Pennsylvania State Police. Please read it carefully. Updates will be provided to you as necessary. If you terminate employment, you must return this handbook to the HR Service Center. If you retire, you should keep this handbook.

While this handbook describes the principal features of your benefit plans, it is not to be considered the contract of benefits and provisions. The complete terms of coverage are set forth in the contracts between the Commonwealth of Pennsylvania and the various benefit carriers. If there is a conflict between the wording of this handbook and the contracts, the contracts will govern.

INFORMATION FOR YOUR USE

_____
Highmark Blue Shield Group Number

_____
Highmark Blue Shield Identification Number

HR Service Center | Phone: 866.377.2672
7:00 am - 5:00 pm | Monday – Friday

Revised December 2011

----------Detach Here----------

I have received a copy of the State Police Health Benefits Program Handbook and the COBRA Initial Notice.

_____ _____
Signature Print Your Name Here

_____
Employee Number

_____
Date

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I. ELIGIBILITY

Handbook Wording

This handbook generally uses the term "member" to refer to an enlisted member of the Pennsylvania State Police, the term "dependent" to refer to a relative or other person who might be covered under the member's health care coverage, and the term "covered person" to refer to either a member or dependent who is actually covered under the benefits in this handbook. For simplicity, the handbook may use the word "you" to refer to any of the above groups. This was done to avoid having to repeat the eligibility rules in every benefit section. The specific eligibility rules follow.

Eligible Members

Members must be permanent enlisted employees of the Pennsylvania State Police. Active members are eligible for all benefits in the State Police Health Benefits Program (including Medical, Dental, Vision, Prescription and Health Reimbursement Arrangement), Emergency Counseling Benefit if enrolled in the Traditional ClassicBlue plan. Retired members retain their Medical, Dental and Prescription Drug benefits.

Eligible Dependents

You may enroll the following dependents:

- Your spouse
- Your common-law spouse as long as the common-law marriage was entered into prior to January 1, 2005. If you are married by common-law, you must obtain a copy of an affidavit from the HR Service Center or online at www.myWorkplace.state.pa.us. The affidavit must be signed by you and your spouse, notarized, and returned to the HR Service Center. Cohabitation alone does not constitute a common-law marriage and a divorce is required in order to terminate a common-law marriage.
- If your spouse also is an active State Police member who is eligible to participate in the State Police Health Benefits Program, they must enroll as a single member under their own coverage.
- Your unmarried children under 19 years of age:
    - Your natural child
    - Legally-adopted child, including coverage during the adoption probationary period
    - Stepchild living with you
    - Child who is living with and being solely supported by you and who is related to you by blood or marriage
    - Child who is living with and being solely supported by you and for whom you are the court-appointed legal guardian
    - Child age 18 living with and being solely supported by you if you were the child's legal guardian or foster parent prior to the child's 18th birthday
    - Child being supported by you under a court ordered Qualified Medical Child Support Order

Foster children under age 18 are not eligible dependents.

- Children who are enrolled as full-time students in a recognized course of study or training, if they meet all of the following requirements:
    - Are age 19 to 25
    - Are not married
    - Do not work full-time
    - Are not covered under any group insurance plan or prepayment plan through the student's employer
    - Renew their student certification twice a year. Highmark Blue Shield sends student certification forms in May and November. Forms returned to Highmark Blue Shield in May/June will be used to provide coverage from the time period of July 1 - December 31. Forms returned to Highmark Blue Shield in November/December will be used to provide coverage for the time period of January 1 - June 30.
    - Was your dependent before the age of 19
- Full-time students who are on medical leave and cannot continue their education due to an illness or disability will continue to have coverage for a period of one year from the date the student is unable to attend school full time due to the medical condition, until the date the dependent ceases to be on medical leave, or until the date the dependent turns age 25, whichever is earlier.
    - If you wish to apply for coverage for your dependent who is unable to continue their education due to an illness or disability, you must complete and return the Student Medical Leave Application form to:

      Office of Administration
      Bureau of Employee Benefits and Services
      Group Insurance Division
      513 Finance Building
      Harrisburg, PA 17120
- Coverage for full-time students continues during a regularly scheduled vacation period or between-term periods as established by the institution. Work limited to that period is not considered employment "on a regularly scheduled basis."
- Your unmarried disabled dependent of any age may be covered if he or she meets all of the following requirements:
    - Is incapable of self-support because of a physical or mental disability, provided that the child became disabled prior to age 19
    - Was your dependent before the age of 19
    - Is approved by Highmark Blue Shield for such coverage provided based on medical review

  If you wish to apply for coverage for your unmarried disabled dependent, contact Highmark Blue Shield at 1-866-727-4935. Highmark Blue Shield will mail you a Disabled Dependent Certification Form. Follow the instructions on the form. If the disabled dependent is approved for coverage, Highmark Blue Shield will notify you of the decision and the disabled dependent will be added automatically to your contract. The completed form should be mailed to:

  Highmark Blue Shield
  P.O. Box 890173
  Camp Hill, PA 17089-0173
  Attention: Medical Claims Review

  The disabled dependent's status will be reviewed periodically based upon the dependent's condition usually for a period of one to five years.

- Dependent children become ineligible* the day that they:
    - Reach age 19 or lose full-time student status prior to age 25
    - Become employed full-time
    - Marry
    - No longer meet the dependent eligibility requirements of the State Police Health Benefits Program

  *Refer to the State Police Eligibility Rules Chart to determine the actual coverage ending date.
- Children may be enrolled only on one member's State Police Health Benefits Program contract.

When Does Coverage Begin?

In most cases, coverage begins on the date you become an enlisted member of the Pennsylvania State Police. For dependents who are added later, coverage usually begins on the first date they are eligible if you contact the HR Service Center to add them in a timely manner.

If you marry, your spouse will have coverage as of the date of marriage; however, you must contact the HR Service Center to add your spouse to your contract before claims will be paid. A newborn child will be covered under the plan for 31 days following birth. Coverage will not continue beyond 31 days unless you contact the HR Service Center.

It is your responsibility to notify the HR Service Center within 60 days of any of the following changes in life status:

- You gain a dependent through birth, adoption, or marriage
- You lose a dependent through divorce, death or ineligibility under this or any other plan
- Stepchildren are no longer eligible after a divorce unless you have legally adopted the child or have court documents that require you to cover the child
- Your spouse's employment or other dependent's medical coverage begins or ends

If an eligible dependent is not added to your contract within 60 days of his or her initial date of eligibility, the dependent may not be retroactively enrolled more than 60 days from the date you notified the HR Service Center. Health expenses incurred for a dependent who is not enrolled will not be paid. If the dependent incurred health expenses prior to 60 days from the date you notified the HR Service Center, you may write to:

Office of Administration
Bureau of Employee Benefits and Services
Group Insurance Division
513 Finance Building
Harrisburg, PA 17120

to request that an exception be made to cover the dependent as of the initial date of eligibility.

Other certification, in addition to a completed enrollment form, may be required if your dependent is a common-law spouse, over age 19, adopted, or disabled. Such

documentation might include adoption documents, legal guardian documents, court orders, or other proof of eligibility.

When Does Coverage End?

Refer to the State Police Eligibility Rules Chart on the following page to determine when coverage ends for you and your dependents.

You are responsible to notify the HR Service Center of any changes in life status for you or your dependents. If changes are not reported in a timely manner your dependents will not be eligible for COBRA. If you do not report a life status change timely and you or your dependents use your health coverage after eligibility ends, you are required to reimburse the commonwealth for any services paid inappropriately by the commonwealth.

STATE POLICE ELIGIBILITY RULES

Member or Dependent	Type of Coverage	Type of Qualifying Event	When Does State-Paid Coverage End
Member and Dependent	Medical, Dental, Vision & Prescription	Sick or Parental LWOPWB	At the end of the 1048 hours of leave entitlement
Member and Dependent	Medical, Dental, Vision & Prescription	Family Care LWOPWB	At the end of the 480 hours of leave entitlement
Member and Dependent	Medical, Dental, Vision & Prescription	Military LWOPWB	When Military LWOPWB changes to a without benefits status. Contact your Troop Administrative Manager or Bureau Administrative staff for information on Military Leave.
Spouse	Medical, Dental & Vision	Divorce	the end of month in which the spouse is divorced
Spouse	Prescription	Divorce	On the date of divorce
Full-Time Student Dependent (age 19 or 25)	Medical, Dental & Vision	Ceases to be a full-time student, marries, takes full-time job	the end of month of the qualifying event
Full-Time Student Dependent (age 19 or 25)	Prescription	Ceases to be a full-time student; marries, takes full-time job	On the date of the qualifying event
Member and Dependent	Medical, Dental, Vision & Prescription	Suspension WOP With Benefits	At such time as the cost of the benefits paid equals the amount of the member's accumulated retirement deductions and interest, plus the amount of all eligible leave payouts
Member and Dependent	Medical, Dental, Vision & Prescription	Suspension WOP Without Benefits	When the event falls between the 1st and 14th of the month, coverage will end on the last day of the month; when the event falls between the 15th and the last day of the month, coverage will end on the 14th of the following month
Surviving Dependent and Furloughed Member	Medical, Dental & Vision	Employee's death (other than killed in the line of duty) or Furlough of Member.	When the event falls between the 1st and 14th of the month, coverage will end on the last day of the month; when the event falls between the 15th and the last day of the month, coverage will end on the 14th of the following month
Surviving Dependent and Furloughed Member	Prescription	Same as Above	Date of qualifying event
Spouse and Eligible Dependent	Medical, Dental, Vision & Prescription	Member Killed in Line of Duty	Spouse: Remains covered until the spouse remarries Other Dependents: Continues as long as eligibility requirements are met
Member and Dependent	Medical, Dental, Vision & Prescription	Separation	Date of the qualifying event

Contact your Troop Administrative Manager or Bureau Administrative staff for information regarding your Leave entitlements.

Student on Military Leave

Act 83 of 2005, effective February 21, 2006, provides for extension of health insurance coverage in certain circumstances. To qualify for this extension you must meet all of the following eligibility requirements:

- Be a member of the Pennsylvania National Guard or a Reserve Component of the Armed Forces of the United States
- Be ordered to active federal duty or state active duty (other than active duty for training) for 30 or more consecutive days
- Be enrolled as a full-time student in a recognized course of study or training
- Be eligible for coverage under the State Police Health Benefits Program at the time you are ordered to active duty
- Not be eligible because of your age for coverage under the State Police Health Benefits Program when you become a full-time student after your active duty tour
- Re-enroll as a full-time student for the first term or semester beginning 60 or more days after your release from active duty

If you meet these eligibility criteria, you may qualify to extend your coverage under the State Police Health Benefits Program while you are a full-time student for a period equal to your active duty tour. To qualify you must submit three forms to Highmark Blue Shield:

- Notification to Insurer of Placement of Active Duty (DMVA Form 83-1)
- Notification to Insurer of Completion of Active Duty (DMVA Form 83-2)
- Notification to Insurer of Re-Enrollment as Full-Time Student (DMVA Form 83-3)

Act 83 of 2005 extends eligibility for coverage for a period equal to the time you were on active duty other than active duty training. It also says that coverage ends when you are no longer a full-time student. For example, if you were on active duty (not for training) for 18 months and you re-enroll as a full-time student, you should get 18 months of additional eligibility as long as you remain a full-time student.

Student Certification

The HR Service Center will notify you and send you a Student Certification Form in the month when your dependent turns age 19. If your dependent is a full-time student, complete the form and send it to the HR Service Center for further processing. You may verify dependent eligibility via Employee Self Service (ESS) at https://www.myworkplace.state.pa.us. Click on Benefits, Participation Overview, choose Medical or Supplemental, click on Show Participation Details. If the dependent is listed, they are currently enrolled in coverage.

Any questions relating to COBRA Continuation Coverage may be directed to the Pennsylvania Employees Benefit Trust Fund at 1-800-522-7279.

You are required to certify your full-time student dependent semi-annually. Highmark Blue Shield handles the student certification process and will mail a Student Certification notification form to your residence, which you must complete and return by the due date in order for your dependent to remain eligible for coverage. If you do not complete and return the form to the carrier, they will assume your dependent is no longer an eligible student dependent and he or she will be removed from all coverage, health and supplemental benefits. Students removed this way are not COBRA eligible. You are responsible to notify the HR Service Center

within 60 days of the date the dependent ceases to be a full-time student in order for the dependent to be COBRA eligible.

Highmark Blue Shield will send certification forms twice a year in May and November. Forms received by Highmark Blue Shield in May/June will be used to provide coverage for the time period of July 1 - December 31. Any student dependent who is not certified within 31 days of the May certification letter deadline will be cancelled from coverage effective June 30.

Forms received by Highmark Blue Shield in November/December will be used to provide coverage for the time period of January 1 - June 30. Any student dependent who is not certified within 31 days of the November certification letter deadline will be cancelled from coverage effective December 31.

The semi-annual certification mailing from Highmark Blue Shield includes a "Notice of Continuation Coverage Full-Time Students on Medical Leave". This Notice informs members that full-time students unable to continue their education due to a medical condition will continue to have coverage for a period of up to one year from the date the student is unable to attend school full-time due to the medical condition. Benefits coverage eligibility ceases earlier than one year if the student becomes ineligible for coverage due to the eligibility rules contained within this Handbook. If you wish to apply for coverage for your dependent who is unable to continue their education due to an illness or disability, please refer to the *Eligible Dependents* section of this handbook for additional information.

To reinstate a canceled student's coverage, you must obtain a Student Certification form from the HR Service Center. THIS FORM MUST BE COMPLETED AND RETURNED TO THE HR SERVICE CENTER.

Member Killed In the Line of Duty

In the event a member is killed in the line of duty, all State Police Health Benefits will continue for the eligible dependents of the deceased member for the life of the spouse or until the spouse remarries, and for the children as long as they meet the eligibility requirements.

Identification Cards

After you have been enrolled, you will be issued medical/hospital, dental, vision, and prescription identification cards. You must use the appropriate identification card when you receive any of the benefits provided by this program.

Keep your cards with you at all times and be sure to destroy any old identification cards you may have. If you lose your ID card, contact the appropriate provider.

Providers can check eligibility and provide services if you give them your unique identification number. To protect your identity, providers no longer use Social Security numbers.

If you lose or misplace your **medical/hospital** identification card, please contact Highmark Blue Shield's customer service telephone number at 1-866-727-4935.

If you lose or misplace your **dental** identification card, please contact a United Concordia Companies, Inc. (UCCI) customer service representative at 1-800-332-0366.

If you lose or misplace your **vision** identification card, please contact Davis Vision at 1-888-235-3251.

If you lose or misplace your **prescription** identification card, please contact Express Scripts, Inc. (ESI) at 1-800-467-2006.

Continuation of Coverage - COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires the commonwealth to extend temporary health care coverage to certain categories of employees and their covered dependents when they are no longer eligible for group coverage. You and your dependents will be eligible for continued coverage identical to your current program. You will, however, be required to pay the applicable premium plus a minimal administrative fee.

The following events allow you and your dependents 18 months of extended coverage:

- termination, except for gross misconduct; or
- reduction of hours that results in the loss of eligibility for health care benefits.

Note: A qualified beneficiary determined to be disabled for Social Security benefits at the time of the qualifying event or within 60 days thereafter, may be entitled to 29 months of coverage from the date of the original qualifying event.

The following events allow your dependents 36 months of extended coverage:

- your death;
- legal separation or divorce (Pennsylvania does not recognize legal separation);
- you become entitled to Medicare; or
- your dependent children are no longer eligible under the current program.

In the case of a divorce, legal separation (Pennsylvania does not recognize legal separation), or a child's loss of eligibility as a dependent under this program, you are responsible to notify the HR Service Center within 60 days of the date of the event. The commonwealth has the responsibility to notify the benefit providers of your death, termination of employment or reduction in hours, or Medicare eligibility. Failure to notify the HR Service Center in a timely manner of any life status event changes for you or your dependents could result in COBRA coverage being unavailable.

If you voluntarily drop (terminate) a dependent from coverage as allowed by the eligibility rules, this dependent would not be eligible for COBRA. This is not considered a COBRA qualifying event.

When any of these events occur, you will be notified of how to continue coverage. Once you receive the information, if you choose to continue coverage, you must elect this coverage within 60 days from the date of termination or notification, whichever is later.

