OPERATING ENGINEERS LOCAL 66 WELFARE FUND

Benefit Programs and Summary Plan Description

REVISED 1-1-2020 BOOKLET 14

All other booklets and amendments previously issued are canceled and replaced by this booklet.

OPERATING ENGINEERS
LOCAL 66 WELFARE FUND

UNION TRUSTEES

James T. Kunz, Jr., Chairman
Shawn Bertiaux
Thomas C. Melisko, Jr.
William S. Pellish
Jesse DiRenna
Carlton K. Ingram
Kevin F. Pahach

EMPLOYER TRUSTEES

Gary Hartman,Sec.
Mark Gentile
Russell Kohler
Charles J. Wisniewski
Ali Mills
G. Douglas Mosites
Jack Ramage

FUND ADMINISTRATOR

M. Scott Anderson, C.E.B.S.

MAILING ADDRESS
FOR CLAIMS AND CORRESPONDENCE

Operating Engineers
Local 66 Welfare Fund
P.O. Box 38682
Pittsburgh, PA 15238

ADMINISTRATION OFFICE

Operating Engineers
Local 66 Welfare Fund
111 Zeta Drive
Pittsburgh, PA 15238

Phone (412) 968-9750
FAX (412) 968-9757
www.oe66.com

TABLE OF CONTENTS

	Page
TYPES OF BENEFIT PROGRAMS	8
Trustees Rights to Amend	8
SCHEDULE OF BENEFITS	
Plan One	9
Plan Two	15
Medicare Supplemental Plan	21
Freedom Blue High Option	28
Freedom Blue 2 Low Option	34
GENERAL INFORMATION	
Fund Office Information Card	39
Health Care Identification Cards	39
Effective Date of Coverage	39
Change in Family Status	39
Change of Address	39
FILING FOR BENEFITS	
Blue Cross and Blue Shield Benefits	41
Vision Care Benefits	41
Prescription Drug Benefits	41
Dental Benefits	41
Claim Forms	41
Information	42
Weekly Disability Benefits	42
PAYMENT OF BENEFITS	
Hospital, Medical Surgical Benefits	43
Vision Care Benefits	43
Prescription Drug Benefits	43
Physical Examination	43
Errors in Benefit Payments	43
Fraud	43
Liability for the Payment of Benefits	44
Laws Affecting Benefits	44
Eligibility Requirements for Active Employees Figure 1	46
RULES OF ELIGIBILITY	
Active Employees	47
Fixed Premium Employee	47
Special Categories	47
Dependent Child Working as an Operating Engineer	48
Husband and Wife Working as Operating Engineers	48
Medicare	49
Medicare Rules – Retirees	49
Medicare Eligible Retirees	51

Retirees Not Eligible for Medicare 51
All Retirees 51
MAINTENANCE OF ELIGIBILITY
Active Employees 52
PLAN ONE 52
PLAN TWO 52
Fixed Premium Employee...53
Special Categories 53
RESERVE OF CONTRIBUTIONS
Additions to the Reserve 54
Applying the Reserve 54
Limitations on Reserve Usage 54
Reserve Usage After Retirement 55
Maximum Reserve 55
VOLUNTARY CONTRIBUTIONS...56
Active Employees 57
Limitations on Voluntary Contributions 57
Special Categories 58
DISABILITY CREDITS...59
WORKERS' COMPENSATION CREDITS.................................59
RETIREE WELFARE CONTRIBUTION ACCOUNT 60
EMPLOYEES RECIPROCAL AGREEMENTS 60
SPECIAL CATEGORIES
Spouses and Dependent Children of Deceased.................63
Retirees 63
Dependents of Eligible Retirees...63
Field Supervisory Employees 64
Totally Disabled Employees 64
TERMINATION OF ELIGIBILITY
Active Employees Working at Trade 66
Fixed Premium Employees 66
Dependents of Active Employees 66
Spouses and Children of Deceased Employees 66
Retired Employees and their Dependents.............................67
Field Supervisory Employees 67
Totally Disabled Employees 67
Uniformed Services 67
COBRA CONTINUATION COVERAGE
Qualifying Event 68
Notification of Qualifying Event..69
COBRA Election Form..69
COBRA Benefits 69
Disability 70
HIPAA...70
COBRA Premium Payment 70

Termination of COBRA Coverage....71
TEMPORARY ELIGIBILITY
Initial Eligibility....72
Maintaining Eligibility....72
Hourly Rate Employees....73
Flat Rate Employees....73
Reserve of Contributions....74
Voluntary Contributions....74
Weekly Disability/Workers' Compensation....74
Termination....75
Benefit Payments....75
Work Periods and Benefit Periods....75
FIXED PREMIUM
Actuarial Approval....76
Premiums....76
Initial Eligibility....76
Maintaining Eligibility....76
Weekly Disability and Workers' Compensation....77
Voluntary Contributions....77
Termination....77
Retirees....77
PLAN ONE / PLAN TWO
Weekly Disability Benefits....78
Notice of Loss....79
Claims Payments....79
Vision Care Benefits
Administration....80
Benefits Provided....80
Prior Authorization....80
How do I use the Plan....81
Non Participating Provider....81
How Much Do I Pay....81
Non Participating Provider....82
Non Participating Provider Reimbursement....82
How Often are Services Available....82
Where to get Benefits....82
What Vision Services and Materials....82
Items Not Covered....82
ANNUAL DENTAL BENEFIT
Items Covered....83
Items Not Covered....83
PLAN ONE
Death Benefits....84
Plan One....84
Plan One Retired and Totally Disabled....84

Beneficiary 84
Assignment of Death Benefit 84
Total Disability Benefits 85
Filing for Death Benefits 85
Payment of Death Benefits 85
Accidental Death and Dismemberment...............................86
Prescription Drug Benefits
Plan One Participants and Dependents 87
Covered Drugs 87
Filling Prescriptions 87
Retail Pharmacies 88
Participating Retail Pharmacy 88
Non Participating Retail Pharmacy 88
Mail Order Pharmacy 89
Maintenance Drugs 89
Generic Drugs 89
Co-Payments 90
Eligibility Questions 90
Allergy Serum 90
Diabetic Supplies at Retail 90
Diabetic Supplies at Mail Order 91
Retin-A 91
Exclusions and Limitations 91
MEMBER REIMBURSEMENT BENEFIT (MRB) 93
MEDICAL BENEFITS..100
PLAN TWO
Death Benefits...101
Plan Two 101
Plan Two Retired and Totally Disabled 101
Beneficiary 101
Assignment of Death Benefit 101
Total Disability Benefits 102
Filing for Death Benefits 102
Payment of Death Benefits 102
Accidental Death and Dismemberment............................103
Medical Benefits..104
HIGHMARK PPO, Plan One/Plan Two...................................105
How Your Benefits Are Applied.......................................107
Covered Services...109
What Is Not Covered..134
How Your Healthcare Program Works.............................143
Health Care Management...152
General Information...159
A Recognized Identification Card.....................................162
How to File A Claim..163

Member Service 171
MEDICARE SUPPLEMENTAL PLAN
Death Benefits........ 177
Vision Care Benefits........ 179
Prescription Drug Benefits........ 183
Medicare Supplemental Medical Benefits 189
How Your Benefits are Applied........ 191
Covered Services........ 193
What Is Not Covered........ 232
Out-of-Area Care........ 250
Health Care Management........ 257
General Information........ 264
How to File a Claim 268
Member Service........ 275
ALL PLANS
Highmark Notice of Privacy Practices 281
OPTUMRx Notice of Privacy Practices 298
Welfare Fund Notice of Privacy Practices 305
APPEAL PROCEDURES........ 312
Highmark Group Health Benefits 312
General Appeal Procedure 312
MRB/Annual Dental Benefit 314
General Provisions and Definitions........ 319
General Exceptions and Limitations........ 320
ERISA INFORMATION 321
Establishment of the Program........ 324
Administration of the Plan 324
Rights Under ERISA 325
Plan Termination or Benefit Elimination 327
Trustees Policy 328
Military Service 329
DEFINITIONS........ 331
INDEX........ 335

BENEFIT PROGRAMS

The Welfare Fund provides four Benefit Programs to fit the different needs of its participants and their dependents:

PLAN ONE. Regular Benefit Program. A schedule of benefits is on Page 9. Details of benefits can be found on page 84.

PLAN TWO. A reduced Benefit Program with higher co-payments and out-of-pocket limits, at a lower cost. A schedule of benefits is on Page 15. Details of benefits can be found on page 101.

MEDICARE SUPPLEMENTAL PLAN. A Program that provides supplemental benefits for those eligible to receive Medicare. A schedule of benefits is on Page 21. Details of benefits can be found on page 177.

FREEDOM BLUE HIGH OPTION or FREEDOM BLUE LOW OPTION. Medicare+Choice PPO programs providing benefits to Medicare eligible participants and dependents living in covered counties. See pages 28-38.

TRUSTEES RIGHTS TO AMEND. The Trustees have the right to change any of the terms of the Welfare Fund including the Plan of Benefits, the Rules and Regulations, Minimum Contributions Required, Reserve of Contribution and Voluntary Contribution Schedules of this Plan at any time. No participant, retiree, beneficiary or eligible dependent has a vested right or contractual interest in the benefits provided.

The Trustees, this Summary Plan Description, and written information from the personnel at the Fund Office are the only authorized sources of Plan information for you. The Trustees of the Plan have not empowered anyone else to speak for them with regard to this Plan. No employer, local union business agent or representative, supervisor or shop steward is in a position to discuss your rights under this Plan with authority.

Summary of PLAN ONE PPO Benefits

A PPO, or Preferred Provider Organization, offers two levels of benefits. If you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the Out-of-network lower level of benefits.

Benefits	Network	Out-of-Network
General Provisions		
Benefit Period	Calendar Year	
Deductible (per benefit period) Individual Family Wellness Individual Wellness Family	 $250 $500 $150 $300	 $250 $500 $250 $500
Plan Payment Level - Based on the provider's reasonable charge	90% after deductible until out-of-pocket limit is met; then 100%	70% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limits Individual Family	 $500 $1,000	 $1,500 $3,000
Lifetime Maximum (per member)	Unlimited	
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits (including virtual visits)	100% after $20 copayment; deductible does not apply	70% after deductible
		Limit: 15 retail clinic visits per benefit period
Primary Care Physician Office Visits (including virtual visits)[1 2]	100% after $20 copayment; deductible does not apply	70% after deductible
		Limit: 15 primary care physician visits per benefit period

Benefits	Network	Out-of-Network
Specialist Office Visits (including virtual visits)[1]	100% after $20 copayment; deductible does not apply	70% after deductible
		Limit: 15 specialist visits per benefit period
Virtual Visit Originating Site Fee[1]	90% after deductible	70% after deductible
Urgent Care Center Visits	100% after $20 copayment; deductible does not apply	70% after deductible
		Limit: 15 urgent care center visits per benefit period
Preventive Care Services[3]		
Adult		
Routine physical exams	100%; deductible does not apply	Not Covered
Adult Immunizations	100% ; deductible does not apply	70% after deductible
Routine screening tests and procedures	100%; deductible does not apply	70% after deductible
Routine gynecological exams, including a PAP Test	100%; deductible does not apply	70%; deductible does not apply
Mammograms, annual routine and medically necessary	100%; deductible does not apply	70% after deductible
Colorectal cancer screening	100%; deductible does not apply	70% after deductible
Pediatric		
Routine physical exams	100%; deductible does not apply	Not Covered
Pediatric immunizations	100%; deductible does not apply	70%; deductible does not apply
Routine screening tests and procedures	100%; deductible does not apply	70% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Services - Inpatient	90% after deductible	70% after deductible
	Unlimited	Limit: 90 inpatient days per benefit period (Inpatient mental health care and substance abuse services accumulate toward this limit.)

Benefits	Network	Out-of-Network
Hospital Services - Outpatient[4]	90% after deductible	70% after deductible
Maternity (non-preventive facility and professional services)	90% after deductible	70% after deductible
Medical/Surgical Expenses (except office visits)	90% after deductible	70% after deductible
Emergency Services		
Emergency Room Services	90% after $75 copayment (waived if admitted as an inpatient) after deductible	Same as network services
Emergency Ambulance Service	90% after deductible	90% after deductible
Non-Emergency Ambulance Service	90% after deductible	90% after deductible
Therapy and Rehabilitation Services		
Infusion Therapy	90% after deductible	70% after deductible
Occupational Therapy	90% after deductible	70% after deductible
	Limit: 21 visits per benefit period	
Physical Medicine	90% after deductible	70% after deductible
	Limit: 21 visits per benefit period	
Radiation Therapy	90% after deductible	70% after deductible
Respiratory Therapy	90% after deductible	Same as network services
Speech Therapy	90% after deductible	70% after deductible
	Limit: 21 visits per benefit period	
Spinal Manipulations	100% after $20 copayment; deductible does not apply	70% after deductible
	Limit: 10 visits per benefit period	
Other Therapy Services (Cardiac Rehabilitation, Chemotherapy, and Dialysis Treatment)	90% after deductible	70% after deductible

Benefits	Network	Out-of-Network
Mental Health/Substance Abuse Services		
Mental Health Care Services - Inpatient	90% after deductible	70% after deductible
Mental Health Care Services - Outpatient (including virtual visits)	100% after $20 copayment; deductible does not apply	70% after deductible
Substance Abuse Services - Inpatient Detoxification	90% after deductible	70% after deductible
Substance Abuse Services - Inpatient Residential Treatment and Rehabilitation Services	90% after deductible	70% after deductible
Substance Abuse Services - Outpatient	100% after $20 copayment; deductible does not apply	70% after deductible
Other Services		
Allergy Extracts and Injections	90% after deductible	70% after deductible
Anesthesia for Non-Covered Dental Procedures (Limited)	90% after deductible	70% after deductible
Autism Spectrum Disorders including Applied Behavioral Analysis[5]	90% after deductible	70% after deductible
Assisted Fertilization Treatment	Not Covered	
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible
Diabetes Treatment	90% after deductible	70% after deductible
Diagnostic Services *Advanced Imaging* (MRI, CAT Scan, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services • standard imaging • diagnostic medical • lab/pathology • allergy testing	90% after deductible	70% after deductible
Durable Medical	90% after deductible	90% after deductible

Benefits	Network	Out-of-Network
Equipment		
Enteral Foods	90%; deductible does not apply	70%; deductible does not apply
Home Infusion and Suite Infusion Therapy Services	90% after deductible	Same as network services
Home Health Care[6]	90% after deductible	70% after deductible
	Limit: 100 visits per benefit period	
Hospice	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment[7]	90% after deductible	70% after deductible
Orthotics	90% after deductible	90% after deductible
Pediatric Extended Care Services	90% after deductible	70% after deductible
	Limit: 100 days per benefit period	
Private Duty Nursing	90% after deductible	Same as network services
	Limit: 240 hours per benefit period	
Prosthetics	90% after deductible	90% after deductible
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	Limit: 100 days per benefit period	
Transplant Services	90% after deductible	70% after deductible
Precertification Requirements	Yes[8]	

Prescription Drugs		
Retail Pharmacy	Brand - $20 copay Generic – $10 copay	Re-imbursed by mail after Rx purchased.
Mail Order[9]	Brand - $40 copay Generic – $20 copay	Not covered

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during a benefit period will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

[1] You ***may*** be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a hospital, facility provider, ancillary provider, retail clinic or urgent care center. The specialist virtual visit is subject to availability within your service area.

[2] A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics.

[3] Services are limited to those on the Highmark Preventive Schedule and the Women's Health Preventive Schedule. Gender, age and frequency limits may apply.

[4] Other cost sharing provisions and/or limits may apply to specific benefits, i.e., physical medicine, therapies, diagnostic services, mental health/substance abuse visits.

[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.

[6] The maternity home health care visit for network care is not subject to the program copayment, coinsurance or deductible amounts, if applicable. See Maternity Home Health Care Visit in the Covered Services section.

[7] If testing is required, cost sharing may apply as outlined under Diagnostic Services. Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

[8] Highmark must be contacted prior to a planned inpatient admission or within 48 hours of an emergency inpatient admission. Some facility providers will contact Highmark and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Highmark for precertification. If your provider does not, you are responsible for contacting Highmark. Also be sure to confirm Highmark's determination of medical necessity and appropriateness. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

[9] OptumRx administers the CVS90 Saver Plus program that allows mail order prescriptions to be filled at local CVS retail pharmacies as an alternative to mailing the medications.

Summary of PLAN TWO PPO Benefits

A PPO, or Preferred Provider Organization, offers two levels of benefits. If you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits.

Benefits	Network	Out-of-Network
General Provisions		
Benefit Period	Calendar Year	
Deductible (per benefit period) Individual Family Wellness Individual Wellness Family	 $250 $500 $150 $300	 $250 $500 $250 $500
Plan Payment Level - Based on the plan allowance	80% after deductible until out-of-pocket limit is met; then 100%	60% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limits Individual Family	 $750 $1,500	 $1,500 $3,000
Lifetime Maximum (per member)	Unlimited	
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits (including virtual visits)	100% after $30 copayment; deductible does not apply	60% after deductible
		Limit: 15 retail clinic visits per benefit period
Primary Care Physician Office Visits (including virtual visits)[1 2]	100% after $30 copayment; deductible does not apply	60% after deductible
		Limit: 15 primary care physician visits per benefit period
Specialist Office Visits (including virtual visits)[1]	100% after $30 copayment; deductible does not apply	60% after deductible
		Limit: 15 specialist visits per benefit period
Virtual Visit Originating Site Fee[1]	80% after deductible	60% after deductible

Benefits	Network	Out-of-Network
Urgent Care Center Visits	100% after $30 copayment; deductible does not apply	60% after deductible
		Limit: 15 urgent care center visits per benefit period
Preventive Care Services[3]		
Adult		
Routine physical exams	100%; deductible does not apply	Not Covered
Adult Immunizations	100%; deductible does not apply	60% after deductible
Routine screening tests and procedures	100%; deductible does not apply	60% after deductible
Routine gynecological exams, including a PAP Test	100%; deductible does not apply	60%; deductible does not apply
Mammograms, annual routine and medically necessary	100%; deductible does not apply	60% after deductible
Colorectal cancer screening	100%; deductible does not apply	60% after deductible
Pediatric		
Routine physical exams	100%; deductible does not apply	Not Covered
Pediatric immunizations	100%; deductible does not apply	60%; deductible does not apply
Routine screening tests and procedures	100%; deductible does not apply	60% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Services - Inpatient	80% after deductible	60% after deductible
	Unlimited	Limit: 90 inpatient days per benefit period (Inpatient mental health care and substance abuse services accumulate toward this limit.)
Hospital Services - Outpatient[4]	80% after deductible	60% after deductible
Maternity (non-preventive facility and professional services)	80% after deductible	60% after deductible
Medical/Surgical Expenses (except office visits)	80% after deductible	60% after deductible

Benefits	Network	Out-of-Network
Emergency Services		
Emergency Room Services	80% after $100 copayment (waived if admitted as an inpatient) after deductible	Same as network services
Emergency Ambulance Service	80% after deductible	80% after deductible
Non-Emergency Ambulance Service	80% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Infusion Therapy	80% after deductible	60% after deductible
Occupational Therapy	80% after deductible	60% after deductible
	Limit: 21 visits per benefit period	
Physical Medicine	80% after deductible	60% after deductible
	Limit: 21 visits per benefit period	
Radiation Therapy	80% after deductible	60% after deductible
Respiratory Therapy	80% after deductible	Same as network services
Speech Therapy	80% after deductible	60% after deductible
	Limit: 21 visits per benefit period	
Spinal Manipulations	100% after $30 copayment; deductible does not apply	60% after deductible
	Limit: 10 visits per benefit period	
Other Therapy Services (Cardiac Rehabilitation, Chemotherapy, and Dialysis Treatment)	80% after deductible	60% after deductible
Mental Health/Substance Abuse Services		
Mental Health Care Services - Inpatient	80% after deductible	60% after deductible
Mental Health Care Services - Outpatient (including virtual visits)	100% after $30 copayment; deductible does not apply	60% after deductible
Substance Abuse Services - Inpatient Detoxification	80% after deductible	60% after deductible

Benefits	Network	Out-of-Network
Substance Abuse Services - Inpatient Residential Treatment and Rehabilitation Services	80% after deductible	60% after deductible
Substance Abuse Services - Outpatient	100% after $30 copayment; deductible does not apply	60% after deductible
Other Services		
Allergy Extracts and Injections	80% after deductible	60% after deductible
Anesthesia for Non-Covered Dental Procedures (Limited)	80% after deductible	60% after deductible
Autism Spectrum Disorders including Applied Behavioral Analysis[5]	80% after deductible	60% after deductible
Assisted Fertilization Treatment	Not Covered	
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Diabetes Treatment	80% after deductible	60% after deductible
Diagnostic Services *Advanced Imaging* (MRI, CAT Scan, PET scan, etc.)	80% after deductible	60% after deductible
Basic Diagnostic Services • standard imaging • diagnostic medical • lab/pathology • allergy testing	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	80% after deductible
Enteral Foods	80%; deductible does not apply	60%; deductible does not apply
Home Infusion and Suite Infusion Therapy Services	80% after deductible	Same as network services
Home Health Care[6]	80% after deductible	60% after deductible
	Limit: 100 visits per benefit period	

Benefits	Network	Out-of-Network
Hospice	80% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment[7]	80% after deductible	60% after deductible
Orthotics	80% after deductible	80% after deductible
Pediatric Extended Care Services	80% after deductible	60% after deductible
	Limit: 100 days per benefit period	
Private Duty Nursing	80% after deductible	Same as network services
	Limit: 240 hours per benefit period	
Prosthetics	80% after deductible	80% after deductible
Skilled Nursing Facility Care	80% after deductible	60% after deductible
	Limit: 100 days per benefit period	
Transplant Services	80% after deductible	60% after deductible
Precertification Requirements	Yes[8]	
Prescription Drug	NOT COVERED	

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during a benefit period will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

1 You ***may*** be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a hospital, facility provider, ancillary provider, retail clinic or urgent care center. The specialist virtual visit is subject to availability within your service area.

2 A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics.

3 Services are limited to those on the Highmark Preventive Schedule and the Women's Health Preventive Schedule. Gender, age and frequency limits may apply.

4 Other cost sharing provisions and/or limits may apply to specific benefits, i.e., physical medicine, therapies, diagnostic services, mental health/substance abuse visits.

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.

6 The maternity home health care visit for network care is not subject to the program copayment, coinsurance or deductible amounts, if applicable. See Maternity Home Health Care Visit in the Covered Services section.

[7] If testing is required, cost sharing may apply as outlined under Diagnostic Services. Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

[8] Highmark must be contacted prior to a planned inpatient admission or within 48 hours of an emergency inpatient admission. Some facility providers will contact Highmark and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Highmark for precertification. If your provider does not, you are responsible for contacting Highmark. Also be sure to confirm Highmark's determination of medical necessity and appropriateness. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

Summary of Medicare Supplemental Benefits

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

Benefits	Hospital	Medical Surgical	Major Medical
General Provisions			
Benefit Period	Calendar Year	Calendar Year	Calendar Year
Deductible (per benefit period)	None	None	$100 Individual $300 Family Non-Aggregate
Plan Payment Level -- Based on the plan allowance	100%	100%	80% after deductible
Lifetime Maximum (per member)	None	None	$250,000
Office/Clinic/Urgent Care Visits			
Outpatient Medical Visits Physician Office Visits[1] (including virtual visits)	Not Covered	Not Covered	80% after deductible
Virtual Visit Originating Site Fee[1]	Not Covered	Not Covered	80% after deductible
Retail Clinic Visits (including virtual visits)	Not Covered	Not Covered	80% after deductible
Urgent Care Center Visits	Not Covered	Not Covered	80% after deductible
Preventive Care Services[2]			
Adult Routine physical exams	Not Covered	Not Covered	Not Covered
Immunizations	Not Covered	Not Covered	Not Covered
Hepatitis B Vaccine Immunization	Not Covered	Not Covered	Not Covered
Colorectal Cancer Screenings	100%	100%	80% after deductible

Benefits	Hospital	Medical Surgical	Major Medical
Routine gynecological exams, including a PAP Test	100%	100%	80%; deductible does not apply ; maximum does not apply
Mammograms, annual routine and medically necessary	100%	100%	80% after deductible
Pediatric Routine physical exams	Not Covered	Not Covered	Not Covered
Immunizations	100%	100%	80%; deductible does not apply; maximum does not apply
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Services - Inpatient	100% Limited to 365 days of inpatient care. You become eligible for a new benefit period (an additional 365 days) whenever you do not use any inpatient care for at least 90 consecutive days.	Not Covered	80% after deductible
Hospital Services - Outpatient	100%	Not Covered	80% after deductible
Inpatient Medical Care (professional)	Not Covered	100%	80% after deductible
		Limited to 365 days per admission (At least 90 consecutive days must lapse between discharge from and subsequent admission to a hospital or skilled	

Benefits	Hospital	Medical Surgical	Major Medical
		nursing facility before inpatient stays will be considered a new period of hospitalization)	
Concurrent Care	Not Covered	100%	80% after deductible
Consultations	Not Covered	100% Limited to 1 consultation per consultant per inpatient stay	80% after deductible
Maternity (non-preventive facility and professional services)	100%	100%	80% after deductible
Medical/Surgical (except office visits)	100%	100%	80% after deductible
Assistant At Surgery	Not Covered	100%	80% after deductible
Second Surgical Opinion	Not Covered	100%	80% after deductible
Emergency Services			
Emergency Room Care	100%	100%	80% after deductible
Ambulance	Not Covered	Not Covered	80% after deductible
Therapy and Rehabilitation Services			
Occupational Therapy	Not Covered	Not Covered	80% after deductible
Physical Medicine	100% Limited to 21 treatments per 12 consecutive months	100% Limited to inpatient care	80% after deductible Limited to 20 visits per benefit period
Radiation Therapy	100%	100%	80% after deductible
Speech Therapy	Not Covered	Not Covered	80% after deductible

Benefits	Hospital	Medical Surgical	Major Medical
Spinal Manipulations	Not Covered	Not Covered	80% after deductible
Other Therapy and Rehabilitation Services (Cardiac Rehab, Chemotherapy, Dialysis, Infusion Therapy and Respiratory Therapy)	100% (Cardiac Rehab and Respiratory Therapy; Not Covered) Chemotherapy limited to intravenous and oral	100% (Cardiac Rehab, Infusion Therapy and Respiratory Therapy; Not Covered)	80% after deductible
Mental Health/Substance Abuse Services			
Mental Health - Inpatient	100%	100%	80% after deductible
	Limited to 90 days per Benefit Period (applies toward your inpatient hospital facility day limit)	Limited to 90 days per Benefit Period	
Mental Health - Outpatient (including virtual visits)	Not Covered	Not Covered	50% after deductible
Substance Abuse - Inpatient Detoxification	100% Limited to 7 days/admission; 4 admissions per lifetime	100%	80% after deductible
Substance Abuse - Inpatient Residential Treatment and Rehabilitation Services	100% Limited to 30 days/calendar year; 90 days/lifetime	100% Limited to 30 days per calendar year	80% after deductible
Substance Abuse - Outpatient[3]	100% Limited to 60 visits/calendar year; 120 visits/lifetime	Not Covered	80% after deductible
Other Services			
Anesthesia	Not Covered	100%[4]	80% after deductible
Anesthesia for Non-Covered Dental Procedures	100%	100%	80% after deductible

Benefits	Hospital	Medical Surgical	Major Medical
(Limited)			
Autism Spectrum Disorders including Applied Behavioral Analysis[5]	100%	100%	80% after deductible
Assisted Fertilization Treatment	Not Covered	Not Covered	Not Covered
Dental Services Related to Accidental Injury	Not Covered	Not Covered	80% after deductible
Diabetes Treatment	100%	Not Covered	80% after deductible
Diagnostic Services	100%	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	Not Covered	Not Covered	80% after deductible
Enteral Foods	Not Covered	Not Covered	80%; deductible does not apply
Home Health Care	100%	Not Covered	80% after deductible
	Limited to 100 visits per 12-month period		
Hospice	Not Covered	Not Covered	Not Covered
Infertility Counseling, Testing and Treatment[6]	100%	100%	80% after deductible

Benefits	Hospital	Medical Surgical	Major Medical
Pediatric Extended Care Services	100% Limited to 100 days per calendar year	Not Covered	Not Covered
Private Duty Nursing	Not Covered	Not Covered	80% after deductible Limited to 240 hours per benefit period
Skilled Nursing Facility Services	100%	100%	80% after deductible
	Two days of skilled nursing facility care is available for each unused inpatient hospital day.	Each day of skilled nursing care reduces the benefit period by ½ day.	Limited to 365 days per illness per member
Transplant Services	100%	100%	80% after deductible
Visiting Nurse Services	100%	Not Covered	80% after deductible
Precertification Requirements		Yes[7]	

Prescription Drugs	In-network	Out-of-network
Retail Pharmacy	Brand - $20 copay Generic – $10 copay	Re-imbursed by mail after Rx purchased.
Mail Order[8]	Brand - $40 copay Generic – $20 copay	Not covered

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during a benefit period will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

[1] You ***may*** be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a hospital, facility provider, retail clinic or urgent care center. The specialist virtual visit is subject to availability within your service area.

[2] Services are limited to those on the Highmark Preventive Schedule . Gender, age and frequency limits may apply.

[3] Of the 60 outpatient visits or equivalent partial visits or partial hospitalization services per benefit period, a maximum of 30 of these visits may be exchanged on a two-for-one basis to secure up to 15 additional days per benefit period beyond the 30-day limit for inpatient non-hospital rehabilitation services.

[4] When medical direction (supervision) is provided by a nurse anesthetist not employed by a professional provider, payment will be made at 50% of the plan allowance. When anesthesia services are administered by an independently practicing certified registered nurse anesthetist under the medical direction (supervision) of a professional provider other than a surgeon, assistant surgeon or attending professional provider, payment will be made at 50% of the certified registered nurse anesthetist reasonable charge. When anesthesia services are administered by an independently practicing certified registered nurse anesthetist working in cooperation with the surgeon, assistant surgeon or attending professional provider, payment will be made at 100% of the certified registered nurse anesthetist reasonable charge.

[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.

[6] Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

[7] Highmark must be contacted prior to a planned inpatient admission or within 48 hours of an emergency inpatient admission. Some facility providers will contact Highmark and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Highmark for precertification. If your provider does not, you are responsible for contacting Highmark. Also be sure to confirm Highmark's determination of medical necessity and appropriateness If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

[8] OptumRx administers the CVS90 Saver Plus program that allows mail order prescriptions to be filled at local CVS retail pharmacies as an alternative to mailing the medications.

For all MEDICARE SUPPLEMENTAL PLAN Employees and MEDICARE SUPPLEMENTAL PLAN Dependents who are entitled to Medicare Benefits from Social Security (either due to age or disability), the Blue Cross-Blue Shield Program and the Major Medical Expense Program will not duplicate payments or benefits provided under Medicare.

Summary of FREEDOM BLUE Benefits - HIGH OPTION

Operating Engineers #66, Pennsylvania Participants Selected Freedom Blue Copays and Limits, effective January 1, 2020

If you receive services in the Plan Service Area from a Network Provider, Participating Facility Provider or Contracting Supplier, you will receive the highest level of benefits. If you choose to obtain medical care through another provider or a provider outside of the Plan Service Area or outside the Highmark Managed Care Network Service Area, you will receive the lower level of benefits.

Questions? Call 1-866-456-7739 (TTY User, call 1-800-862-0709
Reference Code: 16FB9341 **(Please have this number ready when you call.**

Operating Engineers Local #66 Welfare Fund		Freedom Blue PPO (High Option)	
		In Network	Out Of Network
	Deductible	$0	
	Coinsurance	0%	20%
	Out-of-Pocket Maximum	$3,400	
PREVENTIVE CARE (OFFICE VISIT COST SHARING MAY APPLY)	Annual Physical Exam	Covered in Full	Covered in Full

Operating Engineers Local #66 Welfare Fund		Freedom Blue PPO (High Option)	
		In Network	Out Of Network
	Screenings & Exams (Preventative PAP/Pelvic, Mammograms, Colorectal, Prostate & Bone Mass Measurement)	Covered in Full	Covered in Full
PHYSICIAN SERVICES	Doctor Office Visit	$20	$20
	Specialist Office Visit	$20	$20
	X-ray or Radiology	0% coinsurance	0% coinsurance
	Diagnostic Testing	0% coinsurance	0% coinsurance
FACILITY SERVICES	Outpatient Surgery	0% coinsurance	0% coinsurance
	Emergency Room Services (Worldwide Coverage)	$50	$50
	Urgently Needed Care (this is NOT emergency care)	$40	$40
	Inpatient Hospital Stay	0% coinsurance per admission	0% coinsurance per admission
	Skilled Nursing Facility Care (100 days per Medicare benefit period)	0% coinsurance per admission	0% coinsurance per admission

Operating Engineers Local #66 Welfare Fund		Freedom Blue PPO (High Option)	
		In Network	Out Of Network
ADDITIONAL BENEFITS	Annual Routine Vision Exam (Includes refraction)	$0	$50
	Eyeglasses or Contact Lenses (Covered every year)	Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames and a $100 benefit maximum for specialty contact lenses.	You have a $100 benefit maximum for out-of-network specialty frames or specialty contact lenses.
	Annual Routine Hearing Exam	$20	$20
	Hearing Aids (In network covered every year)	$499 copay per aid for TruHearing Advanced $799 copay per aid for TruHearing Premium $500 allowance for any other aids thru TruHearing	$500 allowance for hearing aids through TruHearing
	Chiropractic Office Visits	$20	$20
	Home Health	0% coinsurance for Medicare covered home health services	0% coinsurance for Medicare covered home health services

Operating Engineers Local #66 Welfare Fund	Freedom Blue PPO (High Option)	
	In Network	Out Of Network
Physical, Speech and Occupational Therapy (per visit/per day/per provider)	$20	$20
Part B Drugs	0% coinsurance	0% coinsurance
Ambulance (Emergent Services per one way trip)	$25	$25
Durable Medical Equipment (Prosthetics/Orthotics Diabetic Testing Supplies,	15% coinsurance	20% coinsurance
Oxygen/Oxygen Supplies)	15% coinsurance	20% coinsurance
Inpatient Psychiatric Hospital Care (Limited to 190 days per lifetime)	0% coinsurance per admission	0% coinsurance per admission

Operating Engineers Local #66 Welfare Fund		Freedom Blue PPO (High Option)	
		In Network	Out Of Network
MENTAL HEALTH SERVICES	Outpatient Mental Health/Psychiatric Services or Chemical Dependency Substance Abuse Treatment (per individual or group session)	$20	$20

PART D DRUGS (UP TO 31 DAY RETAIL SUPPLY)		
	Initial Coverage Period (up to $4,020 in total drug costs)	Preferred / Standard Pharmacy $15/$20 Tier 1 $15/$20 Tier 2 $15/$20 Tier 3 $45/$50 Tier 4 $50/$50 Tier 5
	Coverage Gap Period (from $4,020.01 in total drug costs to $6,350 in yearly out-of-pocket drug costs)	Preferred / Standard Pharmacy $15/$20 Tier 1 $15/$20 Tier 2 $15/$20 Tier 3 $45/$50 Tier 4 $50/$50 Tier 5
	Catastrophic Coverage Period (after $6,350.01 in total out-of-pocket drug costs)	The greater of 5% Coinsurance or $3.60 for Generic/Preferred Multi-Source or $8.95 for all others
	Mail Order (up to 90-day supply, Specialty Drug up to 31-day supply)	$30 Tier 1 $30 Tier 2 $30 Tier 3 $90 Tier 4 N/A Tier 5

- Diagnostic or outpatient surgery cost sharing may apply for non-screening preventive services.
- Physician office visit cost sharing may apply if a separately billable physician service is rendered.
- Certain categories of Medicare Part B drugs have been excluded from member cost sharing. They include certain vaccines and toxoids, certain miscellaneous drugs and solutions, certain miscellaneous pathology and laboratory drugs, and certain contrast materials. Prior authorization is

necessary for coverage of certain medications. Medicare Part B drugs are not available via retail pharmacy network.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. You must continue to pay your Medicare Part B premium. Highmark Senior Health Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Health Company depends on contract renewal. Highmark is a registered mark of Highmark Inc. Highmark Senior Health Company is an independent licensee of the Blue Cross and Blue Shield Association. Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. Blue Cross, Blue Shield and the Cross and Shield symbols are registered service marks of the Blue Cross and Blue Shield Association.

