PRODUCER MANUAL

For Highmark Blue Cross Blue Shield Medically Underwritten Health Coverage Programs

This manual, which is being provided to you by Highmark Blue Cross Blue Shield as a courtesy, is intended to provide useful information and is not intended to be complete or exhaustive. The guidelines governing the offering of health insurance and Highmark's policies may change from time to time. Please check for periodic updates to this manual.

This manual is a confidential and proprietary document of Highmark Blue Cross Blue Shield. Any use or duplication of this manual for any purpose, except to provide guidance to producers of Highmark Blue Cross Blue Shield, is prohibited.

Highmark may require you to return or destroy this manual at any time, at its sole discretion, and to certify that such action has been performed.

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INTRODUCTION

As the area's health care leader, Highmark Blue Cross Blue Shield has offered individuals and their dependents quality health care programs for almost 70 years. This reference manual was designed to introduce producers to the following medically underwritten programs available from Highmark Blue Cross Blue Shield – to help you better understand the unique benefits and coverage features of these programs:

DirectBlue® Comprehensive Major Medical Preferred-Provider Program

PPOBlue℠ Individual Comprehensive Major Medical Preferred-Provider High-Deductible Program

CompleteCare℠ Comprehensive Major Medical Program

KeystoneBlue℠ Individual HMO, a product of Keystone Health Plan West

ShortTermBlue℠, a Single-Term, Non-Renewable Comprehensive Major Medical Individual Preferred-Provider Program

Please take the time to become familiar with the manual. It explains how these programs work, enrollment and underwriting requirements, payment options and billing procedures, so you can help individuals and families select convenient and affordable coverage. In keeping pace with changes in today's marketplace, Highmark Blue Cross Blue Shield is constantly reviewing and improving its health care benefits. As a result, benefits and enrollment requirements for programs are modified from time to time. To keep you abreast of any such changes, we will periodically update this manual and include changes in *Producer News*, your electronic newsletter available at www.highmarkbcbs.com.

These programs are available only to persons living in the 29-county area served by Highmark Blue Cross Blue Shield. If an individual enrolled in one of these programs moves out of the 29-county service area, his/her agreement will be terminated.

If the individual moves to the 21-county service area of Highmark Blue Shield, he/she has the option of picking up the same program, if offered in the Central Region, and medical underwriting is waived. If the same program is not offered in the Central Region, he/she can pick up another medically underwritten program. Pre-existing condition limitations are credited for the time spent in the Highmark Blue Cross Blue Shield program.

If the member has ShortTermBlue in the West and moves to the Central Region, the member has the option to pick up the ShortTermBlue program for the remainder of the coverage period selected.

In order to transfer from Highmark Blue Cross Blue Shield to Highmark Blue Shield for any of our other medically underwritten programs, the member should contact Member Service by calling the number listed on the back of their identification (ID) card.

PRODUCER NETWORK QUICK REFERENCE

Important numbers to know when you need to call Highmark Blue Cross Blue Shield:

PRODUCER INFORMATION *(For Producer Use Only)*

Questions about Highmark Appointment and Portal Entitlements	1-412-544-2285
Producer Portal Access Requests	ProducerAffairsWest@highmark.com
Questions about benefits, claims, etc.	Highmark Blue Cross Blue Shield General Agency Hotline 1-866-602-1248 Monday – Friday 8:00 a.m. to 5:00 p.m. • For password reset, press 1 • For Web technical/portal issues, press 2 • To speak with a service representative for all other issues, including benefits, claims, direct pay applications' status, etc., press 3
Guaranteed issue programs sales service	1-800-876-7639 Monday through Friday, 8:00 a.m. to 9:00 p.m.; Saturday, 8:00 a.m. to 8:00 p.m.
Technical assistance with online applications via the Producer Portal at www.highmarkbcbs.com or contact your General Agency	1-866-306-1059
For additional information or to order supplies	Access the Producer Portal at www.highmarkbcbs.com or contact your General Agency

For status of applications, contact your General Agency. General Agencies have access to Agency Activity Reports via the Producer Portal on the Highmark Blue Cross Blue Shield Web site. Agency Activity Reports reflect status of pending applications for all producers that report through the General Agencies. Active and Terminated Member Reports are also available to General Agencies on the Producer Portal.

To order supplies, contact your General Agency.

MEMBER INFORMATION

Web Inquiries:
Claim forms, duplicate explanation of benefits, general inquiries and identification cards can also be handled on the Web: www.highmarkbcbs.com.

Submit appeals for member denials for coverage to:

Highmark Blue Cross Blue Shield
Individual Product Appeals
120 Fifth Avenue, Suite 1224
Pittsburgh, PA 15222-3099

Fax: 412-544-4009

Telephone Inquiries:
Benefits, claims and enrollment information about
Under 65 Individual Programs:.....1-800-544-6679
Hearing impaired may call.....1-877-323-8480

Or, members can mail their inquiries to:

Highmark Blue Cross Blue Shield
P.O. Box 70
Pittsburgh, PA 15230-0070

SERVICE CENTERS

The following Highmark Blue Cross Blue Shield walk-in Service Centers are located in convenient areas for members living in the 29-county Highmark Blue Cross Blue Shield service area:

Pittsburgh Service Center
Penn Avenue Place
501 Penn Avenue
Pittsburgh, PA 15222

Johnstown Service Center
Crown American Building
One Pasquerilla Plaza
Franklin and Vine Street
Johnstown, PA 15901

Erie Service Center
717 State Street
Erie, PA 16501

State College Service Center
2040 Sandy Drive
State College, PA 16803

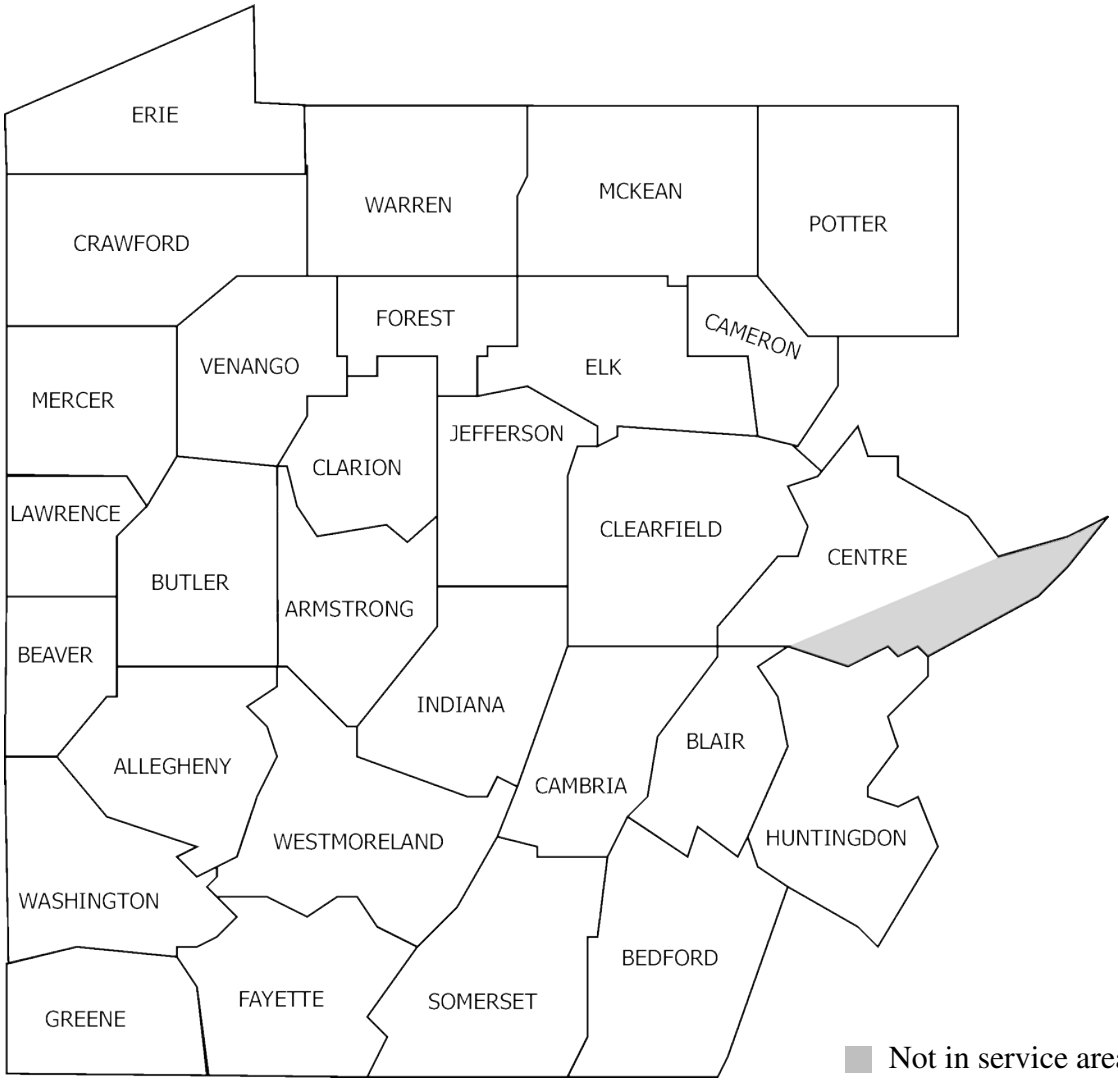
Service Centers are open Monday – Friday from 8:30 a.m. to 4:30 p.m.

Satellite Locations
There are also a number of satellite locations. Please call 1-800-816-5527 for locations, days and times available, and to schedule an appointment.

Member service issues such as claims and identification cards can also be handled on the Web: www.highmarkbcbs.com.

SERVICE AREA

29 counties where Highmark Blue Cross Blue Shield medically underwritten programs are available



These programs are available to residents of the western part of Centre County who have these zip codes:

16677 – Sandy Ridge
16686 – Tyrone
16829 – Clarence
16845 – Karthaus
16859 – Moshannon
16865 – Pennsylvania Furnace
16866 – Philipsburg
16874 – Snowshoe
16877 – Warriors Mark

MEDICARE ELIGIBILITY

Customers who are eligible for Medicare benefits are not eligible to enroll in these programs. They may, however, be qualified to enroll for Highmark Blue Cross Blue Shield Medicare coverage. Individuals interested in obtaining more information about this coverage may visit one of our local Service Centers or call:

MediGapBlue℠.....1-800-789-9002

FreedomBlue℠.....1-800-350-1973

SecurityBlue℠.....1-800-576-6343

GENERAL PROGRAM INFORMATION

The DirectBlue, PPOBlue, KeystoneBlue HMO, CompleteCare* and ShortTermBlue programs explained in this manual should not be represented as group programs. They are filed with the Pennsylvania Insurance Department as individual direct payment programs. These programs are designed specifically for individuals who are not covered by an employer group program and who are looking for reliable, affordable coverage. Following are general descriptions of the five medically underwritten programs.

Highmark Blue Cross Blue Shield medically underwritten programs cover many medical services both in and out of the hospital. Individuals/families apply for coverage by submitting an application, including a health questionnaire. For all medically underwritten programs except ShortTermBlue, the information reported is reviewed, based on Highmark's medical underwriting guidelines, to determine each individual's eligibility to enroll in the medically underwritten program.

All of these programs feature:

- A wide range of covered preventive and routine care
- A wide range of coverage levels, including single, parent/child, parent/children, husband/wife, husband/wife/child, husband/wife/children**
- No occupational exclusions

ShortTermBlue is a medically underwritten program that provides temporary health insurance for individuals. Producers must screen applicants prior to applying for coverage using the two sets of medical questions on the application. Highmark reserves the right to cancel coverage for misrepresentation on responses to medical questions. The applicant is not reviewed for eligibility by the Medical Underwriting Department.

***CompleteCare is not available for sale after September 1, 2009. Existing members will be allowed to stay in CompleteCare. Subscribers will still be allowed to add dependents to their CompleteCare coverage.**

**Does not apply to ShortTermBlue. ShortTermBlue has only individual coverage.

SPECIFIC PROGRAM INFORMATION

DirectBlue Comprehensive Major Medical Preferred-Provider Program

DirectBlue covers most hospital and medical expenses, including routine and preventive care, such as physical exams, mammograms and immunizations; hospital care; women's care, emergency care and prescription drugs. One routine vision exam every 24 months by a Davis Vision network provider is paid-in-full for DirectBlue members. Members also receive up to a 50 percent discount on eyewear purchased from Davis Vision providers.