Continued coverage may be discontinued for any of the following reasons:

- Failure to pay the premiums in a timely manner;
- After the COBRA election, coverage is obtained through another group plan (may not be applicable if new group plan includes any exclusion or limitation relating to any pre-existing condition you may have);
- After the COBRA election, a covered individual becomes entitled to Medicare; or
- The commonwealth discontinues all group health care plans.

If you do not elect to continue coverage through the State Police Health Benefits Program, you still will have the opportunity to convert to a direct payment health care program.

Benefits After Termination of Coverage

If you are totally disabled on the date your coverage under this program terminates, benefits will be continued for covered services which are directly related to the condition causing the total disability as follows, whichever occurs first:

- up to a maximum of 12 consecutive months;
- until the maximum amount of benefits has been paid;
- until the total disability ends; or
- until you become covered under another group program for the condition for which you are receiving care.

If you are an inpatient on the date your coverage terminates, inpatient benefits will end on your coverage termination date. Your benefits will not be continued if your coverage is terminated because you failed to pay any required premium.

Conversion – (Direct Payment of Premiums)

If your coverage through the State Police Health Benefits Program is discontinued for any reason, except as specified below, you and your eligible dependents may convert to a direct payment program offered by Highmark Blue Shield. Also, conversion is available to anyone who has elected COBRA continuation coverage when that coverage expires. You and/or your dependents are responsible for payment of the premium. The conversion coverage may be different from the coverage under the State Police Health Benefits Program. The conversion opportunity is not available if either of the following applies:

- you are eligible for another group health care benefits program through your place of employment; or
- when the State Police Health Benefits Program is terminated and replaced by another health care benefits program.

Certificates of Creditable Coverage

Highmark Blue Shield is required to issue a certificate to you if you change jobs or lose your health coverage. This Certificate of Creditable Coverage provides evidence of your prior coverage. Certificates will be mailed automatically to everyone who changes or loses their health coverage. You also can request a certificate from your previous employer or insurance company.

How Medicare Affects Your Benefits

An enlisted member can qualify for Medicare based on either his or her prior employment or if he or she was hired on or after April 21, 1986. A dependent can qualify for Medicare either based on the member's eligibility or his or her own employment.

Enlisted members hired on or after April 21, 1986 should enroll in Medicare Parts A and B once they become eligible for such coverage either because of age (currently 65) or as a result of disability. To sign up for Medicare coverage, retired or disabled member should contact their local Social Security Office.

Medicare Part A is provided at no cost to eligible participants. Medicare Part A will be primary for hospital coverage with Highmark Blue Shield primary for medical/surgical coverage for a member or dependent with end stage renal disease. Social Security normally bills for the Medicare Part B premium on a quarterly basis. The commonwealth will reimburse members hired on or after April 21, 1986 and their eligible covered dependents for the cost for the Medicare Part B premium on a quarterly basis. Medicare Part B will be primary for medical/surgical with the State Police Health Benefits Program as secondary.

In all other instances, Medicare will be secondary to the State Police Health Benefits Program's medical benefits offered through Highmark Blue Shield for active enlisted members and their dependents who are eligible for, and enrolled in, Medicare coverage.

If for some reason, a retired or disabled member is notified that they are not eligible for Medicare or if there is a cost associated with Medicare Part A, then the retired and disabled member's existing medical coverage through Highmark Blue Shield will continue.

II. GENERAL INFORMATION

Restitution

If you or your covered dependent(s) receives benefits when you or they are not eligible, the member is required to refund the commonwealth the amount of the overpayment. The policy and procedures are included in Management Directive 315.8 amended, Restitution of Overpayments. Examples include:

- Delays in reporting a dependent who has lost eligibility. The dependent has claims during that time.
- Payments made for services rendered at a time when you or a dependent are ineligible for benefits under the State Police Health Benefits Program.

Highmark Blue Shield Coverage Overview

When you carry a Highmark Blue Shield card, your coverage goes with you at home and abroad. You can receive inpatient health care from local Blue Cross Blue Shield Plan hospitals and doctors and pay nothing more than the out-of-pocket expenses you would have paid at home.

BlueCard® Program

When a member obtains covered services through BlueCard outside the geographic area Highmark serves, the amount a member pays for covered services is calculated on the **lower** of:

- The billed charges for a member's covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan (Host Blue) passes on to the Plan.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price an amount expected from settlements, withholds, any other contingent payment arrangements and non-claims transactions with a member's health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with a member's health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over or underestimation of past prices. However, the amount a member pays is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating member liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate member liability calculation methods that differ from the usual BlueCard method noted above in this section or require a surcharge, Highmark Blue Shield would then calculate a member's liability for any covered services in accordance with the applicable state statute in effect at the time a member received care.

BlueCard Worldwide® Program

Your coverage also travels abroad. The Blue Shield symbol on your ID card is recognized around the world. That is important protection. PPOBlue provides all of the services of the BlueCard Worldwide Program. These services include access to a worldwide network of health care providers. Medical Assistance services are included as well. You can access these services by calling 1-800-810-BLUE or by logging onto www.bcbs.com.

Services may include:

- making referrals and appointments for you with nearby physicians and hospitals;
- verbal translation from a multilingual service representative;
- providing assistance if special medical help is needed;
- making arrangements for medical evacuation services;
- processing inpatient hospitalization claims; and
- for outpatient or professional services received abroad, you should pay the provider, then complete an international claim form and send it to the BlueCard Worldwide Service Center. Claim forms can be obtained by calling 1-800-810-BLUE or the Member Service telephone number on your ID card. Claim forms can also be downloaded from www.bcbs.com.

Claim Review Procedure

If, under the medical program, you have a claim denied, you may request, in writing, a full review of that denial to the local Plan. The written request must be made within 60 days following receipt of a notice of denial and must include the member's name and Highmark Blue Shield's agreement number. You, upon request to Highmark Blue Shield, may, at reasonable times, review documents in the possession of Highmark Blue Shield and submit written comments pertinent to your claim. Highmark Blue Shield will complete review of the claim within 60 days of receipt of request for review unless special circumstances require an extension of time. Upon completion of the review by Highmark Blue Shield, you will be advised, in writing, of the final outcome of the claim.

Coordination of Benefits

Most health care programs contain a coordination of benefits provision. This provision is used when you, your spouse or your covered dependents are eligible for payment under more than one health program. The object of coordination of benefits is to assure you that your covered expenses will be paid, while preventing duplicate benefit payments. When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your program. When the person who received care is covered as an employee under one contract, and as a dependent under another, then the employee coverage pays first. When a dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the

calendar year pays first. But, if both parents have the same birthday, the program which covered the parent longer will be the primary program. If the dependent child's parents are separated or divorced, the following applies:

- if the parent with custody of the child has *not* remarried, the coverage of the parent with custody pays first;
- when a divorced parent with custody has remarried, the coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody;
- regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

When none of the above circumstances applies, the coverage you have had for the longest time pays first, provided that:

- the benefits of a program covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a program covering the person as a laid-off or retired employee or as a dependent of such person; and
- if the other program does not have a provision regarding laid-off or retired employees, and, as a result, the benefits of each program are determined after the other, then the provisions listed above shall not apply.

If you receive more than you should have when your benefits are coordinated, you will be expected to repay any overpayment. Coordination of benefits prevents duplication and works to the advantage of all covered persons of the group.

Group Contracts and Plan Administrator

While this handbook describes the principal features of the Highmark Blue Shield Plan and other benefits, it is not to be considered the contract of benefits and provisions. The complete terms of coverage are set forth in the group contract issued by Highmark Blue Shield and other carriers. If there is a conflict between the wording of this handbook and a group contract, the applicable group contract will govern.

Your State Police Health Benefits Program coverage is administered according to contracts between the commonwealth and Highmark Blue Shield and other applicable carriers. The Plan Administrator is the Office of Administration, Commonwealth of Pennsylvania.

You may want to see the complete contracts or other original materials about the plan. The Commonwealth will make copies of this information available for your inspection in the office of Group Insurance Division, Office of Administration in Harrisburg between 8:30 a.m. and 5 p.m. on all working days.

If you want a copy of any document, you may write to the Group Insurance Division for the material. A charge of 25 cents per page is required for copying the material. Checks should be made payable to the Commonwealth of Pennsylvania and be sent along with a written request for the information to:

Office of Administration
Bureau of Employee Benefits and Services
Group Insurance Division
513 Finance Building
Harrisburg, PA 17120

Medical Necessity and Appropriateness

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

Relationship to Blue Cross and Blue Shield Plans

Your health care benefit program is between the group, on behalf of itself and its members, and Highmark Blue Shield. Highmark Blue Shield is an independent corporation operating under a license from the Blue Cross Blue Shield Association ("the Association"), which is a national association of independent Blue Cross Blue Shield Plans throughout the United States. Although all of these independent Blue Cross Blue Shield Plans operate from a license with the Association, each of them is a separate and distinct corporation. The Association allows Highmark Blue Shield to use the familiar Blue Shield words and symbol. Highmark Blue Shield shall be liable to the group, on behalf of itself and its employees for any of the Plan's obligations under your health care benefit program.

Workers' Compensation

Any claims incurred as a result of your work-related injury or disease are the sole responsibility of Workers' Compensation. Such claims must be denied by the individual's Workers' Compensation plan prior to their submission to Highmark Blue Shield and the other health plans for consideration. Claims for employed dependents should be submitted to their Workers' Compensation plan.

Subrogation

Subrogation means that if you or your dependents incur health care expenses for injuries due to an accident caused by another person, the person causing the accident is responsible for paying those expenses. Subrogation is a provision used to prevent duplicate payments. If you or one of your dependents receives Blue Shield benefits for injuries caused by another person, Blue Shield has the right, through subrogation, to seek repayment from the other person or his/her insurance company for benefits already paid. Examples are duplicate amounts you or your dependents receive through a lawsuit, a settlement or from any third party or his or her insurer. You and your dependents have the legal obligation to help the Blue Shield Plan in all possible ways when they try to recover the amount they paid. Blue Shield will provide eligible benefits when needed, but you or your dependents may be asked to show documents or take other necessary actions to support Blue Shield in its subrogation efforts. Subrogation does not apply to an individual policy you or your dependents may have purchased or if specifically prohibited by law.

Motor Vehicle Insurance

If you or your dependents are injured as a result of a motor vehicle accident in Pennsylvania, you should contact your motor vehicle insurance carrier for information regarding submission of a claim for medical benefits. Medical benefits payable under your motor vehicle insurance policy, including self-insurance, will not be paid by the State Police Health Benefits Program. A letter from the insurance company noting that benefits have been exhausted must accompany claims for any additional charges.

Within the Commonwealth of Pennsylvania, bills for medical services required as a result of a motor vehicle accident may not be billed at a rate greater than 100% of the Medicare Allowance. If you are billed an amount in excess of the Medicare Allowance, you should contact your motor vehicle insurance company. If you or your dependent fail to obtain primary automobile insurance as required by Pennsylvania law, the first $5,000 of claims resulting from an automobile accident are excluded from Highmark Blue Shield coverage.

Member Services

Whether it's for help with a claim or a question about your benefits, you can call Highmark's toll-free Member Service number 1-866-727-4935, which is located on the back of your ID card, or log onto Highmark Blue Shield's Web site, **www.highmarkblueshield.com**. A Highmark Blue Shield Member Service representative can also help you with any coverage inquiry. Representatives are trained to answer your questions quickly and accurately.

Blues On Call℠

Blues On Call, your health information and support service, provides you with up-to-date, easy to understand information about medical conditions and treatment options.

A Health Coach is available at the toll-free telephone number, 1-888-BLUE-428, 24 hours a day, 7 days a week to help you make informed health care decisions, optimize your self-care capabilities, and follow your prescribed treatment plans. Blues On Call offers three levels of health coaching and support:

- Information and support regarding medical procedures and treatment decisions following a doctor's visit, plus access to audiotapes on hundreds of health-related topics
- Support for making medical and surgical decisions that reflect personal preferences, information regarding treatment options, and ongoing support and follow-up throughout treatment, plus links to health information sources
- Condition management for those at risk for hospitalization, including needs assessments, information on effectively managing a chronic condition, and referrals to appropriate resources

Personal Health Care Assistance
A Health Coach (registered nurse) is available 24 hours a day, 7 days a week for a confidential discussion on any health care topic. Examples of topics you can discuss with the Health Coach include:

- Your doctor has recommended a certain medical test and you'd like more information about it;
- You or a family member has been diagnosed with a particular illness and you want to know what to expect;
- Your doctor suggests surgery for low back pain, but you want information about possible alternatives.

These are examples only. You can phone Blues On Call whenever you would want to discuss any health care problem or issue, in confidence, with a nurse.

Immediate Health Care Assessment
You can also phone Blues On Call about an immediate illness or injury. When you do so, the Health Coach can perform a comprehensive health care assessment to help you determine your next step.

Educational Audiotapes & Videotapes
Information and preparation are the key to taking an active role in the medical and surgical decisions that affect you. Blues On Call can help you with both.

- For specific medical information, you can access audiotapes on more than 400 health care topics ranging from acne to weight management. These tapes contain the most up-to-date information available and are reviewed for accuracy by a panel of care professionals.
- For more in-depth, comprehensive information on a health care problem facing you, the Blues On Call Health Coach may send you a videotape and accompanying brochure. Video topics include: low back pain; heart disease; breast cancer; prostate cancer; prostate enlargement; benign uterine conditions; hormone replacement therapy; and high blood pressure.

Chronic Care Support
Should you have a chronic medical condition such as asthma, arthritis, Chronic Obstructive Pulmonary Disease (COPD), diabetes, depression, or heart disease, your Blues On Call Health Coach may provide you with valuable information to help you reduce your medical risks and manage your illness more effectively. Improving your health habits helps you take charge of your life and can make a real difference in the way you feel.

Highmark Blue Shield's Web site
Visit **www.highmarkblueshield.com** for a wide range of health-related information, interactive tools and services.

As a Highmark Blue Shield member, at My Shield Online, your personal Web page, you have access to health and wellness information, user-friendly services related to your health care coverage and valuable tools for managing your own health and well-being. Simply go to **www.highmarkblueshield.com**, and log onto My Shield Online where you can:

- ***Utilize Online Self-Service Capabilities***
  Access a variety of services related to your Highmark Blue Shield coverage—find a physician, review claim status, or order an ID card or claim form. Have questions for Member Service? Send a secure message—just use your My Shield Online Message Center to send the message and check for a response from Member Service.

- ***Access Health and Wellness Content and Tools***
  Customize your content to include the latest in breaking health news, diet and exercise tips, or articles specific to your health-related interests. Access valuable online health resources: you can contact a Blues On Call Health Coach, or look up any medical topic in the Healthwise Knowledgebase® and the Illustrated Health Encyclopedia, two comprehensive health information resources.

Find out just what to expect from a surgery or procedure in the illustrated *Surgeries and Procedures Guide*, or track the progress of a pregnancy in our Pregnancy Center. You can also complete the Personal Wellness Profile, which helps you identify your personal health risks and set goals to improve your wellness. Stay on the track to wellness with our interactive calculators, including body mass index, ideal weight, and nutritional needs.

III. GLOSSARY OF TERMS

To help you understand your coverage, here is an explanation of some terms found in this handbook and a description of how your benefits work. For specific amounts, refer to your Summary of Benefits Chart.

Benefit Period - The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by the Plan. A charge shall be considered incurred on the date a member receives the service or supply for which the charge is made.

Claims Filing - In most instances, hospitals and physicians will submit a claim on your behalf directly to the health plan. If your claim is not submitted directly by the provider, you must submit itemized bills along with a claim form. Claim forms can be obtained from the HR Service Center or directly from the health plan. Please follow the instructions on the claim form so that your claim will not be delayed. You must submit the claim within one year from the date of service. If additional information is required, the health plan may request additional data from you or the provider. When benefits cannot be provided under the State Police Health Benefits Program, you will be notified by the health plan that the claim has been denied with an explanation of the reason(s) for the denial.

Not all non-participating providers will file a claim for you. When you receive services from a non-participating provider, you are responsible for paying the provider and for submitting claim forms to the health plan if the provider does not. You will then be paid the allowance for the covered service (subject to the Plan deductibles and coinsurance).

Classic Blue Members: Only one claim has to be submitted to Highmark Blue Shield for consideration under your basic program and Major Medical.

Covered Service – Service or charge that is allowed under the Plan, which is Medically Necessary and which is rendered by an eligible provider or supplier.