Summary of FREEDOM BLUE 2 Benefits - LOW OPTION

Operating Engineers #66, Pennsylvania Participants Selected Freedom Blue Copays and Limits, effective January 1, 2020

If you receive services in the Plan Service Area from a Network Provider, Participating Facility Provider or Contracting Supplier, you will receive the highest level of benefits. If you choose to obtain medical care through another provider or a provider outside of the Plan Service Area or outside the Highmark Managed Care Network Service Area, you will receive the lower level of benefits.

Questions? Call 1-866-456-7739 (TTY User, call 1-800-862-0709
Reference Code: **16FB9342** **(Please have this number ready when you call.**

Operating Engineers Local #66 Welfare Fund		Freedom Blue PPO (Low Option)	
		In Network	Out Of Network
	Deductible	$1,500	
	Coinsurance	0%	20%
	Out-of-Pocket Maximum	$3,400	
PREVENTIVE CARE (OFFICE VISIT COST SHARING MAY APPLY)	Annual Physical Exam	Covered in Full	Covered in Full
	Screenings & Exams (Preventative PAP/Pelvic, Mammograms, Colorectal, Prostate & Bone Mass Measurement)	Covered in Full	Covered in Full

Operating Engineers Local #66 Welfare Fund		Freedom Blue PPO (Low Option)	
		In Network	Out Of Network
PHYSICIAN SERVICES	Doctor Office Visit	$20	$20
	Specialist Office Visit	$25	$25
	X-ray or Radiology	0% coinsurance	0% coinsurance
	Diagnostic Testing	0% coinsurance	0% coinsurance
FACILITY SERVICES	Outpatient Surgery	0% coinsurance	0% coinsurance
	Emergency Room Services (Worldwide Coverage)	$50	$50
	Urgently Needed Care (this is NOT emergency care)	$40	$40
	Inpatient Hospital Stay	0% coinsurance per admission	0% coinsurance per admission
	Skilled Nursing Facility Care (100 days per Medicare benefit period)	0% coinsurance per admission	0% coinsurance per admission
	Annual Routine Vision Exam (Includes refraction)	$0	$50

Operating Engineers Local #66 Welfare Fund	Freedom Blue PPO (Low Option)	
	In Network	Out Of Network
Eyeglasses or Contact Lenses (Covered every year)	Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames and a $100 benefit maximum for specialty contact lenses.	Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames and a $100 benefit maximum for specialty contact lenses.
Annual Routine Hearing Exam	$25	$25
Hearing Aids (covered every three years)	$500 coverage	
Chiropractic Office Visits	$20	20%
Home Health	0% coinsurance for Medicare covered home health services	0% coinsurance for Medicare covered home health services
Physical, Speech and Occupational Therapy (per visit/per day/per provider)	$25	$25
Part B Drugs	0% coinsurance	0% coinsurance
Ambulance (Emergent Services per one way trip)	$25	20% coinsurance

Operating Engineers Local #66 Welfare Fund		Freedom Blue PPO (Low Option)	
		In Network	Out Of Network
	Durable Medical Equipment (Prosthetics/Orthotics, Diabetic Testing Supplies, Oxygen/Oxygen Supplies)	0% coinsurance	20% coinsurance
MENTAL HEALTH SERVICES	Inpatient Psychiatric Hospital Care (Limited to 190 days per lifetime)	0% coinsurance per admission	0% coinsurance per admission
MENTAL HEALTH SERVICES	Outpatient Mental Health/Psychiatric Services or Chemical Dependency Substance Abuse Treatment (per individual or group session)	$25	$25

DRUGS	PART D DRUGS (UP TO 31 DAY RETAIL SUPPLY)	Initial Coverage Period (up to $4,020 in total drug costs)	Preferred / Standard Pharmacy $2/$7 Tier 1 $2/$7 Tier 2 $37/$42 Tier 3 $85/$90 Tier 4 33%/33% Tier 5 Mail Order $5 Tier 1 $5 Tier 2 $92.50 Tier 3 $212.50 Tier 4 N/A Tier 5

Coverage Gap Period (from $4,020.01 in total drug costs to $6,350 in yearly out-of-pocket drug costs)	Preferred / Standard Pharmacy $10/$15 Tier 1 $10/$15 Tier 2 20%/25% Tier 3 20%/25% Tier 4 25%/25% Tier 5 Mail Order $25 Tier 1 $25 Tier 2 20% Tier 3 20% Tier 4 N/A Tier 5
Catastrophic Coverage Period (after $6,350.01 in total out-of-pocket drug costs)	The greater of 5% Coinsurance or $3.60 for Generic/Preferred Multi-Source or $8.95 for all others

- Diagnostic or outpatient surgery cost sharing may apply for non-screening preventive services.
- Physician office visit cost sharing may apply if a separately billable physician service is rendered.
- Certain categories of Medicare Part B drugs have been excluded from member cost sharing. They include certain vaccines and toxoids, certain miscellaneous drugs and solutions, certain miscellaneous pathology and laboratory drugs, and certain contrast materials. Prior authorization is necessary for coverage of certain medications. Medicare Part B drugs are not available via retail pharmacy network.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. You must continue to pay your Medicare Part B premium. Highmark Senior Health Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Health Company depends on contract renewal. Highmark is a registered mark of Highmark Inc. Highmark Senior Health Company is an independent licensee of the Blue Cross and Blue Shield Association. Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. Blue Cross, Blue Shield and the Cross and Shield symbols are registered service marks of the Blue Cross and Blue Shield Association.

Questions on Freedom Blue PPO benefits? **Call 1-866-456-7739** (TTY users call 711)
Reference Code (Please have this number ready when you call): **<u>18FB8342</u>**

GENERAL INFORMATION

Fund Office Information Card.

Every participant must file a completed Fund Office Information Card with the Fund Office, which may be obtained by calling or writing to the Fund Office.

Health Care Identification Cards.

When you become eligible in the Welfare Fund a check will be made for a properly completed and filed Fund Office Identification Card. Provided all requirements are met you will be issued medical cards. If you are eligible in Plan One three cards will be mailed to you (prescription drug, medical, and vision). If you are eligible for Plan Two only two cards will be mailed to you (medical and vision).

Effective Date of Coverage.

Your coverage and that of your eligible dependent or dependents will be made effective on the day you become eligible. All benefits will be based on charges for services rendered while eligible.

Change in Family Status.

It is important that you give prompt written notice to the Fund Office of any change in your family status, such as marriage, legal separation, divorce, birth of a child, adoption or placement for adoption the marriage of any of your enrolled children, or death of any dependent.

If you are enrolled for individual coverage (single only) and thereafter marry or otherwise acquire a dependent, dependent coverage will become effective on the date you acquire the dependent, provided you notify the Fund Office of the change in status.

A new completed Fund Office Information Card must be filed with the Fund Office if you wish to change your family status, address, phone and/or Beneficiary. The Fund Office Information Card with the latest date is the one recognized by the Welfare Fund.

Change of Address.

Please be sure to immediately notify the Fund Office of any change in your address by completing a new Fund Office Information Card. Any correspondence to you will be to your last address on file at the Fund Office and will constitute receipt by

you. Correspondence includes Eligibility Statements, Termination Notices, COBRA Notices and any other correspondence.

FILING FOR BENEFITS

Blue Cross and Blue Shield Benefits.

After you're covered, Highmark will issue you an identification card to be used whenever you receive any of the basic benefits provided. Always keep your current card in your possession and destroy any old Blue Cross and Blue Shield cards you may have in your possession. If you require health care service, simply show your Blue Cross-Blue Shield card and pay the co-pay if applicable. See page 105 for additional details.

Plan One and Plan Two PPO benefits have two distinct schedules for in and out of network medical services. It is important to use Highmark/AHN network providers or you will incur a higher cost for your health care. To locate a network provider is simple. You can call your current medical provider and ask if they participate in the BLUE CARD PPO NETWORK. You can also call Highmark at 1-800-241-5704 or use the Fund's website www.oe66.com, click on **"Highmark Blue Cross Blue Shield."** See Page 105 for additional details.

Vision Care Benefits.

National Vision Administrators provides vision care benefits. Call NVA at 800-672-7723 to verify eligibility for vision benefits before scheduling an eye exam. See details beginning on Page 80 or page 179 for the MEDICARE SUPPLEMENTAL PLAN.

Prescription Drug Benefits.

Prescription drug coverage is provided by OptumRx, including retail pharmacy dispensing and mail order dispensing. See details beginning on page 87 for Plan One and page 183 for MEDICARE SUPPLEMENTAL PLAN.

Dental Benefits.

Limited dental benefits are provided through the Fund Office. The annual benefit for each participant requires a claim form that can be received by calling the Fund Office, or can be found on our website.

Claim Forms.

Claim forms should be unnecessary if you use participating providers for vision, prescription, and medical services. If you use an out of network provider you may need to pay for services when they are rendered. To be reimbursed a claim form will need to be completed and sent to the proper address as noted upon the

reimbursement claim form. You may call the Welfare Fund to obtain claim forms.

Information.

Every Participant will furnish to the Trustees all information in writing, as may be reasonably requested by them for the purpose of establishing, maintaining and administering this Plan. A failure on the part of the participant to comply with the request, in good faith, will be sufficient grounds for delaying payments of benefits. The Trustees will be the sole judge of the standard of proof required in any case and they may, from time to time, adopt methods and procedures as they consider advisable. In order to process a claim under the Plan, it may be necessary to obtain your medical records. Every person covered under this Plan gives permission to this Plan to obtain their medical records from any provider, nurse, physician, hospital, nursing home, skilled nursing facility or other health care personnel or institution.

Weekly Disability Benefits.

How to file a claim. Request a claim form from the Fund Office, to be completed by you and the attending physician. Mail the completed form to the Fund Office at P.O. Box 38682, Pittsburgh, PA 15238.

Proof of Loss. Written proof of loss must be filed within one year from the date of commencement of the disability. Failure to give proper notice within 1 year from the commencement date of disability will result in loss of benefits.

PAYMENT OF BENEFITS

Hospital, Medical-Surgical Benefits, and Physician Benefits.

Benefits are underwritten by Highmark Blue Cross-Blue Shield. Covered medical expenses incurred by you or your dependents will be paid directly by Highmark to the network medical provider.

Vision Care Benefits.

These benefits are underwritten by National Vision Administrators if you use their panel of participating optometrists. Benefits are paid directly to eligible participants for services from non-panel eye doctors.

Prescription Drug Benefits.

These benefits are underwritten by OptumRx. See details beginning on Page 87 for Plan One and on Page 183 for the MEDICARE SUPPLEMENTAL PLAN.

Physical Examination.

The Trustees have the right to have any participant or dependent examined when and as often as it may reasonably require during the processing of a claim hereunder. Failure without reasonable cause to report to the Physician designated by the Trustees, after notice to do so, may disqualify a claimant from further benefit payments, at the discretion of the Trustees.

Errors in Benefit Payments.

The Trustees specifically retain the right to recover all money paid in error to, or on behalf of any person, from that person. Upon the discovery of a payment "made in error", the Trustees will notify the recipient or beneficiary of the payment, indicating the circumstances and amount of the payment, together with a request for repayment. Upon failure to repay the amount due within a reasonable time after the notification, the Trustees may take legal action, as they deem necessary. In the case of a participant of the Fund, the amount of the payment made in error may be deducted from any future benefit payments that the participant or his dependents or beneficiary may become entitled to under this Plan.

Fraud.

Any person attempting to submit false, misleading or incomplete information, or who in any way attempts to defraud the

Welfare Fund may be prosecuted in a manner the Trustees deem advisable.

Liability for the Payment of Benefits.

The total liability for the payment of all benefits under the Welfare Fund, shall be limited to the assets of the Welfare Fund.

Laws Affecting Benefits.

Employees and/or their dependents may be subject to State and Federal Laws which impact health insurance coverage. These laws include the Family and Medical Leave Act, Americans and Disabilities Act, Consolidated Omnibus Budget Reconciliation Act (COBRA), Qualified Medical Child Support Orders (QMCSO), Mental Health and Parity Act, Health Insurance Portability and Accountability Act (HIPAA), Newborns and Mothers Health Protection Act, Women's Health and Cancer Rights Act, Uniformed Services Employment and Reemployment Rights Act (USERRA), Pennsylvania Act 98, Pennsylvania Act 150 and any laws that may be enacted now or in the future. The eligibility rules and the benefits provided by this Welfare Fund will be modified to reflect the provisions of these laws.

Participants can receive a copy of the procedures for Qualified Medical Child Support Orders (QMCSO) determinations from the plan administrator at no cost. Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), participants who enter military service may elect to continued health care coverage for themselves and their dependents, while on active or reserve duty. In order to be eligible for benefits, the participant must notify the Fund Office and the Union before leaving for military service.

One of the laws impacting health insurance coverage is the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP). The required notice follows.

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Pennsylvania, New York, West Virginia, or other eligible state (a full list is available from the Fund Office), contact your State Medicaid or CHIP office to find out if premium assistance is available. Contact information is available from the Fund Office.

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

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

ELIGIBILITY REQUIREMENTS FOR ACTIVE EMPLOYEES WORKING AT THE TRADE FOR CONTRIBUTING EMPLOYERS

Benefit Period To be eligible:	Work Period You must have contributions:	Minimum Contribution Requirement As of 1/1/2020
January February March	**August September October**	PLAN ONE $3,843 PLAN TWO $1,941
April May June	**November December January**	PLAN ONE $3,843 PLAN TWO $1,941
July August September	**February March April**	PLAN ONE $3,843 PLAN TWO $1,941
October November December	**May June July**	PLAN ONE $3,843 PLAN TWO $1,941
Temporary Eligibility for Employees.	See rules for Temporary Eligibility employees.	**Monthly** PLAN ONE $1,281 PLAN TWO $647

*For subsequent periods, the above listed minimum contributions required are subject to change by the Board of Trustees.

Figure 1.

RULES OF ELIGIBILITY

Active Employees.

Active Employees working at the trade under the jurisdiction of the Union, who have been credited with the minimum contribution requirement in a Work Period, shall be eligible on the first day of the Benefit Period immediately following such Work Period. Coverage for the Active Employee's dependents, if any, will also become effective on the same first day of the Benefit Period. Employer Contributions received after a Benefit Period has started will provide retroactive coverage to the beginning of the correct Benefit Period.

An Active Employee who in his first Work Period has sufficient contributions credited to meet the Minimum Contribution Requirement for:

- Plan One will automatically be eligible for Plan One Benefits, and may not select Plan Two coverage.
- Plan Two will be eligible for Plan Two and may elect to pay for Plan One coverage.

Plan Selection for subsequent Work Periods is explained under Maintenance of Eligibility on page 52.

A schedule illustrating the Work Periods, corresponding Benefit Periods and the Minimum Contribution Requirements is shown on page 46.

Fixed Premium Employee.

For Fixed Premium Employees working under the jurisdiction of the Union, see page 76.

Special Categories.

Special categories are employees who are no longer working or dependents of former working employees, spouses and dependent children of deceased employees, early retirees, retirees, disabled, totally disabled employees and their dependents. Initial eligibility for them was established when the employee last worked. Provided the Voluntary Contribution required is received, coverage will become effective on the first day of the next Benefit Period. Additional information concerning Special Categories Quarterly Voluntary Contributions are on page 58 and 63.

Dependent Child Working as an Operating Engineer.

An eligible dependent child who works sufficient hours at the trade may become eligible and be covered as a member in either Plan One or Plan Two.

If the working dependent child is also eligible as a dependent child under the parent's eligibility, the dependent child's coverage will be in the plan that provides the better benefits.

A dependent child's contributions cannot be accumulated in a parent's account and no dependent contributions can be accumulated in a parent's Reserve of Contributions.

Husband and Wife Working as Operating Engineers.

Plan eligibility will be determined as if the husband and wife were one individual, but both husband and wife's employer contributions and Reserve of Contribution balance, if any, will be used. The plan of benefits will be based on applicable minimum contribution requirements for Plan One or Plan Two. The husband, wife and dependent children will always be covered under the same plan. The definition of dependents shall be the same as those listed in the Rules of Eligibility.

The husband and wife must both be working as Operating Engineers and give written notification to the Fund Office of their desire to follow these rules. During any subsequent eligibility period, either individual may cancel their selection. If there is a divorce, each individual will retain their own Reserve of Contributions, if any. If one spouse retires from the trade and the other continues to be employed, coverage is still calculated based upon both spouses working. This is required since any actively employed spouse eligible for benefits also maintains coverage for the other family members.

The following method will be used in determining HUSBAND AND WIFE WORKING AS OPERATING ENGINEERS eligibility -

- The actual cost for the benefit period will be applied on a 50/50 basis against the contributions and reserves of each individual. If the balance in either of the accounts is not sufficient to establish eligibility, then an amount may be transferred from the other spouse's account (if any is available) to establish eligibility. If there is still an amount due, a Voluntary Contribution will be required.
- Any excess of contributions not necessary to meet the cost of plan benefits will be added to

the individual's own reserve at 100% of the excess.

Medicare.

If you and/or your dependents qualify for Medicare benefits, you must enroll when the Medicare's rules permit you to enroll in both Medicare Part A and Part B. All employees, without a Reserve of Contributions balance who retire and their dependents if applicable should apply for Medicare Part A and Part B coverage about three months prior to eligibility or to becoming age 65. Employees who retire with a Reserve of Contributions balance, and dependents who are not disabled should wait until their Reserve is exhausted prior to applying for Medicare Part B.

Benefit payments from this Welfare Fund, Blue Cross and/or Blue Shield will take into account payments from Medicare.

Medicare Rules – Retirees.

Federal Medicare Rules have been changed which affect all retirees who return to work in the industry.

- Medicare benefits are secondary to Operating Engineers Local 66 Welfare Fund plan benefits if an individual is employed and covered, by reason of employment, under a group health plan.
- The Operating Engineers Welfare Fund (Plan One or Plan Two) automatically becomes the primary provider of health coverage when a retiree, covered by Medicare, returns to work - unless the retiree refuses coverage by completing a waiver of Plan One or Plan Two coverage.
- The Operating Engineers Welfare Fund cannot induce a retiree returning to work to waive Plan One or Plan Two coverage - for example, by offering a Medicare Supplemental Plan or a contribution credit.
- The same benefit and eligibility rules must apply to retirees returning to work as apply to active employees.

To coordinate the Welfare Fund with Medicare, the following Welfare Fund rules will apply:

- A retiree eligible for Medicare who returns to work and does not refuse coverage under the Operating Engineers Welfare Fund, will be eligible only for Plan One or Plan Two coverage in the

corresponding Benefit Period at active rates. Active rates will apply until all new Employer Contributions and new Reserve of Contributions earned during the return to work are exhausted.

This means the rehired retiree will **NOT** be eligible for the Operating Engineers Medicare Supplemental Plan, either of the Medicare PPO plans or the credit from the Retirees Contribution Account.

- A Medicare eligible retiree who returns to work and refuses active employee coverage under the Operating Engineers Welfare Fund will not be eligible for any benefits in Plan One or Plan Two for the corresponding Benefit Period. However, the retiree may remain covered by the Medicare Supplemental Plan, Freedom Blue or Freedom Blue TWO.

  The rehired retiree will **NOT** be eligible for the credit from the Retirees Contribution Account, or the credit of Employer Contributions that have been paid in during the work period.

- Reserve of Contributions will be treated as contributions by reason of employment. Therefore, an employee who retires with a Reserve of Contributions and/or Employer Contributions paid during the work period will continue in Plan One or Plan Two at retiree rates until the Reserve and/or contributions are exhausted, even if the person is eligible for Medicare.

- A retiree who returns to work at any age will be charged the Active Employees Minimum Contribution Rates for coverage under Plan One or Plan Two. Active rates will apply until all new Employer Contributions and new Reserve of Contributions earned during the return to work are exhausted.

- A retiree age 62 or older who returns to work will not be eligible for the credit from the Retirees Contribution Account.

- The dependent of a retiree who returns to work will only be covered under the same Benefit Plan as the retiree (Plan One or Plan Two).

Medicare Eligible Retirees.

If you are not disabled, initially retire at age 65 or older, and eligible for Medicare with a Reserve of Contributions or Employer Contributions in a work period, you will remain in Plan One or Plan Two and charged retiree rates until your Reserve of Contributions and/or Employer Contributions is exhausted. You will be eligible for the Welfare Fund's Medicare Supplemental Plan or Freedom Blue or Freedom Blue TWO and credit from the Retiree's Contribution Account, in the eligibility period **following** the period in which your Reserve of Contributions and/or Employer Contributions are exhausted.

If you are receiving Social Security Disability Insurance benefits and eligible for Medicare Part B you will be eligible for the Welfare Fund's Medicare Supplemental Plan, Freedom Blue, or Freedom Blue TWO and if applicable the credit from the Retiree's Contribution Account.

Retirees Not Eligible for Medicare.

If you initially retire prior to age 65 as an early retiree with a Reserve of Contributions and/or Employer Contributions in the Work Period, you will remain in Plan One or Plan Two and charged retiree rates until your Reserve of Contributions and/or Employer Contributions are exhausted, even if this period extends beyond age 65 when you would otherwise be eligible for Medicare. If you are age 62 or older, you will become eligible for the credit from the Retirees' Contribution Account in the eligibility period **following** the period your Reserve of Contributions and/or Employer Contributions are exhausted.

All Retirees.

Timely enrollment in Medicare Part A and Part B will avoid any surcharge or delay once you become eligible for Medicare as your primary plan.

MAINTENANCE OF ELIGIBILITY

Active Employees.

Active Employees shall continue to be eligible for benefits in subsequent Benefit Periods, provided they have been credited with the Minimum Contribution Requirement in the preceding Work Period.

PLAN ONE - An Active Employee who in the previous Benefit Period was covered in Plan One and who in the current Benefit Period -

- Has Employer Contributions plus a Reserve of Contributions balance which in total is in excess of twice the Minimum Contribution Requirement for Plan One, will automatically be eligible for Plan One.

- Meets the Minimum Contribution Requirement for Plan One, will be given the choice of selecting Plan One or Plan Two. The selection is made by indicating the choice on the Welfare Fund Eligibility Statement Stub and returning it to the Fund Office by the stated due date. Failure to do so will automatically result in a Plan One selection.

- Does not meet the Minimum Contribution Requirement for Plan One will be given the choice of-
  - Making a Voluntary Contribution for the balance due to be eligible for Plan One or Plan Two.

    -or-
  - Selecting Plan Two, if the Minimum Contribution Requirement for Plan Two is met.

PLAN TWO - An Active Employee who in the previous Benefit Period was covered in Plan Two and who in the current Benefit Period-

- Has Employer Contributions plus a Reserve of Contributions balance which in total is in excess of twice the Minimum Contribution Requirement for Plan One, will automatically be eligible for Plan One.

- Has Employer Contributions plus a Reserve of Contributions balance which in total equals the Minimum Contribution Requirement for Plan One, is given the choice of selecting either Plan One or Plan Two. The selection is made by indicating the choice on the Welfare Fund Eligibility Statement Stub and returning it to the Fund Office by the stated due date. Failure to do so will automatically result in a Plan One selection.

- Does not meet the Minimum Contribution Requirement for Plan One and/or Plan Two, will have to make a Voluntary Contribution for the balance due, in order to be eligible for Plan Two only.

Employer contributions, disability credits, Worker's Compensation credits and Voluntary Contributions, if necessary can meet the Minimum Contribution Requirement. If the employee has less than the minimum contribution requirement, see Voluntary Contributions page 56.

Fixed Premium Employee.

For Fixed Premium Employees working under the jurisdiction of the Union, see section – Fixed Premium Employees Eligibility Rules on page 76.

Special Categories.

Special Categories shall continue to be eligible for benefits provided the proper Voluntary Contributions are made.

RESERVE OF CONTRIBUTIONS

Employer Contributions received in a Work Period, which are in excess of the Minimum Contribution Requirement for a Benefit Plan, may be accumulated as Contribution Credits in a Reserve of Contributions Account.

Additions to the Reserve.

The excess of the minimum Employer Contributions required for eligibility will be accumulated in the Reserve of Contributions as Contribution Credits.

Applying the Reserve.

Contribution Credits held in the Reserve of Contributions Account will automatically be withdrawn, to the extent necessary, in order to maintain the eligibility of an employee who fails to meet the Minimum Contribution Requirement in a subsequent Work Period. Should the Employer Contributions and/or the Contribution Credits held in the employee's Reserve of Contributions Account be insufficient to meet the Minimum Contribution Requirement, the employee may make up the shortage in contributions through a Voluntary Contribution. If an employee fails to make the Voluntary Contribution, coverage will be terminated and any balance in the Reserve of Contributions Account and any Employer Contributions Credits will be canceled.

Application of the Reserve of Contributions is automatic, when needed to maintain eligibility and cannot be waived for any reason. The credits in the account are for maintaining eligibility in the Welfare Fund and as permitted under the Member Reimbursement Benefit only and cannot be applied for any other purpose nor withdrawn.

Limitations on Reserve Usage.

The Reserve of Contributions Account is intended to allow an active employee to maintain eligibility under the Welfare Fund when the employee is unable to work in employment covered by the Welfare Fund due to periods of low or no employment within the trade.

Active employees not in the employ of a contributing employer will only have access to their Reserve and Member Reimbursement Benefit (MRB) if they are actively seeking, and available for employment with a contributing employer. Employees will be considered to be actively seeking and available

for employment for a benefit period if they are on the Local Union's Referral (out-of-work) List at the beginning of the benefit period.

Limitations do not apply if any of the following occur:

- Employee retirement.
- Employee is disabled due to a non-occupational accident or illness and entitled to Disability Credits from the Welfare Fund.
- Employee is receiving Workers' Compensation and entitled to Workers' Compensation Credits from the Welfare Fund.
- Employee continues to be unable to work due to an accident or illness and Disability or Workers' Compensation credits are exhausted. Medical evidence of the accident or illness must be presented upon request.
- Employee is totally disabled as per the Welfare Fund.

If this rule is applicable and coverage is lost under the Welfare Fund Plan, the employee and any eligible dependents will then be offered COBRA continuation coverage and/or conversion rights with respect to health care coverage.

Reserve Usage After Retirement.

Retirees eligible for Medicare based upon age with a Reserve of Contributions balance must remain in Plan One or Plan Two until their Reserve is exhausted, at that point a Medicare Supplemental or Medicare Advantage Plan will be available. Retirees with a Reserve balance who are not disabled should consider delaying application for Medicare Part B benefits when attaining age 65.

Maximum Reserve.

The maximum reserve that may be accrued is $30,000.00.

VOLUNTARY CONTRIBUTIONS

In order to provide benefit coverage to as many participants as possible and to allow participants who might otherwise lose Welfare Fund benefits because of lack of employment, disability or retirement from the trade, the Fund has extended to these individuals the privilege of making Voluntary Contributions. Indicated below are the RULES AND REGULATIONS pertaining to the payment of VOLUNTARY CONTRIBUTIONS:

- All Voluntary Contributions must be paid by check or money order made payable to OPERATING ENGINEERS LOCAL 66 WELFARE FUND. No cash will be accepted. No installment payments will be permitted.
- Voluntary Contributions can only be made for the Benefit Period immediately following the Work Period in which the person has failed to earn the required contributions. No advance payments for other than the current Benefit Period will be accepted.
- All Voluntary Contributions must be paid within 60 calendar days following the end of a Work Period. Payment due dates are: March 31, June 30, September 30 and December 31.
- Voluntary Contributions from Active Employees who have less than the minimum contributions required will be accepted if they have been eligible in the previous Benefit Period.
- Active Employees that do not have any employer contributions may make Voluntary Contributions for a maximum of 18 months (six quarterly eligibility periods). After this time, if the Active Employee has not been credited with employer contributions, no further Voluntary Contributions will be accepted.
- If you were not eligible in the previous Benefit Period, you will not be able to make a Voluntary Contribution until you re-establish your eligibility.

Active Employees.

Active employees, who were eligible for Plan One in the preceding Benefit Period and who fail to earn sufficient contributions to maintain their eligibility in a subsequent Benefit Period, may make a Voluntary Contribution for the difference between the total contributions credited on their behalf and the Minimum Contribution Requirement for either Plan One or Plan Two.

An Active Employee who in the previous Benefit Period was covered by Plan Two and who does not meet the current Minimum Contribution Requirement for Plan Two may make a Voluntary Contribution to meet the Minimum Contribution Requirement for Plan Two. This employee cannot make a Voluntary Contribution for Plan One.

An Active Employee who in the previous Benefit Period was covered by Plan Two and who has Employer Contributions plus a Reserve of Contributions balance which equals the Minimum Contribution Requirement for Plan One, will be given the choice of selecting either Plan One or Plan Two.

If you are eligible in the preceding Benefit Period and you do not have any employer contributions in subsequent Work Periods, Voluntary Contributions may be made for a maximum of 18 months (six quarterly eligibility periods). After this time, if the Active Employee has not been credited with employer contributions, no further Voluntary Contributions will be accepted. The Active Employee and any eligible dependents will then be eligible for COBRA and/or conversion rights.

Voluntary Contributions will not be accepted from any Employee who was not eligible in the preceding Benefit Period.

If an Active Employee has not been eligible in the previous Benefit Period and has employer contributions made in the current Work Period, which are less than the minimum contributions requirement for Plan Two, the employee will not be able to make a Voluntary Contribution for eligibility in the current Benefit Period. These contributions will be accumulated for up to 12 months, on a quarterly basis. If sufficient contributions to meet the minimum eligibility requirement for at least Plan Two are accumulated during the 12 months period, the employee will be eligible in the next Benefit Period.

Limitations on Voluntary Contributions.

Voluntary Contributions are intended to allow an active employee to maintain eligibility under the Welfare Fund when the employee is unable to work in employment covered by the Welfare Fund due to periods of low or no employment within the trade.

Active employees not in the employ of a contributing employer will only be able to make a Voluntary Contribution if they are actively seeking, and available for employment with a contributing employer. Employees will be considered to be actively seeking and available for employment for a benefit period if they are on the Local Union's Referral (out-of-work) List at the beginning of the benefit period.

Limitations do not apply if any of the following occur:

- Employee retirement.
- Employee is disabled due to a non-occupational accident or illness and entitled to Disability Credits from the Welfare Fund.
- Employee is receiving Workers' Compensation and entitled to Workers' Compensation Credits from the Welfare Fund.
- Employee continues to be unable to work due to an accident or illness and Disability or Workers' Compensation credits are exhausted. Medical evidence of the accident or illness must be presented upon request.
- Employee is totally disabled as per the Welfare Fund.

Special Categories (retirees).

Employer Contribution Credits and personal payments made or credited during the Work Period will be offset against the amount due. You are advised to check with the Fund Office if you have any questions concerning the amount you may be required to contribute. Not all possible combinations are listed.

All Quarterly Voluntary Contributions are for a three-month Benefit Period. No partial refunds will be made because of a desire to terminate eligibility, except for Freedom Blue and Freedom Blue Two, which are not administered by the Welfare fund. The Welfare Fund will refund the unused portion of a self-contribution paid when a Special Category member or participant dies in either the first or second month of a Benefit Period. In the case of divorce, the Welfare Fund will refund the unused portion of a self-contribution paid, upon request, when the divorce occurs in either the first or second month of a Benefit Period.

THE BOARD OF TRUSTEES RESERVES THE RIGHT TO CHANGE OR AMEND THE VOLUNTARY CONTRIBUTIONS SCHEDULE AT ANY TIME.

DISABILITY CREDITS

Active employees who become disabled and unable to work because of a non-occupational accident or sickness while eligible under this Plan, will be credited with forty hours of Disability Credits for each full week that disability benefits are paid by the Welfare Fund, subject to a maximum of twenty-six (26) weeks of credit per period of disability. There will be no credit for the first week of disability or less than a full week of disability. Disability credits will not be accumulated in the Reserve of Contribution Account. Disability Credits are to be credited to the Work Period corresponding to the period of time weekly disability has been paid. Disability credits are calculated based upon the employees Plan One or Plan Two eligibility on the initial date of disability.

WORKERS' COMPENSATION CREDITS

Active employees who are receiving Worker's Compensation Benefits, must notify the Fund Office immediately and must furnish satisfactory proof of disability in order to receive Worker's Compensation Credits during the period of disability resulting from occupational illness or injuries. Failure to comply with the foregoing will disqualify a disabled person from receiving Worker Compensation Credits for the disability.

Employees who are receiving Worker's Compensation Benefits while eligible under this Plan, will be credited with forty hours of Worker's Compensation Credits for each full week of Worker's Compensation, commencing with the second week, subject to a maximum of twenty-six (26) weeks of credit per period of Worker's Compensation. There will be no credit for the first week, less than a full week or after retirement. Worker's Compensation Credits will not be accumulated in the Reserve of Contributions. Worker's Compensation Credits are to be credited to the Work Period corresponding to the period of time Worker's Compensation benefits have been paid.

Successive periods of Worker's Compensation Benefits separated by less than 150 hours of employment will be considered one continuous period, unless they arise from different and unrelated causes. If you have a different and unrelated disability and return to work for only one full day, you will be entitled to a new period of Worker's Compensation Credits.

RETIREES' WELFARE CONTRIBUTION ACCOUNT

The Welfare Fund receives a separate employer contribution to be accumulated in the Retirees' Welfare Contribution Account. This is used to reduce the Voluntary Contributions of retired employees 62 and older and totally and permanently disabled employees in receipt of Medicare. Only employees with contributions to this fund are eligible for its benefit.

The Board of Trustees will make a determination as to the amount to be distributed from the Retirees' Welfare Contribution Account. Distributions may increase or decrease from benefit period to benefit period, based on the seasonal employer contributions to the Retirees' Welfare Contribution Account.