DirectBlue provides coverage for services received in and out of the Keystone Health Plan West network, after the member meets separate network and out-of-network deductibles. When network providers are used, eligible services are covered at the higher benefits level – 90 percent after the deductible is met. If out-of-network providers are used, eligible services are covered at the lower benefits level – 70 percent after the deductible is met. Balance billing may occur if the member uses an out-of-network provider. Copayments apply to emergency room visits and prescription drugs. All eligible expenses are subject to both the contract year and lifetime maximums (except state-mandated benefits).

There is a required 12-month waiting period before a policy will pay benefits for a pre-existing condition. DirectBlue applicants are subject to this pre-existing condition clause regardless of any prior Highmark Blue Cross Blue Shield affiliation. For the first 12 months of coverage, DirectBlue will not pay for expenses related to a condition for which medical advice or treatment was recommended by, or received from, a physician or other professional provider within a five-year period immediately preceding the effective date of the member's coverage.

Family Deductible for DirectBlue

For an agreement covering more than one family member, each covered individual must satisfy his/her individual deductible in one benefit period before Highmark will pay for covered services for each member. Only after three members enrolled under DirectBlue have each satisfied their individual deductibles will the family deductible be satisfied. Deductibles for all remaining family members will also be considered to be satisfied. No one member can satisfy the entire family deductible.

PPOBlue Individual Comprehensive Major Medical Preferred-Provider High-Deductible Program

A qualified high-deductible health plan with lower premiums designed for use with a Health Savings Account (HSA) as defined by the Internal Revenue Service. PPOBlue covers most hospital and medical expenses, including routine and preventive care, such as physical exams, mammograms and immunizations; hospital care; women's care, emergency care and prescription drugs. Many preventive services are not subject to the deductible.

Members have the choice of using providers in or out of the Keystone Health Plan West network. After members meet the contract year deductible and when they use network providers and facilities, PPOBlue pays 90 percent of most eligible hospital and medical expenses, including prescription drugs. When out-of-network providers are used, PPOBlue pays 70 percent of most eligible expenses after the member meets the annual deductible. Balance billing may occur if the member uses an out-of-network provider. When a member reaches their network or out-of-network out-of-pocket maximums, PPOBlue pays 100 percent of eligible expenses for the remainder of the contract year. All eligible expenses are subject to the lifetime maximum, a contract year maximum (excluding drugs), and a separate contract year prescription drug maximum that applies to the lifetime maximum. The individual deductible must be met before PPOBlue pays for eligible expenses.

There is a required 12-month waiting period before PPOBlue will pay benefits for a pre-existing condition. PPOBlue applicants are subject to this pre-existing condition clause regardless of any prior Highmark Blue Cross Blue Shield affiliation. For the first 12 months of coverage, PPOBlue will not pay for expenses related to a condition for which medical advice or treatment was recommended by, or received from, a physician or other professional provider within a five-year period immediately preceding the effective date of the member's coverage

Family Deductible for PPOBlue

For the family agreement covering more than one family member, the ENTIRE family deductible must be met within a benefit period before Highmark will pay for covered services for ANY family member. The family deductible can be satisfied by an individual family member or a combination of one or more family members.

BlueAccount℠ Health Savings Account (HSA)

While your customers are free to open a Health Savings Account with any company of their choice, members enrolled in PPOBlue are not required to establish an HSA. Advantages to opening a Highmark BlueAccount HSA include:

- **Investment Choice** – BlueAccount HSA offers a variety of mutual fund investment options. This means that your client can choose how to invest his account dollars – either for immediate access to pay his expenses or for longer-term growth potential. The account is administered by PNC Global Investment Servicing.
- **Highmark Online Convenience Makes It Easy** – To establish a BlueAccount HSA through Highmark, members simply log onto the Highmark Web site www.highmarkbcbs.com and click on "Establish a BlueAccount HSA." Both the Highmark health care coverage and the HSA can be managed through this single Web site. Your customers can elect to have Highmark automatically send unpaid claims to the HSA directly, submit only certain claims using the Highmark Blue Cross Blue Shield Web site, pay out-of-pocket expenses using the HSA debit card, or submit a paper claim form. They even can choose how reimbursements are made – via check sent to them or automatic deposit into a bank account.

If your customer does not have access to the Web site, direct them to call 1-877-245-0116 to ask for the HSA Application Package to open the BlueAccount HSA.

CompleteCare Comprehensive Major Medical Program

Effective September 1, 2009, CompleteCare will no longer be marketed to new customers. CompleteCare will not be available on www.highmarkbcbs.com after August 31, 2009.

The information below pertains to existing CompleteCare members.

CompleteCare is a program that combines hospital, medical/surgical and major medical benefits. CompleteCare pays for a full range of inpatient and outpatient eligible services, emergency care, preventive care, prescription drugs and many other important services. One routine vision exam every 24 months by a Davis Vision network provider is paid-in-full for CompleteCare members. Members also receive up to a 50 percent discount on eyewear purchased from Davis Vision providers.

Members have the choice of using Highmark Blue Cross Blue Shield participating providers or nonparticipating providers. Balance billing may occur if the member uses a non-participating provider. After the deductible is met, CompleteCare pays 80 percent of the provider's reasonable charge for all eligible hospital and medical expenses including routine and preventive care, for the

rest of the contract year. The member is responsible for 20 percent coinsurance, up to an out-of-pocket maximum per contract year. When the out-of-pocket maximum has been reached, CompleteCare pays 100 percent of eligible expenses from participating providers for the remainder of the contract year. All eligible expenses are subject to the lifetime maximum (excluding drugs), a contract year maximum (excluding drugs), and a separate calendar year prescription drug maximum that does not apply to the lifetime maximum.

There is a required 12-month waiting period before CompleteCare will pay benefits for a pre-existing condition. CompleteCare applicants are subject to this pre-existing condition clause regardless of any prior Highmark Blue Cross Blue Shield affiliation. For the first 12 months of coverage, CompleteCare will not pay for expenses related to a condition for which medical advice or treatment was recommended by, or received from, a physician or other professional provider within a five-year period immediately preceding the effective date of the member's coverage.

Family Deductible for CompleteCare

For an agreement covering more than one family member, each covered individual must satisfy his/her individual deductible in one benefit period before Highmark will pay for covered services for each member. Only after three members enrolled under CompleteCare have each satisfied their individual deductibles will the family deductible be satisfied. Deductibles for all remaining family members will also be considered to be satisfied. No one member can satisfy the entire family deductible.

KeystoneBlue℠ Individual HMO

A product of the Highmark Blue Cross Blue Shield health maintenance organization (HMO), Keystone Health Plan West, Inc. is the only individual Blue Cross Blue Shield HMO in western Pennsylvania. As a managed care program, KeystoneBlue requires members to choose a primary care physician (PCP) to provide preventive care and to use network providers for all care. When selecting a PCP, members may choose a doctor who specializes in family practice, internal medicine, general practice or pediatrics. Each family member may select a different PCP.

Unlike traditional health insurance, KeystoneBlue Individual HMO covers most medical and hospital expenses, including routine and preventive care, such as physical exams, mammograms and immunizations; hospital care; specialty care without a referral; women's care and emergency care. KeystoneBlue also provides mental health/substance abuse care. One routine vision exam every 24 months by a Davis Vision network provider is paid-in-full for KeystoneBlue members. Members also receive up to a 50 percent discount on eyewear purchased from Davis Vision providers.

With KeystoneBlue coverage, members have access to the largest HMO network in western Pennsylvania, including more primary care physicians, specialists and hospitals than any other managed care plan. The provider network also includes psychiatrists, doctoral-level psychologists, licensed social workers and master level therapists who provide mental health/substance abuse care.

ShortTermBlue Comprehensive Major Medical Preferred-Provider Program

ShortTermBlue is a Preferred-Provider Program (PPO) designed to provide individuals with temporary, non-renewable short term coverage. ShortTermBlue is medically underwritten. Eligibility is immediately determined based on the applicant's responses on a short medical questionnaire. Highmark reserves the right to cancel coverage for inaccurate responses to medical questions.

Members have the choice of using providers in the Keystone Health Plan West network, where eligible services are covered at the higher benefits level. If out-of-network providers are used, eligible services are covered at the lower benefits level. After the deductible is met, payment is made at 80 percent for network services and 60 percent for out-of-network services. Balance billing may occur if the member uses an out-of-network provider. When a member reaches their coinsurance percentage limit (out-of-pocket maximum) for coverage in the network or out of the network, ShortTermBlue pays 100 percent of eligible expenses for the remainder of the contract period.

ShortTermBlue provides a variety of deductible options. Copayments apply to emergency room visits. Pre-existing condition limitations apply, including for prescription drugs. The member pays the prescription drug cost in full at the point of sale (at the discounted rate). The member is reimbursed for prescription drug costs upon completion of a pre-existing condition form.

For ShortTermBlue, the pre-existing condition limitation applies to the entire coverage period. Members enrolled in ShortTermBlue are subject to the pre-existing condition limitation regardless of any prior Highmark Blue Cross Blue Shield affiliation. For the entire coverage period, ShortTermBlue will not pay for expenses related to a condition or for a prescription drug for which medical advice or treatment was recommended by, or received from, a physician or other professional provider within a five-year period immediately preceding the effective date of the member's coverage.

ShortTermBlue provides individual coverage only. Family coverage is not offered. If a customer wants coverage for a spouse or child(ren), they must submit a separate application for each person.

Coverage is available for a minimum of 31 days up to and including 180 days. Coverage can begin as early as the next day after the submission of an online application. Because ShortTermBlue is designed to provide coverage while waiting for more permanent health care coverage, it is not renewable. However, a member can apply for additional coverage (certain restrictions apply).

To obtain additional coverage after a coverage period ends, a member must submit a new application. The member may enroll for two consecutive coverage periods. Coverage periods are considered consecutive only if there are 60 days or less between the end of one coverage period and the beginning of the next coverage period. The member must wait 90 days, after enrolling in consecutive coverage periods, before applying for a third coverage period.

Highmark sends the member and General Agency a Confirmation of Enrollment approval letter that lists the first and last dates of coverage. This letter is considered part of the Subscriber Agreement.

BENEFITS OF COVERAGE

An Outline of Coverage is to be reviewed and given to the customer prior to submission of the application. Reference the relevant outline of coverage for additional program exclusions and limitations.

All five medically underwritten programs cover the following, unless otherwise noted:

Covered Inpatient Services
Hospital Room and Board Fees
Doctors' Fees
Surgeons' Fees
Anesthesia
Maternity Care*
Newborn Care
Pregnancy Complications
Skilled Nursing Care
Prescription Drugs
Durable Medical Equipment
Prosthetic Appliances
Orthotic Devices
Transplant Services
Surgery
Dental Services Related to Accidental Injury

Covered Outpatient Services
Doctors' Fees
Surgeons' Fees
Surgery
Prescription Drugs (subject to pre-existing condition limitations for ShortTermBlue)
Emergency Accident Care
Emergency Medical Care
Diabetes Education
Office Visits for Preventive Care* according to the Highmark Preventive Schedule
Office Visits for Illness and Injury
Annual Mammogram for Women– beginning at age 40
Routine Gynecological Examination and Pap Test
Pediatric Immunizations

Therapy Service Benefits
Radiation Therapy
Chemotherapy
Dialysis Treatment
Physical Medicine
Occupational Therapy
Speech Therapy
Spinal Manipulation (not covered by ShortTermBlue or CompleteCare)

KeystoneBlue also provides mental health/substance abuse benefits.

CompleteCare, DirectBlue, PPOBlue and ShortTermBlue exclude coverage for mental health and substance abuse services and prescription drugs related to these services.

*Does not apply to ShortTermBlue.

NETWORK/PARTICIPATING PROVIDERS

KeystoneBlue HMO Network Providers

Keystone Health Plan West is the largest provider network of any area HMO. KeystoneBlue lets members choose from more physicians, more hospitals and more pharmacies than any other HMO in western Pennsylvania.

Out-of-Area Network Coverage through BlueCard®

When traveling outside of the Highmark service area, members may call BlueCard Access at 1-800-810-BLUE or visit the BlueCard doctor and hospital Web site at www.bcbs.com. Members will be given names and addresses of up to three nearby HMO or network doctors. After a member receives care, the member should not have to complete a claim form or pay for eligible services other than copayments or the deductible. If a member goes to an out-of-area HMO provider, benefits will be paid at the highest network level.

Coverage Out of the United States through BlueCard Worldwide®

Prior to traveling outside of the United States, call 1-800-810-BLUE to locate providers and discuss how to access coverage. The member should call their PCP when they return home to inform him or her about their care. The member should save their medical receipts to file for reimbursement and call the Member Service number on the back of their ID card for assistance.