Copayment - The fixed dollar amount you pay for eligible services to the provider at the time of service. Copayments do not apply toward the deductible or out-of-pocket limits. This amount will be deducted from the allowable charge before a determination of benefits payable is made by Highmark Blue Shield.

Deductible - The specified dollar amount you must pay each year before the Plan begins to pay all or part of the remaining covered expenses. To help employees with several covered dependents, the deductible you pay for the entire family, regardless of its size, is specified under "family" deductible. To reach the “family” deductible, you can count the expenses incurred by three or more family members. However, the deductible contributed toward the total by any one family member cannot be more than the amount of the individual deductible. If one family member meets the individual deductible and again needs to use benefits, the program would begin to pay for that person's covered services even if the deductible for the entire family has not been met.

Expenses for covered services incurred during the last three months of a benefit period will be credited toward the out-of-network deductible required in the following benefit period.

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

Coinsurance - The specific percentage of the provider's reasonable charge you must pay for certain eligible expenses after your deductible, if applicable, has been met.

Cost-Sharing Provisions – Major Medical - If you could not meet your deductible during a preceding calendar year, then any covered medical expenses incurred during the last three months of the calendar year which were applied to all or part of the deductible for that year, may be carried over and applied against the deductible owed for the next calendar year.

Maximum - The greatest quantity or amount payable by the Plan for covered services within a prescribed period of time. The Maximum may be expressed in dollars, number of days or number of services, for a specified period of time.

Lifetime Maximum - The maximum benefit that the program will provide for any covered individual during his or her lifetime. At the start of each benefit period, the amount paid for covered services in the preceding benefit period (up to $1,000) will be restored to the lifetime maximum of each person who used the benefits. The amount paid for covered services for any individual covered under this program will be added to any amount paid for benefits for that same individual under any other group health care expense plan between the group and Highmark Blue Shield, for the purpose of calculating the benefit period or lifetime maximum applicable to each individual.

Network Provider – Medical Providers, such as doctors and hospitals who have a contractual agreement with the health plans to provide medical service or mental health services to enrolled members.

Non-Participating Providers – Traditional ClassicBlue - Some providers do not have an agreement with Highmark Blue Shield and do not accept Highmark Blue Shield's allowance as payment in full.

Out-of-Network – Care provided by physicians or other medical professionals who have not contracted to provide services within the parameters established by the health plans.

You also are responsible for paying any difference between the provider's actual charge and the plan's allowed amount. When you receive care from an out-of-network provider, coverage is almost always paid at the lower level – *even if you were directed to the out-of-network provider by a network provider*. **That's why it is important, in all cases, to check to see that your provider is in the network before you receive care.**

Out-of-Pocket Limit - The specified dollar amount of coinsurance incurred for covered services in a benefit period. When the specified dollar amount is attained, Highmark Blue Shield begins to pay 100% of all covered expenses. The out-of-pocket limit does not include copayments, deductibles, prescription drug expenses or amounts in excess of the provider's reasonable charge.

Once an individual member of the family has incurred an amount equal to the individual out-of-pocket limit, the benefits payable for claims received by the Plan thereafter for that particular individual family member during the remainder of the benefit period will increase to 100% of the provider's reasonable charge.

If your group changes group health care expense coverage during your benefit period, the amount paid to you or on your behalf during the last partial benefit period for services covered under the prior Highmark Blue Shield coverage will be applied to the out-of-network out-of-pocket limit of the initial benefit period under this program.

Providers Reasonable Charge (Plan Allowance, or Maximum Allowable Charge) - The provider's reasonable charge is the amount agreed to by the health plans and the provider or an amount that the health plans determines is reasonable for covered services. In the case of participating providers, the provider's reasonable charge will be accepted as payment in full. You are responsible only for the cost sharing provisions such as deductible and coinsurance as described in this handbook. If you use non-participating providers, there is no agreement with the provider to accept the Plan allowance. You will be responsible to pay not only any deductible or coinsurance, but also the difference between the non-participating provider's actual charge and the health plan's allowance.

Participating Providers – Traditional ClassicBlue - Medical Providers, such as doctors and hospitals who have a contractual agreement with Highmark Blue Shield to provide medical service or mental health services to enrolled members.

IV. ELIGIBLE MEDICAL PROVIDERS

Eligible Providers

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

Facility Providers

- Ambulance service
- Ambulatory surgical facility
- Birthing facility
- Day/night psychiatric facility
- Freestanding dialysis facility
- Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility
- Home health care agency
- Home infusion therapy provider
- Hospice
- Hospital
- Outpatient substance abuse treatment facility
- Outpatient physical rehabilitation facility
- Outpatient psychiatric facility
- Pharmacy provider
- Psychiatric hospital
- Rehabilitation hospital
- Skilled nursing facility
- Substance abuse treatment facility

Professional Providers

- Audiologist
- Certified registered nurse*
- Chiropractor
- Clinical laboratory
- Dentist
- Licensed practical nurse
- Marriage and Family Therapist
- Nurse-midwife
- Occupational therapist**
- Optometrist
- Physical therapist
- Physician
- Podiatrist
- Professional Counselor
- Psychologist
- Registered nurse
- Respiratory therapist**
- Speech-language pathologist
- Teacher of hearing impaired

Contracting Suppliers (for the sale or lease of):

- Durable medical equipment
- Supplies
- Orthotics
- Prosthetics

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

***Covered services must be prescribed by a physician. Services of an occupational therapist and respiratory therapist are only reimbursable through a facility provider*

V. COVERED SERVICES

The State Police Health Benefits Program provides benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate. All benefit limits, deductibles and copayment amounts are described in the section "*Summary of Benefits.*"

Unless otherwise noted, the benefits are the same for members who are enrolled in either the Traditional ClassicBlue or PPOBlue plans.

Ambulance Services

Ambulance service providing local transportation by means of a specially designed and equipped vehicle, including air ambulance, used only to transport the sick and injured:

- From your home, the scene of an accident or medical emergency to a hospital;
- From skilled nursing facility to home;
- From hospital to home;
- Between hospitals; or
- Between a hospital and a skilled nursing facility; when such facility is the closest institution that can provide covered services appropriate for your condition. If there is no facility in the local area that can provide covered services appropriate for your condition, then you are covered for ambulance service to the closest facility outside your local area that can provide the necessary service.

Traditional ClassicBlue Members Only - Charges for advance life support may be submitted for consideration under Major Medical. Out-of-pocket expense for true emergency transports will be limited to cost sharing.

Autism Spectrum Disorder

Benefits are provided to members under 21 years of age for the following:

Diagnostic Assessment of Autism Spectrum Disorders

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

Treatment of Autism Spectrum Disorders

Services must be specified in a treatment plan developed by a physician or psychologist following a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. Highmark may review a treatment plan for autism spectrum disorders once every six months, or as agreed upon between Highmark Blue Shield and the physician or psychologist developing the treatment plan. Treatment may include the following medically necessary and appropriate services:

Psychiatric and psychological care
Direct or consultative services provided by a psychologist or by a physician who specializes in psychiatry.

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

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

Members are required to pay the regular co-payments/deductibles. There is no limit on the number of visits until the individual reaches the benefit period maximum of $36,000. ($36,000 maximum applies to all health plans; including Prescription, Dental, Vision and HRA)

Dental Services Related to Accidental Injury

Dental services rendered by a physician or dentist which are required as the result of accidental injury to the jaw, mouth or face that occur on or after your effective date. Injury caused by chewing or biting will not be considered accidental injury.

Diabetes Treatment

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

- **Equipment and Supplies**: Blood glucose monitors, monitor supplies, and insulin infusion devices; and
- **Outpatient Diabetes Education**: a program of self-management, training and education, including medical nutrition therapy, for the treatment of diabetes. Such program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education services will be covered subject to the criteria of the Plan. These criteria are based on the certification programs for outpatient diabetes education developed by the American Diabetes Association (ADA). When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through an outpatient diabetes education program:
  - visits medically necessary and appropriate upon the diagnosis of diabetes; and
  - subsequent visits under circumstances whereby your physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in self-management, or b) identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to the treatment and/or management of diabetes.

Diagnostic Services

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

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

Durable Medical Equipment

The rental (but not to exceed the total cost of purchase) or, at the option of the Plan, the purchase, adjustment, repair and replacement of durable medical equipment when prescribed by a professional provider, within the scope of their license and required for therapeutic use.

Emergency Accident Care

Medical care for the emergency treatment of traumatic bodily injuries resulting from an accident. Benefits are also provided for all follow-up care within 60 days. However, if the accident services are classified as surgery (e.g., suturing, fracture care, etc.) payment will be made as a surgical benefit.

Emergency Medical Care

Medical care for emergency treatment of a sudden onset of a medical condition manifesting itself by acute symptoms that require immediate attention.

Enteral Formulae

Enteral formulae is a liquid source of nutrition administered under the direction of a physician that may contain some or all of the nutrients necessary to meet minimum daily nutritional requirements and is administered into the gastrointestinal tract either orally or through a tube.

Coverage is provided for enteral formulae when administered on an outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders. Benefits for such enteral formulae are exempt from any applicable deductible requirements.

Home Health Care Services

Services rendered by a home health care agency or a hospital program for home health care for which benefits are available as follows:

- Skilled nursing services of an RN or LPN, excluding private duty nursing services;
- Physical medicine, occupational therapy and speech therapy;
- Medical and surgical supplies provided by the home health care agency or hospital program for home health care;
- Oxygen and its administration;
- Medical social service consultations; and
- Health aide services to an individual who is receiving covered nursing or therapy and rehabilitation services.

No home health care benefits will be provided for:

- Dietitian services;
- Homemaker services;
- Maintenance therapy;
- Dialysis treatment;
- Custodial care; and
- Food or home-delivered meals.

You must be essentially confined at home and home health care services must be rendered for treatment of the same illness or injury for which you received inpatient care.

Home Infusion Therapy Services

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

Hospice Care Services

Hospice care services will be provided to members with a life expectancy of 180 days or less, as certified by a physician. Services rendered by a home health care agency or a hospital program for hospice care for which benefits are available are as follows:

- Skilled nursing services of an RN or LPN, excluding private duty nursing services;
- Physical medicine, occupational therapy and speech therapy;
- Medical and surgical supplies provided by the home health care agency or hospital program for hospice care;
- Oxygen and its administration;
- Medical social service consultations;
- Health aide services to a member who is receiving covered nursing or therapy and rehabilitation services;

- Respite care, up to 240 hours in your home or up to a maximum of 10 days in an Inpatient Facility Provider; and
- Family counseling related to the member's terminal condition.

No hospice care benefits will be provided for:

- Dietitian services;
- Homemaker services;
- Maintenance therapy;
- Dialysis treatment;
- Custodial care; and
- Food or home delivered meals.

Hospital Services

This program covers the following services you receive in a hospital or other facility provider. Benefits will be covered only when, and so long as, they are determined to be medically necessary and appropriate for the proper treatment of the patient's condition. If you use an out-of-network professional provider and an inpatient hospital admission is required, you must contact HMS prior to your admission.

Bed and Board

Bed, board and general nursing services in a facility provider when the member occupies:

- a room with two or more beds; or
- a private room, when medically necessary and appropriate (For Traditional ClassicBlue Members - An additional $10 toward the cost of a private room may be submitted to Major Medical for consideration when a private room is not covered at 100 percent); or
- a bed in a special care unit -- a designated unit which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients.

Ancillary Services

Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms and equipment;
- drugs and medicines provided to you while you are an inpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives;
- anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the hospital or other facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a

- professional provider other than the surgeon or assistant at surgery; medical and surgical dressings, supplies, casts and splints;
- diagnostic services;
- therapy and rehabilitation services.

Inpatient Hospitalization Dental Benefits

Inpatient Facility Provider benefits under the program are available if you are admitted for:

- dental or oral surgery necessary for the treatment of fractures and/or dislocations of the jaw;
- the extraction of impacted teeth; or
- other dental processes provided the admission is required to safeguard the health of the patient from the effect of the dentistry because of specific nondental organic impairment.

Surgery

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

Pre-Admission Testing

Tests and studies required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient. Pre-admission testing must be conducted within 7 days prior to your hospital admission.

Emergency Care Services

You are covered at the network level of benefits for emergency care received from a participating or non-participating provider. This flexibility helps accommodate your needs when you need care immediately. Your outpatient emergency room visits may be subject to a copayment, which is waived if you are admitted as an inpatient.

Please keep in mind, however, if your care is determined not to be emergency in nature and you receive care at an out-of-network hospital, you may be subject to deductible and coinsurance amounts, resulting in your benefits being paid at the lower out-of-network level.

You should use emergency services only when appropriate. In some situations, such as strains or sprains, fevers and sore throats, it may make sense to contact a network doctor. Doing this puts you in touch with the person who truly knows your health history. It can save you hours of waiting in a crowded emergency room where more critical injuries are being treated.

In true emergency situations where you must be treated immediately, go directly to your nearest hospital emergency provider; or call "911" or your area's emergency number. Once the crisis has passed, call your physician to receive appropriate follow-up care.

Emergency Accident Care
Hospital services and supplies for the outpatient emergency treatment of traumatic bodily injuries resulting from an accident. Must commence within 72 hours of an accidental injury and include all follow-up care.

Emergency Medical Care
Hospital services and supplies for the outpatient emergency treatment of a sudden onset of a medical condition manifesting itself by acute symptoms that require immediate medical attention. Must commence within 72 hours of the onset of the medical emergency.

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

Invisible Providers
When in the hospital, there are situations when the member doesn't have the ability to select a network provider. When this occurs and certain specialty services are rendered by a non-participating provider, the patient is insulated from the cost-sharing features (deductible and coinsurance) normally applied to services provided by a non-participating provider. Invisible provider services are payable at the network allowance, even though they are performed by an out-of-network provider. The normal cost sharing (deductible and coinsurance) associated with using a non-participating provider is waived. The services that qualify for "invisible provider" consideration are:

- Diagnostic Pathology and Laboratory (lab) Tests
- Anesthesia
- Diagnostic X-ray and Radiology Services

Maternity Services
If you think you are pregnant, you may contact your physician or go to an obstetrician or nurse midwife. When your pregnancy is confirmed, you may continue to receive follow-up care which includes prenatal visits, delivery, postpartum and newborn care in the hospital that is covered at the higher level of benefits. This program provides services for:

Normal Pregnancy

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

Complications of Pregnancy

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

Interruptions of Pregnancy

Interruptions of pregnancy are covered under this program when they meet one of the following conditions: the services are provided to treat a miscarriage or the services constitute an abortion, subject to the limitations below.

No coverage is provided for abortions unless one of the following three conditions is met:

- the abortion is necessary to avert the death of the patient;
- the abortion is performed in the case of pregnancy caused by rape; or
- the abortion is performed in the case of pregnancy caused by incest.

Although maternity services are not provided to accomplish an elective abortion not meeting one of the criteria specified above, maternity services are covered to treat illness or injury resulting from elective abortion.

Nursery care

Ordinary nursery care of the newborn infant, including inpatient medical visits by a professional provider.

Maternity Home Health Care Visit

You are covered for one (1) maternity home health care visit provided at your home within forty-eight (48) hours of discharge when the discharge from a facility provider occurs prior to: (a) forty-eight (48) hours of inpatient care following a normal vaginal delivery, or (b) ninety-six (96) hours of inpatient care following a cesarean delivery. This visit shall be made by a provider whose scope of practice includes postpartum care. The visit includes parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests, and the performance of any necessary maternal and neonatal physical assessments. The visit may, at your sole discretion, occur at the office of your provider. The visit is subject to all the terms of this program and is exempt from any copayment, coinsurance or deductible amounts.

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

PPOBlue members must use network providers to receive the highest level of benefits.

Dependent Coverage
Maternity benefits, except for complications of pregnancy, are not provided for an eligible dependent who is the child of an eligible person (a dependent daughter).

Medical Services

Inpatient Medical Services
This program covers the following services you receive from a professional provider when you are an inpatient for a condition not related to surgery, pregnancy or mental illness:

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

Consultation

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

Intensive Medical Care

Constant attendance and treatment by a professional provider when your condition requires it for a prolonged period of time.

Routine Newborn Care

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

Traditional ClassicBlue Members Only - Inpatient medical care is renewed when 90 days have elapsed between discharge from and subsequent admission to a hospital or skilled nursing facility.