The money distributed will be shared equally and will be posted on the eligibility statements of a retired employee, who is 62 or older and a totally and permanently disabled employee, who is in receipt of Medicare. If the amount of this distribution exceeds the amount required for the Voluntary Contribution, the amount of the distribution will be reduced to the amount necessary to meet the Voluntary Contribution due. Any balance of the distribution not used will be returned to the Retirees' Welfare Contribution Account. Any employee who has a Reserve of Contributions balance or employer contributions will not be eligible for the distribution from the Retirees' Welfare Contribution Account.

EMPLOYEES WORKING UNDER RECIPROCAL AGREEMENTS

In order to extend coverage to those employees who are required from time to time to work outside the jurisdiction of this Fund, Reciprocal Agreements have been executed with many of the Welfare Funds nationwide. These Reciprocal Agreements provide for the transfer to this Fund of contributions earned by those employees who were temporarily working under the jurisdiction of another Welfare Fund signed to an Agreement. The employee will be credited with the actual amount of the contributions transferred under the Agreement and the contributions must be applied to the actual month in which the work was performed.

It is not always possible to obtain the transfer of contributions from another Welfare Fund during the current eligibility period. Employees will be credited with the actual amount of the contributions transferred under an Agreement and

credit can only be given when the contributions are received from the other Welfare Fund. Therefore, it may be necessary for the employee to make a Voluntary Contribution in order to maintain eligibility in the Local 66 Welfare Fund. Upon receipt of the contributions from the other Welfare Fund, a refund will be made to the employee, if any is due.

If an employee worked in the jurisdiction of another Welfare Fund and that Welfare Fund refuses to transfer contributions for any reason (including not collecting contributions), then no credit will be given by this Welfare Fund.

If there is no Reciprocal Agreement in effect with the other Welfare Fund or the transfer of contributions is not done, you may be able to continue your coverage by making a Voluntary Contribution. Please refer to Voluntary Contributions on page 56.

Before leaving the jurisdictional area of Local 66, check with our Fund Office to confirm that a Reciprocal Agreement is in effect in the area where you will be working. It is your responsibility to contact the Operating Engineers Local in the area you are working to obtain a Transfer Authorization form. This form needs to be completed and returned to the Local where you are working. If you do not complete these steps you will not be credited any Welfare Fund employer contributions while working outside the Local 66 jurisdiction.

Below is a list of some of the Welfare Funds with whom Reciprocal Agreements have been signed as of the date of this booklet.

Local 3	Alameda, CA
Local 4	Boston, MA
Local 9	Denver, CO
Local 14	Queens, NY
Local 15	New York, NY
Local 17, 158, 463	Upstate, NY
Local 18	Columbus, OH
Local 25	New York, NY
Local 37	Baltimore, MD
Local 49	St. Paul, MN
Local 57	Providence, RI
Local 77	Washington, DC
Local 98	Springfield, MA
Local 101	Kansas City, MO
Local 103	Indianapolis, IN
Local 132	Huntington, WV
Local 137	Briarcliff Manor, NY
Local 138	Farmingdale, NY

Local 139	Pewaukee, WI
Local 147	Norfolk, VA
Local 150	Countryside, IL
Local 150R	Springfield, IL
Local 181,320	Henderson, KY
Local 234	Des Moines, IA
Local 302	Bothell, WA
Local 312	Birmingham, AL
Local 318	Indianapolis, IN
Local 324	Livonia, MI
Local 369	Cordova, TN
Local 406	New Orleans, LA
Local 450	Dayton, TX
Local 465	Durham, NC
Local 470	Graniteville, SC
Local 474	Pooler, GA
Local 478	Hamden, CT
Local 487	Miami, FL
Local 513	Bridgeton, MO
Local 542	Blue Bell, PA
Local 571	Omaha, NE
Local 612	Tacoma, WA
Local 624	Jackson, MS
Local 627	Tulsa, OK
Local 649	Peoria, IL
Local 653	Mobile, AL
Local 673	Jacksonville, FL
Local 793	Midland, Ontario
Local 800	Bar Nunn, WY
Local 825	Newark, NJ
Local 841	Terre Haute, IN
Local 917	Knoxville, TN
Local 925	Mango, FL
Local 926	Rex, GA
Local 953	Blue Bell, PA
Pipeline	Washington, DC

SPECIAL CATEGORIES

Spouses and Dependent Children of Deceased Employees.

The eligibility of a spouse or child(ren) of deceased employee will be continued for the duration of the Benefit Period in which the death occurred. Thereafter the spouse's coverage and that of the dependent children, as herein defined, may be continued provided the required voluntary contribution is received by the Welfare Fund Office. Upon remarriage, coverage of that person will cease on the earlier of either (a) 90 days from the date of remarriage or (b) the last day of the Benefit Period in which remarriage occurred.

Coverage for a spouse and dependents will continue in the same plan in which the employee was last eligible at the time of death.

Retirees.

An employee age 55 or over who retires from the trade shall be eligible for benefits, provided (1) employee has been eligible under this Plan at least one Benefit Period in each year of the five consecutive years prior to the time of retirement, and (2) employee files an application for Welfare Retirement benefits and the application is approved, and (3) employee makes the required Voluntary Contribution.

Retirees who are eligible for Medicare based upon age and do not have a Reserve of Contributions balance are eligible only for the MEDICARE SUPPLEMENTAL PLAN, FREEDOM BLUE or FREEDOM BLUE TWO. Retirees who are eligible for Medicare based upon age and have a Reserve of Contributions balance are only eligible for Plan One or Plan Two. Retirees who are eligible for Medicare based upon disability are eligible only for the MEDICARE SUPPLEMENTAL PLAN, FREEDOM BLUE or FREEDOM BLUE TWO. Retirees who are not eligible for Medicare and have employer contributions and/or a reserve balance in excess of the cost of Plan One, will be eligible for Plan One only. Retirees with less than the cost of Plan One may select Plan One or Plan Two. Once selected, plan coverage cannot be changed until the Retiree becomes subsequently eligible for Medicare.

Dependents of Eligible Retirees.

An eligible retiree may elect to continue the coverage for a dependent spouse and/or children at the time of retirement.

Retirees electing to continue eligibility for their dependent spouse and/or children may terminate the dependent coverage at the end of any subsequent Benefit Period by notifying the Fund Office, in writing and by not making the required Voluntary Contribution for the dependents. In this event, no further contributions will be accepted for the terminated dependents and their dependent coverage may never be reinstated in the future.

Retirees' dependents who are eligible for Medicare are eligible only for MEDICARE SUPPLEMENTAL PLAN, FREEDOM BLUE or FREEDOM BLUE TWO. Retirees' dependents who are not eligible for Medicare are eligible in the same plan as selected by the Retiree. Once selected, plan coverage cannot be changed unless the dependent becomes eligible for Medicare.

Field Supervisory Employees.

Field Supervisory Employees and Foremen shall be eligible only if their employer contributes on the same basis as an active employee working at the trade (a minimum of 40 hours a week).

These Employees who become disabled while eligible, may continue the eligibility for themselves and their dependents in the event their employment is terminated by making Voluntary Contributions in the amount set by the Trustees.

Totally Disabled Employees.

An Employee, who becomes totally disabled as a result of an injury, illness, or pregnancy incurred while eligible shall continue to be covered for benefits, provided the employee makes the required Voluntary Contribution. Employees that have Disability or Worker's compensation credits must use these credits before they can be classified as disabled for the purposes of this plan. "Total Disability" is defined as being disabled as a result of an injury, illness, or pregnancy, which prevents the Employee from engaging in any and every type of employment for wage or profit, for which the employee is reasonably fitted by education, training or experience. Employees who have a Social Security Disability Award are also considered totally disabled.

Dependents of Disabled Employees will also remain eligible for benefits during the period of the employee's total disability, provided the required Voluntary Contribution is made. If the required Voluntary Contribution is not made for a dependent, that dependent is terminated and the dependent cannot be reinstated unless the employee becomes eligible as an active participant again.

Coverage for employees disabled less than 24 months and their dependents will continue in the same Plan in which the

employee was last eligible at the time of his disability. The Fund Office will require employees to update their disability status on an annual basis. Failure to complete the requested forms will classify the employee as being no longer disabled. If disabled for more than 24 months and eligible for Medicare, the employee must enroll in Medicare and will be eligible only for the MEDICARE SUPPLEMENTAL PLAN, FREEDOM BLUE or FREEDOM BLUE TWO from this Welfare Fund. If the employee is disabled for more than 24 months and found by the Centers for Medicare and Medicaid Services not to be eligible for Medicare benefits, he may select either Plan One or Plan Two. Once selected, the coverage cannot be changed.

TERMINATION OF ELIGIBILITY

Active Employees Working at Trade.

The coverage of an Active Employee, working at the trade, will be terminated on the day immediately preceding any Benefit Period following a Work Period in which the amount of contributions and/or Voluntary Contributions required for eligibility was not received. If only Voluntary Contributions have been made for a maximum of 18 months (six quarterly eligibility periods) and the active employee has not been credited with Employer Contributions, coverage will be terminated.

The Active Employee and any eligible dependents will then be eligible for COBRA and/or conversion rights.

Fixed Premium Employees.

For Active members whose employer pays a fixed premium amount per month see section – FIXED PREMIUM on Page 76.

Dependents of Active Employees.

Dependent coverage normally will terminate on the same date as the employees coverage terminates. The coverage of a dependent spouse or child under age 19 cannot be terminated at the employee's request, unless ordered by a Court**.** However, coverage of a dependent will terminate on the last day of the month in which the dependent ceases to be a dependent, as defined herein.

In the case of divorce, a spouse's coverage will terminate on the last day of the month in which the divorce occurred. Members are responsible for notifying the Fund Office at the time of their divorce. Members have until the end of an eligibility quarter to notify the Fund Office of a divorce. Any delay in providing a timely notification of your divorce will allow your former spouse to maintain coverage through the Welfare Fund. Since coverage is incorrectly provided for your ex-spouse, members will be responsible to pay any cost incurred by the Welfare Fund.

Spouses and Children of Deceased Employees.

A deceased employee's dependent's coverage will terminate either, (1) on the last day of the benefit period in which death occurred, or (2) in the event the required Voluntary Contribution was made, the last day of the benefit period for which a Voluntary Contribution was made.

In the event of remarriage, the spouse's coverage will be terminated on the earlier of, (a) 90 days from the date of

remarriage, or (b) the last day of the benefit period in which remarriage occurred. A dependent child, in this case, can make a Voluntary Contribution to continue his or her coverage as long as he or she qualifies as a dependent.

Retired Employees and Their Dependents.

The coverage of retired employees and their eligible dependents shall be terminated on the day immediately preceding any Benefit Period following a Work Period in which the amount of the required Voluntary Contribution is not received. In the case of a divorce, dependent coverage can remain until the end of the current quarter.

Field Supervisory Employees.

The coverage of a Field Supervisory Employee will be terminated on the day immediately preceding any Benefit Period following a Work Period in which the amount of the required Voluntary Contribution is not received.

Totally Disabled Employees.

Coverage of totally disabled employees and their eligible dependents shall terminate on the last day of the Benefit Period in which the disabled employee recovers or on the day immediately preceding any Benefit Period following a Work Period in which the amount of the required Voluntary Contribution is not received. An employee who recovers shall no longer be considered a totally disabled employee.

Uniformed Services.

Coverage of an employee entering the uniformed services will be governed by the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994. Under USERRA, participants who enter military service may elect to continued health care coverage for themselves and their dependents, while on active or reserve duty. In order to be eligible for benefits, the participant must notify the Fund Office and the Union before leaving for military service. Upon reemployment with a contributing employer, the employee will be reinstated to coverage without any exclusions or waiting periods, except for coverage of any injury or illness determined by the Veterans Administration to have been incurred or aggravated during the period of uniformed service. Subsequent eligibility will be based upon employment in the industry, in accordance with the rules of eligibility then in effect.

COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act (COBRA), a Federal law, requires most employer sponsored health care plans to offer temporary continuation of health care coverage to certain categories of employees and their eligible dependents when there is a termination of coverage because of a qualifying event.

Qualifying Event.

A "Qualifying Event" is a situation that involves a covered participant and/or their eligible dependents that results in the loss (or termination) of group health coverage (for reasons other than gross misconduct).

The following is a list of Qualifying Events and the period of time COBRA coverage can be continued:

Qualifying Event	Qualifying Beneficiaries	Continuation Coverage
Employee's termination of employment or reduction in hours of employment	Employee, Spouse and dependent child	18 months (29 months if qualified beneficiary is disabled)
Death of Employee	Spouse and dependent child	36 months
Employee's divorce from spouse	Spouse and dependent child	36 months
Employee's entitlement to Medicare	Spouse and dependent child	36 months
Dependent child is no longer an eligible dependent	Dependent child	36 months

The Board of Trustees has determined that because of the nature of the construction industry with its multi-employer work and seasonal employment, an employee's termination of employment and/or hours of employment will be considered reduced, if the employee fails to meet the eligibility requirements and terminates regular benefits.

In the event more than one qualifying event applies, the periods of COBRA Continuation Coverage will run concurrently.

Notification of Qualifying Event.

Under the COBRA Law, the participant or family member has the responsibility to inform the Welfare Fund Office of a death, divorce, legal separation or a child losing dependent status under the plan within 60 days of the date of the event. Dependent children who attain age 26 will lose their dependent status.

It is not the responsibility of the Welfare Fund Office to be aware of any changes in your family status. Under all circumstances, you must notify the Welfare Fund Office, in writing, of any changes. If notice is not received within the 60 day time period, the member, spouse and/or dependents will not be entitled to choose COBRA Continuation Coverage.

COBRA Election Form.

When the Fund Office is notified that one of the qualifying events has happened, the Fund Office will in turn notify you, at your last known address, within 14 days of receiving the notice, that you have the right to choose COBRA Continuation Coverage.

Under COBRA law, you have 60 days from the date you lose coverage, or are sent a Cobra Election Form due to a qualifying event to inform the Fund Office in writing, that you want COBRA Continuation Coverage by completing and filing the COBRA Election Form.

The Welfare Fund must offer each qualified beneficiary the opportunity to make an independent election to receive COBRA Continuation Coverage. The eligible participant or spouse, however, can make the election on behalf of other qualified beneficiaries affected by the qualifying event. This decision is binding on each family member once the choice is made.

If you do not choose COBRA Continuation Coverage on a timely basis, your Welfare Fund health coverage will have ended at your date of termination.

COBRA Benefits.

If you choose COBRA Continuation Coverage, benefits will be identical to those you were covered for prior to termination. That means if you were in Plan One in the previous Benefit Period, you will now be eligible for Plan One COBRA Core Benefits. If you were eligible for Plan Two in the previous Benefit Period, you will be eligible for Plan Two COBRA Core Benefits. However, Death, Accidental Death & Dismemberment and Weekly Disability Benefits will be excluded. You cannot switch between Plans.

Disability.

The 18 months of COBRA Continuation Coverage may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination of eligibility. To benefit from this extension, a qualified beneficiary must notify the Fund Office, in writing, of that determination within 60 days and before the end of the original 18-month period. The affected individual must also notify the Fund Office within 30 days of any financial determination that the individual is no longer disabled.

Health Insurance Portability and Accountability Act (HIPAA).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 1, 1997. HIPAA coordinates COBRA's other coverage cut-off rule with the HIPAA limits as follows.

If a qualified beneficiary becomes covered by another group health plan and that plan contains a pre-existing condition limitation that affects this individual, this individual's COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to the qualified beneficiary by reason of HIPAA's restrictions on pre-existing condition clauses, the Welfare Fund may terminate this individual's COBRA coverage.

COBRA Premium Payment.

You do not have to show that you're insurable to choose COBRA Continuation Coverage. However, under the law, you have to pay all or part of the premium for your continuation coverage.

If you elect the continuation coverage, you will be required to make the payment retroactive to the date your coverage was terminated. You must pay the cost to maintain the coverage. There will be a forty-five (45) day grace period for the payment of the initial premium from the date you elect to continue COBRA coverage. COBRA Continuation Coverage will not be in effect until premiums are paid.

After your initial premium payment, premiums will be payable on the first of each month. A thirty-day grace period will

be allowed for all premium payments after the initial premium. If any premium payment is not received within the grace period, COBRA Continuation Coverage will automatically terminate retroactive to the date through which a premium was last received. At the end of the COBRA Continuation Coverage period, you will be allowed to enroll in an individual conversion health plan if you had that right while covered by the Fund.

Any employer contributions and reserve of contribution balances that had been dropped at termination will be reinstated and subtracted from the initial payment due under COBRA. If these credits are in excess of the initial payment due, the unused credits will be applied to subsequent monthly COBRA payments. Any unused credits cannot be used to re-establish eligibility. New employer contributions that are received for a subsequent period cannot be applied to the COBRA payments or accumulated for future eligibility. New employer contributions, as defined, will only be used to re-establish eligibility in the Plan, in the Benefit Period that corresponds to the Work Period, as provided for in the Eligibility Rules (see page 47).

Termination of COBRA Continuation Coverage.

COBRA Continuation Coverage may be discontinued for any of the following reasons:

- The date the 18 month or 36 month coverage period ends.
- The premium for continuation coverage is not paid on time.
- The qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition.
- Covered individuals become eligible for Medicare;
- The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.
- The Welfare Fund discontinues all group health plans.

TEMPORARY ELIGIBILITY

Temporary Eligibility is only available to employees of contributing employers that agree to the rules of temporary eligibility through their Collective Bargaining Agreement.

Initial Eligibility.

A new employee or those who have not been eligible for 18 consecutive months can have a temporary monthly enrollment period provided. The enrollment period will last no less than three consecutive months and no more than five consecutive months. After the completion of the enrollment period, coverage will be provided on a quarterly basis as defined in the plan.

The employee and his dependents will become eligible on a monthly basis on the first day of the second full month, following the first month in which the employer is obligated to make contributions, provided sufficient contributions are received. Sufficient contributions are defined as an amount equal to the Minimum Monthly Contribution required from either hourly contributions or flat rate Minimum Monthly Contributions.

The current minimum monthly contribution requirement for Temporary Eligibility Employees for Plan One and Plan Two are listed on Page 46.

If the employer, under the Collective Bargaining Agreement, is obligated to begin contributions for an employee at a date later than when the employee is first hired, the employee will be covered on the first day of the second full month, following the first month for which the employer actually commences contributions.

Those covered under initial eligibility can be eligible for Plan One or Plan Two. If the employee has sufficient contributions for Plan Two, he may make the required Voluntary Contribution for Plan One. If the employee does not have sufficient employer contributions to meet the Minimum Monthly Contribution for Plan Two, he may not make a Voluntary Contribution for either Plan One or Plan Two. These employer contributions can be accumulated for up to 12 months. If sufficient contributions to meet the minimum eligibility requirement for at least Plan Two are accumulated during the 12-month period, the employee will be eligible for the next benefit month.

Maintaining Eligibility.

During the temporary enrollment period, active employees will be eligible for benefits each month that they meet the minimum monthly contribution requirement from employer contributions,

Reserve of Contributions and/or Voluntary Contributions. Eligible employees will be covered for benefits on the first day of the benefit month following the month for which contributions are received. For example, work performed in January will be received by the Welfare Fund during the month of February; you will then be eligible for benefits during the benefit month of March. See Temporary Eligibility Table on page 75.

Hourly-Rate Employees.

During the enrollment period, an eligible employee whose employer makes hourly contributions will continue to be eligible for benefits on a rolling monthly basis, provided the required minimum monthly requirement is paid (See Page 46). This amount may consist of employer contributions, any Reserve of Contributions balance (as explained later) and Voluntary Contributions that the employee may be required to make. Employees who have contributions paid on an hourly basis will be covered for the benefit month following the month for which contributions are received. If the employee does not have the amount necessary for eligibility, the Fund Office will bill the employee for the amount due for that month. The employee will be required to make a Voluntary Contribution for the difference.

Flat-Rate Employees.

During the enrollment period, an employee who was eligible in the previous month and who meets minimum contribution requirements from employer contributions, Reserve of Contributions or Voluntary Contributions, will be eligible on a rolling monthly basis for benefits. If the flat rate monthly contribution does not cover the full amount of the Minimum Monthly Contribution requirement for Plan One, any Reserve of Contributions balance may be applied. If this is not sufficient, then a Voluntary Contribution will be required for the difference.

As long as there are sufficient contributions and/or reserves for Plan One, the employee, who was eligible in the previous month, may remain in Plan One. In any month that employee does not have the required contributions and/or reserves for Plan One, he may select Plan One for the corresponding benefit month, provided a Voluntary Contribution is made or select Plan Two and make a Voluntary Contribution, if necessary. If the employee selects Plan Two, the employee must remain in Plan Two until the monthly employer contributions and/or reserves equal the cost of the minimum monthly contribution requirement for Plan One.

Reserve of Contributions.

In any month that the employer contributions exceed the cost of the minimum monthly contribution requirement for Plan One (see page 46), the excess will be added to the employee's Reserve at 100%. If an employee is eligible for and selects Plan Two, any monthly contribution that exceeds the cost of the minimum monthly contribution rate for Plan Two (see page 46) will be added to the employee's Reserve at 100%.

Voluntary Contributions for Unemployed or On Layoff.

During the enrollment period, if you are unemployed or on a layoff and were previously eligible in Plan One and have less than the required minimum monthly contribution for Plan One, you may select Plan One or Plan Two for the corresponding benefit month and make a Voluntary Contribution, if necessary. However, once you have selected Plan Two you must remain in Plan Two until you are re-employed by a contributing employer and qualify for Plan One. If you were previously eligible in Plan Two and have less than the required minimum monthly contribution for Plan Two, you may make a Voluntary Contribution for Plan Two.

During the enrollment period, if while unemployed or on a layoff and you make a Voluntary Contribution, additional monthly Voluntary Contributions may be made for a period of up to 18 months. After this time, if the employee has not been credited with Employer Contributions, no further Voluntary Contributions will be accepted. The employee and any eligible dependents will then be eligible for COBRA and/or conversion rights.

Weekly Disability and Workers' Compensation Credits.

Temporary Eligibility Employees who become disabled while eligible under this Plan, will be credited with forty hours of Contribution Credits for each full week of disability paid, commencing with the second week of disability, subject to a maximum of twenty-six (26) weeks of credit per any period of disability. There will be no credit for the first week of disability or less than a full week of disability, nor will Contribution Credits be accumulated in the Reserve of Contributions. Contribution Credits are to be credited to the Work Period corresponding to the periods of time weekly disability benefits or Workers' Compensation has been paid.

Temporary Eligibility Employees receiving Workers' Compensation Benefits must notify the Welfare Fund Office immediately and must furnish satisfactory proof of disability, in order to receive Contribution Credits during period of disability

resulting from occupational injuries. Failure to promptly comply with the foregoing could disqualify you from receiving Contribution Credits for disability or Workers' Compensation.

Termination.

A Temporary Eligibility Employee, who fails to make a voluntary contribution by the due date listed on the Eligibility Statement, will be terminated on the last day of the month in which the employee was eligible. At that time, any contributions received and any reserve balance will be forfeited. The employee and eligible dependents will then be eligible for COBRA and/or conversion rights.

Benefit Payments.

During the enrollment period, the Fund will process claims for any benefit month in which the Temporary Eligibility Employee is eligible. However, benefit claims will not be processed until eligibility has been determined for the benefit month in which the claims have been incurred.

Work Periods and Benefit Periods.

If you were employed in this work month.	You are eligible in this benefit month.
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

Temporary Eligibility statements will be mailed out on a monthly basis.

FIXED PREMIUM

Beginning September 1, 2003 all employers entering into a Fixed Premium Agreement will be required to meet the specifications as set forth herein. Only the employees that are part of the Collective Bargaining Unit are permitted to be eligible for health care from the Welfare Fund.

Actuarial Approval.

New employers wishing to enter into a Fixed Premium Agreement for coverage by Welfare Fund must be approved by the Fund's Actuary. The employer will be required to provide information as deemed necessary by the Board of Trustees to allow the actuary to properly complete their review of the employer. Only after the actuary completes their review and approves an employer for acceptance into the Welfare Fund, will coverage be offered to the employees.

Premiums.

A monthly per employee premium will be calculated annually and will not be guaranteed for more than one calendar year. Each year the actuary will re-calculate the calendar year premium to be applied to the Fixed Premium group. The premium amount can be adjusted by the board of trustees at their discretion when necessary.

Initial Eligibility.

The employee and their dependents will become eligible on a monthly basis on the first day of the month following the receipt of the premium due from an employer. Eligibility is provided in the Plan One group only. There are no provisions for Plan Two coverage for Fixed Premium Employees. Employees covered by a Fixed Premium Agreement cannot obtain a Reserve of Contributions.

Maintaining Eligibility.

The employer is responsible for the remittance of premiums for each employee to be covered by the Welfare Fund. Each company will be billed the premium due by the Combined Funds on a monthly basis. Failure to pay the premium by the due date specified will be grounds for termination of coverage.

The employer is responsible to remit the full amount due. Any company entering into cost sharing arrangements with their employees regarding premium costs is outside the terms of this

document. No voluntary contributions/payments can be paid directly by an employee to continue coverage. Payments can only be made by the employer for covered employees.

Weekly Disability and Workers' Compensation Credits.

Fixed Premium Agreement employees who become disabled while eligible under this Plan, will be credited with forty hours of Contribution Credits for each full week of disability paid, commencing with the second week of disability, subject to a maximum of twenty-six (26) weeks of credit per any period of disability. There will be no credit for the first week of disability or less than a full week of disability, nor will Contribution Credits be accumulated in the Reserve of Contributions. Contribution Credits are to be credited to the Work Period corresponding to the periods of time weekly disability benefits or Workers' Compensation has been paid.

Fixed Premium Agreement employees receiving Workers' Compensation Benefits must notify the Welfare Fund Office immediately and must furnish satisfactory proof of disability, in order to receive Contribution Credits during period of disability resulting from occupational injuries. Failure to promptly comply with the foregoing could disqualify you from receiving Contribution Credits for disability or Workers' Compensation.

Voluntary Contributions.

There is no provision for Fixed Premium Agreement employees to pay a Voluntary Contribution to maintain coverage. Payment can be made by the employer only.

Termination.

When an employer does not pay the premium due for an employee the Welfare Fund will cancel the participant's health care coverage. Termination will occur on the last day of the month for which the employer did pay a proper premium. The employee and eligible dependents will then be eligible for COBRA and/or conversion rights.

Retirees.

Retirees covered by a fixed premium plan are not eligible for retiree benefits from the Welfare Fund.

PLAN ONE / PLAN TWO BENEFITS

WEEKLY DISABILITY BENEFITS

(For Employees Only)

Weekly disability benefits will be payable only if you become disabled and unable to work because of a non-occupational accident or sickness, while eligible for benefits and you are:

- Employed by an employer who is required to make contributions to the Welfare Fund on your behalf.

-or-

- In receipt of State Unemployment Benefits and on the Local Union's Referral List immediately prior to the date of your disability.

Injuries or sickness sustained on the job or covered by Worker's Compensation are not eligible for weekly disability benefits.

Benefits will begin on the eighth day of disability and will be limited to a maximum of 26 weeks during any one period of disability. Weekly benefit payments will be paid at the rate of $325 per week.

Successive periods of disability separated by less than 150 hours of employment will be considered one continuous period of disability, unless they arise from different and unrelated causes. If you have a different and unrelated disability and return to work for only one full day, you will be entitled to a new period of disability.

You do not have to be confined to your home to collect benefits, but you must be under the regular care and attendance of a legally qualified physician or surgeon. A legally qualified physician or a surgeon must certify all periods of total disability. Periods of treatment rendered by a chiropractor will not qualify for Weekly Disability Benefits.

No disability will be considered as beginning prior to the first visit or treatment by a physician.

A disabled employee's Weekly Disability Benefits will terminate once the employee has exhausted his maximum benefit, retires, or has been released by his doctor.

Notice of Loss.

Written notice of loss must be given to the Fund Office within one year from the date of the commencement of disability. Failure to give proper notice within one year from the commencement date of disability will result in a loss of Weekly Disability Benefits.

Claims Payments.

To receive Weekly Disability Benefits, a disabled employee must submit a completed claim form. The employee's attending physician (as specified above) must certify on this form that the employee was disabled and show the initial disability date and the dates of all examinations and treatments.

The Trustees reserve the right to have any claimant for Weekly Disability Benefits referred to a physician of their choice for examination or re-examination. Failure to report to the Fund's physician within 48 hours after notice to do so, without a good excuse, may result in suspension of disability payments.

Employees receiving Unemployment Compensation, Worker's Compensation, Supplemental Unemployment Benefits from an industry fund, or retirement benefits from an industry pension fund are not eligible for Weekly Disability Benefits.

VISION-CARE BENEFITS

Eligible participants can have vision benefits provided once per calendar year. Services can be obtained by either:

- The use of a network Optometrist provided by National Vision Administrators (NVA).

  -or-

- The services of a non-participating eye doctor of your choice.

ADMINISTRATION

National Vision Administrators, Inc is administering your Vision Care Program. If you have any questions or require information of any kind, please call or write:

National Vision Administrators, Inc.
P.O. Box 2187
Clifton, New Jersey 07015
800-672-7723
www.e-nva.com

BENEFITS PROVIDED

Vision Examination: A complete analysis of eyes and related structures.

Lenses: To correct vision problems—lenses may be plastic or impact-resistant glass.

Frames: The Plan offers a wide selection of frames; however, if you select a frame that costs more than the amount allowed by your Plan, there will be an additional charge.

Contact Lenses: The Plan will contribute an allowance of $110.00 including exam towards the purchase of contacts.

PRIOR AUTHORIZATION

Contact Lenses which are deemed Medically Necessary will be considered for payment by NVA when an NVA Participating Provider secures prior authorization for the following conditions: a) following cataract surgery, b) to correct extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, c) anisometropia, d) keratoconus. Maximum allowance is usual, customary and reasonable when medically necessary.

How Do I Use The Plan?
Make an appointment with a NVA Participating Provider, please notify them that your coverage is administered by NVA and sponsored by Operating Engineers Local 66 Welfare Fund, Sponsor #1076. The Provider will telephone NVA to verify your vision care eligibility.

At the time of your first appointment present your NVA Vision Care identification card. You do not need to obtain a vision claim form. The Provider will inform you of your eligibility status prior to rendering services. To verify benefit eligibility yourself prior to scheduling your eye-care appointment, you may wish to contact NVA's Customer Service Department at the following toll-free number: 1-800-672-7723.

When the services have been completed, the Provider will have you sign a claim form and he or she will then forward the form to NVA for processing and payment.

Non-Participating Provider: If you select a non-participating eye-care provider you will be responsible for one hundred percent (100%) of the cost at the time of service. Obtaining vision-care services from a non-participating provider will result in higher unnecessary out-of-pocket expenses. You must submit a copy of the itemized receipt along with a note containing your name, Social Security number or a photocopy of your identification card to NVA at the following address:

National Vision Administrators, Inc.
P.O. Box 2187
Clifton, New Jersey 07015
800-672-7723

How Much Do I Pay?
When you receive an examination, spectacle lenses and/or frames from an NVA participating provider, the provider accepts the NVA payment as payment (provided you stay within the limitation of the program). Extra materials that are not covered by the Plan may be purchased through the NVA participating provider at a controlled cost.

Non-Participating Provider:
When you receive services from a non-participating provider, you will be reimbursed directly by NVA, according to the Non-participating Provider Reimbursement Schedule.

Non-Participating Provider Reimbursement Schedule:
$100.00 total reimbursement for examination, lenses and frames or contact lenses per benefit period.

How Often Are These Services Available?
Each eligible member and their covered dependents are entitled to one vision examination, and one pair of glasses (lenses or frames) or contact lenses once per calendar year beginning July 1, 2019.

Where To Get Benefits.
NVA has a network of participating Ophthalmologists, Optometrists, and Opticians to serve you. To find a participating provider you can call (800) 672-7723 or use oe66.com and select Welfare then NVA.

What Vision Services And Materials Are Limited or Not Covered Under This Plan?
The items below can be provided under your plan. However, if you select any of these items, you must pay the difference between your scheduled plan allowance and the cost of the item selected: Photochromatic (gray and brown) light or dark, tinted (other than pink #1 or #2), gradient or fashion colors, progressive or no-line multifocal, a frame costing more than the plan allowance; Coatings: mirror, anti-reflective, super a.r., color, edge, ultraviolet, polish edges, smart segment, rimless, polycarbonate.

Items Not Covered:
Services and materials not covered under the plan. No payment will be made for: medical or surgical treatments, drugs or medications, non-prescription lenses, examinations or materials not listed as a covered service, replacement of lost stolen broken or damaged lenses, contact lenses or frames except at normal intervals when service is otherwise available, services or materials provided by Federal, State, Local Government or Workers' Compensation, Examination procedure training or materials not listed, industrial (3mm) safety lenses and safety frames with side shields, parts or repair of frame, sunglasses. If any item is selected from the exclusion list, you will be required to pay the total cost of the lenses.

ANNUAL DENTAL BENEFIT

Beginning April 1, 2018, and once per calendar year thereafter each Plan One or Plan Two participant is eligible for the annual dental benefit. Only dental services performed on or after April 1, 2018 can be paid by the dental benefit.

Items Covered

Dental procedures such as preventive and diagnostic Services, cleanings, X-rays, oral examinations, fillings, extractions, and root canals can qualify for this benefit.

To obtain benefits:

- Select any licensed dental provider to have dental services performed.
- Request an itemized receipt that shows the name of the participant, date of service, the procedure performed, and the cost.
- Contact the Fund Office for a Dental Benefit Form or download the form at oe66.com/Welfare Fund.
- Complete the form, attach your receipt and submit it to the Welfare Fund.
- You will receive a check for up to $50.
- No assignment of benefits is allowed.
- Timely filing of claims.

Items Not Covered

Cosmetic procedures are not covered. Such as, teeth whitening, dental veneers, bonding, implants, Invisalign, or alternative braces.

PLAN ONE

DEATH BENEFITS

Plan One.

In the event of the death of an eligible employee in Plan One, from any cause, a $6,000 Death Benefit will be paid to the named Beneficiary.

Plan One Retired and Totally Disabled Employees.

In the event of the death of an eligible retired or totally disabled employee in Plan One, Death Benefits will be paid to the named Beneficiary as follows:

Totally Disabled while eligible under Plan One.
Death prior to age 60.................................$6,000
Death at age 60 and older.........................$1,500
Retirees $1,500

Beneficiary.

It is very important that you designate the person to whom the Death Benefit is to be paid. You do this by filling in his or her name on the Fund Office Information Card, which may be obtained by contacting the Fund Office. The Beneficiary may be changed at any time and as often as desired by completing a new Fund Office Information Card.

The designation of a beneficiary will take effect upon receipt of the Fund Office Information Card by the Fund Office. If the beneficiary dies before the eligible employee, the interest of the beneficiary will terminate.

If there is no beneficiary designated or surviving at the death of the eligible employee, payment will be made to the first surviving of the following classes of preferential beneficiaries: (a) the widow or widower; (b) the surviving children; (c) the surviving parents; (d) the surviving sisters and brothers; (e) the executors or administrators of the estate.

Assignment of Death Benefit.

No assignment of the Death Benefits under this Plan will be valid.

Total Disability Benefits.