Living Out of the Highmark Service Area for 90 Days or More – Away from Home Care®

For long-term travelers, separated families or students living out of the service area for 90 days or more, KeystoneBlue allows members to receive benefits through the Away From Home Care Guest Membership Program. Through this program, members residing in another plan area for at least 90 days are able to become guest members in the area's local Blue Cross and/or Blue Shield HMO, if one is available. This service can be especially valuable for members who have ongoing health needs that require regular care while they are away, or for college students living away from home. More information on this guest membership program is available by calling KeystoneBlue Member Service.

Physician Network

When selecting a PCP, members may choose a doctor who specializes in family practice, general practice, internal medicine or pediatrics, depending upon needs and preferences. Each KeystoneBlue member can select a different PCP.

The PCP must provide certain services, such as routine adult physicals, routine pediatric physicals, and routine pediatric immunizations. For all other services, members can go directly to any network provider. Refer to the KeystoneBlue Subscriber Agreement, Section SC-Schedule of Copayments and Limitations, for current copayment information. After the member receives care, they should not have to complete a claim form or pay for any eligible services other than deductibles, coinsurance or copayments.

Highmark has established strict standards for network Primary Care Physicians. We evaluate physicians' educational and training backgrounds, office services and access to care. We also routinely conduct member satisfaction surveys to learn first-hand about quality of care.

Members don't need to contact their PCPs to receive specialty care. However, to receive the best care available, members and their PCPs should establish a relationship. KeystoneBlue PCPs should provide considerate, courteous and confidential care, clear treatment and diagnosis information, and access to appropriate medical services. In turn, members need to take an active role in maintaining their own health care, talk openly and honestly with their PCP, ask questions and follow their PCP's treatment plan and recommendations.

While members should establish a long-term relationship with their PCP, they can change PCPs for any reason, just by calling the Member Service number on their ID card.

Specialists

KeystoneBlue network specialists must go through the same credentialing process as PCPs. The same strict standards regarding education, board certification, office procedures and performance history apply.

Network specialists cover the spectrum of care. Specialists include allergists, cardiologists, dermatologists, endocrinologists, gastroenterologists, neonatalogists, neurosurgeons, ophthalmologists, oncologists, oral surgeons, orthopedic surgeons, pediatric specialists, podiatrists and psychiatrists, just to name a few. See the KeystoneBlue Subscriber Agreement, Section SC-Schedule of Copayments and Limitations, for current copayment information for specialty services.

Though members do not need to contact their PCPs to receive specialty care, they may want to talk to their PCP about which type of care they need, as the PCP may be able to provide guidance on a network specialist best suited to the patient.

DirectBlue, PPOBlue and ShortTermBlue In-Area Services

DirectBlue, PPOBlue and ShortTermBlue utilize the Keystone Health Plan West Network.

In-Area Network Coverage

The Plan's coinsurance liability arises after the member's deductible obligation is met. For DirectBlue and PPOBlue, the Plan will pay 90 percent of most eligible services after the member reaches the deductible obligation. For ShortTermBlue, the Plan will pay 80 percent of most eligible services after the member reaches the deductible obligation. The member is obligated to pay the coinsurance amount as well as any deductible and/or copayment amounts. The network professional provider or the network supplier will accept the Plan's payment, plus the member's coinsurance and/or deductible and/or copayment as payment in full for covered services rendered to the member.

The network professional provider is not obligated to accept such payment as payment in full if the member fails to remit the coinsurance and/or deductible and/or copayment amounts to the network professional provider in a timely manner. The member shall remit or make arrangements to pay any coinsurance and/or deductible and/or copayment amounts directly to the network professional provider within ninety (90) days of the Plan's finalization of the claim. Otherwise, the member will also be responsible for the difference between the network professional provider's billed charge and the Plan's payment.

Out-of-Network Coverage

When members in DirectBlue and PPOBlue use out-of-network providers, the Plan pays 70 percent of most eligible services after the member reaches the deductible obligation. When members in ShortTermBlue use out-of-network providers, the Plan pays 60 percent of most eligible services after the member reaches the deductible obligation. Balance billing may occur if a member uses an out-of-network provider.

DirectBlue, PPOBlue and ShortTermBlue Out-of-Area Services

Network Out-of-Area Coverage through BlueCard

Members have access to health care benefits across the country. If a member is out of the Highmark service area and away from home, and a sudden illness or injury occurs that requires immediate emergency attention, the member should get treatment from the nearest hospital, emergency room or clinic. The member will be responsible for paying deductibles, coinsurances and copayments.

When traveling, members may call BlueCard Access at 1-800-810-BLUE or visit the BlueCard Doctor and Hospital Finder Web site at www.bcbs.com For less serious conditions, members will be given the names and addresses of up to three nearby PPO doctors. After the member receives care, they should not have to complete a claim form or pay for any eligible services other than deductibles, coinsurance or copayments. If the member goes to an out-of-area PPO provider, benefits will be paid at the highest network level.

Out-of-Network Out-of-Area Coverage

If care is received from a non-participating out-of-area provider, benefits for eligible services will be provided at the lower, out-of-network level, and members may have to file claim forms and may be responsible for additional charges.

Coverage Out of the United States through BlueCard Worldwide

Prior to traveling outside of the United States, call 1-800-810-BLUE to locate providers and discuss how to access coverage. The member should call their PCP when they return home to inform him or her about their care. The member should save their medical receipts to file for reimbursement and call Member Service at the number on the back of their ID card for assistance.

CompleteCare Participating and Non-Participating Providers In-Area Services

Under this program, members can select Highmark Blue Cross Blue Shield participating providers or providers of their choice. Applicants should know that they can incur additional expenses if they receive services from non-participating providers.

Highmark Blue Cross Blue Shield participating providers agree to accept Highmark's determined allowance as payment in full for eligible services. The payment is made first with a cost-sharing split between the program and the member. Then the program pays 100 percent, once the out-of-pocket limit is satisfied. Payment excludes any member coinsurance.

Non-participating providers do not have to accept Highmark's allowance as payment in full and may bill the customer for the difference between the UCR allowance and the provider's actual charges.

CompleteCare Participating and Non-Participating Providers–Out-of-Area Services

Participating Providers Out-of-Area Coverage through BlueCard Access

When traveling, members may call BlueCard Access at 1-800-810-BLUE or visit the BlueCard Doctor and Hospital Finder Web site at www.bcbs.com Members will be given the names and addresses of up to three nearby participating or indemnity doctors. After the member receives care, they should not have to complete a claim form or pay for any eligible services other than deductibles, coinsurance or copayments. Benefits to participating providers will be calculated and paid based on the lower of the billed charges for a member's covered services or the negotiated price that the Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to the Plan.

Non-Participating Providers Out-of-Area Coverage

If care is received from a non-participating provider, benefits for eligible services will be provided at the Provider's Reasonable Charge or PRC, and members may have to file claim forms and may be responsible for additional charges.

Coverage Out of the United States through BlueCard Worldwide

Prior to traveling outside of the United States, call 1-800-810-BLUE to locate providers and discuss how to access coverage. The member should call their PCP when they return home to inform him or her about their care. The member should save their medical receipts to file for reimbursement and call Member Service on the back of their ID card for assistance.

AUTHORIZATION OR PREADMISSION CERTIFICATION

Authorization or Preadmission Certification is the process through which certain services are approved as "medically necessary and appropriate." Listed below are descriptions of those processes.

Inpatient Admissions

Network and Participating Facility Providers

In the event of a proposed inpatient admission for other than an emergency or delivery-related maternity condition, the network KeystoneBlue, DirectBlue, PPOBlue and ShortTermBlue (HMO/PPO) or participating (CompleteCare) provider is responsible for contacting the Highmark Blue Cross Blue Shield Healthcare Management Services (HMS) division prior to the proposed admission to determine if the admission is medically necessary and appropriate. The prior authorized benefits from a network provider for HMO and PPO will be covered at the high level. The prior authorized benefits from a participating provider for CompleteCare will be covered with the applicable deductible and coinsurance.

With prior written notice that the admission or services will not be covered, the member will be held financially responsible for charges for such admission or services.

Out-of-Network and Non-Participating Facility Providers

For a proposed inpatient admission to a non-participating or out-of-network hospital or facility, the member is responsible for contacting HMS at our toll-free number noted on the back of the members ID card, 1-800-544-6679, or assuring that the provider contacts HMS prior to the proposed admission to determine medical necessity and appropriateness.

Precertification for Inpatient Admissions

Precertification obtained
If precertification from an out-of-network provider (or non-participating provider for CompleteCare) has been obtained as required for a medically necessary and appropriate inpatient admission, benefits will be paid in accordance with the member's agreement:

- KeystoneBlue HMO – Benefits will be paid in full

- DirectBlue, PPOBlue and ShortTermBlue – The member will be financially responsible for out-of-network payment level, in addition to the difference between the Highmark Blue Cross Blue Shield allowance and the non-participating provider's actual charges
- CompleteCare – The member will be financially responsible for the difference between the Highmark Blue Cross Blue Shield allowance and the non-participating provider's actual charges

Precertification not obtained
Any claims submitted for services, when precertification was required but not obtained, will be denied. The claim may be resubmitted with additional documentation on a post-payment basis. If it is determined that the claim meets medical necessity criteria, then refer to the section above about precertification obtained from out-of-network and non-participating facility providers.

Emergency and Delivery-Related Maternity Admissions

Network and Participating Facility Providers

In the event of an emergency or delivery-related maternity admission to a network hospital or a rehabilitation hospital, it is the responsibility of the provider to contact HMS within 24 hours to determine if the admission is medically necessary and appropriate. The member will be held harmless and will NOT be financially responsible for payment.

Out-of-Network and Non-Participating Facility Providers

In the event of an emergency or delivery-related maternity admission to an out-of-network or non-participating hospital or rehabilitation hospital, it is the responsibility of the provider to contact HMS within 24 hours (for CompleteCare) or 48 hours (for DirectBlue, PPOBlue and ShortTermBlue) to determine if the admission is medically necessary and appropriate.

If certification for a medically necessary and appropriate emergency or maternity-related admission has been obtained as required, benefits will be paid in accordance with the member's agreement.

If certification for a medically necessary and appropriate emergency or maternity-related admission has not been obtained as required, claims will be denied. The claim may be resubmitted for payment consideration with additional documentation on a post-payment basis.

If a member elects to remain hospitalized after receipt of written notification that such level of care is no longer medically necessary and appropriate, the member will be financially responsible for the full amount of the provider's actual charges from the date appearing on the written notification.

APPEALS AND GRIEVANCES

Benefits Appeal Procedure for DirectBlue, PPOBlue, CompleteCare and ShortTermBlue

In the event that the Plan or its designated agent has determined in accordance with procedures established by the Plan that a member is not eligible for benefits, the member may submit an appeal in writing to the Plan or its designated agent. Such appeal must be submitted not later than 180 days from the date the Plan or its designated agent notifies the member of its determination and should include specific information in support of the claim for benefits. The Plan or its designated agent will review the information and make a final decision concerning the member's eligibility for benefits and notify the member, in writing, not later than 30 days following receipt of the appeal.

The member can initiate the appeal with a call to Member Service at the number located on the back of their ID card. Their written appeal should be submitted to the following address:

Highmark Blue Cross Blue Shield
Attention: Complaint Committee
P. O. Box 2717
Pittsburgh, PA 15230-2717

Complaint and Grievance Processes for KeystoneBlue HMO

If a member has a complaint about benefits, claims, delivery of service or any other problems, Keystone will try to resolve it informally to the member's satisfaction. The member should simply call Member Service at 1-800-544-6679. Member Service will provide a response to the inquiry/ complaint within 30 days of receipt. The majority of complaints are resolved at this level.

Initial Review
If a member isn't satisfied with Member Service's response to the inquiry, the member may make a written or verbal appeal to Keystone's Initial Grievance Committee. Presentation of an appeal to the Initial Grievance Committee should be submitted within 180 days from the date the member receives an adverse decision. The appeal may include written information from the member or any party or interest.

The member can initiate the appeal with a call to Member Service at the number located on the back of their ID card. Their written appeal should be submitted to the following address:

Highmark Blue Cross Blue Shield
Attention: Complaint Committee
P. O. Box 2717
Pittsburgh, PA 15230-2717

Second Level Review
If the Initial Grievance Committee's decision is not in favor of the member, he or she may appeal the decision to the Second Level Review Committee. This committee is comprised of three individuals who did not participate in any decision to deny payment for the health care service.