Outpatient Medical Care Services (Physician Visits)
This program covers the following outpatient services:

- Medical care rendered to you by a professional provider for a condition not related to surgery, pregnancy or mental illness, except as specifically provided herein; and

- Medical care visits and consultations to examine, diagnose and treat an injury or illness; and
- Therapeutic injections.

Outpatient Medical Care Services for Disabled Member and Consultations (Office Visits)

Traditional ClassicBlue Members Only

Medical care and consultations rendered by a professional provider for the examination, diagnosis and treatment of an injury or illness to an enlisted State Police member who is an outpatient for a condition not related to surgery, pregnancy or mental illness, except as specifically provided. This benefit covers outpatient medical and psychiatric visits performed and billed for by a professional provider and covered for the disabled enlisted State Police member only (no dependents).

There is a maximum of 21 visits for all such illnesses incurred during a 12-month period beginning July 1. You are liable for a $25 deductible beginning with the first visit during the 12-month period. The $25 deductible is eligible under Major Medical. This benefit is limited to enlisted State Police members who are totally (but not necessarily permanently) disabled from gainful employment due to this illness.

Mental Health Care Services

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

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

Inpatient Facility Services

Covered inpatient hospital services provided by a hospital or other facility provider.

Inpatient Medical Services

Covered inpatient medical services provided by a professional provider.

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

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

Outpatient Mental Health Care Services
Inpatient facility service and inpatient medical benefits (except room and board) provided by a facility provider or professional provider as described above are also available when you are an outpatient.

Serious Mental Illness Care Services
Coverage is provided for inpatient care and outpatient care for the treatment of serious mental illness. A serious mental illness service provided on a partial hospitalization basis will be deemed to be an outpatient care visit subject to any outpatient care cost-sharing amounts.

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

Traditional ClassicBlue Members Only - Replacements are covered only in the case of dependent children and only when Highmark Blue Shield determines that such replacement is medically necessary and appropriate.

Preventive Care Services
Adult Care – PPOBlue Only

Adult care includes routine physical examinations, regardless of medical necessity and appropriateness, including a complete medical history limited to covered persons eighteen (18) and older in accordance with a predefined schedule based on age and sex.

Allergy Extract / Injections

Benefits are provided for allergy extract and allergy injections.

Adult Immunizations – PPOBlue Only
Benefits are provided for immunizations for covered persons eighteen (18) years of age and older in accordance with a predefined schedule based on age.

Routine Gynecological Examination and Pap Test
Benefits are provided for one routine gynecological examination, including a pelvic examination and clinical breast examination and one routine Papanicolaou smear per calendar year for all female members. Benefits are exempt from all deductibles or maximums. There is no limit on pap smears that are medically necessary for the diagnosis of a disease or injury.

Benefits are payable only if performed by a provider who is properly certified.

Mammographic Screening

Benefits will be provided for:

- An annual routine mammographic screening for all female members 40 years of age or older; and
- Mammographic examination for all female members regardless of age when prescribed by a physician.

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

Colorectal Cancer Screenings

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

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

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

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

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

Benefits for these services are subject to the applicable co-payments/deductibles.

Pediatric Care

Pediatric care includes routine physical examinations, regardless of medical necessity and appropriateness in accordance with a predefined schedule based on age and sex.

Pediatric Immunizations
Benefits are provided for those pediatric immunizations, including the immunizing agents, which, as determined by the Pennsylvania Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, and the U.S. Department of Health and Human Services. The Immunization Schedule is reviewed and updated periodically by Highmark Blue Shield based on the advice of the American Academy of Pediatrics, U.S. Preventive Service Task Force, the Blue Cross and Blue Shield Association, and the medical consultants. Accordingly, the frequency and eligibility of services is subject to change. Benefits are limited to members under age 21 and are not subject to program deductibles or maximums.

Private Duty Nursing Services

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

- For a member who is an inpatient in a hospital or other facility provider only when Highmark determines that the nursing services required are of a nature or degree of complexity or quantity that could not be provided by the regular nursing staff.
- For a member at home, only when Highmark Blue Shield determines that the nursing services require the skills of an RN or of a LPN.

Prosthetic Appliances

Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies that:

- Replace all or part of a missing body organ and its adjoining tissues; or
- Replace all or part of the function of a permanently inoperative or malfunctioning body organ
- Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof, are also covered.

Dental appliances and the replacement of cataract lenses are not covered.

Skilled Nursing Facility Services

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

No benefits are payable:

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

Traditional ClassicBlue Members Only - Two days of skilled nursing facility care are available for each unused day of the hospital benefit period.

Spinal Manipulations

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

Substance Abuse Services

Benefits are provided for individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance abuse and include the following:

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

For purposes of this benefit, a substance abuse service provided on a partial hospitalization basis shall be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.

When you are admitted to an out-of-network facility, you are responsible for notifying Highmark Blue Shield of your admission.

Surgical Services

This program covers the following services you receive from a professional provider. If an inpatient hospital admission is required, you must contact HMS prior to your admission.

Anesthesia

Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or the assistant at surgery.

Benefits will also be provided for the administration of anesthesia for oral surgical procedures in an outpatient setting when ordered and administered by the attending network professional provider.

Assistant at Surgery

Services of a physician who actively assists the operating surgeon in the performance of covered surgery. Benefits will be provided for an assistant at surgery only if an intern, resident or house staff member is not available.

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

Second Surgical Opinion

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

Keep in mind that:

- The second opinion must be from someone other than your first physician who recommended the elective surgery;
- Elective surgery means a covered surgery that may be deferred and is not an emergency;
- Use of a second surgical opinion is your option;
- If the first opinion for elective surgery and the second opinion conflict, then a third opinion and directly related diagnostic services are covered services; and
- If the consulting opinion is against elective surgery and you decide to have the elective surgery, the surgery is a covered service. In such instances, you will be eligible for a maximum of two such consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

You will be eligible for a maximum of two (2) such consultations involving the elective surgical procedure in question, but limited to one (1) consultation per consultant.

Sterilization

Sterilization and procedures to reverse sterilization regardless of medical necessity and appropriateness.

Oral surgery

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

- Extraction of impacted third molars when partially or totally covered by bone;
- Mandibular frenectomy;
- Accidental injury to the jaw or structures contiguous to the jaw;
- The correction of a non-dental physiological condition which has resulted in a severe functional impairment;
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth; and
- Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

Mastectomy and Breast Cancer Reconstruction

This program covers a mastectomy performed on an inpatient or outpatient basis for the following:

- Surgery to re-establish symmetry or alleviate functional impairment. This includes, but is not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy.
- The use of initial and subsequent prosthetic devices to replace the removed breast or portions thereof.
- Physical complications of all stages of mastectomy, including lymphedemas.

This program covers one (1) home health care visit within forty-eight (48) hours after discharge, as determined by your physician, if discharge occurred within forty-eight (48) hours after admission for a mastectomy.

Surgical Services

- Surgery performed by a professional provider. Separate payment will not be made for pre- and post-operative services.
- If more than one surgical procedure is performed by the same professional provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure; plus 50% of the amount that would have been payable for each of the additional procedures had those procedures been performed alone.

Therapy and Rehabilitation Services

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

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

Transplant Services

Subject to the provisions of this program, benefits will be provided for covered services furnished by a hospital which are directly and specifically related to transplantation of organs, bones or tissue.

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

- When both the recipient and the donor are covered persons, each is entitled to the benefits of the contract;
- When only the recipient is a member, both the donor and the recipient are entitled to the benefits of this program subject to the following additional limitations:
  - the donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, other Highmark coverage, or any government program; and
  - benefits provided to the donor will be charged against the recipient's coverage under this program;
- When only the donor is a member, the donor is entitled to the benefits of the contract, subject to the following additional limitations:
  - the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this program, and
  - no benefits will be provided to the non-member transplant recipient;
- If any organ, tissue or blood stem cell is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the covered recipient’s program limit.

VI. EXCLUSIONS

Your program will not provide benefits for services, supplies or charges:

- Which are not medically necessary or medically appropriate as determined by the Plan;
- Which are not prescribed by or performed by or upon the direction of a professional provider;
- Rendered by other than facility providers, professional providers or other professional providers or suppliers;
- Which are experimental/investigative in nature;
- Rendered prior to your effective date;
- Incurred after the date of termination of your coverage except as provided herein;
- For loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of an act of war whether declared or undeclared;
- For which you would have no legal obligation to pay;
- Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
- To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program and you elect this coverage as primary;
- For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease, or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation;
- To the extent benefits are provided to members of the armed forces or to patients in Veteran's Administration facilities for service-connected illness or injury, unless the member has a legal obligation to pay;
- For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act;
- For nicotine cessation support programs and/or classes;
- For methadone hydrochloride treatment for which no additional functional progress is expected to occur;

- Which are submitted by a certified registered nurse and another professional provider or other provider for the same services performed on the same date for the same patient;
- Rendered by a provider who is a member of the member's immediate family;
- Performed by a professional provider or other provider enrolled in an education or training program when such services are related to the education or training program;
- For ambulance services, except as provided herein;
- For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise provided herein. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; b) surgery to correct congenital birth defects; and c) surgery to correct a functional impairment which results from a covered disease or injury;
- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier-free" home modifications, whether or not specifically recommended by a professional provider or other professional provider;
- For inpatient admissions which are primarily for diagnostic studies;
- For inpatient admissions which are primarily for physical medicine services;
- For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care;
- For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate;
- Directly related to the care, filling, removal or replacement of teeth or the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates as provided herein;
- For oral Surgery procedures, except for the treatment of accidental injury to the jaw, mouth or face, except as provided herein;
- For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma;
- For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails

(except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes;

- For hearing aids, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;
- For any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery;
- Related to treatment provided specifically for the purpose of assisted fertilization; including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law;
- For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, (except for aphakic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury);
- For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services;
- For nutritional counseling, except as provided herein;
- For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate;
- For treatment of obesity, except for medical and surgical treatment of morbid obesity;
- For any food including, but not limited to, enteral formulae, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis. This does not include enteral formulae prescribed solely for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria;
- For preventive care services, wellness services or programs, except as provided herein or as mandated by law;
- For well-baby care visits, except as provided herein;
- For allergy testing, except as provided herein or as mandated by law;
- For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein or as mandated by law;
- For immunizations required for foreign travel;
- For the treatment of sexual dysfunction that is not related to organic disease or injury;

- For any care that is related to conditions such as hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation, but not including care related to autism spectrum disorders, which extends beyond traditional medical management or for inpatient confinement for environmental change. Care which extends beyond traditional medical management or for inpatient confinement for environmental change includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services provided for purposes of behavioral modification and/or training; d) services related to the treatment of learning disorders or learning disabilities; e) services provided primarily for social or environmental change or for respite care; f) developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the member has not yet attained; and g) services provided for which, based on medical standards, there is no established expectation of achieving measurable, sustainable improvement in a reasonable and predictable period of time;
- For any care that is related to autism spectrum disorders which extends beyond traditional medical management, except as otherwise provided herein. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing); except for specific evaluation purposes directly related to medical treatment; and c) services provided primarily for respite care.
- For any care, treatment, or service which has been disallowed under the provisions of Healthcare Management Services;
- For otherwise covered services ordered by a court or other tribunal as part of your or dependent's sentence;
- For any illness or injury suffered during your commission of a felony;
- For any other medical or dental service or treatment except as provided herein or as mandated by law.

VII. HEALTHCARE MANAGEMENT SERVICES

Healthcare Management Services

For your benefits to be paid under your program, services and supplies must be considered "**Medically Necessary and Appropriate**."

Healthcare Management Services (HMS), a division of Highmark Blue Shield, is responsible to help ensure that quality care is delivered to members within the proper setting, at the appropriate cost, and with the right outcome.

Medically Necessary and Appropriate

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

Experimental/Investigative

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

However, Highmark Blue Shield recognizes that situations may occur when you elect to pursue experimental/investigative treatment. If you are to receive a service that Highmark Blue Shield may consider to be experimental/investigative, you or the

hospital and/or professional provider may contact Highmark Blue Shield's Member Service to determine whether Highmark considers a service to be experimental/investigative.

Precertification

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

Precertification is required for the following inpatient services:

- Hospital admissions
- Rehabilitation admissions
- Alcohol abuse treatment
- Drug abuse treatment
- Psychiatric treatment
- Skilled nursing facility admissions

An HMS nurse will review your request for an inpatient admission to ensure it is:

- appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury;
- provided for your diagnosis or the direct care and treatment of your condition, illness, disease or injury;
- not primarily for the convenience of you, your physician, hospital or health care provider;
- in accordance with standards of good medical practice; and
- the most appropriate supply or level of service that can safely be provided to the member. When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered for your condition and you cannot receive safe or adequate care as an outpatient.

Network Care/Participating Provider

When you use a network provider for inpatient care, ***the provider will contact HMS*** for you to receive authorization for your care.

Out-of-Network Care/Non-Participating Provider

When you are admitted to an out-of-network facility provider for an inpatient admission, **you are responsible for contacting HMS** to determine whether your services are medically necessary and appropriate. Contact HMS prior to your admission to an out-of-network facility provider so that you know your financial responsibility. You should call 7 to 10 days prior to your planned admission. For emergency or maternity-related admissions, call HMS within 48 hours of the admission, or as soon as reasonably possible. You can contact HMS via the toll-free Member Service number on the back of your ID card.

If you do not call to certify your admission to an out-of-network facility, your care will be reviewed by HMS after services were received to determine if it was medically necessary and appropriate. **If the admission is determined not to be medically necessary and appropriate, you will be responsible for all costs not covered by your program.**

Remember:
Out-of-network providers are not obligated to contact HMS or to abide by any determination of medical necessity or appropriateness rendered by HMS. Therefore, should you receive services from an out-of-network provider which are not medically necessary and appropriate, you will be billed.

Continued Stay Review
While you or your covered dependent are in a facility as an inpatient, HMS will be in contact with facility personnel familiar with the case to make certain that continued hospitalization is appropriate. Determination of the need for continued inpatient coverage will be made in consultation with the patient's physician. Either HMS or the facility will notify the patient if the inpatient stay is determined to be no longer medically necessary and appropriate. If you or your covered dependent elect to remain in the facility after such notification, no further benefits will be provided for the remainder of the stay.

Decisions on Inpatient Admission Precertification and Other Pre-Service Claims
Requests for precertification of planned inpatient admissions are treated as "pre-service claims." HMS decides pre-service claims and will notify you in writing of its determination, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed 15 days from the date HMS received the claim. This 15-day period of time, however, may be extended one time by HMS for an additional 15 days provided HMS determines that the additional time is necessary due to matters outside its control and notifies you of the extension prior to the expiration of the initial 15-day pre-service claim determination period. If an extension of time is necessary because you have failed to submit information necessary for HMS to make a decision on your pre-service claim, the notice of extension sent to you by HMS will specifically describe the information that you must submit and will afford you at least 45 days in which to submit that information.

Decisions on Claims Involving Urgent Care
If your request for approval of an inpatient admission involves urgent care, HMS will make a decision on your request as soon as possible taking into account the medical urgency involved, not to exceed 72 hours following receipt of the claim. A request for precertification of an inpatient admission or other pre-service claim involves urgent care if the time it would ordinarily take HMS to make a decision on the pre-service claim could result in seriously jeopardizing the patient's life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of the patient's medical condition, subject the patient to severe pain that cannot be adequately managed without the care or treatment requested.

Notice of Determinations on Inpatient Admission Precertification and Other Pre-Service Claims

Any time your request for inpatient admission precertification or other pre-service claim is approved, you will be notified in writing that the claim has been approved.

Any time your request for precertification is denied, you will receive written notification of that denial which will include:

- The specific reason or reason(s) for the denial;
- Reference to the provision of your Highmark program upon which the decision was made;
- A description of any additional information necessary to complete or perfect your claim and why such information is necessary;
- A description of the review procedures and time limits applicable to those procedures and your right to initiate legal action;
- The internal rule, guideline, protocol or other similar criterion relied upon in deciding your claim or a statement of your right to request a copy of the same, free of charge; and
- An explanation of the scientific or clinical judgment used in deciding your claim in cases where medical necessity, experimental treatment or a similar exclusion or limit has been applied or a statement of your right to request a copy of the same, free of charge.

For a description of your right to appeal an adverse benefit determination of an inpatient admission precertification or any other pre-service claim, see the Appeal Procedure provision set forth in the **"*How to File a Claim*"** section of this benefit booklet.