Members who become totally and permanently disabled while eligible under Plan One will receive a Death Benefit based upon age at the time of death. Coverage for the Death Benefit will be continued for as long as you remain totally and permanently disabled, whether or not you continue to be eligible for all other benefits. The Death Benefit for Plan One totally and permanently disabled members under the age of 60 at the time of their death is $6000. Beginning with age 60, the death benefit for Plan One totally and permanently disabled members will be reduced to $1,500.

The disability must prevent you from engaging in any kind of employment or business. You will be required to furnish written proof of total and permanent disability to the Fund Office, between the ninth and twelfth months after the beginning of your disability. Subsequent written proof of total and permanent disability must be given to the Fund Office not less than once each year thereafter. Annual written proof will not be necessary if you are in receipt of a Social Security Disability Award or a normal pension from an industry pension plan.

Filing for Death Benefits.

Written proof of the death of an eligible employee must be filed at the Fund Office within 180 days from the date of death. Failure to furnish the proof within 180 days will not invalidate the claim if it is shown not to have been reasonably possible to furnish the proof within the time required. However, all liability on the part of the Fund and the Trustees will cease and any person's claim to benefits will be forfeited, unless notice and the required proof are submitted within 36 months from the date of death.

Payment of Death Benefits.

All Death Benefits are paid in a single sum to the designated beneficiary or lawful claimant, within twelve months from the date of receipt of the required proof. It is expressly understood that no interest will accrue to the principal benefit of the claimant, during the period between the date of death and date of the benefit payment.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

If you sustain any of the following losses as the result of an accident, while covered under Plan One, the following benefits will be payable:

Loss of Life ....Principal Sum
Loss of two limbs, sight of both eyes ......Principal Sum
Loss of one limb and sight of one eye .....Principal Sum
Loss of one limb or sight of one eye …....One-half of the Principal Sum

Principal sum is defined as an amount equal to the Plan One Death Benefit Payment.

Loss must occur within 90 days from the date of the accident and must be sustained solely through external, violent and accidental means.

Loss of limb means dismemberment by severance at or above the wrist or ankle joint. Loss of sight means the total and irrecoverable loss of sight.

If more than one of the losses set forth above is suffered as the result of any one accident, not more than the Principal Sum amount of Accidental Death and Dismemberment Benefit will be payable.

No benefits are payable for death or for any loss caused by or resulting from:

- Ptomaine or bacterial infections (except pyogenic infection which shall occur through an accidental cut or wound).
- Bodily or mental infirmity, sickness or disease.
- Suicide or attempted suicide and intentionally self-inflicted injury, while sane or insane.
- Participation in the committing of a felony.
- War or any act of war.

No assignment of the Accidental Death or Dismemberment Benefits under this plan will be valid. The beneficiary for Accidental Death Benefits will be the same as that designated for Death Benefit. No Accidental Death or Dismemberment Benefits are provided for Retirees or Totally Disabled Employees.

PRESCRIPTION DRUG BENEFITS

Plan One Participants and Dependents.

The Welfare Fund contracts with OptumRx to manage Prescription Drug Benefits. Coverage is provided for approved drugs dispensed to you or your eligible dependents after the effective date of your coverage, regardless of the date on the prescription order. If a prescription refill is authorized by the subscriber and permitted under Government regulations, it will be refillable up to one year after the original prescription date, provided you are eligible on the refill date.

Covered Drugs.

Covered drugs are those that are required under Federal Law to bear the legend: "Caution: Federal Law prohibits dispensing without prescription", or which are specifically designated by our prescription drug service providers.

Covered prescription drugs include:

- Federal Legend Drugs.
- State Restricted Drugs.
- Compounded Medication.
- Oral Contraceptives.
- Insulin.
- Insulin needles and syringes on prescription only.
- Over-the-counter diabetic supplies.
- Retin-A - See Page 91.

Covered drugs are paid under Prescription Drug Benefits when they are filled at a retail pharmacy or mail-order pharmacy. Payment for covered drugs will not be made under Prescription Drug Benefit if you use a Home Medical Equipment Supplier.

Filling Prescriptions.

Your prescription may be filled at:

- A retail pharmacy of your choice, if the prescription is for up to a 30-day supply.

  Note: Mandatory use of the mail order benefit is required after 3 fills of the same medication at any retail pharmacy.
- A mail-order pharmacy, if the prescription is for a 30 to 90 day supply of maintenance drugs when medically appropriate.

- (OptumRx CVS90 Saver Plus), A CVS retail pharmacy can be used in place of mail order for a 30 to 90 day supply of maintenance drugs when medically appropriate.

Retail Pharmacies.

The Welfare Fund has made arrangements with OptumRx, a company specializing in payment of prescription drugs with retail pharmacies. Within 21 days of the first day of your eligibility for prescription drug benefits, an OptumRx Identification Card will be sent to you. This card will identify the eligible employee. Upon receipt of your I.D. card, please check to see your name is correct.

If you have lost your card, please contact the Fund Office at (412) 968-9750. The Fund Office will order a new card from OptumRx. Please note that it takes 7 to 10 days to obtain the new card.

There is no expiration date on the OptumRx card. It is only for identification purposes. The card will only be valid during those periods of time when you and your dependents are actually eligible for prescription drug benefits under Plan One in the Welfare Fund.

Participating Retail Pharmacy - When you purchase covered drugs from any OptumRx participating pharmacy, present your prescription order and OptumRx identification card to the pharmacist. A prescription order received by phone from your physician or dentist, will also be covered. The pharmacy will bill OptumRx directly and will be paid the difference between its prescription charge and the $20 or $10 co-payment that you pay. You should request and retain a paid receipt for your co-payment amount if you need it for income tax or any other purpose.

If you have any questions concerning a participating retail pharmacy, call OptumRx at 1-855-295-9140 or visit their website at www.OptumRx.com.

Non-participating Retail Pharmacy - When covered drugs are purchased from a non-participating pharmacy, you will be required to pay the full charge made by the pharmacy for the prescription. You must submit a completed Member Reimbursement Drug Claim Form to OptumRx. Forms are available from the Welfare Fund Office at 412-968-9750 or from OptumRx at 1-855-295-9140. Reimbursement will be made directly to you minus the $20 or $10 co-payment.

Mail Order Pharmacy.

The Welfare Fund has made arrangements with OptumRx for the dispensing of prescription maintenance drugs by mail. You will be able to receive a 30 to 90 day supply of a medication with a single co-payment of $40 for brand-name medications or a $20 co-payment for generic medications. For mail order, be sure to ask your doctor to prescribe maintenance drugs for a 90-day supply plus refills, whenever appropriate. All narcotics are limited to a 30 day supply.

No Identification Card is necessary to use the OptumRx Mail Order Program. The Welfare Fund frequently sends information to OptumRx to update eligibility. You will only be able to use the Mail Order Program when you and your dependents are eligible for Plan One.

To order an original prescription from OptumRx Mail Order, obtain a New Prescription Mail-In Order Form from the Fund Office. Complete the form, attach the prescription order and mail both to the address listed on the form.

To order refills through OptumRx - each time you receive your prescription drug order from OptumRx, it will come with a reorder form for refills. You may call OptumRx at 1-855-295-9140 to order a refill, mail in a refill order form, order from their website at www.OptumRx.com, or use the OptumRx mobile app. In any case, please follow OptumRx Home Delivery Service's instructions in regard to any payment due.

OptumRx also offers the ability through its CVS90 Saver Plus program to use a CVS retail pharmacy in place of mail order for maintenance drugs.

If you have any questions concerning the mail-order pharmacy call OptumRx at 1-855-295-9140.

Maintenance Drugs.

Maintenance drugs are any prescription medication prescribed by your physician, which is taken on an ongoing basis for conditions such as diabetes, high blood pressure or arthritis.

Prescription drugs, that are maintenance drugs, are to be purchased from the OptumRx mail-order pharmacy for all prescription orders. The OptumRx mail order pharmacy will mail all your maintenance drug orders to your home.

Generic Drugs.

A generic drug is a medication that, by law, must meet the same standards for strength and effectiveness as the comparable brand name product. The United States Food and Drug Administration (FDA) has determined that there is no significant

difference between most brand name and generic drugs. Ask your doctor to authorize generic substitution if an approved generic is available.

Co-Payments.

Retail Pharmacy - Your co-payment to a retail pharmacy is $20 for brand name and $10 for generic drugs for each prescription or refill. A OptumRx Participating Pharmacy will charge you no more than these co-payment amounts for any prescription.

Mail Order Pharmacy - Your co-payment for mail order is $40 for each prescription or refill if you use a name brand drug. There is a $20 co-payment to you if you use a generic drug by mail order.

IMPORTANT - The co-payment charge that you pay either at the retail pharmacy or mail order pharmacy is not eligible to be paid through the Member Reimbursement Benefit, it is your responsibility. Do not submit a co-payment charge to the Welfare Fund Office, as it is not a payable expense.

Eligibility Questions.

If you go to a retail participating pharmacy and your eligibility is questioned, please have the pharmacist call OptumRx, to obtain additional information on your eligibility. If for any reason you feel that you are eligible and the pharmacist cannot resolve the situation, please have the pharmacist call the Welfare Fund Office at (412) 968-9750 - Monday through Friday between 8:00 a.m. and 3:30 p.m.

If you have your eligibility questioned by the OptumRx mail order pharmacy, call the Welfare Fund Office.

Allergy Serum.

Allergy serum will be covered by OptumRx, if you or your eligible dependent requires allergy injections. You must submit a completed Member Reimbursement Drug Claim Form to OptumRx. Forms are available from the Welfare Fund Office at 412-968-9750 or from OptumRx at 1-855-295-9140.

Diabetic Supplies – Retail Pharmacy.

A separate prescription is required from your doctor, for each item to be given to the OptumRx participating pharmacist. Insulin, syringes, test strips, lancets and needles can be obtained from a participating pharmacy for the $20 co-payment per prescription, for a 30-day supply.

Diabetic Supplies – Mail Order Pharmacy.

A separate prescription is required from your doctor, for each item to mail to OptumRx Home Delivery Service. Insulin, syringes, test strips, lancets and needles can be ordered through the OptumRx program for the $40 co-payment per prescription, for a 90-day supply.

Retin-A.

If Retin-A is prescribed, you must mail a letter of medical necessity from your doctor to the Fund Office. If dispensing is approved by the Fund Office, you will receive payment from the Fund Office minus the applicable co-payment.

OptumRx and OptumRx do not pay for Retin-A. You must submit the charges directly to the Fund Office.

Exclusion and Limitations:

No benefits will be payable for the following:

- Any charges for services for administration of drugs or insulin by a physician, surgeon or other medical attendant.
- Lost, stolen, or damaged medications.
- Medications that are not taken correctly.
- Any drugs dispensed by the Doctor or Dentist except for allergy serum.
- Prescription drugs dispensed for treatment of an illness or injury for which the employer is required by law to furnish care in whole or in part-including, but not limited to state or federal workmen's compensation laws and occupational disease laws and other employer liability laws.
- Prescription drugs to which you are entitled, with or without charge, under a plan or program of any government body.
- The charge for more than a 30-day supply of drugs from a retail pharmacy, or 90-day supply from the mail-order pharmacy.
- Any charges by a pharmacy or pharmacist except as provided herein.
- Multiple and non-therapeutic vitamins, cosmetics, dietary supplements, health and beauty aids.

- Drugs labeled, “Caution-limited by Federal Law to investigational use”, or experimental drugs, even if a charge is made to the individual.
- Any charge where the usual and customary charge is less than the co-payment amount.
- Covered drugs dispensed to patients in hospitals, skilled nursing facilities, nursing homes, or other institutions.
- Non-Federal Legend Drugs, diaphragms, contraceptive jellies, creams, foams or devices, nicorette, therapeutic devices or appliances, drugs whose sole purpose is to promote or stimulate hair growth, Rogaine, Minoxidil, syringes other than for Insulin, injectables, drugs acquired by mail order other than Insulin, over-the-counter medications, except Insulin and diabetic supplies.
- Unauthorized refills of any prescription older than one year.

MEMBER REIMBURSEMENT BENEFIT

Listed below are the rules and procedures of the Member Reimbursement Benefit (MRB). The Trustees reserve the right to amend these rules to insure the success of the MRB, as they deem necessary.

- Only claims incurred on or after July 1, 2001, can be submitted for reimbursement.
- The amount in the member's Reserve of Contributions in excess of twice the cost of Plan One (as of 2020 - $7,686) is available to the member.
- Claims for the member and his or her eligible dependents, as defined in the summary Plan Description, must be submitted to the Fund Office. The member must request reimbursement from the Reserve of contributions in writing under the member's signature only.
- The member must submit claims within 36 months of the date of service. Claims older than 36 months will not be paid. All claims are evaluated upon the original "date of service", not the date payment was made.
- The base medical, prescription or vision plan(s) must be charged first for all eligible expenses before any payment can be made under the MRB.
- The total of the claims submitted for reimbursement must be at least $20.
- Reimbursement will be made only to the member for expenses previously paid. No assignment to the provider will be accepted.
- Reimbursement will be based on the member's Reserve of Contributions balance on the date the claim is processed.

- No reimbursement can lower the member's Reserve of Contributions balance below the minimum balance required.
- Reimbursement will be made to the member within six weeks of receipt at the Fund Office.
- No reimbursement will be made for prescription drug co-payments.
- No reimbursement will be made for medical benefit deductibles or medical benefit coinsurance expenses.
- No reimbursement will be made on the non-covered portion of a claim paid to participating providers by Highmark Blue Cross/Blue Shield at contract rates.
- No reimbursement will be made on expenses covered in full by another plan.

Listed below are those medical services that are eligible for reimbursement:

ABORTION

The amount you pay for a legal abortion.

ACUPUNCTURE

ALCOHOLISM

Amounts you pay for an inpatient's treatment at a therapeutic center for alcohol addiction. This includes meals and lodging provided by the center during treatment.

AMBULANCE

ARTIFICIAL LIMB

ARTIFICIAL TEETH

BRAILLE BOOKS AND MAGAZINES

The part of the cost of Braille books and magazines for use by a visually impaired person that is more than the cost of regular printed editions.

CAR

The cost of special hand controls and other special equipment installed in a car for the use of a person with a disability.

SPECIAL DESIGN

The difference in the cost of a car specially designed to hold a wheelchair and a regular car.

CHIROPRACTOR

CONTACT LENSES

Amounts you pay for contact lenses needed for medical reasons. Also the cost of equipment and materials required for using contact lenses, such as saline solution and enzyme cleaner.

CRUTCHES

The amount you pay to buy or rent crutches.

DENTAL INSURANCE

The amount of premium you pay for the dental plan offered by IUOE Local 66.

DENTAL TREATMENT

DRUG ADDICTION

Amounts you pay for an inpatient's treatment at a therapeutic center for drug addiction. This includes meals and lodging at the center during treatment.

EYEGLASSES AND EYE EXAMS

EYE SURGERY

You can include in medical expenses the amount you pay for eye surgery to treat defective vision, such as laser eye surgery or radial keratotomy.

FERTILITY ENHANCEMENT

The cost of the following procedures to overcome your inability to have children

- Procedures such as in-vitro fertilization (including temporary storage of eggs or sperm).

- Surgery, including an operation to reverse prior surgery that prevents you from having children.

GUIDE DOG OR OTHER ANIMAL

The cost of a guide dog or other animal to be used by a visually impaired or hearing-impaired person. Also, the cost of a dog or other animal trained to assist persons with other physical disabilities. Amounts you pay for the care of these specially trained animals are also medical expenses.

HEALTH INSTITUTE

Fees you pay for treatment at a health institute only if the treatment is prescribed by a physician and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or illness of the individual receiving the treatment.

HEARING AIDS

The cost of a hearing aid and the batteries, repairs and maintenance needed to operate it.

INTELLECTUALLY and DEVELOPMENTALLY DISABLED, SPECIAL HOME

For the cost of keeping an intellectually and developmentally disabled person in a special home, not the home of a relative, on the recommendation of a psychiatrist to help the person adjust from life in a mental hospital to community living.

LABORATORY FEES

Amounts you pay for laboratory fees that are part of your medical care.

LEARNING DISABILITY

See *Special Education*

MEDICAL SERVICES

Amounts you pay for legal medical services provided by:

Physicians,
Surgeons,
Specialists,
Medic Alert, or Other medical practitioners.

MEDICINES

The amount you pay for prescribed medications and drugs. A prescribed drug is one that requires a prescription by a doctor for its use by an individual. Only drugs allowed under federal law can be reimbursed.

NURSING HOME

The costs of medical care in a nursing home or home for the aged for yourself, your spouse, or your dependents. This includes the cost of meals and lodging in the home if the main reason for being there is to get medical care.

Do not include the cost of meals and lodging if the reason for being in the home is personal. You can, however, include the part of the cost that is for medical or nursing care.

OPERATIONS

Amounts you pay for legal operations that are not for unnecessary cosmetic surgery.

OSTEOPATH

Amounts you pay to an osteopath for medical care.

OXYGEN

Amounts you pay for oxygen and oxygen equipment to relieve breathing problems caused by a medical condition.

PSYCHIATRIC CARE

Amounts you pay for psychiatric care. This includes the cost of supporting a mentally ill dependent at a specially equipped medical center where the dependent receives medical care.

PSYCHOLOGIST

Amounts you pay to a psychologist for medical care.

SPECIAL EDUCATION

You can include in medical expenses fees you pay on a doctor's recommendation for a child's tutoring by a teacher who is specially trained and qualified to work with children who have learning disabilities caused by mental or physical impairments, including nervous system disorders.

You can include in medical expenses the cost (tuition, meals, and lodging) of attending a school that furnishes special education to help a child to overcome learning disabilities. Overcoming the learning disabilities must be the primary reason

for attending the school, and any ordinary education received must be incidental to the special education provided.

You can't include in medical expenses the cost of sending a child with behavioral problems to a school where the course of study and the disciplinary methods have a beneficial effect on the child's attitude if the availability of medical care in the school isn't a principal reason for sending the student there.

STERILIZATION

The cost of a legal sterilization.

STOP-SMOKING PROGRAMS

Amounts you pay for a program to stop smoking, including snuff and chewing tobacco. However, you cannot include amounts you pay for drugs that do not require a prescription, such as nicotine gum or patches, that are designed to help stop smoking.

TELEPHONE

The cost and repair of special telephone equipment that lets a hearing-impaired person communicate over a regular telephone.

TELEVISION

The cost of equipment that displays the audio part of television programs as subtitles for hearing-impaired persons. This may be the cost of an adapter that attaches to a regular set. It also may be the cost of a specially equipped television that exceeds the cost of the same model regular television set.

THERAPY

Amounts you pay for therapy you receive as medical treatment.

TRANSPLANTS

You can include in medical expenses amounts paid for medical care you receive because you are a donor or a possible donor of a kidney or other organ. This includes transportation.

You can include any expenses you pay for the medical care of a donor in connection with the donation of an organ. This includes transportation.

TUITION

Charges for medical care included in the tuition of a college or private school, if the charges are separately stated in the bill or given to you by the school.

VASECTOMY

WEIGHT-LOSS PROGRAM

You can include in medical expenses amounts you pay to lose weight if it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease). This includes fees you pay for membership in a weight reduction group as well as fees for attendance at periodic meetings. You can't include membership dues in a gym, health club, or spa as medical expenses, but you can include separate fees charged there for weight loss activities.

You can't include the cost of diet food or beverages in medical expenses because the diet food and beverages substitute for what is normally consumed to satisfy nutritional needs. You can include the cost of special food in medical expenses only if:

- The food doesn't satisfy normal nutritional needs,
- The food alleviates or treats an illness, and
- The need for the food is substantiated by a physician.

The amount you can include in medical expenses is limited to the amount by which the cost of the special food exceeds the cost of a normal diet.

WHEELCHAIR

Amounts you pay for an autoette or a wheelchair used mainly for the relief of sickness or disability. The cost of operating and keeping up the autoette or wheelchair is also a medical expense.

X-RAY FEES

Amounts you pay for X-rays that you get for medical reasons.

MEDICAL BENEFITS

For information related to your Plan One medical coverage please refer to page 105.

PLAN TWO

DEATH BENEFITS

Plan Two.

In the event of the death of an eligible employee in Plan One, from any cause, a $2,400 Death Benefit will be paid to the named Beneficiary.

Plan Two Retired and Totally Disabled Employees.

In the event of the death of an eligible retired or totally disabled employee in Plan Two, Death Benefits will be paid to the named Beneficiary as follows:

Totally Disabled while eligible under Plan One.
Death prior to age 60................................$2,400
Death at age 60 and older.........................$1,500
Retirees $1,500

Beneficiary.

It is very important that you designate the person to whom the Death Benefit is to be paid. You do this by filling in his or her name on the Fund Office Information Card, which may be obtained by contacting the Fund Office. The Beneficiary may be changed at any time and as often as desired by completing a new Fund Office Information Card.

The designation of a beneficiary will take effect upon receipt of the Fund Office Information Card by the Fund Office. If the beneficiary dies before the eligible employee, the interest of the beneficiary will terminate.

If there is no beneficiary designated or surviving at the death of the eligible employee, payment will be made to the first surviving of the following classes of preferential beneficiaries: (a) the widow or widower; (b) the surviving children; (c) the surviving parents; (d) the surviving sisters and brothers; (e) the executors or administrators of the estate.

Assignment of Death Benefit.

No assignment of the Death Benefits under this Plan shall be valid.

Total Disability Benefits.

Members who become totally and permanently disabled while eligible under Plan Two will receive a Death Benefit based upon age at the time of death. Coverage for the Death Benefit will be continued for as long as you remain totally and permanently disabled, whether or not you continue to be eligible for all other benefits. The Death Benefit for Plan Two totally and permanently disabled members under the age of 60 at the time of their death is $2,400. Beginning with age 60, the death benefit for Plan Two totally and permanently disabled members will be reduced to $1,500.

The disability must prevent you from engaging in any kind of employment or business. You will be required to furnish written proof of total and permanent disability to the Fund Office, between the ninth and twelfth months after the beginning of your disability. Subsequent written proof of total and permanent disability must be given to the Fund Office not less than once each year thereafter. Annual written proof will not be necessary if you are in receipt of a Social Security Disability Award or a normal pension from an industry pension plan.

Filing for Death Benefits.

Written proof of the death of an eligible employee must be filed at the Fund Office within 180 days from the date of death. Failure to furnish the proof within 180 days will not invalidate the claim if it is shown that it was not reasonably possible to furnish the proof within the time required. However, all liability on the part of the Fund and the Trustees will cease and any person's claim to benefits will be forfeited unless notice and the required proofs are submitted within 36 months from the date of death.

Payment of Death Benefits.

All Death Benefits are paid in a single sum to the designated beneficiary or lawful claimant, within twelve months from the date of receipt of the required proof. It is expressly understood that no interest will accrue to the principal benefit of the claimant, during the period between the date of death and date of the benefit payment.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

If you sustain any of the following losses as the result of an accident, while covered under Plan Two, the following benefits will be payable:

Loss of Life ....Principal Sum
Loss of two limbs, sight of both eyes ......Principal Sum
Loss of one limb and sight of one eye .....Principal Sum
Loss of one limb or sight of one eye …....One-half of the Principal Sum

Principal sum is defined as an amount equal to the Plan Two Death Benefit Payment.

Loss must occur within 90 days from the date of the accident and must be sustained solely through external, violent and accidental means.

Loss of limb means dismemberment by severance at or above the wrist or ankle joint. Loss of sight means the total and irrecoverable loss of sight.

If more than one of the losses set forth above is suffered as the result of any one accident, not more than the Principal Sum amount of Accidental Death and Dismemberment Benefit will be payable.

No benefits are payable for death or for any loss caused by or resulting from:

- Ptomaines or bacterial infections (except pyogenic infection which shall occur through an accidental cut or wound).
- Bodily or mental infirmity, sickness or disease.
- Suicide or attempted suicide and intentionally self-inflicted injury, while sane or insane.
- Participation in the committing of a felony.
- War or any act of war.

No assignment of the Accidental Death or Dismemberment Benefits by the eligible employee under this plan will be valid. The beneficiary for Accidental Death Benefits will be the same as that designated for Death Benefit. No Accidental Death or Dismemberment Benefits are provided for Retirees or Totally Disabled Employees.

MEDICAL BENEFITS

For information related to your Plan Two medical coverage please refer to page 105.

PLAN ONE / PLAN TWO

Highmark Blue Cross Blue Shield PPO

Introduction to Your Health Care Program

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

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

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

- ***Your health care program gives you freedom of choice.*** You are not required to select a primary care physician to receive covered care. You have access to a large provider network of physicians, hospitals, and other providers in the Highmark service area, as well as providers across the country who are part of the local Blue Cross and Blue Shield PPO network. For a higher level of coverage, you need to receive care from one of these network providers. However, you can go outside the local network and still receive care at the lower level of coverage. To locate a network provider near you, or to learn whether your current physician is in the network, log onto your Highmark member website, www.highmarkbcbs.com.

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

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

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

Information for Non-English-Speaking Members

Non-English-speaking members have access to clear benefits information. They can call the toll-free Member Service telephone number on the back of their ID card to be connected to a language services interpreter line. Highmark Member Service representatives are trained to make the connection.

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

How Your Benefits Are Applied

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

Benefit Period

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

Medical Cost-Sharing Provisions

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

Coinsurance

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

Copayment

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

Deductible

The deductible is a specified dollar amount you must pay for covered services each benefit period before the program begins to provide payment for benefits. See the Summary of Benefits for your deductible pages 9 or 15. You may be required to pay any applicable deductible at the time you receive care from a provider.

Family Deductible

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

For a family with several covered dependents, the deductible you pay for all covered family members, regardless of family size, is specified under family deductible. To reach this total, you can count the expenses incurred by two or more covered family members. However, the deductible contributed towards the total by any one covered family member will not be more than the amount of the individual deductible. If one family member meets the individual deductible and needs to use benefits, the program would begin to pay for that person's covered services even if the deductible for the entire family has not been met.

Out-of-Pocket Limit

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

Maximum

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

Covered Services - Medical Program

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

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

Ambulance Service

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

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

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

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

Use of an ambulance as transportation to an emergency room for an injury or condition that does not satisfy the criteria of

emergency care will not be covered as emergency ambulance services.

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

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

Anesthesia for Non-Covered Dental Procedures (Limited)

Benefits will be provided for general anesthesia and associated hospital and medical services normally related to the administration of general anesthesia which are rendered in connection with non-covered dental procedures or non-covered oral surgery. Benefits are provided for members age seven or under and for developmentally disabled members when determined by Highmark to be medically necessary and appropriate and when a successful result cannot be expected for treatment under local anesthesia, or when a superior result can be expected from treatment under general anesthesia.

Autism Spectrum Disorders

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 and the physician or psychologist developing the treatment plan.

Treatment may include the following medically necessary and appropriate services:

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

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

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

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

Dental Services Related to Accidental Injury

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

Diabetes Treatment

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

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

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

Diagnostic Services

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

Advanced Imaging Services

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

emission tomography (PET scan), positron emission tomography/computed tomography (PET/CT scan).

Basic Diagnostic Services

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

Durable Medical Equipment

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

Enteral Foods

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

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

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

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

Coverage for enteral formulae excludes the following:

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

- Semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally

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

Home Health Care/Hospice Care Services

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

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

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

- dietitian services;
- homemaker services;
- maintenance therapy;
- dialysis treatment;

- custodial care; and
- food or home-delivered meals.

Home Infusion and Suite Infusion Therapy Services

Benefits will be provided when performed by a home infusion and/or suite infusion therapy provider at an infusion suite or in a home setting. This includes pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with infusion therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with infusion therapy. Benefits for certain infusion therapy prescription drugs as identified by Highmark and which are appropriate for self-administration, will be provided only when received from a participating pharmacy provider.

Hospital Services

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

Inpatient Services

Bed and Board

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

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

Ancillary Services
Hospital services and supplies including, but not restricted to:

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

Outpatient Services

Ancillary Services
Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms and equipment;
- drugs and medicines provided to you while you are an outpatient in a facility provider. However, benefits for certain therapeutic injectables as identified by Highmark and which are appropriate for self-administration will be provided only when received from a participating pharmacy provider;
- whole blood, administration of blood, blood processing, and blood derivatives;
- anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;
- medical and surgical dressings, supplies, casts and splints.

Emergency Care Services

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

Emergency care services are services and supplies, including drugs and medicines, for the outpatient emergency treatment of bodily injuries resulting from an accident or a medical condition. Also included is a medical screening examination and ancillary services necessary to evaluate such injury or emergency medical condition and further medical examination and treatment as required to stabilize the patient.

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

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

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

Pre-Admission Testing

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

Surgery

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

Inpatient Medical Services

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

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

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

Inpatient Medical Care Visits
Benefits are provided for inpatient medical care visits.

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

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

Maternity Services

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

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

Maternity Home Health Care Visit

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

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

Normal Pregnancy

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

Nursery Care

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

enrolled as a dependent under this program within such period. Refer to the General Information section for further eligibility information.

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

Mental Health Care Services

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

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

Inpatient Facility Services

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

Inpatient Medical Services

Covered inpatient medical services provided by a professional provider:

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

Partial Hospitalization Mental Health Care Services

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

Outpatient Mental Health Care Services

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

*Some plans may cover telemedicine. Check your Summary of Benefits for more information.

Orthotic Devices

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

Outpatient Medical Care Services (Office Visits)

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

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

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

Or you can interact with a professional provider as follows:

- A virtual visit between you and a PCP or retail clinic via an audio and video telecommunications system
- A virtual visit between you and a specialist via the internet or similar electronic communications for the treatment of skin conditions or diseases
- *A specialist virtual visit between you and a specialist via audio and video telecommunications. Benefits are provided for a specialist virtual visit when you communicate with the specialist from any location, such as your home, office or another mobile location, or if you travel to a provider-based location referred to as a 'provider originating site. If you communicate with the specialist from a provider originating site, you will be responsible for the specialist virtual visit provider originating site fee. Benefits will not be provided for a specialist virtual visit if the visit is related to the treatment of mental illness or substance abuse.

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

*Some plans may cover telemedicine. Check your Summary of Benefits for more information.

Allergy Extract/Injections

Benefits are provided for allergy extract and allergy injections.

Therapeutic Injections

Therapeutic injections required in the diagnosis, prevention and treatment of an injury or illness. However, benefits for certain therapeutic injectables as identified by Highmark and which are appropriate for self-administration will be provided only when received from a participating pharmacy provider.

Pediatric Extended Care Services

Benefits are provided for care received from a pediatric extended care facility that is licensed by the state and is primarily engaged in providing basic non-residential services to infants and/or young

children who have complex medical needs requiring skilled nursing and therapeutic care and who may be technologically dependent.

Services rendered by a pediatric extended care facility pursuant to a treatment plan for which benefits may include one or more of the following:

- Skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN)
  - Physical medicine, speech therapy and occupational therapy
  - Respiratory therapy
  - Medical and surgical supplies provided by the pediatric extended care facility
  - Acute health care support
  - Ongoing assessments of health status, growth and development

Pediatric extended care services will be covered for children eight years of age or under, pursuant to the attending physician's treatment plan only when provided in a pediatric extended care facility, and when approved by Highmark.

A prescription from the child's attending physician is necessary for admission to such facility.

No benefits are payable after the child has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care.

Preventive Care Services

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

Adult and Pediatric Care

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

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

Adult Immunizations

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

Colorectal Cancer Screenings

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

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

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

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

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

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

Diabetes Prevention Program

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

Mammographic Screening

Benefits are provided for the following:

- An annual routine mammographic screening starting at 40 years of age or older pursuant to the 2002 recommendations by the United States Preventive Services Task Force.

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

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

Pediatric Immunizations
Benefits are provided for those pediatric immunizations, including the immunizing agents, which c onform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services.

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

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

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

Private Duty Nursing Services

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

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

Prosthetic Appliances
Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues, or

replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered.

Skilled Nursing Facility Services

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

No benefits are payable:

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

Spinal Manipulations

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

Substance Abuse Services

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

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

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

Surgical Services

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

Anesthesia

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

Assistant at Surgery

Services of a physician who actively assists the operating surgeon in the performance of covered surgery.

Mastectomy and Breast Cancer Reconstruction

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

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

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

Special Surgery

- Oral Surgery

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

  – Extraction of impacted third molars when partially or totally covered by bone

  – Extraction of teeth in preparation for radiation therapy

  – Mandibular staple implant, provided the procedure is not done to prepare the mouth for dentures

  – Lingual frenectomy, frenotomy or frenoplasty (to correct tongue-tie

  – Facility provider and anesthesia services rendered in a facility setting in conjunction with non-covered dental procedures when determined by Highmark to be medically necessary and appropriate due to your age and/or medical condition

  – Accidental injury to the jaw or structures contiguous to the jaw except teeth

  – The correction of a non-dental physiological condition which has resulted in a severe functional impairment

  – Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth

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

- Sterilization

  – Sterilization and its reversal regardless of medical necessity and appropriateness.

Second Surgical Opinion

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

Keep in mind that:

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

Surgery

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

Therapy and Rehabilitation Services

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

- Cardiac rehabilitation
- Chemotherapy
- Dialysis treatment

- Infusion therapy when performed by a facility provider or ancillary provider and for self-administration if the components are furnished and billed by a facility provider or ancillary provider. Benefits for certain infusion therapy prescription drugs as identified by Highmark and which are appropriate for self-administration, will be provided only when received from a participating pharmacy provider.
- Occupational therapy
- Physical medicine
- Radiation therapy
- Respiratory therapy
- Speech therapy

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

Transplant Services

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

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

- when both the recipient and the donor are members, each is entitled to the benefits of their program;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this program subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Cross or Blue Shield coverage or any government program; and 2) benefits provided to the donor will be charged against the recipient's coverage under this program to the extent that benefits remain and are available under this program after benefits for the recipient's own expenses have been paid;
- when only the donor is a member, the donor is entitled to the benefits of this program, subject to the following additional

limitations: 1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this program; and 2) no benefits will be provided to the non-member transplant recipient; and

- if any organ, tissue or blood stem cell is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the member recipient's program limit.

What Is Not Covered

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

Key Word	Exclusion
Acupuncture	• For acupuncture services.
Allergy Testing	• For allergy testing, except as provided herein.
Ambulance	• For ambulance services, except as provided herein.
Assisted Fertilization	• Related to treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization.
Comfort/Convenience Items	• For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider.
Cosmetic Surgery	• For a cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except: a) as otherwise provided herein, b) when required to correct a condition directly resulting from an accident; c) when necessary to correct a functional impairment which directly results from a covered disease or injury, or d) to correct a congenital birth defect.

Court Ordered Services	• For otherwise covered services ordered by a court or other tribunal as part of your or your dependent's sentence.
Custodial Care	• For custodial care, domiciliary care, protective and supportive care including educational services, rest cures and convalescent care .
Dental Care	• Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses related to accidental injury, anesthesia for non-covered dental procedures and orthodontic treatment for congenital cleft palates as provided herein.
Diabetes Prevention Program	• For a diabetes prevention program offered by other than a network diabetes prevention provider or a YMCA diabetes prevention eligible provider.
Effective Date	• Rendered prior to your effective date of coverage.
Enteral Foods	• For the following services associated with the additional enteral foods benefits provided under your program: blenderized food, baby food, or regular shelf food; milk or soy-based infant formulae with intact proteins; any formulae, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or

	for caloric supplementation, limitation or maintenance; semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally; normal food products used in the dietary management of the disorders provided herein.
Experimental/ Investigative	• Which are experimental/investigative in nature.
Eyeglasses/Contac t Lenses	• For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury) .
Felonies	• For any illness or injury you suffer during your commission of a felony, as long as such illness or injuries are not the result of a medical condition or an act of domestic violence.
Foot Care	• For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.