The Second Level Review Committee will hold an informal hearing to consider the member's grievance. When arranging the hearing, Keystone will notify the member in writing of the hearing procedures and rights at such hearing. The hearing will be held within 45 days of receipt of the member's appeal.

The Second Level Committee will issue a formal decision within five business days of the hearing. The decision will provide information regarding the reasons for the Committee's decision and the member's rights of appeal if the decision is not in favor of the member.

The member or their physician can appeal the decision within 15 days to:

Pennsylvania Insurance Department
Bureau of Managed Care
P. O. Box 90
Harrisburg, PA 17108

or

Pennsylvania Insurance Department
Bureau of Consumer Services
1321 Strawberry Square
Harrisburg, PA 17120

If Expedited Review Is Needed for KeystoneBlue HMO Because of Potential Serious Medical Consequences

During each step of the grievance process, the member or their physician should be as specific as possible as to the remedy being sought from Keystone. Grievances usually deal with claim denials, and the remedy being sought is payment of a claim.

However, in cases in which a member believes that serious medical consequences will arise in the near future (7 to 10 days) from Keystone's denial of health services, there is a procedure for expedited review. In such a case, the member should identify the need for an expedited review to the Member Service Department. Keystone will arrange to have the situation reviewed by its Medical Director within 24 hours and the member and their physician will be informed of the decision by phone, then followed in writing.

APPLICATION PROCESS FOR PRODUCERS

All producers must submit online applications in order to receive commissions. You must have Internet Explorer 6.0 or higher in order to submit online applications.

Exceptions to Submitting an Online Application

Producers may submit a paper application under the following circumstances and should indicate on the application the reason for the exception.

- For ShortTermBlue, if the customer wants to submit a check, a Producer's Certificate must accompany the paper application to ensure proper processing of commission payments.
- When the system does not accept the zip code and you have proof that the zip code is within the service area
- If the Social Security number for the applicant subscriber is not available
- When the existing member moves from another Highmark medically underwritten program to the PPOBlue High-Deductible program (use the change form and follow the directions on the form)*
- When changing a contract from husband/wife coverage to separate coverage or to add a spouse/dependent to an existing policy (use the change form and follow the directions on the form)*
- For enrollment in a guaranteed issue program or a program based on income

The online application is very easy to access…

1. Log onto the Highmark Blue Cross Blue Shield Web site at www.highmarkbcbs.com.
2. Select the "Producers" blue tab at the top of the page.
3. Enter your login ID and password.
4. On the Welcome page, scroll down to "Key Site Features" and next to the New Business link click "Go."

*Does not apply to ShortTermBlue.

5. On the New Business page, scroll down to "Individual and Family Coverage" and click "Generate Quote and Apply."

6. Enter a "Quote/Application Name" along with the applicant's zip code and date generated. That way, you can save and access the information later.

The online system walks you through the process…

1. Search for "Saved Information" (or enter new application name)

2. Enter Individual Information

    - Enter the information for each person applying for coverage. (For ShortTermBlue, only individuals can apply for coverage.)

    - Use the pulldown box next to the "Add" button in order to enter additional family members.*

    - Click on "Submit" when all the information is completed.

    - If certain required information is missing, edits will show in red to let you know what needs to be added or corrected.

3. Select Plan

    - You can check the programs for which you want to view benefit grids and rates. Select HMO, Indemnity and/or PPO.

    - The HMO program is KeystoneBlue Individual HMO.

    - Indemnity programs include the SpecialCare℠ Program.

    - PPO programs includes our Medically Underwritten Programs – DirectBlue ($250 or $500 deductible), PPOBlue HDHP ($1,200, $2,600 or $3,500 deductible) and ShortTermBlue ($250, $500 or $1,000 deductible) and the Guaranteed Issue Programs – PPOBlue HDHP ($1,200, $2,600 or $3,500 deductible) and PreferredBlue® ($500 or $1,000 deductible).

*Does not apply to ShortTermBlue.

4. View Quote

   - You can select up to three programs to compare.
   - For Guaranteed Issue Programs, click on "Request Application" to download an application to complete and mail with premium payment.
   - For Medically Underwritten Programs (KeystoneBlue, PPOBlue HDHP, DirectBlue and ShortTermBlue), click on "Apply Now" to begin the application process. For ShortTermBlue, the "View Quote" screen will quote 31 days of coverage.
   - From this screen, you can also look up participating provider and pharmacy locations.
   - You can always click on "Save Quote" to save the information entered so that you can access it later.
   - A description of the programs is printed below the benefit grid.

5. Confirm Quote

   - If you clicked on "Apply Now" for a Medically Underwritten Program, the application type and monthly premium quoted based on the individual information entered will display.
   - For ShortTermBlue, enter the requested effective date of coverage, requested last date of coverage, then select "Calculate Coverage Program" to see the number of days requested and the payment due at application.
   - If you need to make a change, simply go back to generate a new quote (click on "Return to Direct Pay Quotes and Applications").
   - If the information displayed is accurate, click on "Continue" or "Save and Exit."

   Please note: Standard rates are quoted to the applicant at the time of enrollment. If, due to the applicant's medical history, they do not qualify for coverage at the standard rate, they may be offered coverage at a higher rate.*

*Does not apply to ShortTermBlue.

6. Gather Information

    - This section confirms the application type and premium.

    - For ShortTermBlue, two sets of medical eligibility questions are asked relative to pre-existing conditions. If the applicant answers "yes" to one or more of these questions, they are not eligible for coverage. Highmark reserves the right to terminate coverage for misrepresentation of medical facts.

    - Click on "Sample Outline of Coverage" to print the comprehensive outline of benefits. The Pennsylvania Insurance Department requires that a copy of the Outline of Coverage be provided to each individual/family applying for coverage. (Copies of the Outlines of Coverage for each of the Medically Underwritten Programs can also be ordered from Highmark. Producers can request copies from their General Agency.)

    - This section also provides important information regarding the Direct Pay Medically Underwritten Programs. Please read carefully.

7. Complete Application

    - This section outlines Underwriting Guidelines and the Appeal Process.*

    - Information needed to complete the processing of the application is entered in this section. Enter complete and accurate information for each person applying for coverage.

    - For HMO coverage, selection of a Primary Care Physician (PCP) is required. Do not type in the name of the physician. Instead, click on the "Choose PCP" button to bring up the pop-up screen to search for the PCP. Enter the information requested in order to bring up the listing of physicians. In the right column under the "Practice" heading, click on the link, "Select as my PCP" for the physician or practice desired and this will populate the application with the correct name.

    - If certain required information is missing, edits will show in red to let you know what needs to be added or corrected.

8. Make a Payment and Submit Application

    - For all programs except ShortTermBlue, two payment options are available: Credit Card or Bill Me Later. If the Credit Card option is selected, one month's premium will be charged to the applicant's account upon receipt of the application. If the application is approved, coverage will begin on the assigned effective date. If the applicant or any family members

*Does not apply to ShortTermBlue.

are denied coverage, a refund check will be generated and mailed to them. If the Bill Me Later option is selected, the application can be submitted without making the first month's payment. If approved, the assigned effective date will not be delayed; however, no claims will finalize until the first month's premium has been received.

- For ShortTermBlue, credit card payment is the only option for online applications. The full premium for the coverage period selected is charged to the applicant.

- "Pay-It-Easy"* is the automatic monthly premium payment program or Electronic Funds Transfer (EFT) process. Information on the Pay-It-Easy program will be sent in the Member Welcome Packet with the Identification (ID) card. Members can enroll in Pay-It-Easy and have their monthly payments automatically deducted from their bank account. Otherwise, monthly invoices will be mailed to the member.

- Enter the information completely and accurately to finalize the online application process.

- When you complete the "Payment" screen, your application has been submitted.

- When confirmation is received, a copy of the completed application can be printed.

NOTE: If at any time during the application process you want to go back to a previous section, click on one of the links in the blue-grey section in the left-hand column to return there.

When you have pertinent medical records to submit with an online application, fax the records to 1-412-544-4009. Indicate on the application – either in the space next to the pertinent medical condition or in the last question that asks for "Other" information – that you will be faxing medical records.*

And when you actually fax the medical records, please use the Highmark fax cover sheet and complete all the information so that we can correctly match the medical records to the online application.

If you do not clarify the above-requested information on the online application and the faxed medical records, the application will be processed without the medical records.

Remember that <u>only</u> medical records will be accepted on this fax line. Applications, changes to applications and inquiries will not be accepted.

*Does not apply to ShortTermBlue.

Important Information Pertaining to the Application Process

- Verify the accuracy of all information prior to submission. Numerical data is particularly error-prone, so double-check Social Security numbers, height, weight, date of birth, etc.
- The writing producer must be properly licensed and appointed with Highmark to sell individual products prior to acting on Highmark's behalf or as Highmark's representative.
- Applicants must not be eligible for Medicare and must reside within the 29-county area serviced by Highmark Blue Cross Blue Shield to apply for any of these programs. Applicants must use their correct home address. Do not use a business address.
- The provider must review the HIPAA Eligibility Checklist with the customer to determine eligibility for the HIPAA product.
- When submitting online applications, the producer must enter the application via the Producer Portal (not the Consumer Portal) to receive commissions on approved applications. Use your Portal login ID and password to enter the Producer Portal, and enter your Agency and producer numbers on the producer information page of the application. The exception is ShortTermBlue when accompanied by a provider certificate.
- All application information must be completed accurately and in detail to help avoid processing and approval delays.
- The writing producer must complete all questions in the producer section of the application. Incomplete or missing information will result in no commission for the writing producer.
- Producers must provide applicants with an Outline of Coverage.
- Print and maintain a copy of the application for your files.
- Producers must abide by the code of ethics included in this manual on page 72.
- To ensure that applicants submit complete and accurate applications, Highmark has implemented several mechanisms for our medically underwritten programs to detect fraud.
- Any repeated submission by producers of applications for individuals whose applications are determined to be fraudulent will result in termination of their appointment with Highmark and the possible pursuit of legal actions and remedies.

- The evaluation of applicants' medical histories, used to determine eligibility for these programs, is done to keep our rates as low as possible.
- The processing of an application may be delayed if additional information or medical records are required to make a determination. A producer should never guarantee an effective date.
- When applying for husband and wife or family coverage, the older spouse will be considered the applicant and must sign the application, as well as any related documents.
- A single policy can be written for a child. The rate quoted should be the single rate. If coverage is for more than one child, the youngest child must be listed as the applicant. If there are two children on the policy, quote the parent/child rate. If there are three children on the policy, quote the parent/children rate.
- If requesting a specific effective date, it must be within 60 days of submitting the online application.
- Producer must inform applicants that receipt of their initial payment does not constitute enrollment.
- If approved, the effective dates will always be the first of the month.

Family Deductible

If a family deductible applies, it is listed beside the individual deductible on the electronic application. Explanations of family deductibles have been added to the Conditions of Enrollment (signature page) of the DirectBlue and PPOBlue paper and online applications. The customer must acknowledge that they understand how a deductible is applied by initialing the Conditions of Enrollment page on the paper applications (for your files) and with an electronic signature on the online application.

It is important to provide your clients with a thorough explanation of how a family deductible for each program is applied, so they have a clear understanding of the costs they will incur before a program begins to pay for benefits. Not all Highmark program deductibles are applied in the same way. The PPOBlue family deductible is applied differently than the DirectBlue family deductible, as described below:

PPOBlue Annual Family Deductible

For an Agreement covering more than one (1) family member, the ENTIRE family deductible must be met (within a benefit period) before Highmark will pay for covered services to ANY family member. The family deductible can be satisfied by an individual family member or in a combination of one or more family members.

DirectBlue Annual Family Deductibles

For an Agreement covering more than one (1) family member, each covered individual must meet his/her individual deductible (within a benefit period) before Highmark will pay for covered services for that individual. No individual member may satisfy the entire family deductible. Only after three (3) individual family members have satisfied their deductibles will the deductibles for all remaining family members also be considered to have been satisfied.

ShortTermBlue

- If requesting a specific effective date, it must be within 30 days of submitting the online application.
- Only individual policies are sold. There are no family policies. A single policy can be written for a child.
- The effective date is the day after the online application and electronic signature are submitted, unless the customer chooses an effective date no greater than 30 days from the submission date.

ENROLLMENT

Identification Cards and Subscription Agreements

Following approval, Highmark Blue Cross Blue Shield will mail Subscription Agreements and individual identification (ID) cards directly to the member. An ID card, which includes the effective date of coverage, will be issued in the name of each family member covered under the program. Within five to 10 days of enrollment, applicants will receive their welcome kit.