Discharge Planning

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

In planning for discharge, HMS assesses the member's:

- Level of function pre- and post-admission;
- Ability to perform self-care;
- Primary caregiver and support system;
- Living arrangements pre- and post-admission;
- Special equipment, medication, and dietary needs and safety needs;

- Obstacles to care;
- Need for referral to case management or condition management;
- Availability of benefits or need for benefit adjustments; and
- Psychological needs.

Retrospective Review

Retrospective review occurs when a service or procedure has been rendered without the required authorization.

Disease State Management Program

Services are provided to assist you in self-management of certain health conditions such as, but not limited to, diabetes, congestive heart failure and chronic obstructive pulmonary disease. Such services may include:

- An evaluation of your physical and psychosocial status;
- The development of an individualized treatment plan by a nurse in conjunction with your physician;
- Education and training on topics such as symptom monitoring, medication dosages and compliance, appropriate diet and nutrition, smoking cessation and exercise; and
- Ongoing monitoring and treatment modifications, if necessary.

Case Management Services

Should you or a covered family member experience a serious injury or illness, the Case Management Program may be able to provide assistance.

If accepted into the program, and with the member's permission, the program will:

- Work collaboratively with the member, family or significant others, and all providers to coordinate and implement a plan of care which meets the member's holistic needs;
- Identify community-based support and educational services to assist with the member's ongoing health care needs; and
- Assist in the coordination of benefits and alternative resources.

Appeal Procedure

You are entitled to have any complaint or dispute related to the delivery of services reviewed by Highmark Blue Shield. Highmark Blue Shield will coordinate the disposition of complaints and disputes on your behalf.

You are responsible for contacting Highmark Blue Shield. Depending on the reason for the inquiry, the complaint or dispute will either be reviewed and resolved by the Highmark Blue Shield's Member Service Department or transferred to the appropriate area for review and resolution. In the event that Highmark Blue Shield has determined that you are not eligible for full benefits, your appeal must be submitted not later than 60 days from the date that Highmark Blue Shield notified

you of its initial determination. The appeal should include all specific information which is to be considered in support of the claim. Highmark Blue Shield will review the information and will notify you of the resolution within 30 days of the initial inquiry. If additional time is needed for a decision, you will be notified of the reason for the delay.

VIII. PPOBLUE

Under the PPO plan, most covered services by a network provider are reimbursed at a higher level of payment than services by non-network providers.

BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Benefit Period	Contract Year (or Plan Year) - 7/1 through 6/30.	
Deductible *Per Benefit Period (3 per family)*	None	$250 Individual $750 Family Aggregate
Payment Level *Based on Provider's Reasonable Charge (PRC)*	100% PRC	80% PRC after deductible until out-of-pocket limit is met; then 100% PRC
Out-of-Pocket Limit *Includes Coinsurance*	Not Applicable	$1,500 Individual $3,000 Family Aggregate
Lifetime Maximum	Unlimited	$1,000,000/person
Ambulance *ALS and BLS Transports*	100% PRC	80% PRC no deductible Emergency transports payable at 100% PRC
Assisted Fertilization Procedures	Not Covered	Not Covered
Autism Spectrum Disorders maximum (per member) **	$36,000 maximum per benefit period	
Applied Behavior Analysis for Autism Spectrum Disorders (ASD) **	100% PRC after deductible	80% PRC after deductible
Dental Services Related to an Accidental Injury	100% PRC	80% PRC after deductible
Diabetes Treatment	100% PRC	80% PRC after deductible
Diagnostic Services *(Lab, X-ray, and Medical Tests)*	100% PRC	80% PRC after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% PRC	80% PRC after deductible
Elective Abortion	100% PRC	80% PRC after deductible
	Only when necessary to avert the death of the mother or in cases of rape or incest	
Emergency Room Services - *Facility Services*	100% PRC after $50 copayment – waived if admitted	
Enteral Formulae	100% PRC	80% PRC no deductible
Hearing Care Services	Not Covered	Not Covered
Home Health Care *Excludes Respite Care*	100% PRC	80% PRC after deductible
	Unlimited visits/benefit period	
Hospice *Includes Respite Care*	100% PRC	80% PRC after deductible
	Combined Limit: $12,500 lifetime maximum	
Hospital Expenses *Inpatient and Outpatient*	100% PRC	80% PRC after deductible
	Combined Limit: 365 days, 2 pint blood deductible/benefit period	

BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Counseling, Testing and Treatment	100% PRC	80% PRC after deductible
Maternity	100% PRC	80% PRC after deductible
	Includes Dependent Daughters only for complications of pregnancy	
Medical Care *Includes Inpatient Visits and Consultations*	100% PRC	80% PRC after deductible
Mental Health – Inpatient*	100% PRC	80% PRC after deductible
Mental Health – Outpatient*	100% PRC after $25 copayment	80% PRC after deductible
Office Visits *Primary Care Physicians* *Specialists*	100% PRC after $15 copayment 100% PRC after $25 copayment	80% PRC after deductible 80% PRC after deductible
Oral Surgery *(Dental Coverage is Primary)*	100% PRC	80% PRC after deductible
Physical Medicine Outpatient	100% PRC after $15 copayment	80% PRC after deductible
	Unlimited visits/benefit period	
Preventive Care *Adult Preventive Care Schedule includes:* *Routine Physical Exam* *Immunizations* *Routine Diagnostic Screening* *Screening, Mammography* *Routine Gynecological Exam & Pap Test*	 100% PRC after $15 copayment 100% PRC 100% PRC 100% PRC 100% PRC	 80% PRC after deductible 80% PRC after deductible 80% PRC after deductible 80% PRC after deductible 80% PRC no deductible/lifetime maximum
Pediatric Preventive Care Schedule includes: *Routine Physical Exams* *Pediatric Immunizations* *Routine Diagnostic Screening*	100% PRC after $15 copayment 100% PRC 100% PRC	80% PRC after deductible 80% PRC no deductible/lifetime maximum 80% PRC after deductible
Private Duty Nursing	100% PRC	80% PRC after deductible
	Unlimited hours/benefit period	
Skilled Nursing Facility Care	100% PRC	80% PRC after deductible
	Unlimited days/benefit period	
Speech & Occupational Therapy *Outpatient*	100% PRC after $15 copayment	80% PRC after deductible
	Unlimited visits/benefit period/per type of therapy	

BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Spinal Manipulations	100% PRC after $15 copayment	80% PRC after deductible
	Unlimited visits/benefit period	
Substance Abuse - Detoxification	100% PRC	80% PRC after deductible
Substance Abuse – Inpatient Rehabilitation	100% PRC	80% PRC after deductible
Substance Abuse - Outpatient	100% PRC after $25 copayment	80% PRC after deductible
Surgical Expenses *Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, & Neonatal Circumcision*	100% PRC	80% PRC after deductible
Therapy Services *Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiratory Therapy, Physical Therapy Occupational Therapy*	100% PRC	80% PRC after deductible
Transplant Services	100% PRC	80% PRC after deductible
Precertification Requirements for Inpatient Admissions – *No Penalty for Non-compliance*	Performed by Network Provider	Performed by Member
Condition Management	Case Management, Blues on Call, and Disease State Management	

* State mandated minimum benefits apply to a diagnosis of serious mental illness. Serious mental illnesses include: schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa and delusional disorder. (If the above grid does not show a limit, your mental health benefit days and visits are unlimited.)

** Coverage for eligible members to age 21. Services will be paid according to the benefit category, i.e., speech therapy. Treatment for autism spectrum disorders does not reduce visit/day limits.

IX. TRADITIONAL CLASSICBLUE

Under the Traditional benefits program, benefits include coverage for both facility and professional services. Most Major Medical benefits are subject to deductible and coinsurance provisions, which require you to share a portion of the medical costs. Below are specific benefit levels.

BENEFITS	FACILITY PROGRAM	PROFESSIONAL PROGRAM	MAJOR MEDICAL PROGRAM
Benefit Period	Calendar Year		
Deductible *Per Calendar Year (3 per family)*	None	None	$250 Individual $750 Family
Payment Level *Based on Provider's Reasonable Charge (PRC)*	100% PRC	100% PRC	80% PRC after deductible until out-of-pocket is met; then 100% PRC
Out-of-Pocket Limit *Includes Coinsurance - See "How Benefits Are Applied" section for exclusions/details*	None	None	$380 Individual after deductible
Lifetime Maximum	None	None	$1,000,000/person
Ambulance Service *ALS and BLS Transports*	100% PRC facility billed	Not Covered	80% of charge
Air Ambulance	100% PRC	Not Covered	100% PRC
Assisted Fertilization Procedures	Not Covered	Not Covered	Not Covered
Autism Spectrum Disorders maximum (per member) 5	$36,000 maximum per benefit period		
Applied Behavior Analysis for Autism Spectrum Disorders (ASD) 5	100% PRC	100% PRC	80% PRC after deductible

BENEFITS	FACILITY PROGRAM	PROFESSIONAL PROGRAM	MAJOR MEDICAL PROGRAM
Dental Services Related to an Accidental Injury	Not Covered	Not Covered	80% PRC after deductible
Diabetes Treatment	100% PRC	100% PRC	80% PRC after deductible
Diagnostic Services *Lab, X-ray and Medical Tests*	100% PRC	100% PRC	80% PRC after deductible
Durable Medical Equipment, Orthotics and Prosthetics	Not Covered	Not Covered	80% PRC after deductible
Elective Abortion	100% PRC	100% PRC	80% PRC after deductible
	Only when necessary to avert the death of the mother or in cases of rape or incest		
Emergency Room Services *Facility Services*	100% PRC	Not Applicable	80% PRC after deductible
Professional Services	Not Applicable	100% PRC	80% PRC after deductible
Enteral Formulae	Not Covered	Not Covered	80% PRC no deductible
Hearing Care Services	Not Covered	Not Covered	Not Covered
Home Health Care *Excludes Respite Care*	100% PRC	Not Covered	80% PRC after deductible
	60 visits/90-day period, total visits review when 90 consecutive days elapse without home health care		

BENEFITS	FACILITY PROGRAM	PROFESSIONAL PROGRAM	MAJOR MEDICAL PROGRAM
Hospice *Includes Respite Care*	100% PRC $12,500/lifetime	Not Covered	Not Covered
Hospital Expenses *Inpatient and Outpatient*	100% PRC	Not Covered *(See Medical Care)*	80% PRC after deductible
	2 pint blood deductible/benefit period		
Infertility Counseling, Testing and Treatment[1]	100% PRC	100% PRC *Excludes Office Visits*	80% PRC after deductible
Maternity	100% PRC	100% PRC	80% PRC after deductible
	Coverage for female members or a member's wife, dependent daughters are not covered except for complications of pregnancy. Abortions are not covered unless: abortions necessary to avert the death of the mother; abortions performed in the case of pregnancy caused by rape; or abortions performed in the case of pregnancy caused by incest.		
Medical Care *Includes Inpatient Visits and Consultations*	Not Covered *(See Hospital Expenses)*	100% PRC 365 days per admission. Inpatient days renew when 90 consecutive days with no benefit use elapse	80% PRC after deductible

BENEFITS	FACILITY PROGRAM	PROFESSIONAL PROGRAM	MAJOR MEDICAL PROGRAM
Mental Health - Inpatient[2 3]	100% PRC	100% PRC 365 days per admission. Inpatient days renew when 90 consecutive days with no benefit use elapse	80% PRC after deductible
Mental Health – Outpatient	Not Covered	Not Covered	80% PRC after deductible
Office Visits			
Physician Office Visits (includes all types of specialties, including family and internal medicine)	Not Covered	Not Covered	80% PRC after deductible
Disabled Member Medical Visit	Not Covered	100% PRC after $25 deductible per benefit period 21 visit maximum per benefit period	80% PRC after deductible

BENEFITS	FACILITY PROGRAM	PROFESSIONAL PROGRAM	MAJOR MEDICAL PROGRAM
Emergency Counseling Visits Office Visits	100% PRC for 12 visits from 07/01 through 06/30 visits over 12, covered under Major Medical at 80% PRC after deductible		80% PRC after deductible
Oral Surgery *Dental coverage is primary*	100% PRC	100% PRC	80% PRC after deductible
Physical Medicine *Outpatient*	100% PRC	100% PRC	100% PRC
Prescription Drugs *Drug coverage is primary*	Not Covered	Not Covered	80% PRC after deductible for drugs not covered by the drug card plan
Preventive Care *Adult Preventive Care includes:* *Routine Physical Exam*	Not Covered	Not Covered	Not Covered
Immunizations	Not Covered	Not Covered	Not Covered
Routine Diagnostic Screening	Not Covered	Not Covered	Not Covered
Gynecological Exam & Pap Test	100% PRC	100% PRC	80% PRC no deductible
Screening Mammography	100% PRC	100% PRC	80% PRC no deductible/lifetime maximum

BENEFITS	FACILITY PROGRAM	PROFESSIONAL PROGRAM	MAJOR MEDICAL PROGRAM
Pediatric Preventive Care includes: *Routine Physical Exam*	Not Covered	Not Covered	Not Covered
Pediatric Immunizations	100% PRC	100% PRC	80% PRC no deductible/lifetime maximum
Routine Diagnostic Screening	Not Covered	Not Covered	Not Covered
Private Duty Nursing	Not Covered	Not Covered	80% PRC after deductible
Skilled Nursing Facility Care	Not Covered	100% PRC Limited to 2 visits during the first week of confinement and 1 visit a week for each consecutive week of confinement thereafter. Two days of confinement count as 1 day against the benefit period of available inpatient medical care.	80% PRC after deductible
Speech and Occupational Therapy *Outpatient*	Not Covered	Not Covered	80% PRC after deductible
Spinal Manipulations	Not Covered	Not Covered	80% PRC after deductible
Substance Abuse – Detoxification	100% PRC	100% PRC	80% PRC after deductible
Substance Abuse - Inpatient Rehabilitation	100% PRC	100% PRC	80% PRC after deductible

BENEFITS	FACILITY PROGRAM	PROFESSIONAL PROGRAM	MAJOR MEDICAL PROGRAM
Substance Abuse – Outpatient	100% PRC	100% PRC	80% PRC after deductible
Surgical Expenses *Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures*	100% PRC	100% PRC	80% PRC after deductible
Therapy and Rehabilitation Services *Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiration Therapy*	100% PRC	100% PRC	80% PRC after deductible
Transplant Services	100% PRC	100% PRC	80% PRC after deductible
Preadmission Requirements for Inpatient Admissions *No Penalty for Non-compliance*	Performed by Participating Provider	Performed by Participating Provider	Performed by Participating Provider
Condition Management	Case Management, Blues On Call, and Disease State Management	Case Management, Blues On Call, and Disease State Management	Case Management, Blues On Call, and Disease State Management

[1] Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy is covered by your group's prescription drug program.

2 State mandated minimum benefits apply to a diagnosis of serious mental illness. Serious mental illnesses include: schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa and delusional disorder. (If the above grid does not show a limit, your mental health benefit days and visits are unlimited.)

3 To obtain inpatient mental health and substance abuse services at the maximum benefit level, you must contact Highmark Blue Shield's Mental Health & Substance Abuse unit before seeking treatment.

4 If Highmark Blue Shield is not contacted prior to a non-emergency inpatient admission and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the participating provider (or member if services were received from a non-participating provider) will be responsible for any costs not covered. In the event services are rendered by a non-participating provider, it is your responsibility to call HMS, see information on the back of your ID card.

5 Coverage for eligible members to age 21. Services will be paid according to the benefit category, i.e., speech therapy. Treatment for autism spectrum disorders does not reduce visit/day limits.

Reinstatement of Lifetime Maximum – Major Medical

The lifetime maximum amount for you or your dependents will be restored in full at any time a request for reinstatement is submitted to Blue Shield. Contact Highmark Blue Shield's Customer Service with your request.

EMERGENCY COUNSELING BENEFITS

Eligible Members

Active members and their eligible dependents who are enrolled in Traditional ClassicBlue.