Health Care Management program	• For any care, treatment, prescription drug or service which has been disallowed under the provisions of Health Care Management program.
Hearing Care Services	• For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids.
Home Health Care	• For the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: dietitian services; homemaker services; maintenance therapy; dialysis treatment; custodial care; food or home-delivered meals.
Immunizations	• For immunizations required for foreign travel or employment, except as provided herein.
Inpatient Admissions	• For inpatient admissions which are primarily for diagnostic studies. • For inpatient admissions which are primarily for physical medicine services.
Learning Disabilities	• For any care that is related to conditions such as hyperkinetic syndromes, learning disabilities, behavioral problems or intellectual disability, 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.

Legal Obligation	• For which you would have no legal obligation to pay.
Medically Necessary and Appropriate	• Which are not medically necessary and appropriate as determined by Highmark.
Medicare	• To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program.
Medicare	• For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage.
Military Service	• To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.
Miscellaneous	• For telephone consultations , charges for failure to keep a scheduled visit, or charges for completion of a claim form. • For any other medical or dental service or treatment or prescription drug except as provided herein.
Motor Vehicle Accident	• For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable in any manner under the Pennsylvania

	Motor Vehicle Financial Responsibility Act.
Nutritional Counseling	• For nutritional counseling, except as provided herein.
Obesity	• For treatment of obesity, except for medical and surgical treatment of morbid obesity or as provided herein.
Oral Surgery	• For oral surgery procedures, except as provided herein.
Physical Examinations	• For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein.
Prescription Drugs (Medical Program)	• For prescription drugs which were paid or are payable under a freestanding prescription drug program.
Preventive Care Services	• For preventive care services, wellness services or programs, except as provided herein.
Provider of Service	• Which are not prescribed by or performed by or upon the direction of a professional provider. • Rendered by other than ancillary providers, facility providers or professional providers. • Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group. • Which are submitted by a certified

	registered nurse and another professional provider for the same services performed on the same date for the same member. • Rendered by a provider who is a member of your immediate family. • Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
Respite Care	• For respite care.
Sexual Dysfunction	• For treatment of sexual dysfunction that is not related to organic disease or injury.
Skilled Nursing	• For skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness.
Smoking (nicotine) Cessation	• For nicotine cessation support programs and/or classes, except as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
Termination Date	• Incurred after the date of termination of your coverage except as provided herein.
Therapy	• For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving

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

How Your Health Care Program Works

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

Network Care

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

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

Out-of-Network Care

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

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

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

Even though a hospital may be in our network, not every doctor providing services in that hospital is in the network. For example: If you are having surgery, make sure that all of your providers, including surgeons, anesthesiologists and radiologists, are in the network.

Out-of-Area Care

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

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

Provider Reimbursement and Member Liability

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

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

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

Inter-Plan Arrangements

<u>Out-of-Area Services</u>
Highmark has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "inter-plan arrangements." These inter-plan arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association. Whenever members access health care services outside the geographic area Highmark serves, the claim for those services may be processed through one of these inter-plan arrangements, as described generally below.

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

<u>BlueCard® Program</u>
The BlueCard® Program is an inter-plan arrangement. Under this arrangement, when members access covered services outside the geographic area Highmark serves, the Host Blue will be responsible for contracting and handling all interactions with its participating health care providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method per Claim
Unless subject to a fixed dollar copayment, the calculation of the member liability on claims for covered services will be based on the lower of the participating provider's billed charges for covered services or the negotiated price made available to Highmark by the Host Blue.

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

- an actual price - An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases, or
- an estimated price - An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives, or
- an average price - An average price is a percentage of billed charges for covered services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices, (ie, prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Highmark in determining your premiums.

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

Return of Overpayments
Recoveries of overpayments from a Host Blue or its participating and non-participating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/health care provider/hospital bill audits, credit balance

audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to Highmark, they will be credited to your account. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to you as a percentage of the recovery.

Non-Participating Providers Outside of the Plan Service Area

Member Liability Calculation

When covered services are provided outside of the Plan service area by non-participating providers, the amount(s) a member pays for such services will generally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable law. In these situations, the member may be responsible for the difference between the amount that the non-participating provider bills and the payment Highmark will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services are governed by applicable federal and state law.

Exceptions

In some exception cases, Highmark may pay claims from non-participating health care providers outside of the Plan service area based on the provider's billed charge. This may occur in situations where a member did not have reasonable access to the participating provider, as determined by Highmark in Highmark's sole and absolute discretion or by applicable law. In other exception cases, Highmark may pay such claims based on the payment Highmark would make if Highmark were paying a non-participating provider inside the Plan service area. This may occur where the Host Blue's corresponding payment would be more than the plan in-service area non-participating provider payment. Highmark may choose to negotiate a payment with such provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the member may be responsible for the difference between the amount that the non-participating health care provider bills and payment Highmark will make for the covered services as set forth in this paragraph.

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

Inpatient Services
In most cases, if members contact the service center for assistance, hospitals will not require members to pay for inpatient covered services, except for their cost-sharing amounts. In such cases, the hospital will submit member claims to the service center to initiate claims processing. However, if the member paid in full at the time of service, the member must submit a claim to obtain reimbursement for covered services. **Members must contact Highmark to obtain precertification for non-emergency inpatient services**.

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

Submitting a Blue Cross Blue Shield Global Core Claim
When members pay for covered services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, members should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center address on the form to initiate claims processing. The claim form is available from Highmark, the service center or online at www.bcbsglobalcore.com. If members need assistance with their claim submissions, they should call the service center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

Your Provider Network

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

To determine if your physician is in the network, call the Member Service toll-free telephone number on the back of your ID card, or log onto www.highmarkbcbs.com.

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

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

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

How to Obtain Information Regarding Your Physician

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

- Name, address, telephone numbers
- Professional qualifications

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

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

Eligible Providers

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

Facility Providers

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

Professional Providers

- Audiologist
- Behavior specialist
- Certified registered nurse*
- Chiropractor

- Clinical social worker
- Dentist
- Dietician-nutritionist
- Licensed practical nurse
- Marriage and family therapist
- Nurse-midwife
- Occupational therapist
- Optometrist
- Physical therapist
- Physician
- Podiatrist
- Professional counselor
- Psychologist
- Registered nurse
- Respiratory therapist
- Speech-language pathologist
- Teacher of hearing impaired

Ancillary Providers:

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

Contracting Suppliers (for the sale or lease of):

- Durable medical equipment
- Supplies
- Orthotics
- Prosthetics

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

Health Care Management

Medical Management

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

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

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

Network Care

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

If the network provider is located outside the Highmark service area, you are responsible for contacting Highmark at the toll-free number listed on the back of your ID card to confirm Highmark's determination of medical necessity and appropriateness.

Out-of-Network Care

When you are admitted to an out-of-area network facility provider, ***you are responsible*** for notifying Highmark of your admission. However, some facility providers will contact Highmark and obtain preauthorization of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Highmark for preauthorization. If not, you are responsible for contacting Highmark.

You should call 7 to 10 days prior to your planned admission. For emergency admissions, call Highmark within 48 hours of the

admission, or as soon as reasonably possible. You can contact Highmark via the toll-free Member Service telephone number located on the back of your ID card.

If you do not notify Highmark of your admission to an out-of-area network facility provider, Highmark may review your care after services are received to determine if it was medically necessary and appropriate. **If your 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 Highmarkor to abide by any determination of medical necessity or appropriateness rendered by Highmark. You may, therefore, receive services which are not medically necessary and appropriate for which you will be solely responsible.

Care Utilization Review Process

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

Prospective Review

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

After receiving the request for care, Highmark:

- verifies your eligibility for coverage and availability of benefits;
- reviews diagnosis and plan of treatment;
- assesses whether care is medically necessary and appropriate;
- authorizes care and assigns an appropriate length of stay for inpatient admissions

Concurrent Review

Concurrent review may occur during the course of ongoing treatment and is used to assess the medical necessity and appropriateness of the length of stay and level of care.

Discharge Planning

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

Procedure or Covered Service Precertification

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

In-Area Care

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

Out-of-Area Care

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

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

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

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

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

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

Highmark case managers are a free resource to all Highmark members. If you have an inpatient hospital admission, you may be contacted as part of our Outreach program. If your claims history indicates that your needs appear to be more complex, you may be contacted by a case manager from our Complex program. In either case, you are always free to call and request case management services if you feel you need it by contacting Member Services at the telephone number listed on the back of your ID card.

Selection of Providers

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

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

Preauthorization

Certain prescription drugs may require preauthorization to ensure the medical necessity and appropriateness of the prescription order. The prescribing physician must obtain authorization from Highmark prior to prescribing certain covered medications. The specific drugs or drug classifications which require preauthorization may be obtained by calling the toll-free Member Service telephone number appearing on your ID card.

Precertification, Preauthorization and Pre-Service Claims Review Processes

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

Authorized Representatives

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

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

You will receive written notice of any decision on a request for precertification or other pre-service claim, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed 15 days from the date Highmark receives the claim.

Decisions Involving Urgent Care Claims

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

If Highmark determines in connection with an urgent care claim that you have not provided sufficient information to determine whether or to what extent benefits are provided under your coverage, your physician will be notified within 24 hours following Highmark receipt of the claim of the specific information needed to complete your claim. Your physician will then be given not less than 48 hours to provide the specific information to Highmark. Highmark will thereafter notify you of its determination on your claim as soon as possible but not later than 48 hours after the

earlier of (i) its receipt of the additional specific information, or (ii) the date Highmark informed your physician that it must receive the additional specific information.

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

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

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

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

General Information

Benefits After Termination of Coverage

- If you are an inpatient on the day your coverage terminates, facility provider benefits for inpatient covered services will be continued as follows:

  — Until the maximum amount of benefits has been paid; or

  — Until the inpatient stay ends; or

  — Until you become covered, without limitation as to the condition for which you are receiving inpatient care, under another group program; whichever occurs first.

- If you are pregnant on the date coverage terminates, no additional coverage will be provided.

Coordination of Benefits

Most health care programs, including your health care program, contain a coordination of benefits provision. This provision is used when you, your spouse or your covered dependents are eligible for payment under more than one health care program. The object of coordination of benefits is to ensure that your covered expenses will be paid, while preventing duplicate benefit payments.

Here is how the coordination of benefits provision works:

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your program.

- When the person who received care is covered as an employee under one contract, and as a dependent under another, then the employee coverage pays first.

- When a dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the calendar year pays first. But, if both parents have the same birthday, the program which covered the parent longer will be the primary program. If the dependent child's parents are separated or divorced, the following applies:
  - The parent with custody of the child pays first.
  - The coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody.
  - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.
- When none of the above circumstances applies, the coverage you have had for the longest time pays first, provided that:
  - the benefits of a program covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a program covering the person as a laid-off or retired employee or as a dependent of such person and if
  - the other program does not have this provision regarding laid-off or retired employees, and, as a result, plans do not agree on the order of benefits, then this rule is disregarded.

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

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

Subrogation

Subrogation means that if you incur health care expenses for injuries caused by another person or organization, the person or organization causing the accident may be responsible for paying these expenses.

For example, if you or one of your dependents receives benefits through your program for injuries caused by another person or organization, Highmark has the right, through subrogation, to seek repayment from the other person or organization or any applicable insurance company for benefits already paid.

Highmark will provide eligible benefits when needed, but you may be asked to show documents or take other necessary actions to support Highmark in any subrogation efforts.

A Recognized Identification Card

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

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

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

- Your name and your dependent's name, if applicable
- Identification number
- Group number
- Copayment for physician office visits and emergency room visits
- Pharmacy network logo (when applicable)
- Member Service toll-free number (on back of card)
- Toll-free telephone number for Out-of-network facility admissions (on back of card)
- Suitcase symbol

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

How to File a Claim

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

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

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

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

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

- ***Copy Itemized Bills.*** You must submit originals, so you may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.

- ***Complete a Claim Form.*** Make sure all information is completed properly, and then sign and date the form. *Claim forms can be downloaded from blog.highmarkhealth.org by entering "forms" in the search box. Claim forms are also available from the Fund Office, or call the Member Service telephone number on the back of your ID card.*

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

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

If you file the claim yourself, your claim must be submitted within 90 days of the date of service, but in no event will it be accepted later than one year from the 90-day timeframe.

Your Explanation of Benefits Statement

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

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

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

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

How to Voice a Complaint

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

Highmark Blue Cross Blue Shield
P.O. Box 226
Pittsburgh, PA 15222

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

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

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

Additional Information on How to File a Claim

Member Inquiries

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

– ***Authorized Representatives***

You have the right to designate an authorized representative to file or pursue a request for reimbursement or other post-service claim on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

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

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

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

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

Determinations on Benefit Claims

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

For a description of the time frames in which requests for precertification or other pre-service claims will be determined by Highmarkand the notice you will receive concerning its decision, whether adverse or not, see the Precertification,

Preauthorization and Pre-Service Claims Review Processes subsection in the Health Care Management section of this benefit booklet.

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

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

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

Appeal Procedure

Highmark maintains an appeal process involving one level of review. This appeal process is mandatory and must be exhausted before you are permitted to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

At any time during the appeal process, you may choose to designate an authorized representative to participate in the appeal process on your behalf. You or your authorized representative shall notify Highmark in writing of the designation. For purposes of the appeal process, “you” includes designees, legal representatives and, in the case of a minor, parents entitled or authorized to act on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by Highmark shall, in the case of an urgent care claim, permit a physician or other health care provider with knowledge of your medical condition to act as your authorized representative.

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

If you receive notification that a claim has been denied by Highmark, in whole or in part, you may appeal the decision. Your appeal must be submitted within 180 days from the date of your receipt of notification of the adverse decision.

Upon request to Highmark, you may review all documents, records and other information relevant to your appeal and shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal. Your appeal will be reviewed by a representative from the Member Grievance and Appeals Department. The representative shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the claim or matter which is the subject of your appeal. In rendering a decision on your appeal, the Member Grievance and Appeals Department will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Highmark. The Member Grievance and Appeals Department will afford no deference to any prior adverse decision on the claim which is the subject of your appeal.

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

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

In the event Highmark renders an adverse decision on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding your right to pursue legal action .

Autism Spectrum Disorders Expedited Review and Appeal Procedures

Upon denial, in whole or in part, of a pre-service claim or post-service claim for diagnostic assessment or treatment of autism spectrum disorders, there is an appeal procedure for expedited internal review which you may choose as an alternative to those procedures set forth above. In order to obtain an expedited review, you or your authorized representative shall identify the particular claim as one related to the diagnostic assessment or treatment of an autism spectrum disorder to the Member Service Department and request an expedited review which will be provided by Highmark. If, based on the information provided at the time the request is made, the claim cannot be determined as one based on services for the diagnostic assessment or treatment of autism spectrum disorders, Highmark may request from you or the health care provider additional clinical information including the treatment plan described in the Covered Services section of the booklet.

An appeal of a denial of a claim for services for the diagnostic assessment or treatment of an autism spectrum disorder is subject to review by a Review Committee. The request to have the decision reviewed by the Review Committee may be communicated orally or be submitted in writing within 180 days from the date the denial of the claim is received, and may include

any written information from you or the health care provider. The Review Committee shall be comprised of three employees of Highmark who were not involved or the subordinate of any individual that was previously involved in any decision to deny coverage or payment for the health care service. The Review Committee will hold an informal hearing to consider the appeal. When arranging the hearing, Highmark will notify you or the health care provider of the hearing procedures and rights at such hearing, including your or the health care provider's right to be present at the review and to present a case. If you or the health care provider cannot appear in person at the review, Highmark shall provide you or the health care provider the opportunity to communicate with the Review Committee by telephone or other appropriate means.

Highmark shall conduct the expedited internal review and notify you or your authorized representative of its decision as soon as possible but not later than 48 hours following the receipt of your request for an expedited review. The notification to you and the health care provider shall include, among other items, the specific reason or reasons for the adverse decision including any clinical rationale, the procedure for obtaining an expedited external review and a statement regarding your right to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Following the receipt of the expedited internal review decision, you may contact Highmark to request an expedited external review pursuant to the expedited external review procedure for autism spectrum disorders established by the Pennsylvania Insurance Department.

Member Service

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

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

Blues On Call[sm] - 24/7 Health Decision Support

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

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

Help with common illnesses, injuries and questions

Health Coaches can address any health topic that concerns you:

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

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

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

Help with chronic conditions

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

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

myCare Navigator[sm] - 24/7 Health Advocate Support

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

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

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

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

Highmark Website

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

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

Baby Blueprints®

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

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

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

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

Easy Enrollment

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

Member Rights and Responsibilities

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

You have the right to:

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

You have a responsibility to:

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

mutually agreed upon treatment goals. Develop a relationship with your doctor based on trust and cooperation.

How We Protect Your Right to Confidentiality

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

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

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

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

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

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

Notice of Privacy Practices – See page 281

DEATH BENEFITS

(For MEDICARE SUPPLEMENTAL PLAN Employees Only)

Retiree Benefits.

In the event of the death of an eligible employee, from ANY CAUSE, a $1,500 Death Benefit will be paid to the named Beneficiary.

Beneficiary.

It is very important that you designate the person to whom the Death Benefits are to be paid. You do this by filling in his or her name on the Fund Office Information Card, which may be obtained by contacting the Fund Office. The Beneficiary may be changed at any time and as often as desired by completing a new Fund Office Information Card.

The designation of a beneficiary will take effect upon acceptance of the Fund Office Information Card by the Fund Office. If the beneficiary dies before the eligible employee, the interest of the beneficiary will terminate.

If there is no beneficiary designated or surviving at the death of the eligible employee, payment will be made to the first surviving of the following classes of preferential beneficiaries: (a) the widow or widower; (b) the surviving children; (c) the surviving parents; (d) the surviving sisters and brothers; (e) the executors or administrators of the estate.

Assignment of Death Benefits.

No assignment of Death Benefits under this Plan will be valid.

Totally Disabled Benefits.

If you become totally and permanently disabled, as an active employee, before age 60 and while eligible for a Plan One ($6,000) or Plan Two ($2,400) Death Benefit, your coverage for the same amount of Death Benefit will be continued for as long as you remain totally and permanently disabled. However, the disability must prevent you from engaging in any kind of employment or business. You will be required to furnish written proof of total and permanent disability to the Welfare Fund Office between the ninth

and twelfth months after the beginning of your disability. Subsequent written proof of total and permanent disability must be given to the Welfare Fund Office not less than once each year thereafter.

Beginning with age 60, the Death Benefit for a Total and Permanently Disabled Member will be reduced to $1,500.

Filing for Death Benefits.

The Claimant must file written proof of the death of an eligible employee at the Fund Office within 180 days from the date of death.

Failure to furnish proof within 180 days will not invalidate the claim if it can be shown not to have been reasonably possible to furnish the proof within the time required. However, all liability on the part of the Fund and the Trustees will cease and any person's claim to benefits will be forfeited, unless notice and the required proof are submitted within 36 months from the date of death.

Payment of Death Benefits.

All Death Benefits are paid in a single sum to the designated beneficiary or lawful claimant, within twelve months from the date of receipt of the required proof. It is expressly understood that no interest will accrue to the principal benefit of the claimant, during the period between the date of death and date of the benefit payment.

Accidental Death and Dismemberment.

MEDICARE SUPPLEMENTAL PLAN EMPLOYEES ARE NOT ELIGIBLE FOR THIS BENEFIT.

VISION-CARE BENEFITS

(For MEDICARE SUPPLEMENTAL PLAN Employees and MEDICARE SUPPLEMENTAL PLAN Dependents Only)

Eligible participants can have vision benefits provided once per calendar year. Services can be obtained by either:

- The use of a network Optometrist provided by National Vision Administrators (NVA).

  -or-

- The services of a non-participating eye doctor of your choice.

ADMINISTRATION

National Vision Administrators, Inc is administering your Vision Care Program. If you have any questions or require information of any kind, please call or write:

National Vision Administrators, Inc.
P.O. Box 2187
Clifton, New Jersey 07015
800-672-7723
www.e-nva.com

BENEFITS PROVIDED

Vision Examination: A complete analysis of eyes and related structures.

Lenses: To correct vision problems—lenses may be plastic or impact-resistant glass.

Frames: The Plan offers a wide selection of frames; however, if you select a frame that costs more than the amount allowed by your Plan, there will be an additional charge.

Contact Lenses: The Plan will contribute an allowance of $110.00 including exam towards the purchase of contacts.

PRIOR AUTHORIZATION

Contact Lenses which are deemed Medically Necessary will be considered for payment by NVA when an NVA Participating Provider secures prior authorization for the following conditions: a)

following cataract surgery, b) to correct extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, c) anisometropia, d) keratoconus. Maximum allowance is usual, customary and reasonable when medically necessary.

How Do I Use The Plan?

Make an appointment with a NVA Participating Provider, please notify them that your coverage is administered by NVA and sponsored by Operating Engineers Local 66 Welfare Fund, Sponsor #1076. The Provider will telephone NVA to verify your vision care eligibility.

At the time of your first appointment present your NVA Vision Care identification card. You do not need to obtain a vision claim form. The Provider will inform you of your eligibility status prior to rendering services. To verify benefit eligibility yourself prior to scheduling your eye-care appointment, you may wish to contact NVA's Customer Service Department at the following toll-free number: 1-800-672-7723.

When the services have been completed, the Provider will have you sign a claim form and he or she will then forward the form to NVA for processing and payment.

Non-Participating Provider: If you select a non-participating eye-care provider you will be responsible for one hundred percent (100%) of the cost at the time of service. Obtaining vision-care services from a non-participating provider will result in higher unnecessary out-of-pocket expenses. You must submit a copy of the itemized receipt along with a note containing your name, Social Security number or a photocopy of your identification card to NVA at the following address:

National Vision Administrators, Inc.
P.O. Box 2187
Clifton, New Jersey 07015
800-672-7723

How Much Do I Pay?

When you receive an examination, spectacle lenses and/or frames from an NVA participating provider, the provider accepts the NVA payment as payment (provided you stay within the limitation of the program). Extra materials that are not covered by the Plan may be purchased through the NVA participating provider at a controlled cost.

Non-Participating Provider:
When you receive services from a non-participating provider, you will be reimbursed directly by NVA, according to the Non-participating Provider Reimbursement Schedule.

Non-Participating Provider Reimbursement Schedule:
$100.00 total reimbursement for examination, lenses and frames or contact lenses per benefit period.

How Often Are These Services Available?
Each eligible member and their covered dependents are entitled to one vision examination, and one pair of glasses (lenses or frames) or contact lenses once per calendar year beginning July 1, 2019.

Where To Get Benefits.
NVA has a network of participating Ophthalmologists, Optometrists, and Opticians to serve you. To find a participating provider you can call (800) 672-7723 or use oe66.com and select Welfare then NVA.

What Vision Services And Materials Are Limited or Not Covered Under This Plan?
The items below can be provided under your plan. However, if you select any of these items, you must pay the difference between your scheduled plan allowance and the cost of the item selected: Photochromatic (gray and brown) light or dark, tinted (other than pink #1 or #2), gradient or fashion colors, progressive or no-line multifocal, a frame costing more than the plan allowance; Coatings: mirror, anti-reflective, super a.r., color, edge, ultraviolet, polish edges, smart segment, rimless, polycarbonate.

Items Not Covered:
Services and materials not covered under the plan. No payment will be made for: medical or surgical treatments, drugs or medications, non-prescription lenses, examinations or materials not listed as a covered service, replacement of lost stolen broken or damaged lenses, contact lenses or frames except at normal intervals when service is otherwise available, services or materials provided by Federal, State, Local Government or Workers' Compensation, Examination procedure training or materials not listed, industrial (3mm) safety lenses and safety frames with side shields, parts or repair of frame, sunglasses. If any item is

selected from the exclusion list, you will be required to pay the total cost of the lenses.

PRESCRIPTION DRUG BENEFITS

(For MEDICARE SUPPLEMENTAL PLAN Employees and MEDICARE SUPPLEMENTAL PLAN Dependents Only)

The Welfare Fund contracts with OptumRx to manage Prescription Drug Benefits. Coverage is provided for approved drugs dispensed to you or your eligible dependents after the effective date of your coverage, regardless of the date on the prescription order. If a prescription refill is authorized by the subscriber and permitted under Government regulations, it will be refillable up to one year after the original prescription date, provided you are eligible on the refill date.

Covered Drugs.

Covered drugs are those that are required under Federal Law to bear the legend: "Caution: Federal Law prohibits dispensing without prescription", or which are specifically designated by our prescription drug service providers.

Covered prescription drugs include:

- Federal Legend Drugs.
- State Restricted Drugs.
- Compounded Medication.
- Oral Contraceptives.
- Insulin.
- Insulin needles and syringes on prescription only.
- Over-the-counter diabetic supplies.
- Retin-A - See Page 187.

Covered drugs are paid under Prescription Drug Benefits when they are filled at a retail pharmacy or mail-order pharmacy. Payment for covered drugs will not be made under Prescription Drug Benefit if you use a Home Medical Equipment Supplier.

Filling Prescriptions.

Your prescription may be filled at:

- A retail pharmacy of your choice, if the prescription is for up to a 30-day supply.

  Note: Mandatory use of the mail order benefit is required after 3 fills of the same medication at any retail pharmacy.

- A mail-order pharmacy, if the prescription is for a 30 to 90 day supply of maintenance drugs when medically appropriate.
  - (OptumRx CVS90 Saver Plus), A CVS retail pharmacy can be used in place of mail order for a 30 to 90 day supply of maintenance drugs when medically appropriate.

Retail Pharmacies.

The Welfare Fund has made arrangements with OptumRx, a company specializing in payment of prescription drugs with retail pharmacies. Within 21 days of the first day of your eligibility for prescription drug benefits, an OptumRx Identification Card will be sent to you. This card will identify the eligible employee. Upon receipt of your I.D. card, please check to see your name is correct.

If you have lost your card, please contact the Fund Office at (412) 968-9750. The Fund Office will order a new card from OptumRx. Please note that it takes 7 to 10 days to obtain the new card.

Participating Retail Pharmacy - When you purchase covered drugs from any OptumRx participating pharmacy, present your prescription order and OptumRx identification card to the pharmacist. A prescription order received by phone from your physician or dentist, will also be covered. The pharmacy will bill OptumRx directly and will be paid the difference between its prescription charge and the $20 or $10 co-payment that you pay. You should request and retain a paid receipt for your co-payment amount if you need it for income tax or any other purpose.

If you have any questions concerning a participating retail pharmacy, call OptumRx at 1-855-295-9140 or visit their website at www.OptumRx.com.

Non-participating Retail Pharmacy - When covered drugs are purchased from a non-participating pharmacy, you will be required to pay the full charge made by the pharmacy for the prescription. You must submit a completed Member Reimbursement Drug Claim Form to OptumRx. Forms are available from the Welfare Fund Office at 412-968-9750 or from OptumRx at 1-855-295-9140. Reimbursement will be made directly to you minus the $20 or $10 co-payment.

Mail Order Pharmacy.

The Welfare Fund has made arrangements with OptumRx for the dispensing of prescription maintenance drugs by mail. You will be able to receive a 30 to 90 day supply of a medication with a single co-payment of $40 for brand-name medications or a $20 co-payment for generic medications. For mail order, be sure to ask your doctor to prescribe maintenance drugs for a 90-day supply plus refills, whenever appropriate. All narcotics are limited to a 30 day supply.

No Identification Card is necessary to use the OptumRx Mail Order Program. The Welfare Fund frequently sends information to OptumRx to update eligibility.

To order an original prescription from OptumRx Mail Order, obtain a New Prescription Mail-In Order Form from the Fund Office. Complete the form, attach the prescription order and mail both to the address listed on the form.

To order refills through OptumRx - each time you receive your prescription drug order from OptumRx, it will come with a reorder form for refills. You may call OptumRx at 1-855-295-9140 to order a refill, mail in a refill order form, order from their website at www.OptumRx.com, or use the OptumRx mobile app. In any case, please follow OptumRx Home Delivery Service's instructions in regard to any payment due.

OptumRx also offers the ability through its CVS90 Saver Plus program to use a CVS retail pharmacy in place of mail order for maintenance drugs.

If you have any questions concerning the mail-order pharmacy call OptumRx at 1-855-295-9140.

Maintenance Drugs.

Maintenance drugs are any prescription medication prescribed by your physician, which is taken on an ongoing basis for conditions such as diabetes, high blood pressure or arthritis.

Prescription drugs, that are maintenance drugs, are to be purchased from the OptumRx mail-order pharmacy for all prescription orders. The OptumRx mail order pharmacy will mail all your maintenance drug orders to your home.

Generic Drugs.

A generic drug is a medication that, by law, must meet the same standards for strength and effectiveness as the comparable brand name product. The United States Food and Drug Administration (FDA) has determined that there is no significant difference between most brand name and generic drugs. Ask your

doctor to authorize generic substitution if an approved generic is available.

Co-Payments.

Retail Pharmacy - Your co-payment to a retail pharmacy is $20 for brand name and $10 for generic drugs for each prescription or refill. A OptumRx Participating Pharmacy will charge you no more than these co-payment amounts for any prescription.

Mail Order Pharmacy - Your co-payment for mail order is $40 for each prescription or refill if you use a name brand drug. There is a $20 co-payment to you if you use a generic drug by mail order.

IMPORTANT - The co-payment charge that you pay either at the retail pharmacy or mail order pharmacy is not eligible to be paid through the Member Reimbursement Benefit, it is your responsibility. Do not submit a co-payment charge to the Welfare Fund Office, as it is not a payable expense.

Eligibility Questions.

If you go to a retail participating pharmacy and your eligibility is questioned, please have the pharmacist call OptumRx, to obtain additional information on your eligibility. If for any reason you feel that you are eligible and the pharmacist cannot resolve the situation, please have the pharmacist call the Welfare Fund Office at (412) 968-9750 - Monday through Friday between 8:00 a.m. and 3:30 p.m.

If you have your eligibility questioned by the OptumRx mail order pharmacy, call the Welfare Fund Office.

Allergy Serum.

Allergy serum will be covered by OptumRx, if you or your eligible dependent requires allergy injections. You must submit a completed Member Reimbursement Drug Claim Form to OptumRx. Forms are available from the Welfare Fund Office at 412-968-9750 or from OptumRx at 1-855-295-9140.

Diabetic Supplies – Retail Pharmacy.

A separate prescription is required from your doctor, for each item to be given to the OptumRx participating pharmacist. Insulin, syringes, test strips, lancets and needles can be obtained from a participating pharmacy for the $20 co-payment per prescription, for a 30-day supply.

Diabetic Supplies – Mail Order Pharmacy.

A separate prescription is required from your doctor, for each item to mail to OptumRx Home Delivery Service. Insulin, syringes, test strips, lancets and needles can be ordered through the OptumRx program for the $40 co-payment per prescription, for a 90-day supply.

Retin-A.

If Retin-A is prescribed, you must mail a letter of medical necessity from your doctor to the Fund Office. If dispensing is approved by the Fund Office, you will receive payment from the Fund Office minus the applicable co-payment.

OptumRx and OptumRx do not pay for Retin-A. You must submit the charges directly to the Fund Office.

Exclusion and Limitations:

No benefits will be payable for the following:

- Any charges for services for administration of drugs or insulin by a physician, surgeon or other medical attendant.
- Lost, stolen, or damaged medications.
- Medications that are not taken correctly.
- Any drugs dispensed by the Doctor or Dentist except for allergy serum.
- Prescription drugs dispensed for treatment of an illness or injury for which the employer is required by law to furnish care in whole or in part-including, but not limited to state or federal workmen’s compensation laws and occupational disease laws and other employer liability laws.
- Prescription drugs to which you are entitled, with or without charge, under a plan or program of any government body.
- The charge for more than a 30-day supply of drugs from a retail pharmacy, or 90-day supply from the mail-order pharmacy.
- Any charges by a pharmacy or pharmacist except as provided herein.
- Multiple and non-therapeutic vitamins, cosmetics, dietary supplements, health and beauty aids.
- Drugs labeled, “Caution-limited by Federal Law to investigational use”, or experimental

drugs, even if a charge is made to the individual.

- Any charge where the usual and customary charge is less than the co-payment amount.
- Covered drugs dispensed to patients in hospitals, skilled nursing facilities, nursing homes, or other institutions.
- Non-Federal Legend Drugs, diaphragms, contraceptive jellies, creams, foams or devices, nicorette, therapeutic devices or appliances, drugs whose sole purpose is to promote or stimulate hair growth, Rogaine, Minoxidil, syringes other than for Insulin, injectables, drugs acquired by mail order other than Insulin, over-the-counter medications, except Insulin and diabetic supplies.
- Unauthorized refills of any prescription older than one year.

Medicare Supplemental

Highmark Blue Cross Blue Shield PPO

Introduction to Your Traditional Benefits Program

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

We think you will be very pleased with the freedom and flexibility, the provider choice and the coverage your program provides you.

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

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

Information for Non-English-Speaking Members

Non-English-speaking members have access to clear benefits information. They can call the toll-free Member Service telephone number on the back of their ID card to be connected to a language services interpreter line. Highmark Member Service representatives are trained to make the connection.

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

How Your Benefits Are Applied

To help you understand your coverage and how it works, here's an explanation of some benefit terms found in your Summary of Benefits and a description of how your benefits are applied. For specific amounts, refer to your Summary of Benefits.

Medical Cost-Sharing Provisions

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

Major Medical Covered Services

Benefit Period

Your benefit period is a calendar year starting on January 1.

Coinsurance

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

Deductible

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

Family Deductible

For a family with several covered dependents, you pay no more than three individual deductibles per family, as specified under family deductible. After each of the three covered persons meets the individual deductible specified in the Summary of Benefits, the deductible for the entire family is met. If one family member meets the deductible and needs to use benefits, the program would

begin to pay for that person's covered services even if the deductible for the entire family had not been met.

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

The deductible does not include any charges for which benefits are excluded in whole or in part under the provisions in the Health Care Management section.

Lifetime Maximum

The maximum benefit that the program will provide for any covered individual during his or her lifetime is specified in your Summary of Benefits.

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 plan will be added to any amount paid for benefits for that same individual under any other group health care expense program between the group and Highmark, for the purpose of calculating the benefit period or lifetime maximum applicable to each individual.

Summary of Benefits

Please see page 21.

Covered Services - Medical Program

The program provides benefits for the following hospital, medical-surgical and major medical services you receive from an eligible provider.

HOSPITAL SERVICES

The benefits in this section 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. Please refer to the section headed "Terms You Should Know" and also the section headed "Health Care Management" for specific details. Any benefit limits, deductibles and coinsurance amounts are described in the Summary of Benefits.