Advise applicants that they have a 10-day free-look period from the date they receive their ID card.

For ShortTermBlue, prior to receiving an identification (ID) card, the new member will receive an approval or Confirmation of Enrollment letter with the member's effective start date and last date of coverage. The General Agency and the producer who sold the policy will receive a copy of this letter.

Advise applicants that they have a 10-day free-look period from the date they receive their ID card.

Free-look Enrollment Period

Members may choose to cancel their coverage within 10 days after receiving their Agreement by:

1) Submitting a signed written request
2) Returning all identification cards to Highmark Blue Cross Blue Shield

They will then be eligible for a full refund provided no claims for eligible services are outstanding or have been paid. Members who submit cancellation requests postmarked after 10 days will be entitled to any applicable refund the first of the month following the postmark date.

This cancellation information should be mailed to:

Highmark Blue Cross Blue Shield
Membership
120 Fifth Avenue, Suite 2318
Pittsburgh, PA 15222-3099

CANCELLING POLICIES

DirectBlue, PPO Blue, KeystoneBlue HMO and CompleteCare

Members should notify Highmark Blue Cross Blue Shield 30 days prior to the requested effective date of cancellation by calling Member Service at 1-800-544-6679, or by mailing written notification to:

Highmark Blue Cross Blue Shield
Membership
Fifth Avenue Place
120 Fifth Avenue, Suite 2318
Pittsburgh, PA 15222-0399

OR

Fax to: 412-544-4176

ShortTermBlue

Members are locked into their coverage period. The only exceptions are the 10-day free-look period, duplicate coverage, death or court order.

CONVERSION FROM HIGHMARK GROUP COVERAGE AND HIPAA OPTIONS

Conversion and HIPAA Options

Customers who are losing their coverage in a Highmark group program may want options for individual and family coverage. If these individuals are not eligible for a Highmark medically underwritten program because of pre-existing conditions, they may be eligible for a Highmark guaranteed issue conversion program (if they are leaving certain Highmark groups) or the Highmark HIPAA program (PreferredBlue PPO®). Neither program includes a pre-existing condition waiting period.

Conversion

If an individual is cancelled from a Highmark group, he or she may be eligible for a conversion to the PreferredBlue PPO, PPOBlue or SpecialCare (must meet income guidelines) individual program. The customer can enroll in one of the conversion programs with no pre-existing condition waiting period and no lapse in coverage between the group cancel date and the date the new individual coverage begins.

Individuals interested in applying for a conversion should:

- Call the toll-free Member Service phone number on the back of the Highmark group ID card and ask if his/her group offers conversions. If a conversion is available, Highmark will mail a conversion pre-interest letter to the customer, upon notification by the group of the cancellation date.
- Call the phone number indicated on the pre-interest letter, when received, to request a conversion application.
- Complete and mail the conversion application to Highmark within 90 days of the group cancellation date.

HIPAA Program and Eligibility Checklist

It's a requirement of the Pennsylvania Insurance Department that producers advise customers of their HIPAA rights.

If a customer is losing coverage provided by a non-Highmark group, he or she will not be eligible for a Highmark conversion. However, the customer may be eligible for the HIPAA program.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was designed to improve access to individual health insurance coverage for certain eligible individuals who previously had coverage through an employer group, association, trust fund or welfare fund, and to guarantee the renewability of all coverage in the individual market.

Highmark Blue Cross Blue Shield complies with HIPAA by offering to all HIPAA-eligible applicants a PreferredBlue PPO product with two deductible options. **The customer can enroll in the HIPAA program with no pre-existing condition waiting period and no lapse in coverage between the group cancel date and the date the new individual coverage begins.** HIPAA-eligible parents who do not elect HIPAA coverage for themselves may still enroll their HIPAA-eligible children in the program.

Individuals interested in applying for HIPAA coverage should:

1) Obtain a Certificate of Prior Creditable Coverage from all previous employers with whom they had coverage during the past 18 months.

2) Determine if he/she meets the government-mandated guidelines for the HIPAA program (see the HIPAA Eligibility Checklist below).

3) Once eligibility is determined, call 1-800-876-7639 to request a Highmark HIPAA enrollment kit.

4) Submit the HIPAA application to Highmark within 63 days of the group cancellation date.

By law, you must make applicants aware of the HIPAA option available to them. Applicants have 63 days from the date on which their prior coverage ended to apply for the Highmark Blue Cross Blue Shield HIPAA product. The HIPAA Eligibility Checklist was created as a tool to help you review eligibility questions with your customers.

Following is a checklist of guidelines that can help you determine if an applicant qualifies for the HIPAA product. All must be checked to qualify.

☐ Applicant is a resident of the 29-county geographical area of western Pennsylvania served by Highmark Blue Cross Blue Shield.

☐ Applicant is not eligible for or enrolled in Medicare, Medicaid or any group health insurance plan.

☐ Applicant does not have any other health insurance coverage, either group or individual.

☐ Applicant has elected and exhausted all "COBRA" or similar continuation of coverage benefits available through his/her former employer or group benefits plan.

☐ Applicant has had a minimum of 18 months of health care coverage (without any breaks in coverage of more than 63 days) prior to applying for this new coverage.

☐ Applicant's most recent health care coverage was provided through a group, governmental or church plan.

☐ Applicant's most recent health care coverage is no longer in effect and ended within the last 63 days.

☐ Applicant's most recent health care coverage was not terminated due to non-payment of premiums (including employee contributions) or fraud.

☐ Applicant is attaching a copy of his/her "Certificate of Prior Creditable Coverage" to the application. Or, if applicant does not have a certificate, applicant is attaching a statement describing his/her prior coverage, including the name of the plan(s) and the time during which he/she was covered, together with additional evidence of that coverage, such as copies of identification cards, explanation of benefits (EOB) forms, etc.

Call the Highmark Blue Cross Blue Shield Producer Hotline at 1-800-602-1248 if you need more information.

ENROLLMENT GUIDELINES

Effective Date of Coverage*

A producer can never guarantee an effective date.

- If an application is approved on or before the last day of the month, coverage will become effective the first of the following month.
- If an application is approved after the last day of the month, coverage will become effective the first of the second month following approval.
- Example: Applications approved on or before May 31st will become effective June 1.
- For ShortTermBlue, an eligible applicant can choose that their coverage becomes effective the next day after the signature date of the application.

Dependents*

Under all of these programs except ShortTermBlue*, a "child" is defined as the:

- Applicant's son or daughter, or
- A stepchild dependent upon the applicant, or
- A legally adopted child (including the child during a probationary period), or
- A child for whom the applicant is legal guardian
- Children may be considered for coverage on the applicant's agreement if the following additional standards are met:
    - They are not married, and
    - They are under the age of 19, regardless of student status
    - They are not eligible for Medicare Part A and/or Part B

Adding Newborns/Infants to Medically Underwritten Coverage*

Based on Pennsylvania Act 81 of 1975, natural born, adopted, or placed for adoption newborns are covered under their parent's policy for the first 31 days after birth. In order to continue coverage under the parent's policy beyond 31 days, the following guidelines apply:

- To add a natural born newborn to the parent's policy as of the 32nd day following birth, without medical underwriting and with no pre-existing condition limitation, the member must contact Member Service within 31 days of the date of birth. Member Service will send an application, attached to a change form. The application and change form must be signed and submitted to Highmark.

- To add an adopted newborn or a newborn placed for adoption to the parent's policy, without medical underwriting and with no pre-existing condition limitation, the date of adoption or the date placed for adoption must be within 31 days of the date of birth, and the member must contact Member Service within 31 days of adoption or the date placed for adoption. Member Service will send an application attached to a change form. The application and change form must be signed and submitted to Highmark.

If the parent or legal guardian does not contact Highmark within 31 days from the date of birth or 31 days from the date placed for adoption, the guidelines for adding dependent children apply.

Newborn Coverage in ShortTermBlue

While ShortTermBlue does not include dependent coverage, in accordance with Act 81, a newborn or an adopted newborn child may be on their parent or legal guardian's coverage for the first 31 days from the date of birth. If the parent notifies us within 31 days of birth, they may enroll in a guaranteed issue program and pre-existing limitations will not apply. Adopting parents must notify Highmark within 31 days that the child has been added to the family. They may also apply for any medically underwritten product. If approved, they can discontinue their coverage with the guaranteed issue program.

If notification is not received until 31 days from birth, the newborn is treated as a new applicant, and medical underwriting and pre-existing conditions apply.

* This applies to medically underwritten direct-pay programs that include dependent coverage. It does not apply to ShortTermBlue, which does not include dependent coverage.

Adding Children*

Newly acquired dependent children other than newborns, adopted newborns, newborns placed for adoption, or dependent children resulting from a court order may apply for coverage under a parent's agreement 60 days prior to the contract anniversary date to effect the change as of the contract anniversary date. Medical Underwriting is required. The effective date is based on established underwriting guidelines. Limitations for pre-existing conditions will apply.

When adding children to an existing policy, a change form should be submitted along with the completed application. Children can also apply for their own policy.

Deleting Children*

Dependent children can be deleted from their medically underwritten program by completing a change form. Dependents are automatically deleted from their parents' agreements the first of the month following their 19th birthday. They will receive a letter and an application for the same program their parent(s) or legal guardian are enrolled in prior to their deletion date. If the deleted dependent wants to continue being covered under the program, medical underwriting is not required if the application is received within 30 days of the deletion date.

Disabled Dependents*

Disabled dependents reaching age 19 can remain as eligible dependents on a policy if they are certified by a physician to be incapable of self-support by reason of physical or mental disability, if they became incapable of self-support before reaching age 19, and if they were an active dependent on the contract.

A disabled dependent who is deleted from Highmark Blue Cross Blue Shield coverage and who wants to enroll for coverage will be subject to medical underwriting per the established policies and procedures of the program.

Adding a Spouse*

A spouse may apply for coverage based on the following criteria:

1) A dependent spouse may be added on the first of the month following the medical underwriting approval date, providing that contact was made within 60 days of the marriage date, or

*Does not apply to ShortTermBlue.

2) If more than 60 days have elapsed from the marriage date, the dependent spouse may be added on the anniversary date of the agreement, providing contact is made and medical underwriting approval is received within 60 days prior to the anniversary date of the agreement. (A spouse can enroll in their own policy at any point in time.)

3) A change form should be completed and submitted with the spouse's application.

MEDICAL UNDERWRITING IS REQUIRED FOR ADDING DISABLED DEPENDENTS AND ADDING A SPOUSE. THE EFFECTIVE DATE WILL BE BASED ON ESTABLISHED UNDERWRITING GUIDELINES.

Changes in Eligibility

Have the member notify Member Service at 1-800-544-6679 as soon as they experience a change in the following:

- Name or address
- Marriage or divorce*
- Addition of a newborn, natural born, adopted or placed for adoption dependent (birth, placement for adoption or adoption)*
- Termination or death of a dependent*
- Eligibility for Medicare or employer group health insurance*

Medical Underwriting Waived for DirectBlue, KeystoneBlue and CompleteCare Members Who Switch to PPOBlue HDHP*

Existing CompleteCare, DirectBlue and KeystoneBlue members may switch to the Highmark PPOBlue High Deductible Health Plan (HDHP), which will allow them to take advantage of lower premiums and the tax savings associated with a Health Savings Account (HSA).** CompleteCare, DirectBlue and KeystoneBlue members may make this switch without undergoing new medical underwriting.

*Does not apply to ShortTermBlue.

**While PPOBlue members may establish an HSA with the financial institution of their choosing, they may also take advantage of the many benefits provided through the Highmark BlueAccount HSA, including easy online access to the Highmark Web site at www.highmarkbcbs.com to track HSA deposits, withdrawals and earnings. The Web site also provides access to all of their health care coverage information, self-service options and health information resources.

In addition, members who have met the 12-month pre-existing condition waiting period under their original coverage will not be required to meet a new waiting period under PPOBlue.

Individuals who have not yet met the full 12-month pre-existing condition waiting period will be credited with the portion of the waiting period they have met, but must complete the remainder of the waiting period under the PPOBlue coverage. For example, if a customer has been enrolled in DirectBlue for nine months and switches to PPOBlue, he/she will only have three months of the pre-existing condition waiting period remaining under PPOBlue.

Commissions will not start over, but will continue, based on the original effective date.

To make the change, current members simply:

1) Complete a Change Form (CC-043), indicating the contract holder's name, Social Security number, group number and the PPOBlue deductible level they want. The member's signature, date of signature and phone numbers must be included on the back of the Change Form.