Emergency Counseling Benefit

This benefit provides you and your eligible dependents with 12 medically necessary emergency mental health psychotherapy visits during the period July 1 through June 30. You or your dependents must utilize an eligible provider. Counseling services are eligible when provided by a licensed psychologist or psychiatrist. A listing of participating licensed psychologists and licensed psychiatrists can be found on Highmark Blue Shield's web site at www.highmarkblueshield.com

Your Costs

Eligible visits will be paid at 100% of the plan allowance when you use a participating provider for emergency counseling services. If you use a non-participating provider, the plan will pay 100% of PRC; but you will be responsible for any difference between the allowance and the provider's charge. Such difference is not eligible under Major Medical. If your participating provider should bill you for an additional amount, contact Highmark Blue Shield for assistance. Any additional visits beyond the 12 visits payable, will be eligible under Major Medical, subject to any deductible and coinsurance amounts required by the plan. Please refer to the Major Medical Services section for further reference.

Exclusions

The following items are not covered under the Emergency Counseling benefit:

- Charges incurred after twelve (12) psychotherapy visits per each member and each eligible dependent during the period July 1 – June 30;
- Charges for psychiatric evaluation services;
- Charges for any visit that is determined not to be medically necessary;
- Services which are provided under Workers' Compensation.

Filing an Emergency Counseling Claim

Present your Highmark Blue Shield medical ID card at the time Emergency Counseling services are provided. Participating providers will submit claims directly to Highmark Blue Shield and will receive reimbursement directly. You will receive an Explanation of Benefits (EOB) form indicating the status of the claim.

Claims Filing

In most instances, hospitals and physicians will submit a claim on your behalf directly to your Blue Shield Plan. If your claim is not submitted directly by the provider, you must submit itemized bills along with a claim form. Claim forms can be obtained from Highmark Blue Shield. Please follow the instructions on the claim form so that your claim will not be delayed. You must submit the claim within one year from the date of service. Highmark Blue Shield will process your claim within 90 days of receipt, unless special circumstances require an extension of time. If additional information is required, Highmark Blue Shield may request additional data from you or the provider. When benefits cannot be provided under this health care program, you will be notified by Highmark Blue Shield that the claim has been denied with an explanation of the reasons for the denial.

Medical Necessity

You and your eligible dependents are entitled to receive benefits under the Emergency Counseling benefit only when the services are medically necessary. Highmark Blue Shield will determine whether the services are medically necessary to achieve the level of care required by your condition. Highmark Blue Shield is entitled to receive and review any records from your provider in order to determine benefits. Participating providers are required to provide Highmark Blue Shield with the records. Such information will be kept confidential.

X. PRESCRIPTION DRUG PLAN

Prescription Drug Coverage

Your prescription drug benefit provides you and your eligible dependents with several options for payment of your prescription drugs. You may use your ID cards at any Express Scripts, Inc. (ESI) participating retail pharmacy; you may use the mail order drug option; or you may pay for the prescription and submit a direct reimbursement form to ESI for repayment. If you have any questions on your prescription drug benefit you can contact ESI at 1-800-467-2006 or at www.express-scripts.com.

Your prescription drug plan covers:

1. Medically necessary prescription drugs and authorized refills which by state or federal law can be prescribed only by a Doctor or appropriately licensed nurse which are dispensed by a licensed pharmacy;
2. Insulin, when prescribed on a provider's prescription form;
3. Oral contraceptives;
4. Compounded prescriptions;
5. Medications for weight reduction (with prior authorization);
6. Allergy extracts and antigens where the fee for the serum can be separated from the injection fee; and
7. Drugs prescribed to treat a member's work-related injury or disease that was a direct result of Pennsylvania State Police employment.

Prescription Coverage - Effective July 1, 2007

A three-tier system will be used. The plan will include a list of generic and brand-name drugs called a formulary. Drugs included on that list are called "preferred." Drugs not on that list are called "non-preferred."

The following copayments are effective July 1, 2007.

Prescriptions at a Participating Pharmacy- Up to a 30 day supply	**Your Copayment**
Generic Drug	$5.00
Preferred Brand-Name Drug	$10.00
Non-Preferred Brand-Name Drug	$15.00

Mail Order – up to a 6 month (180 day) supply	**Your Copayment**
Generic Drug	$10.00
Preferred Brand-Name Drug	$20.00
Non-Preferred Brand-Name Drug	$30.00

Drug Quantity Limits

Your plan uses a Drug Quantity Management program. That is, for certain medications, you can receive an amount to last you for a certain number of days. That amount is the daily dose that is considered safe and effective according to the recommendations of the U.S. Food and Drug Administration (FDA).

Limitations

1. When you obtain prescriptions from a pharmacy and use your ID card or Prescription Drug Claim Forms, the Plan will pay for each covered prescription or authorized refill up to a 30-day supply. (Federal and state law may require additional limits.)
2. When you obtain prescriptions through the mail order drug option, the Plan will pay for each covered prescription or authorized refill up to a six-month supply.
3. When you obtain contraceptives prescribed by your Doctor from a pharmacy and use your ID card or Prescription Drug Claim Forms, the Plan will pay for a one-month supply of medication. When you obtain oral contraceptives prescribed by your Doctor through the mail order drug option, the Plan will pay for up to a six-month supply of medication.

Exclusions

Payment will not be made for the following:

1. Drugs and medications which can be purchased without a Doctor's prescription even though the Doctor may recommend their use on his or her prescription form. These are usually called "over-the-counter drugs" and include such items as ibuprofen, antacids, antihistamines, and nonprescription vitamins;
2. Non-drug items such as hypodermic syringes and needles, contraceptive devices, crutches, and braces;
3. Drugs administered in a hospital or a Doctor's office, and allergy extracts and antigens where only one amount is reported for both the serum and the injection fee;
4. Blood and blood plasma;
5. Immunizing agents;
6. Experimental drugs and drugs limited by federal law to investigational use;
7. Sexual dysfunction (MSD) drugs;
8. Drugs used for cosmetic purposes, such as hair growth or treatment of wrinkles, or for other uses that are not medically necessary;
9. Drugs prescribed for spouses or dependents to treat an injury or disease covered by Workers' Compensation, or prescribed for a covered person to treat a work-related injury or disease incurred through employment outside of the Pennsylvania State Police; and
10. Drugs which are needed as a result of a motor vehicle accident when such drugs are payable under any motor vehicle insurance, including a certified self-insured plan.

FILING A PRESCRIPTION DRUG CLAIM

Retail Pharmacy

If you use an ESI participating retail pharmacy, the pharmacy will submit the claim to ESI and payment will be issued directly to the pharmacy.

Mail-Order Pharmacy

The mail-order option allows you to obtain up to a 180 day supply of long-term medications. To use the mail-order option, simply complete a mail-order envelope, which is available from ESI, enclose your prescription(s), and enclose the applicable copayment for each prescription plus the cost difference between the brand name and generic drug if one exists. If you have a question on the cost of the medication and how much to enclose, you can contact the Mail-Order Pharmacy at 1-800-223-8975. Your prescription drugs will be delivered by U.S. Mail or UPS within five business days from receipt at the pharmacy. You also will receive another mail-order envelope with your medication. If your drugs do not arrive within five days, contact the Mail-Order Pharmacy at 1-800-223-8975.

CuraScript

CuraScript is a full service specialty mail order pharmacy administered by ESI. CuraScript is offered to members on a voluntary basis. Members are permitted to obtain specialty medications at a retail pharmacy, but all mail order speciality prescriptions will be filled by CuraScripts. Members will be permitted to receive up to a 180 day supply for the applicable copayment of $10.00 for Generic; $20.00 for Preferred Brand Name, and $30.00 for Non-Preferred Brand Name.

A specialty pharmacy provides injectable, oral and infused medications. These complex and costly medications usually require special storage and handling and may not be readily available at the local drug store. Members are appointed a patient care coordinator who will work on their individual needs; verify benefit coverage, assist with letters of medical necessity and coordinate delivery of medications to their home or to their doctor's office. All needed supplies are included with your prescription shipment, such as needles and syringes.

Using A Prescription Claim Form

If you do not have an ID card with you, if you use a non-participating pharmacy, or if your student has not been certified, you must pay for the prescription(s) at the pharmacy. Obtain a Prescription Claim Form for each prescription from www.expressscripts.com. Complete and sign the cardholder portion of the form. Attach an original prescription receipt and mail the form if the receipt includes all of the following information: pharmacy name and address, date of purchase, name of medication, quantity, Rx number and price. Mail the completed form to the preprinted address on the back of the form. Payment will be made directly to you for the amount that the Commonwealth of Pennsylvania would have paid a participating pharmacy, minus the applicable per prescription copayment. **NOTE: That amount will almost always be less than the pharmacy charged you, since the prescription plan obtains prescriptions at a discounted cost from pharmacies' normal charges. To avoid the higher out-of-pocket costs, you should always use your ID card at a participating pharmacy.**

ALL CLAIMS MUST BE SUBMITTED WITHIN ONE YEAR OF THE DATE OF SERVICE.

Reimbursement for Allergy Injections

Allergy medication claims must be submitted on an Allergenic Extract Prescription Claim Form along with an original doctor's receipt showing the purchase price of the allergy serum. Prescription Claim Forms are available from www.expressscripts.com. The completed forms should be mailed to the preprinted address on the back of the form. Payment will be made directly to you minus the applicable per claim copayment.

ALL CLAIMS MUST BE SUBMITTED WITHIN ONE YEAR OF THE DATE OF SERVICE.

Denied Claims

If your claim is denied at the pharmacy, the pharmacist should be able to tell you why the claim was denied. You may also call ESI to discuss the reason for a rejection by a pharmacy. If your Prescription Claim Form is rejected, if you are billed for drug claims and you do not understand the reason, or if you are not satisfied with ESI's explanation of a claim denial, contact ESI. They will assist you in resolving problems with denied claims, and they will contact the appropriate parties.

If ESI states that the rejection or billing was correct, you may question the decision. The billing notice you receive for ineligible drug claims will tell you where to send your questions.

Utilization Review

ESI is required to closely monitor prescription drug plan eligibility and usage. This includes identifying and investigating all claims that exceed normal usage parameters. **Upon review, if it is determined that you or any of your dependents have abused this benefit, the Commonwealth of Pennsylvania will require restitution for inappropriately paid claims and may restrict benefit eligibility.**

Acceptance and use of your prescription drug ID cards authorizes release of all information concerning your prescriptions to ESI. Acceptance and use of the cards also authorizes ESI to contact pharmacies and physicians regarding possible abuse of prescriptions purchased by the plan, and to notify the Commonwealth of Pennsylvania of cases of abuse of the prescription plan.

Please understand that the majority of covered persons will not be affected by this policy, which is needed to curtail the few instances of plan abuse.

For more information please visit www.express-scripts.com

XI. DENTAL PLAN

Dental Benefits

The State Police Health Benefits Program's dental benefits ("Plan") provide you and your eligible dependents with dental care. These benefits are administered by United Concordia Companies, Inc. (UCCI). If you have questions regarding your dental coverage, contact a UCCI Customer Service Representative at 1-800-332-0366. You can also use UCCI's Internet site, www.ucci.com, to locate participating providers with the Concordia Advantage Network.

Predetermination

UCCI uses Predetermination to review the treatment plan to determine the extent of coverage prior to the treatment. This assures both you and your dentist that the particular service that will be performed is a covered service. It also allows you to plan for any additional expenses that you might have to pay for. Finally, it allows UCCI to review proposed services relative to propriety and quality.

UCCI's approval of the treatment plan through predetermination does not mean that the Plan will pay for the services involved in the treatment plan. For example, if your coverage is terminated before the planned treatment is completed, the Plan will usually not be liable for any services provided after the termination of coverage for those services.

Predetermination is required in the following circumstances:

- All treatment plans of $150 or more;
- The extraction of six or more teeth;
- Prosthetics and crown, inlay and onlay restorations;
- Periodontics; and
- Orthodontics.

Your Costs

Payment for services performed by a participating dentist will be made to the dentist on the basis of the Maximum Allowable Charge ("MAC") Schedule set forth below. When the schedule indicates 100% for reimbursement, the dentist will accept the Plan's payment as payment in full, and you will not have any additional costs.

Payment for services performed by a non-participating dentist will be made to you on the basis of the MAC Schedule (as stated in the benefit lists which follow) or the amount charged, whichever is less. You must pay any remaining charges. Since a non-participating dentist's total charge may exceed 100 percent of the MAC allowance, you can save money by using participating dentists.

Basic Program

This is the foundation of your dental coverage. It meets basic needs before they become major problems. It includes diagnostic, preventive, and basic restorative services which are all essential to good dental health.

Routine oral examinations and prophylaxis (including cleaning, scaling, and polishing of teeth), but not more than once in any period of six consecutive months.	100 percent MAC
Bitewing x rays.	100 percent MAC
Periapical x rays.	100 percent MAC
Full mouth x rays, but not more than once in any period of 36 consecutive months.	100 percent MAC
Topical application of fluoride for dependent children under 19 years of age, but not more than once in any period of six consecutive months.	100 percent MAC
Space maintainers (not made of precious metals) that replace prematurely lost teeth for dependent children under 19 years of age. **No payment will be made for duplicate space maintainers.**	100 percent MAC
Repair of broken partial or full removable dentures.	100 percent MAC
Palliative emergency treatment for an acute condition requiring immediate care.	100 percent MAC
Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth. **Gold foil restorations are not eligible.**	100 percent MAC
Simple extractions.	100 percent MAC
Endodontics, including pulpotomy and root canal treatment.	100 percent MAC
Anesthesia services performed by (or under the direct supervision of) and billed for by a dentist other than the operating dentist or his or her assistant in connection with the performance of covered services. Anesthesia services consist of the administration of an anesthetic agent or drug by injection, inhalation or oral means, the purpose of which is to reduce the level of consciousness. The administration of local or block anesthesia is not covered.	100 percent MAC
Consultations, limited to one consultation per consultant during any period of hospitalization.	100 percent MAC

Oral Surgery

The following oral surgical procedures are covered:

Surgical removal of teeth.	100 percent MAC
Surgical removal of maxillary or mandibular intrabony cysts.	100 percent MAC
Procedures performed for the preparation of the mouth for dentures.	100 percent MAC
Apicoectomy (dental root resection).	100 percent MAC

Prosthetics And Crown, Inlay, and Onlay Restorations

Dental services dealing with the restoration and replacement of teeth are included under this coverage. Such treatment helps restore normal functions and prevents the shifting of teeth and other complications from arising. The following services are covered:

Crowns, inlays and onlays. Payment will be made for crown, inlay, and onlay restorations only if the tooth cannot be restored with another material, such as amalgam. However, if the tooth can be restored with another material, payment of the applicable percentage of the MAC allowance for that procedure will be made toward the charge for the restoration selected by you and your dentist. You must pay the balance of the treatment charge.	100 percent MAC
Replacement of crowns, inlays, and onlays will be covered services only if at least five years have elapsed since the date of the insertion of the existing crown, inlay, or onlay, and only if the existing crown, inlay, or onlay is unserviceable and cannot be made serviceable.	100 percent MAC
Initial insertion of bridges (including pontics and abutments).	100 percent MAC
Initial insertion of partial or full dentures (including any adjustments during the six-month period following insertion).	100 percent MAC
Replacement of an existing partial or full denture or bridge by a new denture or by a new bridge, but only if satisfactory evidence is presented that: • The existing denture or bridge was inserted at least five years prior to the replacement; and • The existing denture or bridge is not serviceable and cannot be made serviceable. If the existing denture or bridge can be made serviceable, payment will be made toward the cost of the services which are necessary to render such appliance serviceable.	100 percent MAC
The addition of teeth to an existing partial denture or to a bridge, but only if satisfactory evidence is presented that the addition of teeth is required to replace one or more teeth extracted after the existing denture or bridge was inserted.	100 percent MAC

Relining or rebasing of dentures more than 6 months after the insertion of an initial or replacement denture, but not more than one relining or rebasing in any period of 36 months.	100 percent MAC
Repair of broken crowns, inlays, onlays, or bridges.	100 percent MAC

Exclusions And Limitations On Prosthetics And Crown, Inlay, And Onlay Restorations

1. No payment will be made until services are completed. Crowns, inlays, onlays, bridges, and dentures will be considered completed on the date they are fully inserted.
2. No payment will be made for any crown, inlay, or onlay restoration or for any dentures or bridge and the fitting thereof which was prescribed while the covered person was not covered under this Plan; or for which the restorative treatment was initiated while the covered person was covered under this Plan and which is finally inserted more than 30 days after termination of coverage.
3. If the covered person and dentist decide on personalized prosthetics or crown, inlay and onlay restorations, or specialized techniques as opposed to standard procedures, payment of the applicable percentage of the MAC allowance for the standard service will be made toward such treatment, and you must pay the balance of the cost.
4. If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the MAC allowance for such procedure will be made toward a more elaborate or precision attachment denture or bridge that the covered person and dentist may choose to use, and you must pay the balance of the cost.
5. No payment will be made for precious metal dentures. Payment of the applicable percentage of the MAC allowance for a nonprecious metal denture will be made toward the charge for the precious metal denture selected by the covered person and dentist. You must pay the balance of the cost.
6. No payment will be made for any duplicate or temporary denture or bridge or any other temporary or duplicate appliance.
7. Any denture or bridge replacement made necessary by reason of loss or theft or covered person alteration of a denture or bridge will not be considered a covered service.
8. No payment will be made for veneers or similar properties of crown restorations or of bridges placed on or replaced teeth other than the ten upper and ten lower anterior teeth.

