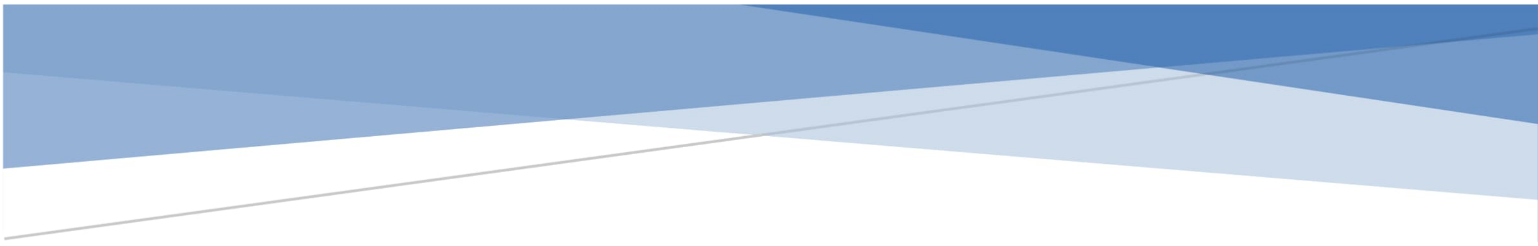

2250 CDHP HPN Plan Document

Plan Year Beginning January 1, 2026

Medical benefit administered by Highmark Blue Shield
Pharmacy benefit administered by Express Scripts

Pages 3 through 93 contain the Highmark Benefit Booklet
Pages 94 to 120 contain information about the services provided by Quantum Health and benefits available through the EAP, Livongo by Teladoc, Hinge Health, Oshi Health, and Carrum Health

Highmark Inc. d/b/a Highmark Blue Shield

Rentokil North America, Inc. 2250 EPO HPN Single
Group 10932401, 02, 04, 05
Effective January 01, 2026

Discrimination is Against the Law

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

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

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

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with:

Civil Rights Coordinator
P.O. Box 22492
Pittsburgh, PA 15222
Phone: 1-866-286-8295 (TTY: 711), Fax: 412-544-2475
Email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

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

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

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

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

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

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

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

ÀKÍYÈSÍ: Tí o bá nsQ èdè Yorùbá, àwQn i$$ ìtumQ ati ògbufQ èdè wà ní àrQwQtó lQ' f$, e fún Q. AwQn i$$ ìtQ' jú ati ìrànlQ' wQ' tó y$ (bíi tit$wé nla, gbigbQ ohùn, ati ìwé afQ' jú) lati pèsè iwifúnni ni awQn Qna ìráàyè si wà p$lu lQ' f$, e . Pe nQmba tó wà l$hin kaádì ìdánimQ r$ (TTY: 711) fún iránlQwQ.

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ĖėĘę ěĜĝĞğ ĠĞ ġ Ģ ģĤĥĦĘģħ ĨĞĩġĘ ĨĞī ġĞ ġĢĘĦĘ ĢĘĬĭ ĮęįİĤĴ ijĘĴĘ ĵĶĥĘķ ĵę ģĸĹĺĦĮĨĩĝę ĻĝĘļ ĽĜīľĿ Ŀ-ģ Ħĩij ŃĞĢ ńĢĘ ŅĢĘņĪģħ Ňħħ ĜĘŊĪĘ ĢĘĬĭ ėĞņė ĻĪĘėĲ ĻĘĿęĻĘĢŌħ ĵę ģĻĝĘļ ŏŎĢ ĲĩĢĞĭn ĮĺĹĨ ņĐĕĞ ĵę ĝŏķīŐ Ĝő ĮęįİĤĴ ĽĜīľĿ Ŀ-ģ Ģķķ ĢĘĬĭ ġĢĘĦĘ ěķĐ'n ĲĘĐŒħ ĜĘœ ěĜĝĘ ęŅĦ ŏTTY: ŔŕŐ ĜĦ ĲŖī ĲĦĞĿ

CHÚ Ý: Ngu quý vh nói tigng Viit, chúng tôi có dhch vj biên dhch và phiên dhch ngôn ngk miln phí dành cho quý vh. Chúng tôi cmng cung cnp miln phí các dhch vj và ho trp bq sung thích hpp (nhr chk in lsn, tip âm thanh và chk nqi) đt cung cnp thông tin u các đhnh dvng dl tigp cwn. Vui lòng gQi sx điin thovi trên myt sau cza th{ nhwn dvng cza quý vh (TTY: 711) đt đrpc trp giúp.