2) On the first page of an accompanying PPOBlue application (ENR-070), complete the General Information section (name, address, county, phone number, e-mail address).

3) In the Enrollment Information section of the PPOBlue application, indicate the deductible selected. There is no need to complete anything else in the Enrollment Information section on the first page or the Medical Information section starting on the second page of the application.

4) Sign and date the application on the second to the last page (Conditions of Enrollment) of the application. Applying members should also indicate on the last page of the application the date they would like the PPOBlue membership to take effect. PPOBlue membership can take effect on the first day of the month following submission of the Change Form and application.

5) On the last page of the application, Producers should fill in Agency, Producer and telephone numbers and sign the application.

6) Submit the Change Form and application. No payment is required at the time of application submission.

Members making the change to PPOBlue should be aware that any medical or prescription drug deductibles they have already met under CompleteCare, DirectBlue or KeystoneBlue will not be transferable to PPOBlue. Upon transfer to PPOBlue, members will have to meet the full deductible they select ($1,200/$2,400, $2,600/$5,200 or $3,500/$7,000 individual/family).

*Does not apply to ShortTermBlue.

MEDICAL UNDERWRITING FOR DIRECTBLUE, PPOBLUE, KEYSTONEBLUE HMO AND COMPLETECARE

General Information

An evaluation of the applicant's medical history will determine acceptance for coverage. To help you assist applicants, underwriting guidelines are included in this manual (see pages 45-64).

Medical Record Submission

Medical underwriting reserves the right to require a current physician health statement when applicants have not been seen regularly by a physician. This medical underwriting decision is based on health factors in consideration of standard recommendations for screening and preventive service schedules.

If you are not sure about the applicant's eligibility, you may send appropriate medical records, along with the application, to expedite the review process.

When you have pertinent medical records to submit with an online application, fax the records to 1-412-544-4009 using the designated Highmark fax cover sheet. Indicate on the application – either in the space next to the pertinent medical condition or in the last question that asks for "Other" information – that you will be faxing medical records.

And when you actually fax the medical records, please use the Highmark fax cover sheet and complete all the information so that we can correctly match the medical records to the online application.

If you do not clarify the above-requested information on the online application and the faxed medical records, the application will be processed without the medical records.

Remember that only medical records will be accepted on this fax line. Applications, changes to applications and inquiries will not be accepted.

Medical information regarding denials will only be released to the applicant. You may call the Producer Hotline at 1-800-356-3327 to determine if an applicant was denied. No medical information will be discussed with a producer without a signed authorization form.

Incomplete Applications

If clarification or additional medical information is necessary to process the application, our medical underwriting staff may contact the applicant directly. The applicant will be asked to submit the appropriate information to Highmark Blue Cross Blue Shield within 30 days. If, after 30 days, additional information is still not received, processing of the application will be cancelled and the premium will be refunded. Any fees requested in the procurement of medical records are the responsibility of the applicant. Medical records are not returned.

Evaluation of the applicant's medical history will determine acceptance for coverage. To help you assist applicants, underwriting guidelines are included in this manual.

Underwriting guidelines are current as of the publication date of this manual. Highmark reserves the right to modify its guidelines as needed based on emergency medical practice and claims experience. Please contact the Highmark Producer Hot Line at 1-866-602-1248 for any updated information. The decision to accept an individual applicant is made by Highmark upon receipt of all required information. No producer should make any representation to an applicant.

Medical Advice or Treatment Received after Application is Submitted

If an applicant applying for coverage receives medical advice or treatment from a physician or other professional provider for a condition which is incurred after the application is signed but prior to the effective date of coverage, the applicant must notify Highmark immediately at 1-800-544-6679. A change in an applicant's medical condition that occurs prior to their coverage effective date could result in a denial of coverage, if their application has not yet been approved, or cancellation of coverage, if the application has been approved but coverage is not yet effective.

MEDICAL UNDERWRITING GUIDELINES

Underwriting Practices and Disclaimer

The medical underwriting process is designed to ensure appropriate risk selection, which is critical to maintaining stable rates and quality benefits for the medically underwritten products. Many items impact the underwriting decision, including but not limited to:

- Combined health conditions
- Frequency and type of health services provided or anticipated
- Onset and recovery date(s)
- Medication type and frequency (Enter drug name as dispensed. If the customer uses the generic form but is unfamiliar with the generic name, the brand name may be used with a note "takes generic").
- Additional factors, such as body build and health habits

This Underwriting Guide for Producers is a reference tool only. It is not intended to provide a comprehensive list of all conditions. Final underwriting decisions rest with the Highmark medical underwriter and physicians.

Note: Due to the Genetic Information Nondiscrimination Act of 2008 (GINA), decisions regarding eligibility for the medically underwritten products, determination of premium level, or determinations upon appeal cannot be based on genetic information, genetic testing or family medical history. This type of genetic information and/or family history is not requested or required for the underwriting process. If received incidental to required information, it is not factored into the decision-making process. Decisions may be based on the actual manifestation of a genetic condition. In no case is the decision based on genetic predisposition, family history or genetic testing without a manifested condition.

To reduce unnecessary delays, appeals and physician requests, please provide the complete status of all health conditions for each applicant.

Body System	You Should Ask	Possible Action by Highmark
Behavioral Health Psychiatric/Substance Abuse		
Addiction/substance abuse	• Name of drug or substance • Current treatment • Inpatient/outpatient • Medical records recommended	Consider for tiering with physician documentation of abstinence for past five years and no significant concurrent problems Deny for active problem within past five years
Tobacco use	• Type of tobacco • Cigarettes/cigars/chew/ pinches/number per day • Date range of tobacco use	Approve if tobacco-free for over one year Consider for tiering for current or recent user Deny for heavy or long-term use
Attention deficit disorder/attention deficit hyperactivity disorder	• Current medications • Current non-pharmaceutical treatment	Standard every time to standard approval, if no treatment required in the past year and no concurrent problems Consider for tiering if undergoing current treatment or treated in past year Deny for unstable, multiple treatments
Psychiatric/psychological counseling/ medications for any condition	• Diagnosis required • Current medications • Current treatments/ counseling • Length of time/number of sessions	Standard if treatment ended over five years ago Consider for tiering if problem active one to five years ago, for a situational diagnosis, or for medication used for non-psychiatric diagnosis Deny for major psychological/nervous diagnosis, current medication, medication within the past year, frequent or recent counseling or suicide attempt

Body System	You Should Ask	Possible Action by Highmark
Behavioral Health Psychiatric/Substance Abuse (continued)		
Sleep disorders/sleeping medications	• Diagnosis • Sleep study done/date • Durable medical equipment required, such as continuous positive airway pressure or bi-level positive airway pressure • Medications/frequency	Standard if surgical correction was more than six months ago and released Consider for tiering for current medications or additional conditions Deny for more severe diagnoses or if durable medical equipment required
Antidepressants or anti-anxiety treatment for smoking cessation/restless legs/hot flashes/ pre-menstrual dysphoric syndrome/ situational adjustment disorder	• Medications/frequency	Consider for tiering
Mental retardation		Deny
Heart/Blood/Circulation		
High cholesterol	• Recent lab results • Medications	Cholesterol level required for decision Approve if well-controlled Deny if unstable or requires multiple medications
Anemia blood disorders	• Kind of anemia • Diagnosis	Standard for simple iron deficiency or oral treatment only and stable
Angina/chest pain	• Diagnosis • Medications/medication changes • Recent ER/doctor visit/ hospitalization/results • Diagnostic tests/date/results • Medical records strongly recommended	Individual consideration Deny if unstable, medications required, heart attack in past five years, heart surgery in past five years or enlarged heart

Body System	You Should Ask	Possible Action by Highmark
Heart/Blood/Circulation (continued)		
Vein/artery problems/deep vein thrombosis/blood clots	• Diagnosis • Describe problems with blood clotting/kinds of disorders	Individual consideration Deny for embolism, phlebitis, significant associated conditions or blood thinners
Hypertension/hypotension	• Average blood pressure/ recent blood pressure **DO NOT ENTER "STABLE" OR "UNDER CONTROL"** • All medications/frequency	Blood pressure reading required for decision Approve if well-controlled Deny if unstable, blood pressure elevated, associated with kidney or neurological problems, recent hospitalization, multiple medications for blood pressure conditions or blood thinners
Irregular heart beat	• Diagnosis, if known • Medications and/or changes to medications/diet • Medical records and/or statement strongly recommended	Individual consideration Deny if unstable, history of heart attack or surgery, artificial valve, pacemaker or defibrillator, functional limitations or heart block
Pacemaker/defibrillator		Deny
Stroke/cerebrovascular accident		Deny
Enlarged heart/cardiomyopathy		Deny
Heart surgery/value replacement		Deny
Hemophilia/blood clotting disorders		Deny
Peripheral vascular disease/ bypass surgery/ implanted filters		Deny

Body System	You Should Ask	Possible Action by Highmark
Eyes/Ears/Nose/Throat		
EYES		
Glaucoma	• Surgery, anticipated or recently performed • Medications	Standard if stable on one to two medications or no recent or planned procedures
Macular degeneration	• Medications	Consider for tiering if no prescription or over-the-counter medications Deny for prescription medications or treatments
Cataract(s)	• Status of both eyes required • Past surgery/date/which eye • Anticipated surgery/which eye	Standard if surgery is completed and applicant is released from care Deny if surgery is planned or performed less than six months ago
Visual impairment	• Impact activities of daily living (No or yes answer required) • Lasik surgery date	Standard if no associated complications or major functional deficit Consider for tiering for recent Lasik surgery or concurrent problems
Enucleated/removed eye	• Date of enucleation, reason, infection, complications, problems with prosthesis	Consider for tiering Deny for current infection, problems with prosthesis or significant underlying condition
Iritis	• Diagnosis/date • Last episode • Frequency of episodes • Doctor's statement strongly recommended	Consider for tiering

Body System	You Should Ask	Possible Action by Highmark
Eyes/Ears/Nose/Throat (continued)		
EYES (CONTINUED)		
Retinal/corneal conditions	• Diagnosis • Specify problem • Past or future surgery • Surgery date	Individual consideration
EARS		
Infections	• Average number of infections per year • Past or future surgery • Surgery date • Medication/frequency	Standard Consider for tiering with multiple episodes
Cochlear implants	• Reason • Date of surgery	Consider for tiering
NOSE		
Deviated septum	• Surgery/date	Standard if no surgery is planned or applicant is released from care Deny if surgery is anticipated or occurred less than three months ago
THROAT/JAW/MOUTH		
Jaw/temporo-mandibular joint problems	• Diagnosis • Specify surgery, splints, treatment	Consider for tiering
Infections	• Type • Frequency • Diagnosis • Medications	Standard if fully resolved and not recurrent

Body System	You Should Ask	Possible Action by Highmark
Endocrine/Hormones/Metabolic/Glandular		
Adrenal gland		Automatic denial
Diabetes	• Type: juvenile/adult onset/ pregnancy related (gestational) • Treatment: none/diet-controlled/medications • Medications: daily/coverage • Labwork: FBS/A1C • Medical records and/or statement highly recommended	Individual consideration for diet-controlled Deny for insulin or medication dependency
Thyroid	• Type: hypo/hyper • Treatment: medications/ surgery and date/ radiation and number of treatments, date, additional planned • Cancer related diagnosis	Standard if hypo and controlled Individual consideration for hyper
Goiter/nodules/other	• Medications	Standard if stable
Pituitary/pineal gland problems		Deny
Chronic fatigue	• Date diagnosed • Medications • Current treatment plan	Individual consideration
Marfan's syndrome		Deny
GI – Gastro-intestinal/Stomach/Intestines		
Abscess/infection	• Location of abscess or infection • Diagnosis/date • Symptoms/treatment plan within the past year • Past/future surgery	Deny if symptomatic or treated in the past year
Cirrhosis/liver disease	• Diagnosis date • Status	Deny
Ulcerative colitis/Crohn's disease	• Diagnosis date • Status	Individual consideration

Body System	You Should Ask	Possible Action by Highmark
GI – Gastro-intestinal/Stomach/Intestines (continued)		
Diverticulitis/diverticulosis/ frequent abdominal pain	• Diagnosis: diverticulitis/osis • Medications • Rectal bleeding episode(s)/ date(s) • Hospitalization/date • ER/date	Standard if well-controlled with diet Deny for recent prescription, hospitalization or treatment
Nutritional disorder	• Medical records or doctor's statement strongly recommended	Individual consideration
Fistula/fissure	• Location • Diagnosis/date • Symptoms and treatment plan within the past year • Surgery	Consider for tiering if resolved over six months Deny if symptomatic or for surgery within six months
Bariatric surgery/gastrectomy/ gastroplasty		Deny
Hemorrhoids	• Surgery type/date	Standard if well-controlled or no need for recent treatment Consider for tiering for recent surgery, multiple or bleeding Deny for anticipated surgery or surgery less than three months ago
Hernia	• Type/diagnosis • Surgery/date • Released from care/date	Standard for surgery more than six months ago Individual consideration for surgery less than six months ago
Hepatitis	• Specify Type: A/B/C/D/E, etc. • Date of diagnosis • Treatment/medications • Medical statement recommended	Individual consideration Deny for Hepatitis B, C, D, E