Periodontal Services

The following services are covered:

Diagnosis and treatment planning, including periodontal examinations.	100 percent MAC
Nonsurgical periodontal therapy, including periodontal scaling and root planning and special periodontal applications.	100 percent MAC
Surgical periodontal therapy.	100 percent MAC
Maintenance post-treatment, preventive periodontal procedures (periodontal prophylaxis) subject to the limitations as specified.	100 percent MAC

Exclusions And Limitations On Periodontal Services

Payment will be limited to four periodontal prophylaxis per 12-month period per covered person, and includes any routine prophylaxis received during that 12-month period. The total number of prophylaxis for a given 12-month period, including both routine and periodontal prophylaxis will not exceed four.

Orthodontics (Dependent Children Only)

Most bite problems are not corrected because of the generally high cost. Yet neglect often leads to tooth decay, gum disease, and deformities of the jaw and face and, in addition, speech and nutritional difficulties. The following services are covered for treatment of handicapping malocclusion and its consequences through the correction of misplaced teeth:

Diagnosis, including radiographs.	70 percent MAC
Active treatments, including necessary appliances.	70 percent MAC
Retention treatment following active treatment.	70 percent MAC

There is an orthodontic *lifetime* maximum of $1,250 for each of your dependent children under age 19.

Exclusions And Limitations On Orthodontics

1. The lifetime maximum amount payable for any eligible dependent child is $1,250. Not withstanding any other provision of this program, benefits for orthodontic services are limited to dependent children under 19, and will terminate at the end of the month in which the child reaches age 19. This program does not provide benefits for full-time students over age 19, or for the employee or spouse.
2. The Plan will make payments over the period of the approved treatment plan. Payments will be made no more frequently than once every three months. The initial payment will be 25 percent (or less) of the Plan's total liability. The remaining 75 percent of the Plan's liability will be payable in equal quarterly amounts during the period covered by the approved treatment plan and while the covered person's coverage is in effect. If the treatment plan is satisfactorily completed in less time than specified in the approved treatment plan, UCCI will, upon appropriate notification from the dentist, make payment on behalf of the Plan in the amount of the remainder of the Plan's liability.
3. If, for any reason, the orthodontic services are terminated before completion of the approved orthodontic treatment, the Plan's responsibility will end with payment through the month of termination.
4. For the purpose of determining benefits available for treatment in progress at the beginning or termination of a covered person's coverage under this plan, all orthodontic services will be deemed to have been provided on the date performed and payment will be limited in accordance with the Plan's formula.
5. A dentist must submit a treatment plan to UCCI with the diagnosis indicating that the orthodontic condition consists of handicapping malocclusion that is abnormal and is correctable.

6. UCCI reserves the right to review the covered person's dental records, including necessary study models and radiographs, to determine whether orthodontic needs and treatment are eligible under this Plan.
7. Any charges for the replacement and/or repair of any appliance furnished under the treatment plan or for any duplicate device or appliance will not be paid by UCCI on behalf of the Plan.
8. Functional/Myofunctional therapy is covered only when provided by a dentist in conjunction with appliance therapy.

General Limitations

Payment for services will be limited as follows:

1. In the event a covered person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist performs services for one dental procedure, the Plan will pay only up to the amount it would have paid had but one dentist performed the services.
2. In all cases involving covered services in which the dentist and covered person select a more expensive form of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, the Plan will pay only the charge allowed for the less expensive procedure.
3. A contract between covered person and dentist, prior to the effective date of coverage under this contract, is not invalidated by a subsequent contract made between UCCI for Plan benefits and/or covered person and/or dentist. The covered person will be liable for any difference due to the dentist under such a contract after the Plan's liability has been satisfied.
4. Any additional treatment that is needed due to lack of covered person cooperation with the dentist or noncompliance with prescribed dental care, and that results in additional expenses, will be the responsibility of the covered person.

Medical Necessity

You and your eligible dependents are entitled to receive benefits under the dental plan only when the services are medically necessary. UCCI will determine whether the services are medically necessary to achieve the level of care required by your condition.

UCCI is entitled to receive and review any records from your provider in order to determine benefits. Participating providers are required to provide UCCI with the records. Such information will be kept confidential.

General Exclusions

Payment will not be made for the following:

- Services which are not prescribed by or performed by or under the direct supervision of a licensed dentist;
- Services which are not medically or dentally necessary as determined by the Plan;
- Services which are experimental or investigative in nature;
- Services for any illness or bodily injury which occur in the course of employment if benefits or compensation are available, in whole or in part, under the

provisions of any legislation of any governmental unit. This exclusion applies whether or not the covered person claims the benefits or compensation;
- Services to the extent benefits are provided by any governmental unit;
- Services for any illness or injury suffered after the covered person's effective date as a result of any act of war;
- Services for which a covered person would have no legal obligation to pay in the absence of this or any similar coverage;
- Services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
- Services performed prior to the effective date of the covered person's coverage;
- Charges incurred after the date of termination of the covered person's coverage unless otherwise indicated;
- Charges for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
- Services or supplies which are cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services or supplies which are not necessary according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist;
- Services which do not meet accepted standards of dental practice;
- Charges for duplicate and temporary devices, appliances, and services;
- Charges related to the diagnosis and treatment of temporomandibular joint dysfunctions;
- Charges for sealants;
- Charges for plaque control program and for oral hygiene and dietary instruction;
- Charges for implantology and related services;
- Charges for unusual procedures and techniques;
- Services for which the covered person incurs no charge;
- Charges which have been or are later recovered in any action at law or in compromise or settlement of any claim except where prohibited by law;
- Services in a facility performed by a professional provider who in any case is compensated by the facility for similar covered services performed for patients;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full-mouth rehabilitation, restoration of tooth structure lost from attrition, and restoration for malalignment of the teeth;
- Charges for local anesthesia when billed for separately by a dentist;
- Charges for gold foil restorations;
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insured plan;
- Services performed for a covered person by a spouse, parent, or child of that covered person;
- Charges for covered services which are submitted by a Certified Registered Nurse Anesthetist and another professional provider for the same covered services performed on the same date for the same patient; and
- Charges for services or supplies other than specifically provided in this handbook.

Filing a Dental Claim

Present your UCCI dental identification card at your dentist's office. Participating dentists will submit claims directly to UCCI and will receive reimbursement directly for covered claims. You will receive an Explanation of Benefits (EOB) form indicating the status of your claim. If you use a non-participating dentist, in most cases, the claim will be handled in the same way. However, if the non-participating dentist will not submit claims to UCCI; it is **your** responsibility to do so. Contact a UCCI Customer Service Representative at 1-800-332-0366 for assistance. Claim forms can be obtained at www.ucci.com.

ALL CLAIMS MUST BE SUBMITTED WITHIN ONE YEAR OF THE DATE OF SERVICE.

Denied Claims

If your dental claim is denied, you will receive a written notice explaining the reason for the denial. If the information received with the claim was incomplete, the notice will tell you what additional facts or materials are needed and why.

You may appeal a denial by sending a letter to UCCI stating why you think your claim should not have been denied along with any additional information you think might affect your claim. Your appeal must be made within 60 days after you have been notified of the denial. In preparing your appeal, you will have the right to examine documents relating to your appeal. However, UCCI cannot release medical information to you unless your dentist authorizes its release in writing. UCCI will review all of the facts on which the original decision was based and any additional information you have provided in your appeal. You will receive a final decision in writing within 60 days of the date your appeal was received. Where there are special circumstances requiring extensive review of technical records by medical specialists, a final decision may take longer than 60 days.

You may take your case to court if you do not agree with UCCI's decision.

XII. VISION PLAN

Pennsylvania State Police
Vision Plan
Administered by Davis Vision

Benefits	Participating	Non-Participating
Eye Examination and Refraction	**Covered in full**	**$45**
Eyeglass Frames	**$30**	**$30**
Eyeglass Lenses *per pair* *		
Single Vision	**$22**	**$22**
Bifocal	**$36**	**$36**
Trifocal	**$57**	**$57**
Aphakic/Lenticular	**$80**	**$80**
Contact Lenses *per pair*		
Cosmetic Lenses per pair *	**$52**	**$52**
Medically Necessary Lenses (prior approval required)**	**$150**	**$150**

Frequency:
Eye examination and refractions, eyeglass lenses and contact lenses are eligible once every 12 months for members under 19 years of age and once every 24 months for members 19 years of age and older. Frames are eligible once every 24 months for all members.

Payment will not be made for both eyeglass lenses and contact lenses within the same benefit period.

* The General Standards provision applies to contact lenses and lenses. Contact lenses and lenses are eligible only when one of the following conditions have been met. (1) There is a change of at least .50 diopter of sphere power in one eye. (2) There is a change of at least .50 diopter of sphere combined between the two eyes. (3) There is an increase in one line of snellen acuity (distance or reduced near) from the old Rx to the new Rx.

** Davis Vision defines medically necessary contact lenses as being required for conditions when visual acuity cannot be corrected to 20/70 in the better eye except by their use or when a serious condition necessitates their use. The provider makes the determination during the comprehensive eye examination. Examples of such conditions are keratoconus, significant amounts of anisometropia, aniseikonia, astigmatism due to irregular corneal curvature, certain corneal conditions and instances in which visual acuity is not correctable with conventional spectacles. Medically necessary contact lenses will be covered up to $150.00; however, prior approval is necessary.

How Your Benefits Are Applied

General Description

Who is eligible to render services under the Davis Vision program?

- A professional provider, who is a licensed doctor of medicine or osteopathic medicine, including a specialist in ophthalmology (Ophthalmologist), or a licensed doctor of optometry (Optometrist).
- Suppliers who are engaged in dispensing ophthalmic lenses, (e.g. contact lenses and/or eyeglass lenses) in accordance with a prescription written by a professional provider, which includes opticians and retail optical dispensing firms.

Covered persons can maximize their benefit by using a Davis Vision participating provider for vision care services. Participating providers have an agreement with the Plan pertaining to payment for covered services rendered to a covered person. You can contact Davis Vision at 1-888-235-3251 or www.davisvision.com if you have any questions on your vision benefits.

Payment for Professional Services

A participating professional provider must accept Davis Vision's allowance as payment in full for covered eye examination and refractive services.

Payment for covered eye examination and refractive services performed by a non-participating provider will not exceed $45.00. Such payment will constitute full discharge of Davis Vision's responsibility under the program. You are responsible for payment of the remaining charge.

Payment for Post-Refractive Services

Payment for covered lenses and frames and associated services will be made in accordance with the indemnity schedule allowance or the amount charged, whichever is less.

When covered services are provided by a participating professional provider, Davis Vision will make the payment to the professional provider. However, when the covered services are provided by a non-participating professional provider, the payment will be made to you. Such payment will constitute full discharge of Davis Vision's responsibility under the program.

Any difference between the charge and the Davis Vision allowance for post-refractive services will be your responsibility.

How Vision Benefits Are Obtained

Participating Provider

Present your Davis Vision identification card at the time services are provided by a participating provider. The provider will verify your eligibility with Davis Vision.

If you receive your professional services (eye examination and refractive services) from a participating provider, you will have your bill paid by the Program, since

participating providers agree to accept Davis Vision's allowance as payment in full. Payment for covered lenses and frames and associated services will be made in accordance with the indemnity schedule allowance or the amount charged, whichever is less. Any difference between the charge and the Davis Vision allowance for post-refractive services will be your responsibility. The participating provider will submit claim forms to Davis Vision on your behalf. When covered services are provided by a participating provider, Davis Vision will make the payment to the provider. However, when the covered services are provided by a non-participating provider, the payment will be made to you.

Non-Participating Provider

If you go to a non-participating provider, you must pay the doctor directly for all charges, or pay any portion of the bill not covered by Davis Vision. Non-participating providers are not required to submit claim forms to Davis Vision.

If you have to submit a claim yourself, you must do so within one year from the date of service. Request an itemized bill which shows:

(1) patient's name and address
(2) date of service
(3) type of service and diagnosis
(4) itemized charges
(5) professional provider's complete name and address

Then add the member's name, group and identification numbers (as shown on your identification card), and the patient's birthdate. If you need assistance, call Davis Vision at 1-888-235-3251. If you do not need assistance, please send your receipt to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

When services are performed by a non-participating professional provider, the payment is made directly to you.

Covered Vision Services

Eye Examination and Refractive Services

Eye examination and refractive services include, but are not limited to, the following:

- Case History – Chief Complaint, Eye and Vision History, Medical History
- Entrance Distance Acuities
- Internal Ocular Examination (Dilated Fundus Evaluation)
- External Ocular Evaluation Including Slit Lamp Examination
- Tonometry
- Distance Refraction – Objective and Subjective
- Binocular Coordination and Ocular Motility Evaluation
- Evaluation of Pupillary Function
- Biomicroscopy
- Gross Visual Fields
- Assessment and Plan
- Patient Education
- Form Completion – School, Motor Vehicle, etc.

Post-Refractive Services

Post-refractive services consist of:

- Ordering lenses and frames (facial measurements, lenticular formula, and other specifications)
- Verification of the completed prescription
- Adjustment of the completed glasses
- Subsequent servicing (refitting, realigning, readjusting, tightening) for a period not to exceed 90 days.
- Repair of lenses or frames (payment limited to the maximum allowances in this section)

Limitations

Payment for covered services will be limited in the following manner:

- Payment for an eye examination and refraction is limited to once every 12 months for covered persons under 19 years of age and once every 24 months for covered persons 19 years of age and older. Eligibility will be determined from the date of the last recorded eye examination and refraction in which payment was made by the Plan.

- Payment for lenses or contact lenses is limited to once every 12 months for covered persons under 19 years of age and once every 24 months for covered persons 19 years of age and older. Eligibility will be determined from the date of the last lens purchase paid by the Plan.

- Regardless of the age of the covered person, payment is limited to one set of frames in any 24-month period. Eligibility will be determined from the date of the last frames purchase paid by the Plan.

- Payment will not be made for both eyeglass lenses and contact lenses within a 12-month period for covered persons under 19 years of age and within a 24-month period for covered persons 19 years of age and older.

- In cases involving services in which the provider and covered person elect to utilize photogray or light sensitive lenses, the Program will provide benefits, but will not provide any additional allowance in excess of those delineated in the allowances schedule, provided the member qualifies for such benefits.

- Payment for frames, lenses and/or contact lenses, not supplied by a professional provider, will be made only if prescribed by a professional provider and in such case will be made to the member.

- Medically necessary contact lenses are defined as being required for conditions when visual acuity cannot be corrected to 20/70 in the better eye except by their use or when a serious condition necessitates their use. The provider makes the determination during the comprehensive eye examination. Examples of such conditions are keratoconus, significant amounts of anisometropia, aniseikonia, astigmatism due to irregular corneal curvature, certain corneal conditions and instances in which visual acuity is not correctable with conventional spectacles. Prior approval is necessary.

Vision Exclusions

Except as specifically provided in this booklet, you are not covered for services, supplies or charges that:

- are for the cost of any insurance premiums indemnifying against losses for lenses or frames;
- are for any illness or bodily injury which occurs in the course of employment if benefits or compensations are available, in whole or in part, under the provisions of any legislation of any governmental unit. This exclusion applies whether or not you claim the benefits or compensation;
- are provided by any governmental unit;
- you would have no legal obligation to pay in the absence of this or any similar coverage;
- are received from a medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
- are performed prior to the effective date;
- are incurred after the your termination date except for lenses and frames prescribed prior to such termination and delivered within 31 days from such date;
- are not billed by the professional provider;
- the cost of which has been or is later recovered in any action or law or in compromise or settlement of any claim except where prohibited by law;
- are performed by a professional provider who, in any case, is compensated by the facility for similar covered services performed for patients.