ŘřŚś ŝŞşŠšŢŤţ řšŞ ťŦŚŧ śŨŚũŪ ūšŬśşŠşũŮ ů ś ŰŦŚŧũŚŰ űśŲųşŬŴ ůŚŵŚ Ŷśşŷ ŚŞ Ÿ Şšůŝ ŢŰŢŷŚŠŹ źŦũŻż ŮśŽţ ŦŞşžſřšƀř ƁŚŹŜŠŹƂŚ ƃŚśŴŚŸŪ ƄŞŚś ƅ ś ƆźŦřşƇť ŢŠŚřŴ ƄƈŷƉż Ÿ ŢŷŚŠŹ ƊƋƌťƍŢūš ƈƄŭƏ ŶƐƑřš Ÿ ƒ ŨƓ Ŧűś űśŲųşŬŴ źŦũŻż ŮśŽţ ƂƔŞťŴš ũŚƉƅ ťŦŚťŴš ŴŚƑ ƖŴš ŦŮŚƐƑŴš śƗũŪŸƂŚ Ŵũ ƅ ś ƘšŢ ţƊTTY: ƙƚƓŽ

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Disclosure

Your health benefits are entirely funded by your employer. Highmark Blue Shield provides administrative and claims payment services only and does not assume any financial risk or obligation with respect to claims.

Non-Assignment

Unless otherwise required by law, Highmark is authorized by the member to make payments directly to providers furnishing Covered Services provided under the program described in this benefit booklet; however, Highmark reserves the right to make these payments directly to the member. The right of a member to receive payment for a Covered Service described in this benefit booklet is not assignable, except to the extent required by law, nor may benefits described in this benefit booklet be transferred either before or after Covered Services are rendered. Any (direct or indirect) attempt to accomplish such an assignment shall be null and void. Nothing contained in this benefit booklet shall be construed to make Highmark, the group health plan or the group health plan sponsor liable to any assignee to whom a member may be liable for medical care, treatment, or services.

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

Introduction to Your Health Care Program

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

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

Blue High Performance Network is an exclusive provider organization health care program, commonly referred to as an EPO. This means that you will receive benefits only when you receive care from network providers, except for covered emergency care. The provider network for EPO members is the same network that is used by Preferred Provider Organization (PPO) members.

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

- ***Your health care program gives you freedom of choice.*** You are not required to select a primary care provider to receive covered care. You have access to a large provider network of physicians, hospitals, and other providers in Pennsylvania, as well as providers across the country who are part of the local PPO network. To locate a network provider near you, or to learn whether your current physician is in the network, log onto your Highmark member website, www.myhighmark.com.

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

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

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

Information for Non-English-Speaking Members

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

How Your Benefits Are Applied

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

Benefit Period

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

Medical Cost-Sharing Provisions

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

Coinsurance

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

Copayment

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

Deductible

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

Unless otherwise indicated, deductible amounts are applicable to covered services provided to covered members per benefit period.

Out-of-Pocket Limit

The out-of-pocket limit refers to the specified dollar amount of expense incurred for covered services in a benefit period. When the specified dollar amount is attained, the level of benefit increases as specified in the Summary of Benefits. See the Summary of Benefits for the out-of-pocket limit. The out-of-pocket limit does not include. All out-of-pocket amounts are based on the plan allowance.

Total Maximum Out-of-Pocket

The total maximum out-of-pocket, as mandated by the federal government, refers to the specified dollar amount of deductible, coinsurance, copayments incurred for network covered services, covered medications and any qualified medical expenses in a benefit period. When the specified individual dollar amount is attained by you, or the specified family dollar amount is attained by you or your covered family members, your program begins to pay 100% of all covered expenses and no additional coinsurance, copayments and deductible will be incurred for network covered services and covered medications in that benefit period. See the Summary of

Benefits for the total maximum out-of-pocket. The total maximum out-of-pocket does not include out-of-network cost-sharing or amounts in excess of the plan allowance.

However, if any covered family member has incurred an amount equal to the individual total maximum out-of-pocket, the benefits payable for covered services for that particular individual family member will be payable at 100% of the plan allowance during the remainder of the benefit period.

Maximum

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

Covered Services - Medical Program

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

Benefits for covered services are based upon the plan allowance at the time services are rendered. You are responsible for payment of any cost-sharing amounts due to the provider after the amounts paid by your program. The payments to a provider may be adjusted from time to time based on settlements with the providers. Such adjustments will not affect your deductible, coinsurance, or copayment obligation.

In the event that you require non-emergency covered services that are not available within the network, you may receive services from a provider outside the network, only when preauthorization from Highmark has been obtained.

Outpatient Medical Care Services (Visits and Consultations)

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

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

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

You can also interact with a professional provider virtually, via telephone, internet, or other electronic communication. Benefits are provided for a virtual visit when you communicate with the professional provider from any location, such as your home, office, or another mobile location. Alternatively, a professional provider may want you to travel to a provider originating site where a virtual interaction with the provider can occur.

Professional providers may also request consultations from another professional provider for an advisory opinion regarding a diagnosis or management of your medical problem. These are called “provider-to-provider” consultations or "interprofessional consultations". ***Interprofessional consultations do not include provider interaction with you.***

Different types of providers, their services and their locations may require different payment amounts and result in different charges. You may be responsible for a facility fee, clinic charge or similar fee (in addition to any professional fees) if your office visit or service is provided at a hospital, facility provider, ancillary provider, retail clinic or urgent care center. You may also be responsible for a charge for an interprofessional consultation, which may occur during your office visit or at a different time.