Anesthesia for Non-Covered Dental Procedures (Limited)

Benefits will be provided for general anesthesia and associated hospital services normally related to the administration of general anesthesia which are rendered in connection with non-covered dental procedures or non-covered oral surgery. Benefits are provided for members age seven or under and for developmentally disabled members when determined by Highmark to be medically necessary and appropriate and when a successful result cannot be expected for treatment under local anesthesia, or when a superior result can be expected from treatment under general anesthesia.

Autism Spectrum Disorders

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 and the physician or psychologist developing the treatment plan.

Treatment may include the following medically necessary and appropriate services:

Pharmacy care

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

Psychiatric and psychological care

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

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.

Diabetes Treatment

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

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

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

Diagnostic Services

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

- Diagnostic X-ray consisting of radiology (including diagnostic mammography), magnetic resonance imaging (MRI), ultrasound and nuclear medicine
- Diagnostic pathology, consisting of laboratory and pathology tests
- Diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by Highmark

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 a Registered Nurse (RN) or Licensed Practical Nurse (LPN), excluding private duty nursing services
- Physical medicine, speech therapy and occupational therapy services
- 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
- Health aide services to an individual who is receiving covered nursing or therapy services

No home health care benefits will be provided for:

- dietitian services;
- homemaker services;
- maintenance therapy;
- dialysis treatment;
- custodial care;
- food or home-delivered meals;
- durable medical equipment; and
- prescription drugs and medication.

Hospital Services-Inpatient

Bed and Board

Bed, board and general nursing services in a facility provider when you occupy:

- a room with two or more beds; or
- a private room (the private room allowance is the hospital's most common charge for semiprivate rooms); 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 when you are an inpatient in a facility provider;
- whole blood, administration of blood, blood processing and blood derivatives;
- anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider;
- medical and surgical dressings, supplies, casts, and splints;
- diagnostic services; or
- therapy and rehabilitation services.

Hospital Services-Outpatient

Emergency Care

Services and supplies for the outpatient emergency treatment of bodily injuries resulting from an accident or medical condition. Also included is a medical screening examination and ancillary services necessary to evaluate such injury or emergency medical condition and further medical examination and treatment as required to stabilize the patient. Emergency care includes benefits for unlimited visits of follow-up care.

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

Pre-Admission Testing

Tests and studies 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. Preadmission testing does not include tests or studies performed to establish a diagnosis.

Surgery

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

Maternity Services

Hospital services rendered by a facility provider 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.

Nursery Care

Care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Benefits will continue for a maximum of 31 days. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within such period. Refer to the General Information section for further eligibility information.

Maternity Home Health Care Visit

Benefits for one maternity home health care visit will be provided at your home within 48 hours of discharge when the discharge from a facility provider occurs prior to: (a) 48 hours of inpatient care following a normal vaginal delivery; or (b) 96 hours of inpatient care following a cesarean delivery. This visit shall be made by a 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 the mother's sole discretion, occur at the office of the provider. The visit is subject to all the terms of the program.

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

Benefits are not provided for normal pregnancy services for dependent children.

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

Mental Health Care Services

If you need help with mental health or substance problems, your program offers professional, confidential care. Inpatient care must be authorized by Highmark.

Inpatient Facility Services

Inpatient hospital services as specified in the Hospital Services section provided by a facility provider when such services are ordered by a physician.

Inpatient Medical Services

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

- Individual psychotherapy

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

Partial Hospitalization Mental Health 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.

Pediatric Extended Care Services

Benefits are provided for basic non-residential services to infants and/or young children who have complex medical needs requiring skilled nursing and therapeutic care and who may be technologically dependent.

Services rendered by a pediatric extended care facility pursuant to a treatment plan for which benefits may include one or more of the following:

- Skilled nursing services of an RN or LPN
- Physical medicine, occupational therapy and speech therapy
- Respiratory therapy
- Medical and surgical supplies provided by the pediatric extended care facility
- Acute health care support
- Ongoing assessments of health status, growth and development

Pediatric extended care services will be covered for children eight years of age or under, pursuant to the attending physician's

treatment plan only when provided in a pediatric extended care facility, and when approved by Highmark.

A prescription from the child's attending physician is necessary for admission to such facility.

No benefits are payable after the child has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care.

Preventive Services

Mammographic Screening

Benefits will be provided for:

- an annual routine mammographic screening starting at 40 years of age or older pursuant to the 2002 recommendations by the United States Preventive Services Task Force; and
- mammographic screenings for all members 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.

Pediatric Immunizations

Benefits are provided to all members under 21 years of age for those pediatric immunizations, including the immunizing agents, which, as determined by the Pennsylvania Department of Health, conform to 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.

Routine Gynecological Examination and Papanicolaou Smear

Benefits are provided for one routine gynecological examination, including a pelvic examination and clinical breast examination and one routine Papanicolaou smear per calendar year.

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:

- Diagnostic pathology and laboratory screening services such as a fecal-occult blood or fecal immunochemical test
- Diagnostic x-ray screening services such as barium enema
- Surgical screening services such as flexible sigmoidoscopy and colonoscopy
- Such other diagnostic pathology and laboratory, diagnostic x-ray and surgical screening tests and diagnostic medical screening services consistent with approved medical standards and practices for the detection of colon cancer

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

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

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

Diabetes Prevention Program

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

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

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 requires definitive treatment other than routine supportive care;
- when confinement in a skilled nursing facility is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience;
- for the treatment of substance abuse or mental illness.

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

Once you have exhausted your benefit period inpatient residential treatment and rehabilitation days, any unused full session, equivalent partial-session or partial hospitalization outpatient care visits may be exchanged on a two-for-one basis to secure additional residential treatment and rehabilitation service days beyond the residential treatment and rehabilitation service day maximum per benefit period as set forth herein. These additional

residential treatment and rehabilitation service days may be deducted from the lifetime residential treatment and rehabilitation service day limit.

Surgical Services

Sterilization

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

Oral Surgery

Benefits are available only for the following:

- Extraction of partial or full bony impactions if you require inpatient hospitalization as the result of a serious non-dental concurrent medical condition
- Removal of extensive cysts on an inpatient basis
- Extraction of partial or full bony impactions on an outpatient basis
- Orthodontic treatment of a congenital cleft palate 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

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

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

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

Therapy and Rehabilitation Services

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

- Radiation therapy
- Chemotherapy
- Dialysis treatment
- Physical medicine
- Infusion therapy (Benefits will be provided when performed by a facility provider and for self-administration if the components are furnished by and billed by a facility provider.)

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, tissue or blood stem cells.

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

- when both the recipient and the donor are members, each is entitled to the benefits of this program;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this program subject to the following additional limitations:
  - 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 Blue Cross or Blue Shield coverage, or any government program; and
  - benefits provided to the donor will be charged against the recipient's coverage under this program to the extent that benefits remain and are available under this program after benefits for the recipient's own expenses have been paid;
- when only the donor is a member, the donor is entitled to the benefits of this program, subject to the following additional limitations:
  - 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 member recipient's program limit.

Visiting Nurse Services

Benefits will be provided for covered services prescribed by your attending physician prior to your discharge from an inpatient stay in a facility provider. Benefits will be provided by a registered nurse who is employed by or working with a visiting nurse society or an association approved by Highmark, and providing visiting nurse services. Such services include skilled nursing services of an RN, under the direction of a physician, excluding private duty nursing services.

MEDICAL-SURGICAL SERVICES

The benefits in this section 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. Please refer to the section headed "Terms You Should Know" and also the section headed “Health Care Management” for specific details. Any benefit limits, deductibles and coinsurance amounts are described in the Summary of Benefits.

Anesthesia for Non-Covered Dental Procedures (Limited)

Benefits will be provided for general anesthesia and associated medical services normally related to the administration of general anesthesia which are rendered in connection with non-covered dental procedures or non-covered oral surgery. Benefits are provided for members age seven or under and for developmentally disabled members when determined by Highmark to be medically necessary and appropriate and when a successful result cannot be expected for treatment under local anesthesia, or when a superior result can be expected from treatment under general anesthesia.

Autism Spectrum Disorders

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 and the physician or psychologist developing the treatment plan.

Treatment may include the following medically necessary and appropriate services:

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

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

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.

Diagnostic Services

Benefits will be provided for the following diagnostic 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 electrocardiogram (ECG/EKG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by Highmark

- Allergy testing consisting of percutaneous, intracutaneous and patch tests. The allergy extract is not covered.

Durable Medical Equipment

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

Emergency Care Services

Medical care for the outpatient emergency treatment of bodily injuries resulting from an accident or medical condition. Also included is a medical screening examination and ancillary services necessary to evaluate such injury or emergency medical condition and further medical examination and treatment as required to stabilize the patient.

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

Maternity Services

Complications of Pregnancy

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

Normal Pregnancy

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

Maternity benefits, except for complications of pregnancy, are not provided for dependent daughters.

Nursery Care

Care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Benefits will continue for a maximum of 31 days. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within such period. Refer to the General Information section for further eligibility information.

Medical Services

Inpatient Medical Services

Medical care rendered by the professional provider in charge of the case when you are an inpatient in a hospital or rehabilitation hospital or skilled nursing facility for a condition not related to surgery, maternity services, radiation therapy or mental illness, except as specifically provided. Such care includes inpatient intensive medical care rendered to you when your condition requires a professional provider's constant attendance and treatment for a prolonged period of time.

Concurrent Care

Services rendered to an inpatient in a hospital or rehabilitation hospital or skilled nursing facility at the request of the attending professional provider by a professional provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include your observation or reassurance, stand-by services, routine pre-operative physical examinations or medical care routinely performed in the pre- or post-operative or pre- or post-natal periods or medical care required by a facility provider's rules and regulations.

Consultations

Consultation services when rendered to an inpatient in a hospital or rehabilitation hospital or skilled nursing facility by a professional provider at the request of the attending professional provider. Consultations do not include staff consultations which are required by facility provider rules and regulations.

Routine Newborn Care

Professional visits to examine the newborn while an inpatient during the mother's confinement in a hospital or birthing facility.

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

Mental Health Care Services
Inpatient Mental Health Care Services
- Inpatient visits/inpatient individual psychotherapy
- Convulsive therapy treatment
- Electroshock treatment including anesthesia.
- Individual psychotherapy.

Substance Abuse Services
The benefits for the treatment of mental illness are also provided for the inpatient treatment of substance abuse.

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

Pediatric Immunizations
Benefits are provided to members under 21 years of age and dependents 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.

Mammographic Screening
Benefits are provided for:

- an annual routine mammographic screening starting at 40 years of age and older pursuant to the 2002 recommendations by the United States Preventive Services Task Force,
- mammographic screenings for all 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:

- Diagnostic pathology and laboratory screening services such as a fecal-occult blood or fecal immunochemical test
- Diagnostic x-ray screening services such as barium enema
- Surgical screening services such as flexible sigmoidoscopy and colonoscopy
- Such other diagnostic pathology and laboratory, diagnostic x-ray and surgical screening tests and diagnostic medical screening services consistent with approved medical standards and practices for the detection of colon cancer

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

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

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

Diabetes Prevention Program

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

Tobacco Use, Counseling and Interventions

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

Adult and Pediatric Preventive Benefits

Your medical and surgical program covers additional preventive services that supplement the mandated preventive benefits.

These preventive benefits are offered in accordance with a predefined schedule based on age, sex and certain risk factors. Highmark periodically reviews the schedule of covered services based on recommendations from organizations such as the American Academy of Pediatrics, the American College of Physicians, the U.S. Preventive Services Task Force, the American Cancer Society and the Blue Cross and Blue Shield Association. Therefore, the frequency and eligibility of services is subject to change. For a current schedule of covered services, log onto the Member Web site, www.highmarkbcbs.com, or call Member Service at the toll-free telephone number listed on the back of your ID card.

Adult Care

Routine physical examinations, regardless of medical necessity and appropriateness, including a complete medical history.

Pediatric Care

Routine physical examinations, regardless of medical necessity and appropriateness.

Prosthetics and Orthotics

Coverage is provided for the initial and subsequent external prosthetic devices incident to a mastectomy to replace the removed breast or portions thereof.

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 in a skilled nursing facility is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or
- for the treatment of substance abuse or mental illness.

Surgical Services

Anesthesia

Administration of anesthesia in connection with the performance of covered services when rendered by a professional provider other than the surgeon, assistant surgeon or attending professional provider.

Administration of local infiltration anesthetic is not covered.

Assistant at Surgery

Services for you by an assistant surgeon who actively assists the operating surgeon in the performance of covered surgery.

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

Second Surgical Opinion

Consultations for surgery to determine the medical necessity of an elective surgical procedure. Elective surgery is that surgery which

is not of an emergency or life-threatening nature. Such covered services must be performed and billed by a professional provider other than the one who initially recommended performing the surgery. One additional consultation, as a third opinion, is eligible in cases where the second opinion disagrees with the first recommendation. 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.

Special Surgery

Mastectomy and Breast Cancer Reconstruction

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

- Surgery to reestablish symmetry or alleviate functional impairment including, but not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy
- Initial and subsequent prosthetic devices to replace the removed breast or portions thereof
- Physical complications of all stages of mastectomy, including lymphedemas

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

Oral Surgery

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

- Extraction of impacted third molars when partially or totally covered by bone
- Mandibular staple implant, provided the procedure is not done in preparation of the mouth for dentures
- Frenectomy, frenulectomy, frenotomy
- Facility provider and anesthesia services rendered in conjunction with non-covered dental procedures when determined by Highmark to be medically necessary and appropriate due to your age and/or medical condition

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

Sterilization
Surgery also includes sterilization procedures and procedures to reverse sterilization regardless of medical necessity.

Surgery
Surgery performed by a professional provider. Separate payment will not be made for pre- and post-operative services.

If more than one surgical procedure is performed by the same professional provider during the same operation, Highmark will pay 100% of the UCR allowance for the highest paying procedure and no allowance for additional procedures except where Highmark deems that an additional allowance is warranted.

Therapy and Rehabilitation Services

Benefits will be provided for the following therapy services :

- Chemotherapy by intravenous or intra-arterial injection, infusion or perfusion, subcutaneous and intramuscular routes into plural cavity, into peritoneal, into spinal cavity, and oral administration. The cost of drugs approved by the Food and Drug Administration (FDA) as antineoplastic agents is covered, provided they are administered as described in this paragraph.
- Dialysis treatment
- Physical medicine for an inpatient

- Radiation therapy, including the cost of radioactive materials

Transplant Services

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

- when both the recipient and the donor are members, each is entitled to the benefits of this program;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this program. 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, or Highmark coverage or any government program. Benefits provided to the donor will be charged against the recipient's coverage under this program and to the extent that benefits remain and are available under this program after benefits for the recipient's own expenses have been paid;
- when only the donor is a member, the donor is entitled to benefits of this program. The 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 or Highmark coverage or any government program available to the recipient. No benefits will be provided to the non-member transplant recipient; and
- if any organ, bone, 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, bone, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the member recipient's program limit.

MAJOR MEDICAL SERVICES

Major Medical coverage is designed to supplement your hospital and medical surgical benefits by providing additional protection against the expenses incurred due to non-occupational illness or accidents only when such services are determined to be medically necessary and appropriate for the proper treatment of the patient's condition. Please refer to the section headed "Terms You Should Know" for specific details. Any benefit limits, deductibles and coinsurance amounts are described in the Summary of Benefits. Major Medical will reimburse you for certain covered medical expenses not covered by the hospital and medical surgical program.

Ambulance Services

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

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

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

Transportation and related emergency services provided by an ambulance service will be considered emergency ambulance service if the injury or condition is considered emergency care. Use of an ambulance as transportation to an emergency room of a facility provider for an injury or condition that is not considered emergency care will not be covered as emergency ambulance services. Refer to the Terms You Should Know section for a definition of emergency care services.

Autism Spectrum Disorders

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 and the physician or psychologist developing the treatment plan.

Treatment may include the following medically necessary and appropriate services:

Pharmacy care

Prescription drugs approved by the Food and Drug Administration (FDA) and designated by Highmark for the treatment of autism spectrum disorders and which are prescribed by a physician, licensed physician assistant or certified registered nurse practitioner. Additionally, pharmacy care for autism spectrum disorders includes any assessment, evaluation or test prescribed or ordered by a physician, licensed physician assistant or certified registered nurse practitioner to determine the need or effectiveness of such prescription drugs.

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.

Dental Services (Limited)

Related to Accidental Injury

Dental services rendered by a physician or dentist which are required as a result of accidental injury to the jaw, sound natural teeth, mouth or face. Injury as a result of chewing or biting will not be considered accidental injury.

Anesthesia for Non-Covered Dental Procedures

General anesthesia and associated hospital and medical services normally related to the administration of general anesthesia which are rendered in connection with non-covered dental procedures or non-covered oral surgery. Benefits are provided for members age seven or under and for developmentally disabled members when determined by Highmark to be medically necessary and appropriate and when a successful result cannot be expected for treatment under local anesthesia, or when a superior result can be expected from treatment under general anesthesia.

Diabetes Treatment

Coverage is provided for the following equipment and supplies when required in connection with treatment of diabetes, and when prescribed by a physician legally authorized to prescribe such items under the law: Blood glucose monitors, monitor supplies, injection aids, syringes and insulin infusion devices.

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
- Allergy testing, consisting of percutaneous, intracutaneous, and patch tests and in vitro tests

Durable Medical Equipment

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

Enteral Foods

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

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

- amino acid-based elemental medical formulae ordered by a physician for infants and children for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short bowel syndrome; and
- nutritional supplements administered under the direction of a physician for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria; and
- enteral foods prescribed by a physician, when administered on an outpatient basis, considered to be your sole source of nutrition and provided:
  - through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulas; or

– orally and identified as one of the following types of defined formulae with hydrolyzed (pre-digested) protein or amino acids, specialized content for special metabolic needs, modular components, or standardized nutrients.

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

Coverage for enteral foods excludes the following:

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

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

Home Health Care 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, speech therapy and occupational therapy
- Medical and surgical supplies and equipment provided by the home health care agency or hospital program for home health care
- Durable medical equipment
- Oxygen and its administration

- Medical social service consultations
- Health aide services to an individual who is receiving covered nursing services or therapy and rehabilitation services

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 the individual was in the facility provider.

No home health care benefits will be provided for:

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

Hospital Services

Bed and Board

Bed, board and general nursing services in a facility provider when you occupy:

- a room with two or more beds; or a private room (private room allowance is the most common semi-private room charge plus $10 per day); 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 when you are an inpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives. Expenses incurred for the first 2 one-pint units of whole blood or blood components are your responsibility.

- medical and surgical dressings, supplies, casts, and splints;
- oxygen and its administration.

Mastectomy and Breast Cancer Reconstruction

The program covers a mastectomy performed on an inpatient or outpatient basis, as well as surgery to reestablish symmetry or alleviate functional impairment. This includes, but is not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy. Also covered is the use of initial and subsequent prosthetic devices to replace the removed breast or portions thereof. Physical complications of all stages of mastectomy are also covered, including lymphedema. The program covers one home health care visit, as determined by your physician, within 48 hours after discharge if discharge occurred within 48 hours after your admission for a mastectomy.

Maternity Services

Hospital, surgical and medical services rendered by a provider 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.

Nursery Care

Ordinary nursery care of the newborn infant, including inpatient medical visits by a professional provider. Benefits will continue for a maximum of 31 days. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within such period. Refer to the General Information section for further eligibility information.

Benefits are not provided for normal pregnancy services for dependent children.

Maternity Home Health Care Visit

Benefits for one maternity home health care visit will be provided at your home within 48 hours of discharge when the discharge from a facility provider occurs prior to: (a) 48 hours of inpatient care following a normal vaginal delivery; or (b) 96 hours of inpatient care following a cesarean delivery. This visit shall be made by a 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 the mother's sole discretion, occur at the office of the provider. The visit is subject to all the terms of this program.

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

Medical Services

Inpatient Medical Services

Medical care and consultations by a professional provider for the diagnosis and treatment of an injury or illness to you when you are an inpatient.

Outpatient Medical Care Services

Medical care and consultations rendered by a professional provider for the examination, diagnosis and treatment of an injury or illness when you are an outpatient for a condition not related to surgery.

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

- Physician's office, including those located in an outpatient hospital/hospital satellite setting
- Urgent Care Center
- Retail site, such as in a pharmacy or other retail store

Or you can interact with a professional provider as follows:

- A virtual visit between you and a physician or retail clinic via an audio and video telecommunications system
- A virtual visit between you and a specialist via the internet or similar electronic communications for the treatment of skin conditions or diseases
- A specialist virtual visit between you and a specialist at a remote location via interactive audio and video telecommunications. Benefits are provided for a specialist virtual visit which is subsequent to your initial visit with your treating specialist for the same condition. The provider-based location from which you communicate with the specialist is referred to as the "originating site". Benefits will not be provided for a specialist virtual visit if the visit is related to the treatment of mental illness or substance abuse. (The specialist virtual visit is subject to availability within your service area.)

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

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.

Preventive Care

Mammographic Screening

Benefits will be provided for:

- an annual routine mammographic screening starting at 40 years of age or older pursuant to the 2002 recommendations by the United States Preventive Services Task Force;
- mammographic screenings for all members regardless of age when prescribed by a physician;
- benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified by the Pennsylvania Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

Pediatric Immunizations

Benefits are provided 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. Benefits are limited to dependent children and are not subject to program deductibles or maximums.

Routine Gynecological Examination and Papanicolaou Smear

Benefits are provided for one routine gynecological examination, including a pelvic examination and clinical breast examination and one routine Papanicolaou smear per calendar year.

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:

- Diagnostic pathology and laboratory screening services such as a fecal-occult blood or fecal immunochemical test
- Diagnostic x-ray screening services such as barium enema
- Surgical screening services such as flexible sigmoidoscopy and colonoscopy
- Such other diagnostic pathology and laboratory, diagnostic x-ray and surgical screening tests and diagnostic medical screening services consistent with approved medical standards and practices for the detection of colon cancer

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

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

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

Diabetes Prevention Program

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

Tobacco Use, Counseling and Interventions

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

Private Duty Nursing Services

Private duty nursing services of an actively practicing Registered Nurse (RN) or a 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.

- When you are an inpatient in a facility provider, only when Highmark determines that the nursing services required are of a nature or degree of complexity or

quantity that could not be provided by the regular nursing staff.
- When you are at home, only when Highmark determines that the nursing services require the skills of a RN or of an LPN.

Prosthetic Appliances

Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses, except when new cataract lenses are needed because of prescription change).

Psychiatric Care Services/Substance Abuse Treatment Services

The following services are provided for the inpatient and outpatient treatment of mental illness and the treatment of alcoholism and drug abuse by a facility or professional provider:

- Inpatient and outpatient medical care visits, including behavioral health virtual visits between you and a specialist via an audio and video telecommunications system
- Individual psychotherapy
- Group psychotherapy
- Psychological testing
- Counseling with family members to assist in the patient's diagnosis and treatment
- Services in a planned therapeutic treatment program on a day or night only basis

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

Skilled Nursing Facility Services

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

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.

Surgical Services

Surgery

Surgery performed by a professional provider. Separate payment will not be made for pre- and post-operative services.

Also covered is the 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.

Assistant At Surgery

Services of a physician who actively assists the operating surgeon in performing a covered surgery if a house staff member, intern or resident is not available.

Anesthesia

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

Therapy and Rehabilitation Services

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

- Radiation therapy
- Chemotherapy
- Dialysis treatment
- Respiratory therapy
- Physical medicine
- Occupational therapy
- Speech therapy
- Infusion therapy of blood components when performed by a facility provider and for self-administration if the

components are furnished by and billed by a facility provider

Transplant Services

Subject to the provisions of the contract, 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 living donor to a human transplant recipient:

- when both the recipient and the donor are members, each is entitled to the benefits of this program;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this program subject to the following additional limitations:
    - 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 this program, 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 or tissue is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the member recipient's program limit.

What Is Not Covered

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

Key Word	Exclusion
Acupuncture	• For acupuncture services.
Allergy Testing	• For allergy testing, except as provided herein;
Assisted Fertilization	• Related to treatment provided specifically for the purpose of assisted fertilization; including pharmacological or hormonal treatments used in conjunction with assisted fertilization;
Ambulance	• For ambulance services, except as provided herein;
Comfort/ Convenience Items	• For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers or physical fitness equipment, stair glides, elevators/lifts or "barrier-free" home modifications, whether or not specifically recommended by a professional provider;
Cosmetic Surgery	• For a cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except: a) as otherwise provided herein, b) when required to correct a condition directly resulting from an accident; c) when necessary to correct a functional impairment which directly results from a covered disease or injury, or d) to correct a congenital birth defect.
Effective Date	• Incurred prior to your effective date;

Experimental/ Investigative	• Which are experimental/investigative in nature;
Hearing Care Services	• For hearing aid devices, tinnitus maskers or examinations for the prescription or fitting of hearing aids;
Learning Disabilities	• For any care that is related to conditions such as hyperkinetic syndromes, learning disabilities, behavioral problems or intellectual disability, 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 you have 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;
Legal Obligation	• For which you have no legal obligation to pay;
Medically Necessary and Appropriate	• Which are not medically necessary or medically appropriate as determined by Highmark;
Medicare	• For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage;
Miscellaneous	• For telephone consultations, charges for failure to keep a scheduled visit or charges for completion of a claim form;
	• For any other medical or dental service or treatment or prescription drug except as provided in this booklet;
Motor Vehicle Accident	• For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the

	Pennsylvania Motor Vehicle Financial Responsibility Act;
Prescription Drugs (Medical Program)	• For prescription drugs and medications, except those which are administered to an inpatient in a facility provider; or as provided herein or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
Preventive Care Services	• For preventive care services, wellness services or programs, except as provided herein;
Provider of Service	• Which are not prescribed by, performed by or upon the direction of a professional provider;
	• Rendered by a provider not specifically listed in this booklet;
	• 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 any similar person or group;
	• Which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same member;
	• Rendered by a provider who is a member of your immediate family;
	• Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program;
Sexual Dysfunction	• For treatment of sexual dysfunction that is not related to organic disease or injury;

Skilled Nursing	• For skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness;
Termination Date	• Incurred after the date of termination of your coverage except as provided herein;
Therapy	• For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur;
TMJ	• For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma;
Well-Baby Care	• For well-baby care visits and immunizations, except as provided herein;

In addition, except as specifically provided in this program or as Highmark is mandated or required to provide based on state or federal law, no benefits will be provided under your hospital coverage for services, supplies, prescription drugs or charges:

Audiometric Testing	• For outpatient audiometric testing;
Blood	• For whole blood, blood components and blood derivatives which are not classified as drugs in the official formularies;
Contraceptive Devices and Implants	• For contraceptive devices and contraceptive implants including services related to the provision of such devices or implants;
Court Ordered Services	• For otherwise covered services ordered by a court or other tribunal unless medically necessary and appropriate or if the reimbursement of such services is required by law;
Custodial Care	• For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care;
Dental Care	• Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy, and treatment of periodontal disease, except anesthesia for non-covered dental procedures and orthodontic treatment for congenital cleft palates as provided herein;

Enteral Foods	• For any food including, but not limited to, enteral foods, 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 those enteral foods, which are exempt from deductible requirements, that are either nutritional supplements prescribed for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria or amino acid-based elemental medical formulae ordered by a physician for infants and children for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short bowel syndrome;
Eyeglasses/Contact Lenses	• For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses and contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses or sclera shells intended for use in the treatment of disease or injury);
Eye Refractions	• For outpatient eye refractions;
Felonies	• For any illness or injury you suffer during your commission of a felony;

Foot Care	• For palliative or cosmetic foot care, including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone surgery), calluses, toe nails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes;
Health Care Management program	• For any care, treatment, prescription drug or service which has been disallowed under the provisions of the Health Care Management section;
Home Health Care	• The following services you receive from a home health care agency or a hospital program for home health care: dietitian services; homemaker services; maintenance therapy; dialysis treatment; custodial care; food or home-delivered meals; durable medical equipment; prescription drugs and medications;
Immunizations	• For immunizations required for foreign travel or employment;
Inpatient Admissions	• For inpatient admissions which are primarily for diagnostic studies; • For inpatient admissions which are primarily for physical medicine services;
Medicare	• To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program and you elect this coverage as primary;

Mental Health Military Service	• For outpatient mental health examinations and outpatient psychological testing, except as provided herein; • To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service-connected illness or injury, unless you have a legal obligation to pay;
   Neonatal Circumcision Nutritional Counseling Obesity Oral Surgery Outpatient Hospital Physical Examinations	• For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared; • For routine neonatal circumcision; • For nutritional counseling, except as provided herein; • For treatment of obesity, except for medical and surgical treatment of morbid obesity; • For oral surgery procedures unless specifically provided, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face; • For treatment or services received as an outpatient in a non-participating hospital or facility provider except for emergency accident and emergency medical care, unless required by law; • For routine or periodic physical examinations, the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as premarital examinations, physicals for school, camp, sports or travel which are not medically necessary and appropriate, except as provided herein;

Pre-Admission Respite Care Smoking (nicotine) Cessation	• Pre-admission testing services that are performed to establish a diagnosis; • For respite care; • For nicotine cessation support programs and/or classes, except as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information;
Spinal Manipulations	• For the detection and correction by manual or mechanical means (including incidental X-rays) of structural imbalance or subluxation for the purpose of removing nerve interference resulting from or related to distortion, misalignment or subluxation of or in the vertebral column; • For spinal manipulation;
Sterilization Vision Correction Surgery Weight Reduction Workers' Compensation	• For sterilization • 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 weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate; • 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 file a claim for benefits or compensation;

In addition, except as specifically provided in this program or as Highmark is mandated or required to provide based on state or federal law, no benefits will be provided under your medical-surgical coverage for services, supplies, prescription drugs or charges:

Clinical Pathology Services	• For clinical pathology services for which a hospital or other facility bills;
Contraceptive Medications, Devices and Implants	• For contraceptive devices, contraceptive implants, oral or injectable contraceptive medications, including services related to the provision of such devices, medications or implants;
Court Ordered Services	• For otherwise covered services ordered by a court or other tribunal as part of your or your dependent's sentence;
Custodial Care	• For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care;
Dental Care	• Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental services related to accidental injury to sound natural teeth, anesthesia for non-covered dental procedures and orthodontic treatment for congenital cleft palates as provided herein;
Enteral Foods	• For any food including, but not limited to, enteral foods, 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 those enteral foods, which are exempt from deductible requirements, that are either nutritional supplements prescribed for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria or amino acid-based elemental medical formulae order by a physician for infants and children for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short bowel syndrome.
Eyeglasses/Contact Lenses Felonies Foot Care Immunizations	• For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, including related diagnostic tests such as, but not limited to, visual fields testing; • For any illness or injury you suffer during your commission of a felony; • 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 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 immunizations required for employment or foreign travel;

Inpatient Admissions	• For inpatient admissions which are primarily for diagnostic studies; • For inpatient admissions which are primarily for physical medicine services;
Military Service	• To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service-connected illness or injury, unless you have a legal obligation to pay;
Medicare	• To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program and you so elect this coverage as primary;
Miscellaneous	• Which are paid, or payable, in whole or in part, by a Blue Cross Plan;
Nutritional Counseling	• For nutritional counseling, except as provided herein;
Obesity	• For treatment of obesity, except for medical and surgical treatment of morbid obesity;
Oral Surgery	• For oral surgery procedures unless specifically provided, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face;
Physical Examinations	• For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein;

Provider of Service	• Performed in a facility by a professional provider who, in any case, is compensated by the facility for similar services performed for patients; • For which the fees or charges are billed by hospitals or other facilities;
Respite Care	• For respite care;
Smoking (nicotine) Cessation	• For nicotine cessation support programs and/or classes, except as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information;
Spinal Manipulations	• For spinal manipulation;
Surgical Procedures	• For pre-operative care when you are not an inpatient and any post-operative care other than that normally provided following surgical procedures;
Vision Correction Surgery	• For the correction of myopia, hyperopia or presbyopia, including but not limited to. corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services;
War	• For 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;
Workers' Compensation	• For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease, or similar type legislation. This exclusion applies

	whether or not you file a claim for benefits or compensation;
Weight Reduction	• For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate;

In addition, except as specifically provided in this program or as Highmark is mandated or required to provide based on state or federal law, no benefits will be provided under your Major Medical coverage for services, supplies, prescription drugs or charges:

Contraceptive Medications, Devices and Implants	• For contraceptive services, including contraceptive prescription drugs, contraceptive devices, implants and injections, and all related services;
Court Ordered Services	• For otherwise covered services ordered by a court or other tribunal unless medically necessary and appropriate or if the reimbursement of such services is required by law;
Custodial Care Dental Care	• For custodial care, domiciliary care or rest cures; • Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, alveolectomy, services related to the placement of dentures and treatment of periodontal disease, except for limited dental services as provided herein;
Enteral Foods	• For the following services associated with the additional enteral foods benefits provided under your program: blenderized food, baby food, or regular shelf food; milk or soy-based infant

	formulae with intact proteins; any formulae, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance; semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally; normal food products used in the dietary management of the disorders provided herein.
Eyeglasses/Contact Lenses Foot Care Health Care Management program	• For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses and contact lenses (except for aphakic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury) ; • For palliative or cosmetic foot care, including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet; • For care, treatment or services which have been disallowed under the provisions of the Health Care Management section of the program;
High Cost Technological Equipment	• Performed on high cost technological equipment such as, but not limited to, computed tomography scanners (CT scanners), lithotriptors, and magnetic resonance imaging (MRI) scanners, as defined by Highmark, which is not approved through the certificate of need process if applicable and/or is not approved by Highmark;

Home Health Care	• The following services you receive from a home health care agency or a hospital program for home health care: dietitian services; homemaker services; maintenance therapy; custodial care; food or home-delivered meals; drugs and medications;
Inpatient Admissions	• For inpatient admissions which are primarily for diagnostic study; • For inpatient admissions which are primarily for physical medicine services; • Rendered prior to your effective date or during an inpatient admission that commenced prior to your effective date; except covered services will be provided for an eligible condition that commenced after your effective date during that inpatient admission;
Medicare	• For any illness or injury to the extent that payment has been made by Medicare or any Medicare supplemental insurance program, when Medicare is primary; • For charges for services, other than emergency and urgent care services when a private contract has not been executed by the Medicare beneficiary, which are payable under Medicare rendered by a Medicare opt-out provider when Medicare is primary; • For charges for any services payable under Medicare and rendered by a Medicare non-participating provider in excess of the Medicare reasonable charge, when Medicare is primary;
Military Service	• To the extent benefits are provided to members of the armed forces and National Health Service or to patients in Veteran's Administration facilities for service-connected illness or injury unless you have a legal obligation to

	pay;
Miscellaneous	• For any amounts the patient is required to pay for under any deductible and/or coinsurance provisions of the basic program;
Nutritional Counseling	• For nutritional counseling and services intended to produce weight loss ;
Oral Surgery	• For oral surgery procedures unless specifically provided, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face;
Physical Examinations	• For routine or periodic physical examinations, except as provided herein;
Respite Care	• For respite care;
Sterilization	• For sterilization and reversal of sterilization;
Vision Correction Surgery	• For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomeleusis, keratophakia, and radial keratotomy and all related services;
War	• For any illness or injury suffered after your effective date as a result of any act of war;
Workers' Compensation	• For any illness or injury eligible for or covered by any federal, state or local government's Worker's Compensation Act or Occupational Disease Law;

Out-of-Area Care

Inter-Plan Arrangements

Out-of-Area Services
Highmark has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "inter-plan arrangements." These inter-plan arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association. Whenever members access health care services outside the geographic area Highmark serves, the claim for those services may be processed through one of these inter-plan arrangements, as described generally below.