Body System	You Should Ask	Possible Action by Highmark
GI – Gastro-intestinal/Stomach/Intestines (continued)		
Irritable bowel syndrome	• Medications • Medical records with treatment plan strongly recommended • Current symptoms	Standard if no medications or hospitalization needed in past year Deny for prescription medications or recent hospitalization
Pancreatitis	• Acute or chronic • Number of episodes • Treatment plan/release from care	Consider for tiering Deny if chronic, treatment in the past two years, abnormal lab results
Gastritis/ulcer/esophagitis/ gastroesophageal reflux disease	• Medications • Surgery/date/release • Hospitalization	Standard on over-the-counter drugs Tiering if on proton pump inhibitor (PPI) drugs. Deny for H. Pylori, Barrett's Esophagus, recent surgery or hospitalization
Polyps	• Biopsy results/date • Pathology reports recommended	Individual consideration
Colorectal cancer	• Medical records required for consideration	Automatic denial if treated within past five years or with additional risk factors
Esophageal varices		Deny

Body System	You Should Ask	Possible Action by Highmark
GU - Kidney/Bladder		
Benign prostatic hyperplasia/ enlarged prostate	• Surgery/date/outcome • Medications • Treatment plan • Release from care	Standard if no medications, surgical history or plan, or biopsy Consider for tiering with any medication Deny for recent surgery
Incontinence	• Diagnosis/date • Surgery/date/outcome • Medications	Standard for surgery and if released from care Consider for tiering for medications on chronic basis Deny for anticipated or recent surgery
Kidney cysts		Standard if stable for two years with no medications or treatment Deny for anticipated surgery, if symptomatic or unstable
Kidney failure/renal failure/ chronic renal failure/end-stage renal disease		Deny
Kidney stones	• Number of episodes in past five years • Date of last episode	Standard for infrequent episodes and more than three years since treatment Consider for tiering for repeat or recent episodes Deny for urinary abnormalities, episodes within the past year or frequent episodes

Body System	You Should Ask	Possible Action by Highmark
GU - Kidney/Bladder (continued)		
Kidney surgery/nephrectomy/ prostrate and testicular cancers/pyelonephritis/cystitis	• Type/date of surgery • Diagnosis/date • Treatment plan/release from care required • Specify number of episodes per year/date/treatment	Individual consideration
Urethral strictures/narrowing	• Frequency • Surgery/type/date/release • Medications • Physician statement or records strongly recommended	Standard if fully resolved and no concurrent problems Deny for ongoing/recent surgery/repetitive treatments
Immune System/Infections		
AIDS/HIV		Deny
Allergies (specify)	• Medication/frequency of use • Allergy shots for desensitization/ treatment date range • Associated conditions/ asthma/rashes	Standard for minimal oral/nasal medications Consider for tiering if steroids by mouth are required, for two or more daily medications, or if allergy shots ended recently Deny for current testing or desensitization, if associated with asthma or other respiratory problems, if multiple daily medications are required
Lupus		Deny
Scleroderma		Deny

Body System	You Should Ask	Possible Action by Highmark
Immune System/Infections (continued)		
Lyme disease	• Diagnosis/date • Treatment plan • Medications	Consider for tiering if treated within past year
Viral infections	• Diagnosis/date • Treatment plan • Medications/frequency of use/episodic or daily	Standard if resolved/infrequent Consider for tiering for active, recent or frequent infections
Epstein-Barr virus/ mononucleosis	• Diagnosis/date • Treatment plan • Medications/frequency	Individual consideration Deny for active treatment
Other/comments: Methicillin Resistant Staff (MRSA)	• Diagnosis/location/date • Number of episodes • Treatment plan • Medications/frequency	Consider for tiering if released for more than one year Deny for active/frequent treatment or treatment within past year
Skin/Nails/Hair/Cosmetic		
Cellulitis	• Onset date • Site of infection • Treatment plan/released • Associated conditions • Medical records and/or statement recommended, if less than three months ago	Standard if resolved Consider for tiering if recent, required hospitalization, is recurrent, or for underlying conditions Deny for current or frequent treatment
Hair loss	• Treatment plan • Associated medical condition • Medical records recommended	Individual consideration
Psoriasis	• Treatment plan/physician statement required • Medications/frequency of use	Individual consideration

Body System	You Should Ask	Possible Action by Highmark
Skin/Nails/Hair/Cosmetic (continued)		
Skin lesions/skin cancer/ pre-cancer	• Frequency • Site • Onset/treatment dates • Treatment plan • Pathology reports strongly recommended	Individual consideration Standard for squamous cell pathology and if resolved and infrequent Consider for tiering based on cell type and frequency of follow up needed Deny for melanoma, if inconclusive, or for recent/frequent intervention
Other skin conditions requiring treatment: acne/fungal infections/rosacea/rashes/ dermatitis/warts/eczema/ keratosis	• Specify diagnosis/date • Medications/frequency of use • Treatment type/surgery/date • Treatment plan/physician statement recommended	Standard for minor treatment or treatment complete for more than six months and/or if clinical statement indicates release without complications Consider for tiering for multiple or costly medications Deny if severe, or for phototherapy, laser treatment, prescription accutane
Cosmetic problems	• Full description/diagnosis/ dates	Individual consideration
Wounds	• Surgery type/date • Wound date • Treatment plan/physician statement recommended, if less than three months ago or long term	Standard if resolved
Sarcoidosis/scleroderma		Deny

Body System	You Should Ask	Possible Action by Highmark
Muscles/Bones		
Amputations	• Exact site • Underlying condition/trauma • Durable medical equipment needed • Prosthetics in use or planned	Standard if traumatic amputation of minor appendage with no prosthesis needed Otherwise, individual consideration
Arthritis	• Specify type • Therapy • Medications/frequency of use • Steroids/oral or injections • Treatment plan	Individual consideration Deny for rheumatoid disease
Fractures/joint replacement/ pins/screws	• Specify underlying condition • Surgery/treatment and date • Rehabilitation plan • Current range of motion • Release from care or follow-up visits • Hardware replacement/ removal schedule	Standard if healed and released from care with full function Individual consideration if criteria not met
Bunion/foot conditions/plantar fasciitis	• Specify diagnosis/type • Therapy/number/date range of visits • Surgery/date • Durable medical equipment/treatment • Release from care/date	Approved if treatment completed and released Deny for surgery or recent or ongoing treatment, or if durable medical equipment is required
Carpal tunnel syndrome	• Medications/pain management • Surgery/treatment/ therapy/date • Splint/durable medical equipment • Release from care/date	Standard if resolved and released from care Individual consideration if criteria not met

Body System	You Should Ask	Possible Action by Highmark
Muscles/Bones (continued)		
Fibromyalgia	• Diagnosis/date • Treatment plan required for consideration • Medications/frequency	Individual consideration
Osteopenia/osteoporosis	• Diagnosis/date • T-scores with dates required for consideration • Physician statement of height loss/fracture history/treatment plan recommended • Medications/schedule	Approve if minor/preventive Consider for tiering for moderate T-score Deny for T-score below minus 2.5

Recurrent pain	• Diagnosis/date
	• Associated conditions
	• Workers-compensation related
	• Site/onset factors/control
	• Treatment
	  • Medication schedule
	  • Therapy
	  • Surgery
	  • Durable medical equipment
		Individual consideration

Spine problems/disc problems/ scoliosis/kyphosis	• Diagnosis/date • Evaluation/treatment/ surgery dates • Therapy/spinal manipulation • Durable medical equipment • Medication/frequency of use • Physician statement recommended for consideration	Individual consideration
Tendonitis/bursitis/myositis	• Specify diagnosis/date • Treatment or surgery/date • Durable medical equipment • Medications/frequency of use/oral or injections • Therapy/spinal manipulations • Recommend physician statement and treatment plan	Individual consideration Deny if severe or if treatment or durable medical equipment required recently or frequently

Body System	You Should Ask	Possible Action by Highmark
Brain/Spine/Nervous System		
Neuro/muscular disorders/Guillain Barre/ multiple sclerosis/ muscular dystrophy/myasthenia gravis/ALS/Lou Gehrig's disease/Alzheimer's/dementia/ senility/hemiplagia/ ahemiparesis/Tourette's syndrome		Deny
Headaches/migraines (Specify type)	• Diagnosis • Frequency • Medications/frequency of use • ER/hospitalization/dates • Other treatment and dates	Individual consideration
Memory loss/cognitive problems	• Diagnosis/date • Treatment plan	Individual consideration
Developmental delays	• Diagnosis/date • Treatment plan	Individual consideration
Narcolepsy		Deny
Parkinson's disease		Deny
Seizure disorder	• Diagnosis/date • Last seizure date • Medications • Related conditions	Approve if no medications, seizure free at least one year and no underlying conditions Consider for tiering if no recent seizures Deny for unstable seizure within the past year, other conditions

Body System	You Should Ask	Possible Action by Highmark
Brain/Spine/Nervous System		
Dizziness/Meuniere's disease/fainting	• Diagnosis/date • Associated conditions • Medications and frequency of use • Current symptoms • Activity limitations • ER/hospital admission/date	Consider for tiering if well controlled or for minor treatment Deny for severe, active treatment, current associated conditions
Tremors/essential or familial/ restless leg syndrome	• Diagnosis/date • Medications/frequency of use • Associated conditions	Individual consideration
Stroke/cerebral vascular accident/transient ischemic attack		Deny
Mental retardation/Down's syndrome		Deny
Reproductive System – Female		
Breast augmentation	• Date of augmentation • Removal/replacement of prosthesis/date	Deny for surgery within past year Consider for tiering if more than one year
Breast problems/fibrocystic breasts/mastitis/lumps/ lumpectomy/mastectomy	• Diagnosis/date • Treatment/surgery/date • Medications/schedule • Therapy • Release from care • Pathology reports recommended for biopsy/surgery	Individual consideration
Childbirth (most recent)	• Date of birth • Postpartum office release date required	Standard if released from care

Body System	You Should Ask	Possible Action by Highmark
Reproductive System – Female (continued)		
Miscarriage/date/complications	• Dates • Treatments/surgery • Complications • Medication • Ongoing treatment plan	Standard if more than one month and no complications
Female fertility	• Last menstrual period required for all females ages 18 to 50 • Reason for no period in past month • Diagnosis/date • Medications/intervention • Infertility/fertility treatment • Pregnancies/delivery dates	Standard if successful and no longer seeking fertility treatment Deny for active treatment
PAP test (females age 18 and older)	• PAP test results/dates recommended for all females 18 and older • Treatment/monitoring plan required for all abnormal results • Treatment follow-up results required	Individual consideration
Infectious disease/sexually transmitted disease/genital warts/chlamydia/human papilloma virus/syphilis/ gonorrhea/herpes	• Diagnosis/date • Treatment plan	Standard if treatment completed and no complications
Menstrual problems/ fibroids/endometriosis	• Diagnosis/date • Treatments • Surgery • Medication • Residual complications	Individual consideration
Ovarian cysts	• Diagnosis/date • Treatment • Surgery • Medication	Standard for surgical correction more than six months ago and released Deny if recently diagnosed, pending surgery, or for drugs other than birth control pills

Body System	You Should Ask	Possible Action by Highmark
Reproductive System – Female (continued)		
Sexual issues/transgender/ dysfunction	• Treatment • Prosthesis • Sexual alterations	Individual consideration
Reproductive System – Male		
Prostate cancer	• Diagnosis/date • Medications • Surgery/radiation/date	Approve if disease-free and no treatment in past five years
Prostate problems/benign prostatic hypertrophy	• Diagnosis/dates • Treatments • Medications • Surgery • PSA level	Standard if mild and does not require treatment Consider for tiering for active treatment Deny for recent or planned surgery
Epididymitis	• Dates • Treatments • Medications • Number of episode(s)	Standard if acute, single episode, full recovery, released from care
Erectile dysfunction	• Associated conditions	Individual consideration
Sexual issues/transgender/ dysfunction	• Diagnosis/dates • Treatment • Medications • Prosthesis • Sexual alterations	Individual consideration
Testicular cancer	• Diagnosis/dates	Standard if disease-free and without treatment for past three years Consider tiering for complications, other conditions
Infectious disease/sexually transmitted diseases)/genital warts/chlamydia/human papilloma virus/syphilis/ gonorrhea/herpes	• Diagnosis/date • Treatment	Standard if treatment completed and no complications