You are not covered for:

- procedures determined by Davis Vision to be special or unusual, such as, but not limited to, orthoptics, vision training, subnormal vision aids, and tonography;
- examinations and materials which are not listed herein as a covered service or item of supply;
- any lenses which do not require a prescription;
- replacement of lost, stolen, broken or damaged lenses, contact lenses or frames, unless the frequency limitations are met;
- sunglasses, whether or not requiring a prescription (tinted glasses with a tint other than Number 1 or Number 2 are considered to be sunglasses for the purpose of this exclusion), industrial safety glasses and safety goggles;
- medical or surgical treatment of the eye;
- diagnostic services, such as diagnostic X-rays, cardiographic, encephalographic examinations and pathological or laboratory tests;
- drugs or any other medications;
- eye examinations or materials necessitated by employment or furnished as a condition of employment;
- telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
- duplicate and temporary devices, appliances, and services;
- services for which the member incurs no charge;
- treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insured plan;
- any other service or treatment except as provided in this booklet;
- Services performed by a spouse, parent or child of the covered person or dependent.

Vision Claim Appeal Procedure

If your claim has been denied in whole or in part, you will be notified by Davis Vision. This rejection letter will set forth the specific reasons for such denial. You may request a fuller explanation of the rejection decision by calling 1-888-235-3251.

You may appeal a denial of benefits within 180 days of the date of the rejection by sending a letter stating why you think your claim should not have been denied, including a copy of the denial letter and any additional claim. Be sure to include in your letter your identification number, claim number, if any, your employer's name and the date of service for which benefits were denied.

Please send your appeal to:

Quality Assurance/Patient Advocate Department
Davis Vision
159 Express Street
Plainview, New York 11803

Upon receipt of your letter and any additional information you provide, your records will be reviewed; and the results of this review will be sent to you normally within 30 days. In unusual cases, as when review of your claim requires examination by qualified medical personnel, including consulting**,** the physicians review may take longer than 30 days.

XIII. HEALTH REIMBURSEMENT ARRANGEMENT

General Information

A Health Reimbursement Arrangement (HRA) is an IRS-approved, tax-favored benefit that reimburses you for certain health care expenses not covered or reimbursed by your health benefits. Typical expenses for which you can use your HRA funds include copayments, deductibles, prescription drugs, dental work, vision expenses such as eyeglasses or contact lenses, and over-the-counter medicines (with prescription).

Here's How It Works

1) The Commonwealth of Pennsylvania will contribute money to your HRA per the following schedule:

Date	Contribution Amount
January 1, 2009	$300.00
January 1, 2010	$300.00
January 1, 2011	$300.00
January 1, 2012	$300.00

2) If you incur eligible health care expenses and pay for them out-of-pocket from your personal bank account, save the documentation.
3) Submit a reimbursement claim for eligible health care expenses, including appropriate documentation showing that the item(s) or service(s) was a valid health care expense.
4) The administrator, WageWorks, will process your claim within a few business days and reimburse your out-of-pocket expenses from your HRA once the total amount you have submitted for reimbursement reaches a minimum of $25.
5) Unused money at the end of the year will carry over to the next year.
6) Upon termination of employment for reasons other than disciplinary discharge, former members may continue to submit claims until all unused balances in their HRA are used.

Note: The plan year runs from January 1 through December 31. You have until March 31st to submit claims from the previous plan year.

Accessing Your Account

You can view your personal account information by visiting www.WageWorks.com. You can also check the status of your claims, get additional claim forms and sign up for direct deposit online. You must first complete a registration to login to the site. Register using the last four of your SSN, which will be your WageWorks unique ID number.

For more information on your online account, please visit www.WageWorks.com and select QuickLinks on the left-hand side of the screen.

If you have further questions about your HRA, contact the HR Service Center.

Who is Covered

You can use the HRA to pay eligible health care expenses for yourself, your spouse and your eligible dependents, as long as the dependent was covered by your health and/or supplemental benefits at the time the claim was incurred.

Eligible Expenses

Eligible expenses include, but are not limited to, the following:

- Copayments, coinsurance and deductibles (but not premiums)
- Acupuncture
- Birth control pills
- Child birth classes
- Chiropractic visits
- Dental care
- Diabetic supplies
- Eye exams, glasses and contacts
- Hearing aids
- Laser eye surgery
- Orthodontia
- Over-the-counter drugs and medical supplies
- Physical therapy
- Prescription drugs
- Psychotherapy
- Smoking cessation programs
- Speech therapy
- Sterilization surgery
- Well-baby and well-child care

Ineligible Expenses

The following Over-the-counter items are not eligible for reimbursement under the HRA. These items are primarily for general health.

- Toothpaste, toothbrushes, dental floss
- Make-up, lipstick, eye cream
- Face cream, moisturizers
- Perfume, body sprays, deodorants
- Shampoos and soaps
- Acne treatments
- Foot-care products like corn pads
- Hair-loss treatments
- Dietary supplements and replacements (vitamins)

Dual-Purpose Over the Counter (OTC) Drugs

Some OTC drugs have both a medical purpose and a general health purpose. In order for the OTC expense to be reimbursed, you will need to obtain a medical practitioner's note stating that you have a specific medical condition and that the OTC drug is recommended to treat the condition.

For information available through the Internet, please visit www.WageWorks.com.

XIV. DEATH BENEFITS

Group Life Insurance

Your Group Life Insurance Program is administered according to a contract between the Commonwealth of Pennsylvania and Prudential Insurance Company of America. You may refer to the Booklet Certificate of Insurance provided by Prudential for more details. If there is a difference between the wording of the Booklet Certificate and the legal contract, the contract will govern.

You should have received from Prudential a group life insurance Welcome Kit shortly after you were hired by the Commonwealth. The Welcome Kit includes an introductory letter, a Group Insurance Beneficiary Designation/Change Form, a self-addressed stamped envelope for mailing the beneficiary form back to Prudential, and a Booklet Certificate describing the plan. It is important to keep this information with the rest of your essential benefit documents.

If you have specific questions, contact Prudential Insurance Company of America, Life Plan Management, P.O. Box 13676, Philadelphia, PA. 19101 (telephone: 1-800-893-7316).

Eligibility

You must be a permanent employee and have completed the 90-day waiting period in order to be eligible for group life insurance coverage. You met the 90-day waiting period prior to your graduation to trooper status.

Cost of Coverage

The cost of the Group Life Insurance Program is paid entirely by the commonwealth. If you go on an unpaid absence that does not include benefits, you will be billed for your premiums for up to one year, except for active military duty which has no time limit. If you do not pay premiums, you will be dropped from the program.

Coverage Begins

Coverage begins after you have completed 90 days of active employment with the Commonwealth.

Coverage Ends

Your group life insurance ends at the earliest time indicated below:

1. when you fail to pay any required premium for your insurance while on an unpaid absence;
2. when you have been on an unpaid absence for 12 months, except for military leave which varies depending upon the type of military duty;
3. when you retire, terminate or cease to be in an active pay status; or
4. when this policy is discontinued.

Conversion privileges

If all or any part of your insurance under this program terminates, you have a 31-day period following the termination of coverage to apply for conversion. Your group life insurance coverage terminates on the last day of the month in which your coverage ends. You may contact Prudential to apply to convert any amount up to the amount you were insured for under this program; conversion policies are paid for by the member, not the commonwealth. You will not be required to have a medical examination to qualify for a conversion policy.

If you should die within the 31-day period following termination of coverage, your Group Life Insurance will be paid to your beneficiary as though your insurance had not terminated or reduced.

Disability Coverage

If you become permanently and totally disabled while insured, your group life insurance coverage will continue as long as you are in an active pay status.

If you remain disabled, you will be eligible to apply for disability life insurance upon loss of active pay status or termination of employment. If you believe you are eligible for this protection, you should contact Prudential to obtain the forms needed to apply. To qualify for this coverage, you must submit proof of the disability. Proof may be submitted at any time following the loss of an active pay status, but no later than 12 months following the last premium payment. When requested by Prudential, you will be required to submit annual proof that you are still disabled.

Amount of Insurance

The amount of insurance is based on your annual pay rate in effect on the preceding January 1, rounded to the nearest $1,000 but not to exceed $50,000.

Changes to the Amount of Insurance

Any increases or decreases in your insurance due to changes in pay will become effective on the first of January following your change in pay if you are in an active pay status on that day, or the last regularly scheduled work day before January 1. If you are not in an active pay status on either date, the increase or decrease will not become effective until you return to an active pay status.

Your Responsibilities

Your beneficiary is the person who is entitled to receive benefits upon your death. You should go to https://gi.prudential.com/bene if you want to change your beneficiary designation for any reason (birth, adoption, marriage, divorce, or legal separation) or if you are in doubt about whom you named as your beneficiary. Use your eight digit personnel number, last name, birth date and the control number 91475 to create a username and password. If your personnel number is less than eight digits, you must use leading zeros, such as 00222222.

It is very important to keep this information up to date so that your life insurance benefits will be paid to the proper person. All beneficiary information is confidential and will not be disclosed.

Benefit Payout

In the event of your death, your life insurance benefits will be paid to your beneficiary. If you have not completed a beneficiary form, the amount of your insurance will be payable in the following order: (a) surviving spouse; (b) surviving children; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate.

Your survivors should contact Prudential to apply for death benefits. Prudential requires a certified death certificate in order to pay a claim.

Additional Services Offered by Prudential

In addition to providing group life insurance coverage, Prudential offers three other services: the Accelerated Benefit Option, the Alliance Account, and Beneficiary Financial Counseling Services (BFCS).

Accelerated Benefit Option

If you are terminally ill with a life expectancy of six months or less, you may apply to Prudential to have part of your group life insurance benefit prepaid. You may apply to receive up to 50 percent (maximum amount payable is $25,000) of the face amount of your insurance tax-free. Medical documentation must be provided. The remaining 50 percent of your life insurance will be paid to your beneficiaries upon your death.

Alliance Account

Prudential's Alliance Account offers a personalized interest-bearing checking account at no additional cost to your beneficiary (or employee who elects the Accelerated Benefit Option) if the life insurance proceeds are $10,000 or more; amounts under $10,000 are paid directly to your beneficiary by check. The checking account gives you or your beneficiaries time to consider financial needs. Proceeds may be withdrawn all at one time or may remain in the account until financial counseling has been requested and received.

Beneficiary Financial Counseling Service (BFCS)

Prudential offers Beneficiary Financial Counseling Services (BFCS) through FinancialPoint Corporation, an independent accounting and consulting firm. FinancialPoint Corporation provides independent financial advice, without cost, to an employee who elects the Accelerated Benefit Option or, upon an employee's death, to beneficiary(ies). FinancialPoint's toll free number is 1-888-327-4260 or e-mail at BCS@financialpoint.com.

Other Death Benefits

Emergency and Law Enforcement Personnel Death Benefits (Act 101)

As a State Police member, your surviving spouse, minor children or parents are eligible to receive benefits under Act 101 of 1976, the Emergency and Law Enforcement Personnel Death Benefits Act. The Act provides a one-time payment of death benefits to survivors of law enforcement officers, firefighters, ambulance and rescue squad members ***killed in the performance of their duties.*** The death must be causally related to the performance of duties. Eligibility for Act 101 benefits ceases when you are not physically present on the job.

Additional information can be obtained through the Internet at http://www.pa.gov/portal/server.pt? Click on PA State Agencies, More agencies, General Services, Doing Business with the Commonwealth, Risk and Insurance, Act 101.

Your Troop, Bureau or State Police Human Resource office can provide additional information about Act 101 benefits. The Pennsylvania State Police Bureau of Human Resources files the claim.

Health Benefits

In the event a State Police member is killed in the line of duty, all State Police Health Program Benefits and State Police Supplemental Benefits will continue for the eligible dependents of the deceased member for the life of the spouse or until the spouse remarries, and for the children as long as they meet the eligibility requirements.

Public Safety Officers' Death Benefits - Federal

The U.S. Department of Justice, Bureau of Justice Assistance, administers death and disability benefits under the Public Safety Officers' Benefits (PSOB) Act. The PSOB Act provides line of duty death benefits for law enforcement officers, firefighters, and ambulance or rescue squad members.

The Department of Justice has a website that you can access information about this program. It is http://www.ojp.usdoj.gov/BJA/grant/psob/psob_main.html.

You may contact the Bureau of Justice Assistance, Public Safety Officers' Benefits Program, 810 Seventh Street N.W., Washington, D.C. 20531 (1-888-744-6513) for further information. The Pennsylvania State Police Bureau of Human Resources files the claim.

Educational Assistance - State / Federal

The Police Officer, Firefighter, Correction Employee, and National Guard Member Child Beneficiary Education Act (Act 129) entitles children of firefighters, policemen, ambulance or rescue squad members, corrections officers, and active National Guard members killed in the line of duty to fully-paid tuition at Pennsylvania community colleges, state-owned universities, and state-related colleges and universities. Children must be 25 years of age or younger, residents of Pennsylvania, working toward an undergraduate degree, and meet other requirements.

For more information about this program and the application process, visit PHEAA's website at www.pheaa.org, Special Programs, Postsecondary Educational Gratuity Programs, or contact PHEAA at 1200 North Seventh Street, Harrisburg, PA 17102-1444 (telephone: 717-720-2860). The site includes forms that can be downloaded.

The federal PSOB program, under the Public Safety Officers' Educational Assistance (PSOEA) Act, provides higher educational assistance for spouses and children of federal, state and local public safety officers killed or permanently disabled in the line of duty. Refer to the Public Safety Officer's Death Benefits - Federal information above.

Pennsylvania State Troopers' Scholarship Fund

This benefit provides scholarship assistance to state-related schools for eligible dependents of members who were killed in the line of duty. An eligible dependent is considered a spouse, child, stepchild, or legally adopted child of a State Police member who qualifies as a dependent under IRS guidelines. The Pennsylvania State Troopers Association (PSTA) or the State Police Human Resource office can provide more information on this benefit.

XV. PSTA HEALTH AND WELFARE BENEFITS

The PSTA Health and Welfare Fund provides an additional death benefit for survivors of members whose death is a result of a non-service connected cause or a supplement to disability retirement benefits to members who become totally and permanently disabled as a result of a non-service connected cause.

The PSTA or the State Police Human Resource office can provide more information on these benefits.

XVI. NOTICE OF PRIVACY PRACTICES

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, we are committed to protecting the privacy of your protected health information. "Protected health information" 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 will inform you of these practices the first time you become a Highmark Inc. customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice became effective April 1, 2003, 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.

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

I. Uses and Disclosures of Protected Health Information

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

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

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

Payment

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

For example:

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

Health Care Operations

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

For example:

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

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

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

(i) Business Associates.

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

(ii) Other Covered Entities.

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

II. Other Possible Uses and Disclosures of Protected Health Information

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

A. To Plan Sponsors

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

B. Required by Law

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

C. Public Health Activities

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

D. Health Oversight Activities

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

E. Abuse or Neglect

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

F. **Legal Proceedings**

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

G. **Law Enforcement**

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

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

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

I. **Research**

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

J. **To Prevent a Serious Threat to Health or Safety**

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

K. **Military Activity and National Security, Protective Services**

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

L. **Inmates**

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

M. **Workers' Compensation**

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

N. **Others Involved in Your Health Care**

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

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

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

V. Your Individual Rights

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

A. Right to Access

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

You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your protected health information.

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

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

B. Right to an Accounting

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

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

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or submitting your request in writing to the Highmark Privacy Department, 1800 Center Street, Camp Hill, PA 17089. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

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

C. Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not

required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

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, 1800 Center Street, Camp Hill, PA 17089. In your request tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

D. Right to Request Confidential Communications

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

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

E. Right to Request Amendment

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

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

F. Right to a Paper Copy of this Notice

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

VI. Questions and Complaints

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

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

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

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

Contact Office: Highmark Privacy Department

Telephone: 1-866-228-9424 (toll free)

Fax: 1-717-302-3601

Address: 1800 Center Street

Camp Hill, PA 17089

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

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

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

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

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

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

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

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

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

For questions about this Privacy Notice, please contact:

Contact Office: Highmark Privacy Department

Telephone: 1-866-228-9424 (toll free)

Fax: 1-717-302-3601

Address: 1800 Center Street

Camp Hill, PA 17089