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

BlueCard® Program
The BlueCard® Program is an inter-plan arrangement. Under this arrangement, when members access covered services outside the geographic area Highmark serves, the Host Blue will be responsible for contracting and handling all interactions with its participating health care providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method per Claim
Unless subject to a fixed dollar copayment, the calculation of the member liability on claims for covered services will be based on the lower of the participating provider's billed charges for covered services or the negotiated price made available to Highmark by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's health care provider contracts. The

negotiated price made available to Highmark by the Host Blue may be represented by one of the following:

- an actual price - An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases, or
- an estimated price - An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives, or
- an average price - An average price is a percentage of billed charges for covered services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices, (ie, prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Highmark in determining your premiums.

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

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

Non-Participating Providers Outside of the Plan Service Area

Member Liability Calculation
When covered services are provided outside of the plan service area by non-participating providers, the amount(s) a member pays for such services will generally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable law. In these situations, the member may be responsible for the difference between the amount that the non-participating provider bills and the payment Highmark will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services are governed by applicable federal and state law.

Exceptions
In some exception cases, Highmark may pay claims from non-participating health care providers outside of the plan service area based on the provider's billed charge. This may occur in situations where a member did not have reasonable access to the participating provider, as determined by Highmark in Highmark's sole and absolute discretion or by applicable law. In other exception cases, Highmark may pay such claims based on the payment Highmark would make if Highmark were paying a non-participating provider inside the plan service area. This may occur where the Host Blue's corresponding payment would be more than the plan in-service area non-participating provider payment. Highmark may choose to negotiate a payment with such provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the member may be responsible for the difference between the

amount that the non-participating health care provider bills and payment Highmark will make for the covered services as set forth in this paragraph.

Blue Cross Blue Shield Global Core Program

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

Inpatient Services

In most cases, if members contact the service center for assistance, hospitals will not require members to pay for inpatient covered services, except for their cost-sharing amounts. In such cases, the hospital will submit member claims to the service center to initiate claims processing. However, if the member paid in full at the time of service, the member must submit a claim to obtain reimbursement for covered services. **Members must contact Highmark to obtain precertification for non-emergency inpatient services**.

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

When members pay for covered services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, members should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center address on the form to initiate claims processing. The claim form is available from Highmark, the service center or online at www.bcbsglobalcore.com. If members need assistance with their claim submissions, they should call the

service center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

Eligible Providers

Facility Providers

- Hospital
- Psychiatric hospital
- Rehabilitation hospital
- Ambulatory surgical facility
- Birthing facility
- Day/night psychiatric facility
- Diabetes Prevention Provider
- Freestanding dialysis facility
- Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility
- Home health care agency
- Home infusion therapy provider
- Independent diagnostic testing facility
- Hospice
- Outpatient physical rehabilitation facility
- Outpatient psychiatric facility
- Outpatient substance abuse treatment facility
- Pediatric extended care facility
- Ambulance service
- Pharmacy provider
- Skilled nursing facility
- State-owned psychiatric hospital
- Substance abuse treatment facility
- Suite infusion therapy provider

Professional Providers

- Audiologist
- Behavior specialist
- Certified registered nurse *
- Chiropractor
- Clinical laboratory
- Clinical social worker
- Dentist
- Dietician-nutritionist
- Licensed practical nurse

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

Suppliers and Contracting Suppliers (for the sale or lease of):

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

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

Participating Providers

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

Participating providers have a contract with Highmark pertaining to payment for covered services and agree to accept Highmark's allowance as full payment for covered services.

Non-Participating Providers

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

Some providers do not have an agreement with Highmark and do not accept Highmark's allowance as payment-in-full.

Health Care Management

Medical Management

Your benefits are subject to review by Highmark, or its designated agent, as part of its health care management program. This program is to help ensure that you receive:

- care that is medically necessary and appropriate; and
- health care services in a setting which best meets your individual treatment needs.

IMPORTANT NOTICE REGARDING TREATMENT WHICH HIGHMARK DETERMINES IS NOT MEDICALLY NECESSARY OR APPROPRIATE:

Highmark only pays for services which it determines to be medically necessary and appropriate. However, not all medically necessary and appropriate services are covered under this program. Highmark participating providers will accept this determination. A non-participating facility provider or a non-participating professional provider is not obligated to accept this determination and may bill you for services determined not to be medically necessary and appropriate. You are solely responsible for payment of such services rendered by a non-participating facility provider or a non-participating professional provider, subject to the conditions and limitations of your benefit program. You will not be financially liable when covered services are received from a Highmark participating provider unless you elect to receive services which have been determined not to be medically necessary and appropriate and you have been notified of this determination prior to receiving the services. If you elect to receive services from a non-participating facility provider or non-participating professional provider, you should contact Highmark to confirm the medical necessity and appropriateness of the services.

Refer to the Terms You Should Know section for a definition of medical necessity and appropriateness.

The health care management services provided by Highmark depend on your benefit program. They may include:

- precertification;
- pre-admission certification;
- admission certification;
- pre-procedure certification;
- pre-service certification;
- continued stay review;
- discharge planning; and
- case management.

Some portions of the program may affect your coverage. Please read the following information carefully.

Precertification

Precertification review is conducted by Highmark 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 services:

* Hospital admissions
* Inpatient rehabilitation admissions
* Psychiatric treatment
* Substance abuse

Depending on your benefit program, precertification may be required for the following services:

* Skilled nursing facility admissions
* Home health services
* Hospice services
* Outpatient surgery

If you use a Highmark Participating Provider:

A Highmark participating provider <u>WILL CONTACT Highmark FOR YOU</u> in order to determine whether services are

medically necessary and appropriate. You are not financially liable for services performed by a Highmark participating provider unless you elect to receive services that have been determined by Highmark to be not medically necessary and appropriate.

When the Highmark participating provider contacts Highmark, a review will determine whether an admission, procedure or requested service is medically necessary and appropriate or whether a specific number of days or visits is required to adequately treat the condition. If Highmark determines that an entire admission, procedure or requested services is not medically necessary and appropriate, you and your provider will be notified in writing that the service will not be paid under your benefits program. If you and your provider decide to proceed with a service that is not medically necessary and appropriate, you will be responsible for full payment of the service. If a limited number of days or visits are approved, the days or visits which are not approved will be your financial responsibility.

If the Highmark participating provider does not contact Highmark prior to an admission, procedure or service when required, your care will be reviewed by Highmark after your services are received, at which time it will be determined whether the admission, procedure or service was medically necessary and appropriate. If Highmark determines that an admission, procedure or service was not medically necessary and appropriate, *you will not be financially liable for charges associated with those services.*

For an emergency or maternity-related admission, a Highmark participating provider is responsible for contacting Highmark following the admission, at which time the admission will be reviewed.

If the admission is found to be not medically necessary and appropriate, *you will not be financially liable for charges associated with those services*.

If You Use a Non-Participating Facility Provider or Non-Participating Professional Provider:

- **For Emergency or delivery-related Maternity Admissions: YOU MUST CONTACT** Highmark to certify any emergency or delivery-related maternity admission. For emergency or delivery-related maternity admissions, you should call

Highmark within hours of the admission, or as soon as reasonably possible.

- **All Planned Admissions, Procedures and Services: YOU MUST CONTACT** Highmark PRIOR TO YOUR ADMISSION OR SERVICE. You should call Highmark 7 to 14 days prior to your planned admission or service.

IMPORTANT: **NON-PARTICIPATING FACILITY PROVIDERS OR NON-PARTICIPATING PROFESSIONAL PROVIDERS ARE NOT OBLIGATED TO CONTACT Highmark OR TO ABIDE BY ANY DETERMINATION OF MEDICAL NECESSITY AND APPROPRIATENESS RENDERED BY Highmark. A non-participating facility provider or non-participating professional provider may, therefore, bill you, the customer, for services that are not medically necessary and appropriate.**

You may certify emergency admissions, delivery-related maternity admissions, or any other service to a non-participating provider by calling the toll-free telephone number on your ID card. *If you do not call to certify your admission to or a service by a non-participating provider, your care will be reviewed by Highmark after your services are received, at which time it will be determined whether such services were medically necessary and appropriate.*

— If an admission, procedure or service is found to be medically necessary and appropriate, your benefit program will pay up to the non-participating facility provider or non-participating professional provider allowance for covered services and your provider can bill you for any balance of the charges which are not covered under your benefit program.

— If the entire admission/service is determined not to be medically necessary and appropriate, you will be responsible for full payment.

— If a specific number of days or visits for an admission or service are approved and you continue to receive services beyond the approved number of days or visits, you will be responsible for full payment of those days or visits which are not approved.

* * *

Depending on your benefit program, other components of the Highmark health care management program available to you as a Highmark member include the following: (These components apply regardless of whether or not you use a Highmark participating provider or a non-participating provider.)

Continued Stay Review

While you or your covered dependent are receiving services that require ongoing review, Highmark will be in contact with medical personnel familiar with your case to make certain that continued service is appropriate. Determination of the need for continued service will be made in consultation with your physician(s). Highmark, the facility or the provider will notify you if continued service is determined to be no longer medically necessary and appropriate. If you or your covered dependent elect to receive service after such notification, no further benefits will be provided for the remainder of the service.

Discharge Planning

Discharge planning is a process that begins prior to your scheduled hospital admission. Working with you, your family, your attending physician(s) and hospital staff, Highmark or designated agent personnel will help plan for and coordinate your discharge to ensure that any continued care is delivered in the most medically appropriate setting.

Case Management

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

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

contacted by a case manager from our Complex program. In either case, you are always free to call and request case management if you feel you need it be contacting Member Services at the telephone number listed on the back of your ID card.

Precertification, Preauthorization and Pre-Service Claims Review Processes

Authorized Representatives

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

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

You will receive written notice of any decision on a request for precertification or other pre-service claim, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed 15 days from the date Highmark receives the claim.

Decisions Involving Urgent Care Claims

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

If Highmark determines in connection with an urgent care claim that you have not provided sufficient information to determine whether or to what extent benefits are provided under your coverage, your physician will be notified within 24 hours following Highmark's receipt of the claim of the specific information needed to complete your claim. Your physician will then be given not less than 48 hours to provide the specific information to Highmark. Highmark will thereafter notify you of its determination on your

claim as soon as possible but not later than 48 hours after the earlier of (i) its receipt of the additional specific information, or (ii) the date Highmark informed your physician that it must receive the additional specific information.

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

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

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

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

General Information

Benefits After Termination of Coverage

- If you are an inpatient on the day your coverage terminates, facility provider benefits for inpatient covered services will be continued as follows:

  — Until the maximum amount of benefits has been paid; or

  — Until the inpatient stay ends; or

  — Until you become covered, without limitation as to the condition for which you are receiving inpatient care, under another group program; whichever occurs first.

- If you are pregnant on the date coverage terminates, no additional coverage will be provided.

- Major Medical benefits will be continued for covered services for a period of six months immediately following the date coverage terminates, provided the benefits are required for the treatment of an injury or illness which began prior to the termination of this program.

  This provision does not apply if your employer replaces this program with another group health care benefits program. In this event, all benefits will cease on the date this program is terminated.

Coordination of Benefits

Most health care programs, including this program, contain a coordination of benefits provision. This provision is used when you, your spouse or your covered dependents are eligible for payment under more than one health care program. The object of coordination of benefits is to ensure that your covered expenses will be paid, while preventing duplicate benefit payments.

Here is how the coordination of benefits provision in your Highmark coverage works:

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your program.

- When the person who received care is covered as an employee under one contract, and as a dependent under another, then the employee coverage pays first.

- When a dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the calendar year pays first. But, if both parents have the same birthday, the program which covered the parent longer will be the primary program. If the dependent child's parents are separated or divorced, the following applies:

  - The parent with custody of the child pays first.

  - The coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody.

  - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

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

  - the benefits of a program covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a program covering the person as a laid-off or retired employee or as a dependent of such person and if

  - the other program does not have this provision regarding laid-off or retired employees, and, as a result, plans do not agree on the order of benefits, then this rule is disregarded.

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

Subrogation

Subrogation means that if you incur health care expenses for injuries caused by another person or organization, the person or organization causing the accident may be responsible for paying these expenses.

For example, if you or one of your dependents receives benefits through your program for injuries caused by another person or organization, Highmark has the right, through subrogation, to seek repayment from the other person or organization or any applicable insurance company for benefits already paid.

Highmark will provide eligible benefits when needed, but you may be asked to show documents or take other necessary actions to support Highmark in any subrogation efforts.

A Recognized Identification Card

The Blue Cross and Blue Shield symbols on your Highmark identification (ID) card are recognized throughout the country and around the world. Carry your ID card with you at all times, destroy any previously issued cards, and show this card to the hospital, doctor, pharmacy, or other health care professional whenever you need medical care.

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

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

- Your name and your dependent's name, if applicable
- Identification number
- Group number
- Premier Pharmacy network logo (when applicable)
- Member Service toll-free number (on back of card)
- Precertification toll-free number (on back of card)

How to File a Claim

In most instances, hospitals and physicians will submit a claim on your behalf directly to Highmark. If your claim is not submitted directly by the provider, you must submit itemized bills along with a special claim form.

The procedure is simple. Just take the following steps:

- ***Know Your Benefits.*** Review this information to see if the services you received are eligible under your medical program.

- ***Get an Itemized Bill.*** Itemized bills must include:

  - The name and address of the service provider;
  - The patient's full name;
  - The date of service or supply ;
  - A description of the service or supply;
  - The amount charged;
  - The diagnosis or nature of illness;
  - For durable medical equipment, the doctor's certification;
  - For private duty nursing, the nurse's license number, charge per day and shift worked, and signature of provider prescribing the service;
  - For ambulance services, the total mileage.

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

- ***Copy Itemized Bills.*** You must submit originals, so you may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.

- ***Complete a Claim Form.*** Make sure all information is completed properly, and then sign and date the form. *Claim forms can be downloaded from blog.highmarkhealth.org by*

entering "forms" in the search box. Claim forms are also available from your employee benefits department, or call the Member Service telephone number on the back of your ID card.

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

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

If you file the claim yourself, your claim must be submitted within 90 days of the date of service, but in no event will it be accepted later than one year from the 90-day timeframe.

Your Explanation of Benefits Statement

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

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

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

If you do not have access to a computer or prefer to continue receiving printed EOBs, please notify Member Service by calling the number on the back of your ID card.

Additional Information on How to File a Claim

Member Inquiries

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

Filing Benefit Claims

– ***Authorized Representatives***

You have the right to designate an authorized representative to file or pursue a request for reimbursement or other post-service claim on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

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

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

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

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

Determinations on Benefit Claims

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

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

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

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

Appeal Procedure

Highmark maintains an appeal process involving one level of review. This appeal process is mandatory and must be exhausted before you are permitted to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

At any time during the appeal process, you may choose to designate an authorized representative to participate in the appeal process on your behalf. You or your authorized representative shall notify Highmark in writing of the designation. For purposes of the appeal process, “you” includes designees, legal representatives and, in the case of a minor, parents entitled or authorized to act on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by Highmark shall, in the case of an urgent care claim, permit a physician or other health care provider with knowledge of your medical condition to act as your authorized representative.

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

If you receive notification that a claim has been denied by Highmark, in whole or in part, you may appeal the decision. Your appeal must be submitted within 180 days from the date of your receipt of notification of the adverse decision.

Upon request to Highmark, you may review all documents, records and other information relevant to your appeal and shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal. Your appeal will be reviewed by a representative from the Member Grievance and Appeals Department. The representative shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the claim or matter

which is the subject of your appeal. In rendering a decision on your appeal, the Member Grievance and Appeals Department will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Highmark. The Member Grievance and Appeals Department will afford no deference to any prior adverse decision on the claim which is the subject of your appeal.

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

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

In the event Highmark renders an adverse decision on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding your right to pursue legal action .

Autism Spectrum Disorders Expedited Review and Appeal Procedures

Upon denial, in whole or in part, of a claim for diagnostic assessment or treatment of autism spectrum disorders, there is an appeal procedure for expedited internal review which you may choose as an alternative to those procedures set forth above. In order to obtain an expedited review, you or your authorized representative shall identify the particular claim as one related to the diagnostic assessment or treatment of an autism spectrum disorder to the Member Service Department and request an expedited review which will be provided by Highmark. If, based on the information provided at the time the request is made, the claim cannot be determined as one based on services for the diagnostic

assessment or treatment of autism spectrum disorders, Highmark may request from you or the health care provider additional clinical information including the treatment plan described in the Covered Services section of the booklet.

An appeal of a denial of a claim for services for the diagnostic assessment or treatment of an autism spectrum disorder is subject to review by a Review Committee. The request to have the decision reviewed by the Review Committee may be communicated orally or be submitted in writing within 180 days from the date the denial of the claim is received, and may include any written information from you or the health care provider. The Review Committee shall be comprised of three employees of Highmark who were not involved or the subordinate of any individual that was previously involved in any decision to deny coverage or payment for the health care service. The Review Committee will hold an informal hearing to consider the appeal. When arranging the hearing, Highmark will notify you or the health care provider of the hearing procedures and rights at such hearing, including your or the health care provider's right to be present at the review and to present a case. If you or the health care provider cannot appear in person at the review, Highmark shall provide you or the health care provider the opportunity to communicate with the Review Committee by telephone or other appropriate means.

Highmark shall conduct the expedited internal review and notify you or your authorized representative of its decision as soon as possible but not later than 48 hours following the receipt of your request for an expedited review. The notification to you and the health care provider shall include, among other items, the specific reason or reasons for the adverse decision including any clinical rationale, the procedure for obtaining an expedited external review and a statement regarding your right to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Following the receipt of the expedited internal review decision, you may contact Highmark to request an expedited external review pursuant to the expedited external review procedure for autism spectrum disorders established by the Pennsylvania Insurance Department.

Member Service

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

Blues On Call[sm] - 24/7 Health Decision Support

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

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

Help with common illnesses, injuries and questions

Health Coaches can address any health topic that concerns you:

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

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

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

- Depression

Help with chronic conditions

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

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

myCare Navigator^{sm} - 24/7 Health Advocate Support

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

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

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

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

Highmark Website

As a Highmark member, you have a wealth of health information at your fingertips. It's easy to access all your online offerings. Whether you are looking for a health care provider or managing

your claims…want to make informed health care decisions on treatment options…or lead a healthier lifestyle, Highmark can help with online tools and resources.

Go to www.highmarkbcbs.com. Then click on the "Members" tab and log in to your homepage to take advantage of all kinds of programs and resources to help you understand your health status, through the online Wellness Profile, then take steps toward real health improvement.

Baby Blueprints®

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

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

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

By enrolling in this free program you will have access to online information on all aspects of pregnancy and childbirth. Baby Blueprints will also provide you with personal support from a nurse Health Coach available to you throughout your pregnancy.

Easy Enrollment

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

Member Service

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

Member Rights and Responsibilities

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

You have the right to:

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

You have a responsibility to:

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

mutually agreed upon treatment goals. Develop a relationship with your doctor based on trust and cooperation.

How We Protect Your Right to Confidentiality

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

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

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

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

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

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

Notice of Privacy Practices – See page 281

HIGHMARK INC.
NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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

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

Our Legal Duties

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

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

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

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

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

I. Uses and Disclosures of Protected Health Information

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

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

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

Payment

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

For example:
We may use and disclose your protected health information to pay claims from doctors, hospitals, pharmacies and others for services delivered to you that

are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and/or to issue explanations of benefits to the person who subscribes to the health plan in which you participate.

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

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

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

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

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

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

II. Other Possible Uses and Disclosures of Protected Health Information

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

A. To Plan Sponsors

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

B. Required by Law

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

C. Public Health Activities

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

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

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

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

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

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

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

I. Research

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

J. To Prevent a Serious Threat to Health or Safety

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

K. Military Activity and National Security, Protective Services

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

L. Inmates

If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for:

(1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

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

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

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

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

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

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

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

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

In order to opt-out, you must complete an opt-out Form, which is available at highmark.com or by calling the customer service number located on the back of your membership card. You should be aware, if you choose to opt-out, your health care providers will not be able to access your health information through the HIE. Even if you chose to opt-out, your information will be sent to the HIE, but provider will not be able to access this information. Additionally, your opt-out does not affect the ability of participating providers to access health information entered into the HIE prior to your opt-out submission.

III. Required Disclosures of Your Protected Health Information

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

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

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

B. Disclosures to You

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

IV. Other Uses and Disclosures of Your Protected Health Information

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

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

    a. Used by the person who created the psychotherapy note for treatment purposes, or
    b. Used or disclosed for the following purposes:

(i) the provider's own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;
(ii) for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;
(iii) if required for enforcement purposes;
(iv) if mandated by law;
(v) if permitted for oversight of the provider that created the note;
(vi) to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or
(vii) if needed to avert a serious and imminent threat to health or safety.

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

V. Your Individual Rights

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

A. Right to Access

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

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

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

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

B. Right to an Accounting

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

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

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

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

C. Right to Request a Restriction

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

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

D. Right to Request Confidential Communications

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

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

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

E. Right to Request Amendment

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

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

F. Right to a Paper Copy of this Notice

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

VI. Questions and Complaints

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

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

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

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

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

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

Highmark is committed to protecting its members' privacy. This notice describes our policies and practices for collecting, handling and protecting personal information about our members. We will inform each group of these policies the first time the group

becomes a Highmark member and will annually reaffirm our privacy policy for as long as the group remains a Highmark customer. We will continually review our privacy policy and monitor our business practices to help ensure the security of our members' personal information. Due to changing circumstances, it may become necessary to revise our privacy policy in the future. Should such a change be required, we will notify all affected customers in writing in advance of the change.

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

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

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

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

<u>Information we may disclose and the purpose</u>: 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.

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

For questions about this Privacy Notice, please contact:

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

OPTUMRx
NOTICE OF PRIVACY PRACTICES

OptumRx is required by law to protect the privacy of your health information and to send you this notice. The notice explains how we[1] may use information about you and when we can give out or "disclose" that information to others. You have rights to your health information that are described in this notice. We are required by law to follow the terms of this notice.

We have the right to change our privacy practices and the terms of this notice at any time. You may obtain the most current notice by visiting the **privacy policy** section of our website, **optumrx.com,** or by contacting customer service at the number printed on your ID card. Customer Service will mail a copy of the revised notice to you, if you make your request on or after the notice's effective date. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

The terms "information" and "health information" in this notice include any information we have that reasonably can be used to identify you and that relates to your physical or mental health condition, the health care you receive or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

How we use or disclose information

We must use or disclose your health information to provide information to:

- You or someone who has the legal right to act for you (your personal representative), to administer your rights as described in this notice; and
- The Secretary of the U.S. Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to bill for your health care and to operate our business. For example, we may use or disclose your health information:

[1] This notice of privacy practices applies to the following entities: OptumRx, Inc., OptumRx Home Delivery of Ohio, LLC, and OptumRx Pharmacy of Nevada, Inc. (dba Culinary and Culinary Pharmacy)

- **For payment.** We may use or disclose health information to obtain payment for your health care services. For example, we may disclose your health information to your health insurance company to collect payment for your pharmacy services.
- **For treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to treating physicians or others involved in your care, regarding possible drug interactions.
- **For health care operations.** We may use or disclose health information as needed to operate and manage our business activities related to providing and managing your health care. For example, we might analyze your information to determine ways to improve our services.
- **We may also de-identify health information** in accordance with applicable laws. After that information is de-identified, it is no longer subject to this notice and we may use it for any lawful purpose.
- **To provide you information** on health-related programs or products such as alternative medical treatments and programs about health-related products and services, subject to the limits of the law.
- **For reminders.** We may use or disclose health information to send you reminders about your care, such as prescription-refill reminders.

We may use or disclose your health information for the following purposes, under limited circumstances:

- **As required by law.** We may disclose information when required to do so by law.
- **To persons involved with your care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure of information is in your best interest. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are

aware that doing so would be inconsistent with a preference previously expressed by the deceased.

- **For public health activities** such as reporting or preventing disease outbreaks. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.
- **For reporting victims of abuse, neglect or domestic violence** to government authorities that are permitted by law to receive such information, including social services or protective service agencies.
- **To health oversight agencies** for activities permitted by law, such as licensure, governmental audits, and fraud and abuse investigations.
- **For judicial or administrative proceedings** such as in response to a court order, search warrant or subpoena.
- **For law enforcement purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To avoid a serious health or safety threat** to you, another person, or the public. For example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For specialized government functions** such as military and veteran activities, national security and intelligence activities, and the protective services of the President and others.
- **For workers' compensation** as permitted by, or to the extent needed to comply with, state workers' compensation laws that govern job-related injuries or illness.
- **For research purposes** related to evaluating certain treatments or to prevent disease or disability, if the research study meets federal privacy law requirements.
- **To provide information regarding decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For organ procurement purposes.** We may use or disclose information to people and organizations who

procure, bank or transplant organs, eyes or tissue, to help with organ donations and transplants.

- **To correctional institutions or law enforcement officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To business associates** that perform activities on our behalf or provide us with services if the information is necessary for such activities or services. Business associates are required, under contract and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as stated in our contract and permitted by law.
- **Additional restrictions on use and disclosure.** Certain federal and state laws may require special privacy protections that limit the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:
    1. Alcohol and Substance Abuse
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases
    5. Genetic Information
    6. HIV/AIDS
    7. Mental Health
    8. Minors' Information
    9. Prescriptions
    10. Reproductive Health
    11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Except for the allowed and required uses and disclosures described in this notice, we will use and disclose your health information only with written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional

communications that are prohibited marketing communications under federal law, without your written authorization. Once you authorize us to release your health information, we cannot guarantee that the recipient we gave the information to is obligated to protect and will not further disclose your information. You may take back or “revoke” your written authorization at any time in writing. This will not apply to uses and disclosures we have already acted upon based on your initial authorization. To find out how to take back your authorization, see our contact information in the section called “Exercising your rights.”

Your rights, with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. You must make a written request to restrict the use or disclosure of your information. See instructions in the “Making a written request” section. Please note that while we will try to honor your request, we are not required to agree to any restriction other than with respect to certain disclosures to health plans as further described in this notice.
- **You have the right to request that we not send health information** to health plans in certain cases if the health information is about a health care item or service for which you or a person on your behalf has paid us in full. You must make this request <u>either verbally or in writing</u> at the time you submit or call in your order. We will agree to all requests meeting the above criteria and submitted in a timely manner.
- **You have the right to ask to receive confidential communications** by asking us to send information by alternative means or at alternative locations, for example, to another address instead of your home address. You must make a written request to receive confidential communications or to cancel or change an earlier request. Please see the section called “Making a written request” for instructions. We will honor reasonable requests.
- **You have the right to ask to make changes** to certain health information we maintain about you, such as

medical records and billing records, if you believe the health information about you is wrong or incomplete. You must make a written request to change your information and explain your reason(s) for the requested change(s). Please see the "Making a written request" section for instructions. If we deny your request, you may have a statement of your disagreement added to your health information.

- **You have the right to see and obtain a copy** of certain of your health information maintained by us, such as your medical records and billing records. If we maintain a copy of your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you name. In some cases, you also may receive a summary of this health information. You must make a written request to inspect and obtain a copy of your health information. Please see the section called "Making a Written Request" for instructions. In certain cases, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to receive a listing** of certain disclosures of your information made by us during the six years before your request. This list will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or people you authorized; (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to keep track of. You must submit a written request for a list of disclosures. Please see the "Making a Written Request" section for instructions.
- **You have the right to request a paper copy of this notice at any time.** You may ask for a copy of this notice at any time by calling our OptumRx customer service advocates at the number printed on your ID card. Even if you have agreed to receive this notice electronically, you can still request additional paper copies of this notice. You may also view and/or print a copy of this notice at our website, **optumrx.com.**

Exercising your rights

Making a written request. You must submit a written request to exercise certain rights. For your convenience, we have created Individual Rights Request forms for you to use to ensure that we properly document and process your request. To obtain a form either:

- Go to **optumrx.com,** scroll to Forms at the bottom of the page. Or,
- Log into **optumrx.com** account and select **Information Center** > Programs & forms
- Contact customer service at **the number printed on your ID card** and have us mail a form to you.

Then, mail or fax your completed **Individual Rights Request** form to the Privacy Office. The contact information is in the "Questions About This Notice or to File a Complaint" section.

Designating a personal or authorized representative so that OptumRx may discuss and give out your health information to a third party named by you, you must send to us written material that names that person, such as:

- A legal document granting personal representation such as health care power of attorney, guardianship, or conservatorship. Or,
- A completed **Authorization** form. To obtain a form:
  - Go to **optumrx.com,** scroll to **Forms** at the bottom of the page. Or,
  - Log into your **optumrx.com** account and select **Information Center** > Programs & forms
  - Contact customer service at the number printed on your ID card and have us mail a form to you.

Questions about this notice or to file a complaint. If you have questions about this notice, please contact the Privacy Office. Also, if you believe your privacy rights have been violated, you may file a complaint with us. You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint. Contact us by mail, phone or fax:

OptumRx
Attn: Privacy Office
2300 Main Street
M/S: CA134-0304
Irvine, CA 92614

Phone: 1-877-598-3646
Fax: 1-888-905-9490

WELFARE FUND
NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. It supplements the Highmark and OptumRx Notice of Privacy Practices on page 281 and 298 respectively, and covers medical and drug information not covered by the Highmark and OptumRx notices. Please review it carefully.

Introduction

The Welfare Fund has established practices to protect the privacy and security of information received and maintained with respect to the medical, prescription drug, and vision benefits provided by the Welfare Fund. These practices were established and are applied in accordance with the privacy regulations issued under the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule").

This Notice is effective September 23, 2013. This Notice will be revised as necessary to comply with the HIPAA Privacy Rule, and the Welfare Fund has the right to change the privacy practices described in the Notice at any time. Any changes will apply to all medical information, including medical information received and maintained before the change. You will be notified in writing of any material changes in the privacy practices.

Protected Health Information ("PHI")

The privacy practices described in this Notice apply to "protected health information" ("PHI") received and maintained by the Welfare Fund in connection with the medical, prescription drug and vision benefits provided by the Welfare Fund. PHI is defined in detail by the HIPAA Privacy Rule. In general, PHI is individually identifiable health information created or received by the Welfare Fund that relates to (i) your past, present, or future physical or mental health or condition, (ii) the provision of health care to you, and (iii) the past, present, or future payment for the provision of health care to you.

Welfare Fund Responsibilities

- The Welfare Fund is required to maintain the privacy and security of your PHI.

- The Welfare Fund must promptly notify you if a breach occurs that may have compromised the privacy or security of your PHI.

- The Welfare Fund must follow the privacy practices described in this Notice and provide you with a copy of the Notice.

- Unless authorized by you, the Welfare Fund cannot use or disclose your PHI other than as described in this Notice.

Permitted Uses and Disclosure of PHI by Welfare Fund

Typical permitted uses and disclosure of your PHI by the Welfare Fund include the following:

- Health Care Treatment – For example, the Welfare Fund may use or disclose your PHI to your doctor (or other health care provider) to facilitate your treatment.

- Payment – For example, the Welfare Fund may use or disclose your PHI to determine eligibility for benefits, to pay for covered health care, or to coordinate coverage. Also, the Welfare Fund may disclose PHI to a health care provider or another entity covered by the HIPAA Privacy Rule for the payment activities of that health care provider or entity.

- Health Care Operation – For example, the Welfare Fund may use or disclose your PHI for activities related to health plan funding, the renewal or replacement of health insurance or reinsurance contracts, audits, and the management of the Welfare Fund's business. Also, the Welfare Fund may disclose PHI to another entity covered by the HIPAA Privacy Rule that has a relationship with you for purposes of health care fraud compliance, quality assessment activities, and review and training of health care providers.

The medical benefits, prescription drug benefits, and the vision benefits provided by the Welfare Fund are each considered to be a health plan that participates in an organized health care arrangement. PHI maintained by one of the health plans may be disclosed to the other as necessary to carry out the treatment, payment and health care operations of the organized health care arrangement.

The Welfare Fund may use PHI to contact you about treatment alternatives or other health-related services that may be of interest to you.

Absent your written authorization, psychotherapy notes (generally, separately maintained notes of a mental health professional of a counseling session) will not be used or disclosed with limited exceptions, including the treatment, payment or health care operations of the mental health professional and the defense of any legal action or proceeding you may bring.

In no event will the Welfare Fund use or disclose PHI that is genetic information for underwriting purposes. Underwriting includes determining eligibility for coverage and benefits and computing the cost of coverage.

If a state law establishes "more stringent" privacy standards than the HIPAA Privacy Rule, the use and disclosure of PHI will take the state law into account.

Disclosure to Board of Trustees

The Board of Trustees is the plan sponsor and administrator of the Welfare Fund. Your PHI may be disclosed to the Board of Trustees for the functions the Board performs on behalf of the Welfare Fund, provided that appropriate privacy safeguards consistent with the HIPAA Privacy Rule are in place.

The Board of Trustees may also be provided with (i) information on whether you are covered by the Welfare Fund and (ii) summary health information (generally, claims history with identifying information removed) for the purpose of obtaining bids on health insurance coverage or amending the terms of the Welfare Fund.

Disclosure to Business Associates

The Welfare Fund may disclose PHI to business associates that perform services for the Welfare Fund, such as auditors, consultants, and lawyers. Each business associate must agree in writing to appropriately safeguard the PHI.

Disclosure to Others

The Welfare Fund may be required or permitted to disclose your PHI to others. There are specific requirements in the HIPAA Privacy Rule to do so. Required and permitted disclosures include the following:

- Public Health and Safety – Disclosure for the purpose of (i) preventing or controlling disease, (ii) enabling product

recalls, (iii) reporting adverse reactions to medications, (iv) reporting suspected abuse, neglect, or domestic violence, or (v) preventing or reducing a serious threat to the health or safety of a person or the public.

- Research – Disclosure for health research (provided that the required conditions have been satisfied).

- Required by Law – Disclosure when required for compliance with federal or state law, including when required by the Department of Health and Human Services to determine the Welfare Fund's compliance with the HIPAA Privacy Rule.

- Funeral Directors, Medical Examiners – Disclosure to coroners, medical directors and funeral directors as necessary for them to carry out their duties.

- Organ and Tissue Donation – Disclosure to organ procurement organizations to facilitate organ, eye or tissue donation and transplantation.

- Law Enforcement, Workers' Compensation, Government Requests – Disclosure (i) to a law enforcement official for law enforcement purposes, (ii) as authorized and necessary to comply with workers' compensation and similar programs, (iii) to a health oversight agency for oversight activities authorized by law, or (iv) for specialized government functions, such as military, national security and presidential protection services.

- Lawsuits and Legal Proceedings – Disclosure in response to (i) a court or administrative order or (ii) a subpoena or discovery request (provided that the required conditions have been satisfied).