Body System	You Should Ask	Possible Action by Highmark
Respiratory		
Asthma	• Diagnosis • Causative factors/triggers/ allergies • All medications • Treatment • Last ER visit	Standard if stable on two or less medications and no ER visits in past year Consider for tiering for steroid therapy by mouth or nasal spray, using two or more medications, or allergy shots ended more than three months to one year Deny if steroid dependent, frequent ER/hospital/ intervention
Bronchitis/pneumonia/upper respiratory infections	• Diagnosis/date • Treatment • Medications	Standard if fully resolved, non-recurrent Deny for active/recent infection
Chronic cough	• Diagnosis/date • Causative factors	Individual consideration
Shortness of breath	• Diagnosis/date • Causative factors	Individual consideration
Pleurisy/pneumothorax	• Diagnosis/date • Episode(s)/date(s) • Treatment • Release from care • Medications	Standard for episode(s) more than six months ago and if released from care
Pulmonary embolism/blood clots	• Diagnosis/date • Associated diagnoses • Medications and anticoagulation therapy or filter	Consider for tiering if more than three years since diagnosis, not receiving anticoagulation therapy, no associated peripheral vascular disease, phlebitis, arrhythmia or coronary artery disease Deny if active treatment continues

Body System	You Should Ask	Possible Action by Highmark
Respiratory (continued)		
Tuberculosis	• Active/inactive • Diagnosis/date • Specify treatment • Medications and dates	Standard if treatment complete
Emphysema/chronic obstructive pulmonary disease/other lung disease or work-related breathing problems	• Diagnosis/date	Deny
Cystic fibrosis/pulmonary fibrosis		Deny
Other Conditions		
Accident/injury	• Specify/describe • Dates • Treatment/dates	Individual consideration
Birth conditions/congenital abnormalities	• Specify/describe • Dates • Treatment/dates	Individual consideration
Organ transplant recipient		Deny

How to Appeal a Denial or Offer to Tier II or Tier III Rate

Applicants denied enrollment or offered enrollment at the Tier II or Tier III rate in a Highmark Blue Cross Blue Shield medically underwritten program have the right to appeal the decision within 60 days of their denial or offer letter. The following guidelines may be used to expedite the process.

1. If the applicant has not already determined the reason for denial or offer to a higher tier rating, they can call Highmark Blue Cross Blue Shield Member Service at 1-800-544-6679, Monday through Friday, between 8:00 a.m. and 4:30 p.m.

2. The applicant should ask the attending physician to write a letter providing additional medical information about all condition(s). The doctor should include any pertinent clinical information to support the appeal. The statement should be a summary of the applicant's current health status for all medical conditions, including, for example, all medications being taken, recent medical visits, diagnostic tests that were performed or proposed, and a tentative course of treatments for the future.

Note: Fees charged by the physician for this service are the responsibility of the APPLICANT. Medical records are not returned.

3. The applicant must send the physician's letter, clinical information and a copy of the denial letter to:

   Highmark Blue Cross Blue Shield
   Individual Product Appeals
   120 Fifth Avenue, Suite 1224
   Pittsburgh, PA 15222-3099

   OR

   Fax to: 412-544-4009. When you fax the medical records, please use the Highmark fax cover sheet and complete all the information so that we can correctly match the medical records to the online application.

   Remember that only medical records will be accepted on this fax line. Applications and inquiries will not be accepted.

4. The applicant should not submit a payment with the appeal.

The writing producer will receive a copy of the final determination.

How to Respond to an Offer Letter

If an individual applies for coverage, and the medical underwriter determines they are not eligible for coverage at the standard rate (Tier I), they may offer them coverage at Tier II or Tier III.

Decisions may differ for each family member. The medical underwriter may offer coverage to eligible applicant(s) at Tier I, Tier II, or Tier III while denying those who fail to meet medical criteria at any level.

A copy of the offer letter will be sent to the writing producer and the General Agency. Applicants approved for coverage who wish to accept the offer must follow this process:

1. To accept the offer for Tier II or Tier III rating, an individual should sign the offer letter and return it in the envelope provided along with a check for one month's premium. To determine the premium, the individual should refer to the rate sheet provided based on gender and age.

2. To accept the offer for a husband/wife or family application, the applicant(s) should sign for each tier offered, and return in the envelope provided along with a check for one month's premium. The premium can be calculated based on the tiers being offered and the rate sheet(s) attached.

3. If the family offer is split between different tiers, the family has the option of either accepting the separate offers being made or choosing to enroll the husband/wife or family under one contract at the highest tier offered. The acceptance of separate offers will create separate contracts for each tier offered. Separate contracts will generate separate monthly invoices.

4. The individual, husband/wife or families accepting the offer made should return the signed offer letter and first month's premium in the envelope provided within 14 days. If they do not return the information within 14 days, Highmark Blue Cross Blue Shield will assume they are no longer interested in coverage. Applicants will need to complete a new application to be considered for any future enrollment.

Please note: Signed offer letters can also be faxed to 412-544-4176. Since the first month's premium cannot be submitted with the fax, the first month's premium will be included on the initial invoice. Therefore, the member can expect the initial invoice to include more than one month's premium.

PAYMENTS

Rates for DirectBlue, PPOBlue, KeystoneBlue HMO and CompleteCare*

Premium rates for these programs are determined by the following criteria:

- Age and gender of the oldest family member listed on the application on the date coverage becomes effective. The age of the applicant is based on birth date and effective date, not the date the applicant signs or submits the application.
- The number of individuals included on the application.

Standard rates (Tier I) are quoted to the applicant (contract holder) based upon the age and gender of the oldest person applying at the time the application for coverage is submitted. If only children are applying, rates are based on the age and gender of the youngest child. If two children are applying, the parent/child rate applies. If more than two children are applying, the parent/children rate applies. If, due to the applicant's medical history, they do not qualify for coverage at the standard rate (Tier I) , they may be offered coverage at a higher rate (Tier II or Tier III), as determined in accordance with our medical criteria ("underwriting guidelines"), or they can be denied coverage. If they are offered coverage at Tier II or Tier III, and they accept the offer, they will be billed the Tier II or Tier III rate. Each contract can be billed only one rate. Therefore, if a husband/wife or family accepts the option to remain under one contract, they will be billed the highest tiered rate offered.

Rates will increase when a contract holder's birthday moves him/her to the next age bracket. They will be charged the higher premium beginning the month following his/her birthday.

There are no rate guarantees for these programs. If a rate adjustment is filed and approved with the Pennsylvania Insurance Department, the rate adjustment will apply to all contracts on the same effective date. Contract holders are notified on their monthly invoices of a rate adjustment filed with the Pennsylvania Insurance Department, when approval has been received, and the effective date of the adjustment.

*Does not apply to ShortTermBlue.

Rates for ShortTermBlue

- Premium rates for this program are determined by five-year age bands and the daily rate times the number of days of coverage, from 31 to 180 days.
- Individual coverage is offered. There is no dependent coverage.
- The rate is locked in at the time of application. Rates are determined based on birth date and the date the applicant signs the application. A rate adjustment or birthday during the coverage period will not impact the premium already paid by the member.

Payment Information

No discounts will be given for advance payments.

Initial Payment Options

When applying online, two payment options for the initial payment are available:

1) Credit Card Payment

   For all programs except ShortTermBlue, one month's premium will be charged to the applicant's account upon receipt of the application. If the application is approved, please note that coverage does not begin until the commencement of the assigned effective date. If the applicant or any family members are denied coverage, a refund check will be generated and mailed to the applicant. For ShortTermBlue, the entire premium will be charged to the applicant's account upon receipt of the application.

2) Check for ShortTermBlue Only

   If the applicant does not want to submit a credit care payment online, the producer may submit a paper application, a check, and the Producer certificate (so that Highmark can pay commission).

3) Bill Me Later*

   If the application is approved and the applicant is enrolled in coverage, an invoice will be sent to the applicant for premium owed. This payment option will not delay the commencement of the assigned effective date; however, claims will not be reimbursed until payment is received. The first invoice may contain two to three months' premium if the Bill Me Later option is utilized. Commissions will not be paid until the first payment is received.

*Does not apply to ShortTermBlue.

Ongoing Payments

1. Automatic Deduction from a Bank Account*

Monthly payments also can be made through automatic deduction from a bank account or electronic funds transfer (EFT). Members will receive information on how to apply for this service with their ID cards. The monthly premium will be deducted on the 27th of each month.

2. Billing*

When completing an application, please make certain that applicants use their correct home address. Do not, under any circumstances, use anything other than a residential address on the application.

NOTE: Highmark Blue Cross Blue Shield will not reinstate a contract that has lapsed because the designated billing address was not accurate or deliverable.

3. Remitting Payment*

To make it more convenient for members to remit payments, Highmark Blue Cross Blue Shield provides several options. Checks, money orders or certified checks can be dropped off at any Highmark Blue Cross Blue Shield Service Center. See page 5 for these locations. Members may mail their payments to:

Highmark
P.O. Box 382089
Pittsburgh, PA 15250-8089

This address is for ongoing bill payments only – do NOT send applications and initial payments to this box. Members submitting a payment without a bill must write their agreement (ID) and group numbers on the front of the check. When paying for multiple policies with one check, please include the individual billing statements. Also list each member's agreement (ID) number with its respective amount due on the enclosed check.

*Does not apply to ShortTermBlue.

The contract for a direct pay program is between the member and Highmark Blue Cross Blue Shield. Even if the employer is paying for the program or reimbursing the employee, all contractual agreements are directly with the member, not the employer. The member, therefore, has final responsibility for timely payments.

No employer checks will be accepted, unless it is payment for a business owner's personal coverage.

Grace Period and Reinstatement*

Members have 31 days past the due date of their bills to submit payment to Highmark Blue Cross Blue Shield. If payment is not received within 31 days from the due date, coverage will be cancelled and the member will have to reapply. Members are allowed one reinstatement per 12-month period and a total of two per lifetime.

No claims will be considered until the account is made current.

*Does not apply to ShortTermBlue.

AGENCY/PRODUCER NETWORK CODE OF ETHICS

Any person selling insurance shall:

1. Seek to truthfully, carefully and accurately present a true picture of coverages and benefits by learning and keeping abreast of all relevant benefits and bodies of knowledge of your products and applicable legislation and regulation, proposed legislation, and regulation, to the best of your ability.
2. Make a conscientious effort to ascertain and understand all relevant circumstances pertaining to the customer in order to recommend appropriate coverages.
3. Orally inventory current coverage with the customer to avoid selling duplicative insurance benefits.
4. Honestly assess as an affirmative obligation the likelihood that a customer will meet needs, underwriting and financial requirements, in order to reduce false expectations of acceptance and adequacy of coverages.

   Honestly try to discover any adverse factors that a reasonably competent and diligent investigation would likely disclose.
5. Have in-depth, sound command of products in order to honestly, openly and effectively portray coverages in a clear and concise fashion; to determine a customer's true understanding and grasp of key benefits, limitations and exclusions, such as waiting periods, inflationary impact on benefits or premiums, and causes for cancellation.

   After said exchange and questioning, to clarify and verify the customer's grasp of information and, if necessary, review pertinent issues.
6. Uphold a customer's right to confidentiality and use personal information with professional integrity solely for making sound insurance recommendations to the customer.

   Under no circumstances reveal information, directly or indirectly, for the purpose of personal advantage, beyond fair and reasonable commission, or for personal advantage to others.
7. Obey all laws governing business and professional activities and honestly represent products in an ethical manner without fraud, misrepresentation, exaggeration, coercion, scare tactics or concealment of pertinent facts. Do so without taking advantage of the customer or potential customer, which could lead to the customer's detriment in insurance choices based on need and financial capability.
8. Accept no gifts, entertainment or favors of more than nominal value from customers or potential customers, which may be deemed professionally questionable.
9. Use only authorized promotional materials unless prior written approval has been obtained from an authorized Highmark representative, and fairly focus presentation on positive benefit comparisons rather than disparaging remarks about the competition.
10. Treat a customer or potential customer with due courtesy, respect and priority in accordance with thoughtful, ethical and legal business practices.

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An Independent Licensee of the Blue Cross and Blue Shield Association

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