Disclosure to Others Involved in Your Health Care

The Welfare Fund may disclose PHI to your family members, friends or others who are involved in your health care. In most cases, you will be provided with an opportunity to agree or object to the disclosure. If you are incapacitated or emergency circumstances exist, the Welfare Fund may make such disclosure if it determines disclosure is in your best interest. The PHI disclosed must be (i) directly relevant to this person’s involvement in your care or payment for your care or (ii) used to provide notice

to this person of your location, general health condition, or death. PHI may also be disclosed to an entity authorized to assist in disaster relief for the purpose of providing notice to this person of your location, general health condition, or death.

Disclosure at Your Authorization

You may authorize the Welfare Fund to disclose your PHI for a purpose not described in this Notice. Your authorization is specifically required for any marketing or sale of PHI. Your authorization must be made in writing. You may revoke your authorization for future uses and disclosures at any time by written notice to the Welfare Fund. A revocation will not apply to PHI already used and disclosed or any action taken by the Welfare Fund in reliance on your authorization to disclose PHI.

Your Rights

You have the following rights for PHI maintained by the Welfare Fund:

- Access to PHI – You may review and obtain a copy of your PHI maintained in a designated record set, with certain exceptions. In general, a designated record set includes enrollment, payment, claims, adjudication, and medical management records used by or for the Welfare Fund to make decisions about individuals. Your request for access must be made in writing, and the Welfare Fund will normally accept or deny your request within 30 days. If denied, you will be notified, and you may have the right to request a review of the denial. A fee may be charged for copying and postage.

- Amendment of PHI – You may request that the Welfare Fund amend your PHI maintained in a designated record set. Your request must be made in writing and include the reason(s) for the amendment. The Welfare Fund will normally accept or deny your request for amendment within 60 days. You will be notified if denied. If denied, you have the right to file a statement of disagreement with the Welfare Fund, and you may file a complaint with the Welfare Fund and the Department of Health and Human Services.

- Request Confidential Communications – You may request that the Welfare Fund communicate your PHI to you in an alternative way or at an alternative location. For example,

you may request that the Welfare Fund communicate with you only at a certain telephone number or a certain address. A reasonable request must be accepted if you inform the Welfare Fund that disclosure of all or part of your PHI could place you in danger.

- Restrictions on Use and Disclosure of PHI – You may request that the Welfare Fund place additional restrictions on (i) the use and disclosure of your PHI to carry out treatment, payment, or health care operations or (ii) the disclosure of your PHI to family members, friends or others involved in your health care or payment for your health care. The Welfare Fund does not have to agree to your request, and the Welfare Fund may terminate any restriction upon notice to you.

- Accounting for Disclosures of PHI – You may request a list of the disclosures of your PHI made by the Welfare Fund in the six years prior to the date of your request. Certain disclosures are excluded from the list, including disclosures (i) to carry out treatment, payment and health care operations, (ii) to you or authorized by you, (iii) to law enforcement officials, and (iv) for national security and intelligence purposes. The right to receive a list of disclosures made to a health oversight agency may be temporarily suspended at the request of the agency. No charge is made for the first accounting in a 12-month period. A fee may be charged for additional accounting(s) in a 12-month period.

- Copy of the Notice – You can request a paper copy of this Notice at any time, even if you agreed to receive it electronically.

Personal Representatives

Your rights, choices and elections may generally be exercised by your personal representative. A personal representative is a person authorized under applicable law to act on your behalf in health care matters.

Additional Information and Complaints

Additional information is available by contacting the Privacy Official, Operating Engineers Local 66 Welfare Fund, P.O. Box 38682, Pittsburgh, PA 15238, 412-968-9750.

If you believe your privacy rights have been violated, you may file a written complaint with the Welfare Fund at the above address or with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. There is no retaliation for filing a complaint.

APPEAL PROCEDURES

Highmark Group Health Benefits
Highmark maintains appeal procedures for claims for medical benefits denied under the PLAN ONE or PLAN TWO PPO health care program and the Medicare Supplemental Plan. An explanation begins on page 167 for the PPO benefits and on page 272 for the Medicare Supplemental benefits.

General Appeal Procedure
The General Appeal Procedure applies to claims for benefits related to your eligibility, or that of your spouse or dependent, to participate in the Welfare Fund and claims for Death Benefits and Accidental Death and Dismemberment benefits.

In most cases, a decision on a claim will be made within 90 days of its receipt. If special circumstances require, the 90-day period may be extended for an additional 90 days. In such case, you will be provided with a written notice of extension setting forth the reasons for the extension and the date by which a decision is expected.

If your claim is denied, you will receive a written explanation setting forth:

- The reasons for the denial;
- The plan provisions on which the denial is based;
- Any additional documents or information you must provide to support your claim and an explanation why it is necessary;
- The appeal procedure for further review of your claim; and
- A statement of your right to bring a lawsuit under ERISA in the event of an adverse decision upon review of your appeal of the denial.

You have the right to appeal any denial of your claim to the Board of Trustees by submitting a written request for appeal to the Fund Office within 60 days of the date you receive the denial. If you do

not file a timely appeal, you will forfeit your right to have the denial reviewed on appeal and your right to file a lawsuit in court.

Your appeal should set forth the reasons why you believe your claim should not have been denied. Your appeal should also identify and include all of the issues related to your claim. Your right to file a lawsuit in court after an adverse decision on appeal is limited to the reasons and issues you raise for review by the Board of Trustees. You may submit any documents, records or other information you believe have a bearing on your claim. In preparing your appeal, you may review all documents, records and other information relevant to your claim and receive copies free of charge.

The Board of Trustees has the authority and discretion to interpret and apply the terms of the Welfare Fund and to resolve any legal and factual issues regarding the Welfare Fund and benefits thereunder.

The Board of Trustees will review and decide your appeal within 60 days of the Fund Office's receipt of your written appeal. If special circumstances require, the 60-day period may be extended for up to an additional 60 days. You will be provided with a written notice of any such extension. The notice of extension will refer to the special circumstances which make an extension necessary and will contain the date by which the Board of Trustees expects to decide and review your appeal.

The Board of Trustees will issue a written decision on your appeal. This decision is final and binding on all interested parties. If adverse, the written decision will include:

- The reasons for the decision;
- The plan provisions on which the decision is based;
- A statement of your right to examine all documents, records and other information that are relevant to your claim and to receive copies free of charge; and
- A statement of your right to bring a lawsuit under ERISA.

Member Reimbursement Benefit/Annual Dental Benefit
Different or additional claims and review procedures apply to your application for a Member Reimbursement Benefit or Annual Dental Benefit:

- A decision on your application will be made within 30 days of its receipt. If special circumstances require, the 30-day period may be extended for a period of up to 15 days if the extension is necessary due to matters outside the control of the Welfare Fund. In such case, the notice of extension will also explain (1) the unresolved issues that prevent a decision on your application and (2) any additional information needed to resolve the issues.

- If the period to consider your application is extended because you fail to submit information needed to decide your application, you will be notified and provided with at least a 45-day period to provide the required information. In that case, the time period to decide your application will be suspended, and a decision on the claim will be made within15 days after the earlier of (1) the date you respond to the request for additional information or (2) the date the period to submit the additional information ends.

- If your application is denied, the explanation of the denial will include (1) an explanation of any internal rule, guideline, or protocol relied on for the denial, or a statement that there are none, (2) if the denial was based on a medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial applying the plan terms to your medical circumstances, or a statement that such explanation will be provided free of charge upon your request, and (3) a statement of your right to examine all documents, records and other information that are relevant to your application and to receive copies free of charge.

- If your application is denied, you will have 180 days from the date you receive the denial to submit a written appeal of the denial.

- Your appeal of a denial of your application will be reviewed by the Board of Trustees. If the denial of your application was based on a medical judgment, the Board of Trustees will consult with an appropriate health care professional, who will not be the same individual consulted in connection with the denial of your application and who will be selected without regard to the likelihood that the health care professional would support the denial. The review will identify any medical or vocational expert consulted in connection with your application.

- Your appeal will be decided and written notice of the decision provided no later than 60 days after receipt of your written appeal.

- If the decision on your appeal is adverse, the written decision will include (1) an explanation of any internal rule, guideline, or protocol relied on for the decision, or a statement that there are none and (2) if the decision was based on a medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the decision applying the plan terms to your medical circumstances, or a statement that such explanation will be provided free of charge upon your request.

Weekly Disability Benefits
Different or additional claims and review procedures apply to your application for a Weekly Disability Benefit:

- A decision on your application will be made within 45 days of its receipt. If special circumstances require, the 45-day period may be extended for two separate periods of up to 30 days if, in each case, the extension is necessary due to matters outside the control of the Welfare Fund. In such

case, the notice of extension will also explain (1) the eligibility requirements for the Weekly Disability Benefit, (2) the unresolved issues that prevent a decision on your application, and (3) any additional information needed to resolve the issues.

- If the period to consider your application is extended because you fail to submit information needed to decide your application, you will be notified and provided with at least a 45-day period to provide the required information. In that case, the time period to decide your application will be suspended, and a decision on the claim will be made within15 days after the earlier of (1) the date you respond to the request for additional information or (2) the date the period to submit the additional information ends.

- If your application is denied, the explanation of the denial will include (1) an explanation of the basis for not following (i) the views of the health care professionals who have treated or evaluated you, (ii) the views of any medical experts consulted by the Welfare Fund, or (iii) any determination of disability by the Social Security Administration you present (2) an explanation of any internal rule, guideline, or protocol relied on for the denial, or a statement that there are none, (3) if the denial was based on a medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial applying the plan terms to your medical circumstances, or a statement that such explanation will be provided free of charge upon your request, and (4) a statement of your right to examine all documents, records and other information that are relevant to your application and to receive copies free of charge.

- If your application is denied, you will have 180 days from the date you receive the denial to submit a written appeal of the denial.

- Your appeal of a denial of your application will be reviewed by the Board of Trustees. If the denial of your application was based on a medical judgment, the Board of Trustees will consult with an appropriate health care professional, who will not be the same individual consulted in connection with the denial of your application and who will be selected without regard to the likelihood that the health care professional would support the denial. The review will identify any medical or vocational expert consulted in connection with your application.

- If any new or additional evidence or rationales are considered during the review of your appeal of the denial of your application, you will be provided with the new or additional evidence or rationales free of charge and provided with an opportunity to respond before a decision is made on the appeal.

- Your appeal will be decided and written notice of the decision provided no later than 45 days after receipt of your written appeal. If special circumstances require, the 45-day period may be extended for up to an additional 45 days.

- If the decision on your appeal is adverse, the written decision will include (1) an explanation of the basis for not following (i) the views of the health care professionals who have treated or evaluated you, (ii) the views of any medical experts consulted by the Welfare Fund, or (iii) any determination of disability by the Social Security Administration you present, (2) an explanation of any internal rule, guideline, or protocol relied on for the decision, or a statement that there are none, (3) if the decision was based on a medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the decision applying the plan terms to your medical circumstances, or a statement that such explanation will be provided free of charge upon your request, and (4) the date

any limitation period to bring a lawsuit described in this booklet expires.

- If you believe that there has been a violation of the claims procedures required by U.S. Department of Labor Regulations that results in the deemed exhaustion of the administrative remedies provided by those Regulations (and which would allow you to bring a lawsuit), you may request a written explanation from the Welfare Fund. The explanation will be provided within 10 days and will address the violation, including the basis for any assertion that the violation should not cause the administrative remedies to be deemed exhausted.

Representative

You have the right to designate a representative to file an application for benefits on your behalf and/or present an appeal on your behalf. This would be at your expense. You will generally be required to provide a written statement of the designation, along with an authorization to release information to your representative.

Beneficiaries

The above appeal procedures apply to your beneficiary who wishes to file a claim for benefits under the Welfare Fund after your death.

GENERAL PROVISIONS AND DEFINITIONS OF THE WELFARE FUND BENEFIT PLAN

1. For any claim for which the benefit is not expressly stated, the Trustees shall have the right to determine an amount which, in their opinion, would be consistent with payments made on similar claims or claims of a like nature. In all cases, their decision shall be final and binding.
2. No action at law or in equity shall be brought to recover payments, under the provisions of the Plan, prior to the expiration of sixty days after proof has been filed, in accordance with the requirements of the Plan. Nor shall such action be brought at all, unless brought within three years from the expiration of the time within which proof is required by the Plan.
3. If any time limitation of the Plan with respect to giving notice, filing proof of loss or commencing an action at law or in equity, is less than that permitted by the laws of the state in which the participant resides at the time the Plan is effective, the limitation is hereby extended to agree with the minimum period permitted by the law.
4. Consent of the beneficiary, if any, shall not be a requisite to any change of beneficiary or to any other changes in the Plan.
5. The Plan is not in lieu of and does not affect any requirements for coverage by Workmen's Compensation Insurance.
6. "Board of Trustees" or "Trustees" shall mean the Trustees of the Operating Engineers Local 66 Welfare Fund, or their duly appointed successors, as provided for in the Agreement and Declaration of Trust.
7. "Fund" or "Trust Fund" shall mean the Trust Estate of the Operating Engineers Local 66 Welfare Fund, as defined in the Agreement and Declaration of Trust.
8. "Fund Office" shall mean the principal place of business of the Operating Engineers Local 66 Welfare Fund, which is located at 111 Zeta Drive, Pittsburgh, PA 15238.

GENERAL EXCEPTIONS AND LIMITATIONS OF THE WELFARE FUND BENEFIT PLAN

The plan does not cover any:

1. Loss caused by accidental bodily injury, which arises out of or occurs in the course of any occupation or employment for wages or profit, or sickness for which you are entitled to benefits under any Worker's Compensation or Occupational Disease Law, except in the Case of Death Benefits and/or Accidental Death and Dismemberment Benefits.
2. Care rendered within any facility of, or provided by, the United States Veterans Administration.
3. Loss caused by war or any act of war (declared or undeclared).
4. Charges for services or supplies furnished by or for the U.S. Government, any other government or military or naval service of any country, unless payment is legally required.
5. Charges in excess of those usually made when there is no insurance, or in excess of the general level of charges in the area.

SUBROGATION

The Welfare Fund seeks to conserve its funds by imposing the expense of accidental injuries suffered by employees and dependents, on those responsible for causing them. If benefits are paid from this Fund because of injuries caused by someone else, the Welfare Fund and Highmark Blue Cross/Blue Shield, through subrogation, will have the right to seek repayment from the other party or the other party's insurance carrier.

Benefits will be provided by this Fund at the time of need, but the participants may be asked to execute and deliver documents or take other action, as necessary to insure the rights of the Welfare Fund or Highmark. Further details will be made available at the time a claim is filed with the Welfare Fund.

Subrogation does not apply to an individual insurance policy you may have purchased for yourself or your dependents or if specifically prohibited by law.

ERISA INFORMATION

This is a Summary Plan Description as required by ERISA and is intended to satisfy that requirement.

NAME OF PLAN...

Operating Engineers Local 66 Welfare Fund or "Welfare Fund"

PLAN IDENTIFICATION NUMBER...

The Employer Identification Number (EIN) issued to the Board of Trustees is 25-1187299.

PLAN NUMBER...

The Board of Trustees has assigned the Plan Number as 501.

PLAN ADMINISTRATOR...

Board of Trustees of the Operating Engineers
Local 66 Welfare Fund
P.O. Box 38682
Pittsburgh, Pa. 15238

BOARD OF TRUSTEES...

EMPLOYEE TRUSTEES	EMPLOYER TRUSTEES
James T. Kunz, Jr., Chairman	Gary Hartman,Sec
Shawn Bertiaux	Mark Gentile
Jesse DiRenna	Russell Kohler
Carlton K. Ingram	Ali Mills
Thomas C. Melisko, Jr.	Douglas Mosites
Kevin F. Pahach	Jack Ramage
William S. Pellish	Charles J. Wisniewski

PLAN YEAR...

January 1 through December 31.

TYPE OF PLAN...

This Plan provides benefits for hospitalization, surgery, vision, prescriptions and medical expense benefits for employees and their eligible dependents. In addition, Weekly Disability benefits, death benefits, accidental death and dismemberment benefits, and Member Reimbursement Benefits are provided to employees.

GRANDFATHERED HEALTH PLAN STATUS...

As general information, the Operating Engineers Local 66 Welfare Fund believes its group health plan coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office in writing at Operating Engineers Local 66 Welfare Fund, P.O. Box 38682, Pittsburgh, PA 15238, or by telephone at 412-968-9750. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans

FUND ATTORNEY...

Meyer, Unkovic & Scott LLP.

FUND ACTUARY...

Segal Consulting.

AGENT FOR SERVICE OF LEGAL PROCESS...

M. Scott Anderson, Fund Administrator
P.O. Box 38682
Pittsburgh, PA 15238
Service of legal process may also be made upon the Board of Trustees or any of the Plan Trustees who jointly are the Plan Administrator.

FUND OFFICE LOCATION...

111 Zeta Drive
Pittsburgh, PA 15238

MAILING ADDRESS

Operating Engineers Local 66 Welfare Fund
P.O. Box 38682
Pittsburgh, PA 15238
Telephone Number: (412) 968-9750
FAX (412) 968-9757

ESTABLISHMENT OF THE PROGRAM

The Plan was established in 1968 by the International Union of Operating Engineers, Local 66 and participating employers who had signed a Collective Bargaining Agreement. These employers make monthly contribution payments in accordance with the terms of each Collective Bargaining Agreement. Copies of Collective Bargaining Agreements may be reviewed at the main office of the Union, Local 66, or at its district dispatch offices during normal business hours.

A list of participating employers is maintained at the Fund Office at 111 Zeta Drive, Pittsburgh, PA 15238. The Administrator will provide to you, without charge and upon request, a complete list of employers, or information as to whether or not your employer is obligated to make contributions to this Plan on behalf of employees working under the Collective Bargaining Agreements.

ADMINISTRATION OF THE PLAN

The Plan is administered by a Joint Board of Trustees, who is the Plan Sponsor. Under the Employee Retirement Income Security Act of 1974 (ERISA), the Board of Trustees is the Plan Administrator with final responsibility for the manner in which the Welfare Fund operates. The Trustees are full time employees of other organizations and serve without pay. They hire a Fund Administrator, as manager of the Plan, to run the Fund on a day-to-day basis.

All employer contributions are received and processed by the Fund Office. All claims for hospitalization are received, processed and paid by Highmark Blue Cross/Blue Shield. All other claims for benefits may be received, processed and paid by Highmark Blue Cross/Blue Shield, National Vision Administrators Inc., OptumRx, and/or the Fund Office. Freedom Blue benefits are provided by Highmark Blue Cross/Blue Shield. The Welfare Fund's assets and reserves are held and invested by Manning & Napier Advisors Inc., PNC Bank and Ameriserv.

RIGHTS UNDER ERISA

As a participant in the Operating Engineers Local 66 Welfare Fund, you have certain rights and protection under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants shall be entitled to:

a. Examine, during normal business hours at the Fund Office, those documents which are available for inspection including Plan documents, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as, annual reports and Plan descriptions. Obtain copies of all Plan documents and other Plan information upon written request to the Board of Trustees (Plan Administrator). The Board may make a reasonable charge for the copies.

b. Receive a summary of the Plan's annual financial report. The Board of Trustees (Plan Administrator) is required by law to furnish each participant with a copy of this Summary Annual Report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employees benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. For Denial of Claims and Appeal Procedures see applicable sections later in this booklet. Under ERISA, there are steps you can take to enforce the above rights.

For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In this case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you

receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim was frivolous

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN TERMINATION OR BENEFIT ELIMINATION

Neither this Plan nor any of its benefits is guaranteed. Although the Plan is intended to be permanent, the Board of Trustees has the authority to terminate the Plan or eliminate Plan benefits, in whole or part, as it finds necessary. The Plan shall terminate upon the occurrence of any one or more of the following events: if the Plan assets are, in the opinion of the Board, inadequate to carry out the intent and purpose of the Plan or are inadequate to meet the payments due or which may become due to Participants and Beneficiaries; if there are no individuals living who can qualify as Employees; if the Union and Employers agree to terminate the Plan; if the Plan is merged into another employee benefit plan; any other event which may, by law, require termination.

In the event of termination of the Plan, the Board shall make provision out of the Plan assets for the payment of expenses incurred up to the date of termination and the expenses incidental to termination; arrange for a final audit and report of the Board's transactions and accounts for the purposes of ending the trusteeship; and apply the Plan assets to the extent available to pay the obligations of the Plan and distribute and apply any surplus in a manner that will inure to the exclusive benefit of the Participants and Beneficiaries in accordance with the purposes of the Plan and the requirements of law.

TRUSTEES POLICY

The Trustees have adopted the following policy in regard to Employer Contributions, Voluntary Contributions, Disability and Worker's Compensation Credits, Minimum Contribution Requirements and Reserve of Contribution Accounts.

- Each Active Employee and each Active Special Agreement Employee will accumulate the minimum contribution required for each benefit period, through employer contributions from covered employment and/or pay a Voluntary Contribution, if necessary, to make up the difference between the minimum contribution requirement and those contributions and credits applied.
- The Reserve of Contribution Account balance can be used to cover any Voluntary Contribution subject to the Plan rules and regulations. It will be required that each Reserve of Contribution Account be fully funded with appropriate segregation of this obligation, as to guarantee payment of reserves.
- Each Special Category participant will pay the cost of the benefits provided to them and their dependents, if any.
- The Retirees Contribution Account will be used to reduce the cost of benefits for each retired employee, who is 62 and over, and every disabled employee covered by Medicare.
- The Minimum Contribution Requirement, the Minimum Monthly Contribution and the Voluntary Contributions will be established at levels deemed appropriate by the Board of Trustees.
- All outstanding liabilities and reserves, as established by the Welfare Fund's Actuary, will be fully funded at all times.

MILITARY SERVICE

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), participants who enter the military service may be entitled to service credits with respect to qualified military service while they are on active duty or away from work as a reservist. However, in order to secure such benefits a participant must notify the Fund Office and the Union before he leaves work for military service and be available for work upon return from service.

Under the Uniformed Services Employment and Reemployment Act (USERRA), if you enter military service or are called for active military service from reserve status you can continue health coverage for yourself or your family, similar to COBRA coverage, while you are on active service or away from work as a reservist.

To be eligible for such benefits you must:

First: Notify the Fund Office and the Union before you leave work for military service. The notice may be oral or written. Failure to notify due to military necessity, impossibility or unreasonable circumstances will not automatically disqualify you.

Second: Notify the Fund Office and the Union of your intention to return to work upon your discharge from military service. The notice to the Fund Office shall include a copy of your discharge papers. An honorable discharge is required. A time limitation exists to return to work. Failure to follow the re-employment time limits will disqualify you. A chart is provided below:

Length of Service	Reemployment Deadline
Less than 31 days	1 work-day from discharge (plus 8 hours)*
31 thru 180 days	14 days after discharge**
more than 180 days	90 days after discharge

* or as soon as possible after the expiration of the 8 hours travel time if such is impossible or unreasonable.

** or if such is impossible, then the next day when it becomes possible after the 14 days.

An absence for purposes of examination for service is treated as a period for less than 31 days. If hospitalization occurs during service, then the time periods above apply after recovery, but such time shall not exceed two years.

These rights are limited and you should contact the Fund Office for further details. This notice is not intended to explain all rights and limitations of USERRA.

OPERATING ENGINEERS LOCAL 66
WELFARE FUND

This booklet sets forth the Death, Disability, Hospital, Medical, Surgical, Prescription Drug, Vision Care and Major Medical Benefit Provisions, as well as the Eligibility Requirements for Employees, Dependents, and Retirees of the Operating Engineers Local 66 Welfare Fund. The provisions, as contained in this booklet, together with the Trust Agreement and all amendments, resolutions and agreements duly adopted and entered into by the Board of Trustees of the Operating Engineers Local 66 Welfare Fund, constitutes the Plan.

The Trustees reserve the right to change or amend this Plan at any time, including but not restricted to, the amount and extent of all benefits; the eligibility requirements; and the contributions and related regulations, in accordance with the provisions of the Trust Agreement. No Employee, Participant, Retiree, Beneficiary, or Eligible Dependent has a vested right or contractual interest in the benefits provided.

DEFINITIONS

BENEFIT PERIOD: The three consecutive calendar months of: (a) January through March, (b) April through June, (c) July through September, and (d) October through December.

BLUES ON CALL: A 24-hour, 7 days a week health decision support number that provides health care information.
Call 1-888-BLUE-428.

DEDUCTIBLE: Initial amount you must pay each year for covered services before the plan begins to provide payment for benefits. The deductible is a specified dollar amount you must pay for covered services e ach year before the program begins to provide payment for benefits. Refer to the Schedules of Benefits beginning on page 9 and select the plan in which you are eligible. You may be required to pay any applicable deductible at the time you receive care from a provider.

DEPENDENTS: A Dependent is a spouse and an employee's child(ren) younger than age 26.

A child for this purpose is (1) the employee's own child, (2) the employee's stepchild, but only for so long as the employee and the stepchild's parent are married, (3) a child legally adopted by the employee or lawfully placed with the employee for legal adoption, and (4) an eligible foster child of the employee (a child placed with the employee by an authorized placement agency or by a court order).

If an unmarried dependent child is incapable of self-sustaining employment by reason of mental or physical handicap and (1) became incapacitated prior to the attainment of age 19, (2) is chiefly dependent upon the employee for support and maintenance, and (3) if the employee furnishes proof of incapacity, at no expense to the Plan, within 31 days of the date the dependent child's coverage would otherwise terminate due to the attainment of age 26, the coverage of the dependent child will be continued for so long as the employee remains eligible under the Plan and the child remains incapacitated and unmarried.

Dependents do not include any other persons. Any employee claiming a dependent must furnish the information and proof requested by the Plan to establish dependent status.

DISABILITY CREDITS: Disability Credit refers to the crediting of contribution credits to an individual's account, for the purpose of maintaining eligibility, during a period of disability resulting from a non-occupational injury or sickness.

ELIGIBLE: Any Employee or Participant who meets the Eligibility Requirements in accordance with the rules contained herein.

EMPLOYEE: Any person defined as follows:

a) An Active Employee, exclusive of an active Special Agreement Employee, working at the trade for an employer who is required to make contributions to the Fund on behalf of the employee. Employees of the Union and its related Funds and Organizations for whom contributions are received, are included.
b) An Active Special Agreement Employee working for an employer covered by a collective bargaining agreement with the Union, which requires contributions to the Fund on behalf of the employee.
c) All Employees who become disabled while covered under the Fund and otherwise meet the requirements of the Plan.
d) Field Supervisory Employees and Foremen for whom employer contributions are received.

EMPLOYER CONTRIBUTIONS: Contributions refer to the payment by the Employer as required by a collective bargaining agreement with the Union. An Employee shall be credited for eligibility purposes with all contributions paid to the Fund on his behalf.

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

MINIMUM CONTRIBUTION REQUIREMENTS: Shall refer to the amount of contributions necessary for an Active Employee in a Work Period to be eligible for coverage in the following Benefit Period. Amounts are specified in the table on Page 46.

MINIMUM MONTHLY CONTRIBUTION: Shall refer to the amount of contributions in a given work month necessary for a Special Agreement Employee to be eligible for coverage in a given benefit month.

NEW EMPLOYER CONTRIBUTIONS: Contributions earned in the current Work Period that must be credited to the current Benefit Period.

PARTICIPANT: Employees and their dependents, who are covered by the Welfare Fund.

PARTICIPATING EMPLOYERS: A Participating Employer is one who is obligated to make contributions to the Operating Engineers Local 66 Welfare Fund. The Union and its related Funds and organizations shall be considered Participating Employers.

PREVIOUS EMPLOYER CONTRIBUTIONS: Contributions earned in a previous Work Period that must be credited to the corresponding previous Benefit Period.

RETIREE: Active Employees and Active Special Agreement Employees who retire and meet the minimum eligibility requirements for coverage under the Plan.

TIMELY FILING – Claims must be submitted within 36 months of the original date of service. Claims older than 36 months cannot be paid.

UNION OR LOCAL 66: Means the International Union of Operating Engineers, Local 66, AFL-CIO.

VOLUNTARY CONTRIBUTIONS: Refer to contributions paid by the Employee (made in accordance with the Rules pertaining to Voluntary Contributions) for the purpose of maintaining eligibility in the Plan.

WELLNESS INITIATIVE: The incentive is a reduction of the Annual Medical Deductible from $250 per individual/$500 per family to $150/$300. Medicare and Freedom Blue retirees are not eligible for this incentive. Members, and if married, spouses must complete an annual physical examination to qualify for the wellness incentive.

WORK PERIOD: The three consecutive calendar months of: (a) August through October, (b) November through January, (c) February through April, and (d) May through July.

WORKER'S COMPENSATION CREDITS: Worker's compensation Credit refers to the crediting of contribution credits to an individual's account for the purpose of maintaining eligibility, during a period of disability resulting from an occupational injury or sickness.

INDEX

ACCIDENTAL DEATH AND DISMEMBERMENT, 86, 103
Active Employees, 3, 4, 47, 50, 52, 56, 57, 66, 333
adult immunizations, 125
Advanced Imaging Services, 112
Allergy Serum, 90, 186
Ambulance Service, 11, 17
Anesthesia, 12, 18, 24, 110, 129, 193, 207, 214, 220, 230
ANNUAL DENTAL BENEFIT, 83
appeal, 167, 272
a ppeal process Highmark, 167
Autism, 12, 18, 25, 110, 169, 194, 207, 219, 273
BENEFIT PERIOD, 331
Blues On Call, 106, 172, 173, 189, 276
BLUES ON CALL, 331
change in your family status, 39
COBRA, 4, 5, 40, 44, 55, 57, 66, 68, 69, 70, 71, 74, 75, 77, 329
Coinsurance, 28, 32, 34, 38, 107, 191
Colorectal Cancer Screenings, 125, 202, 212, 227
Copayment, 107, 162
DEATH BENEFITS, 84, 101, 177, 178
Deductible, 9, 15, 21, 28, 34, 107, 108, 191, 331, 333
DEPENDENTS, 331
Detoxification, 12, 17, 24
Diabetes Prevention Program, 126, 135, 202, 213, 228
Diabetic Supplies, 90, 91, 186, 187
Diagnostic Services, 12, 14, 18, 25, 113, 118
Disability Credits, 3, 4, 55, 58, 59
DISABILITY CREDITS, 4, 59, 332
durable medical equipment, 113, 163, 196, 209, 221, 239, 268
Emergency Room Services, 11, 17, 29, 35
EMPLOYER CONTRIBUTIONS, 332, 333
enteral foods, 114, 135, 221, 222, 238, 242, 246
ERISA, 7, 167, 170, 272, 274, 321, 324, 325, 326
experimental/investigative, 136, 233
Field Supervisory Employees, 4, 64, 67, 332
Filing for Death Benefits, 85, 102, 178
Fixed Premium, 47, 53, 66, 76, 77
FIXED PREMIUM, 5, 66, 76
Fixed Premium Employee, 47, 53
Frames, 80, 179
Fund Office Information Card, 39, 84, 101, 177
Generic Drugs, 89, 185
Gynecological Examination, 127, 201, 211, 227
HIPAA, 4, 44, 70, 281, 283, 284, 285, 289
hospice, 115, 137
Inpatient Facility Services, 121, 199
Inpatient Medical Services, 121, 199, 210, 225
Inpatient Services, 116, 148, 253
Lenses, 30, 36, 80, 136, 179, 238, 243, 247
Maintenance Drugs, 89, 185
Mammographic Screening, 126, 201, 211, 226
Maternity, 11, 14, 16, 23, 119, 120, 121, 173, 198, 199, 209, 224, 225, 259, 277
medically necessary and appropriate, 109, 110, 111, 112, 116, 126, 130, 139, 140,

142, 143, 144, 152, 153, 154, 155, 193, 194, 195, 207, 208, 215, 218, 219, 220, 237, 240, 244, 246, 257, 258, 259, 260, 261
Medicare Eligible Retirees, 51
Medicare Rules – Retirees, 49
MEDICARE SUPPLEMENTAL PLAN, 7, 8, 27, 41, 43, 63, 64, 65, 177, 178, 179, 183
Member Reimbursement Benefit, 5, 54, 93
MEMBER REIMBURSEMENT BENEFIT, 93
MILITARY SERVICE, 329
MINIMUM CONTRIBUTION REQUIREMENTS, 332
MINIMUM MONTHLY CONTRIBUTION, 333
National Vision Administrators, 41, 43, 80, 81, 179, 180, 324
occupational therapy, 115, 124, 196, 200, 222
OptumRx, 14, 27, 41, 43, 87, 88, 89, 90, 91, 183, 184, 185, 186, 187, 324
Orthotic, 122, 226
Out-of-Area Services, 145, 250
Out-of-Network Care, 152, 155
Outpatient Mental Health Care Services, 122
Outpatient Services, 117, 148, 253
Oxygen, 31, 37, 115, 196, 222
PARTICIPATING EMPLOYERS, 333
Payment of Death Benefits, 85, 102
Pediatric, 10, 13, 16, 19, 22, 26, 123, 124, 125, 127, 200, 201, 211, 213, 227, 255
Preferred Provider Organization, 9, 15
PRESCRIPTION DRUG BENEFITS, 87, 183
Preventive Care, 10, 16, 21, 106, 125, 140, 189, 235
PRIVACY PRACTICES HIGHMARK, 281
Qualifying Event, 4, 68, 69
Reciprocal Agreement, 61
remarriage, 63, 66
Reserve, 5, 8, 48, 49, 50, 51, 52, 53, 54, 55, 57, 59, 60, 73, 74, 76, 77, 93, 94, 328
Retirees Not Eligible for Medicare, 51
Retirees’ Welfare Contribution Account, 60
Second Surgical Opinion, 23, 131, 214
Skilled nursing, 115, 124, 150, 196, 200, 222, 255, 258
Special Categories, 47, 53, 58
spouse or child(ren) of deceased, 63
Spouses and Children of Deceased Employees, 4, 66
Subrogation, 160, 266, 320
Temporary Eligibility, 46, 72, 73, 74, 75
TERMINATION OF ELIGIBILITY, 4, 66
Total Disability, 64, 85, 102
Transplant Services, 13, 19, 26
transplantation, 132, 205, 231, 286
Vision Examination, 80, 179
Voluntary Contribution, 8, 47, 48, 52, 53, 54, 56, 57, 58, 60, 61, 63, 64, 66, 67, 72, 73, 74, 77, 328
Voluntary Contributions, 3, 4, 5, 47, 53, 56, 57, 58, 60, 61, 64, 66, 73, 74, 77, 328, 333
VOLUNTARY CONTRIBUTIONS, 4, 56, 58, 333
weekly disability, 59, 74, 77, 78
Weekly Disability Benefits, 5, 42, 69, 78, 79
WEEKLY DISABILITY BENEFITS, 78
WELLNESS INITIATIVE, 333
What Is Not Covered, 6, 7

, 46, 47, 51, 52, 54, 56, 57, 58, 59, 66, 67, 71, 74, 77, 332, 333
WORK PERIOD, 334
Worker's Compensation Credits, 3, 59, 328
WORKER'S COMPENSATION CREDITS, 334