The specific amounts you are responsible for paying depend on your program's particular benefits.

Preventive Care Services

Benefits will be provided for preventive care services in accordance with the preventive schedule. Recommended annual services are based on a calendar year resetting January 1 of every year. Refer to the Summary of Benefits for your program's specific level of coverage.

Adult Care

Routine Physical Examinations

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

Adult Immunizations

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

Routine Gynecological Examination and Pap Test

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

Breast Cancer Screenings

Benefits are provided for the following:

- An annual routine mammographic screening starting at 40 years of age or older as well as, additional imaging (e.g. magnetic resonance imaging (MRI), ultrasound and mammography) and pathology evaluations needed to complete the screening process for malignancies.

- For members believed to be at an increased risk of breast cancer due to:

  1. personal history of atypical breast histologies;

  2. personal history or family history of breast cancer;

  3. genetic predisposition for breast cancer;

  4. prior therapeutic thoracic radiation therapy;

  5. heterogeneously dense breast tissue based on breast composition categories with any one of the following risk factors:

     i. lifetime risk of breast cancer of greater than 20%, according to risk assessment tools based on family history;

     ii. personal history of BRCA1 or BRCA2 gene mutations;

     iii. a first-degree relative with a BRCA1 or BRCA2 gene mutation;

     iv. prior therapeutic thoracic radiation therapy between 10 and 30 years of age; or

v. personal history of Li-Fraumeni syndrome, Cowden syndrome or Bannayan-Riley-Ruvalcaba syndrome or a first-degree relative with one of these syndromes; or

6. extremely dense breast tissue based on breast composition categories;

one (1) supplemental breast screening every year using standard or abbreviated magnetic resonance imaging (MRI) or, if such imaging is not possible, ultrasound if recommended by the treating physician to screen for breast cancer when there is no abnormality seen or suspected in the breast.

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

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

Diabetes Prevention Program

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

Prostate Cancer Screening

Coverage will be provided for a prostate specific antigen (PSA) test and digital rectal exam for all members per calendar year.

Tobacco Use, Counseling and Interventions

Benefits are provided for screenings for tobacco use products and counseling sessions and preventive covered medications.

Well-Woman Coverage

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

Preventive Prescription Drugs (Outpatient)

Coverage will be provided for prescription and over-the-counter drugs that are prescribed for preventive purposes upon presentation of a written prescription order or for which a prescription order is not required by the Plan.

Network services are those services received from a Participating Pharmacy Provider.

Pediatric Care

Routine Physical Examinations

Routine physical examinations, regardless of medical necessity and appropriateness, and other items and services.

Pediatric Immunizations

Benefits are provided to members through 18 years of age and dependent children for those pediatric immunizations, including the immunizing agents, which as determined by the Pennsylvania Department of

Health conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services.

Preventive Prescription Drugs (Outpatient)

Coverage will be provided for prescription and over-the-counter drugs that are prescribed for preventive purposes upon presentation of a written prescription order or for which a prescription order is not required by the Plan.

Network services are those services received from a Participating Pharmacy Provider.

Hospital Services

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

Inpatient Services

Bed and Board

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

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

Ancillary Services

Hospital services and supplies including, but not restricted to:

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

Outpatient Services

Ancillary Services

Hospital services and supplies including, but not restricted to:

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

Pre-Admission Testing
Tests and studies, as indicated in the Diagnostic Services section, required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.

Outpatient Evaluation and Management Services
Benefits are provided for outpatient medical care visits and consultations for the evaluation and management of your condition, including examination, diagnosis and treatment of an injury or illness.

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

Maternity Services

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

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

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

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

Newborn Care
Covered services provided to an enrolled newborn child includes care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity, and routine nursery care. Routine nursery care includes inpatient medical visits by a professional provider.

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

Benefits are not provided for newborn care for the newborn children of dependent children. Refer to the General Information section for further eligibility information.

Inpatient Medical Services

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

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

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

Consultation
Consultation services rendered to an inpatient by another professional provider at the request of the attending professional provider. Consultation does not include staff consultations which are required by facility provider rules and regulations. Benefits are limited to one (1) consultation per consultant per admission.

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

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

Surgical Services

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

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

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

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

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

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

Special Surgery
- Sterilization

- Sterilization regardless of medical necessity and appropriateness.

Second Surgical Opinion

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

Keep in mind that:

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

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

Surgery

- Surgery performed by a professional provider. Separate payment will not be made for pre- and post-operative services.
- If more than one surgical procedure is performed by the same professional provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure and no allowance shall be made for additional procedures except where Highmark deems that an additional allowance is warranted.
- Certain surgeries must be performed at a Carrum Center of Excellence. For more information on if this applies to you, please contact Quantum Health at (866) 317-6103.

Emergency Care Services

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

Emergency care services are available seven (7) days a week, twenty-four (24) hours a day. Emergency care services are services and supplies, including drugs and medicines, for the outpatient emergency treatment of bodily injuries resulting from an accident or a medical condition described in the definition of emergency care services in the Terms You Should Know section. Also included is a medical screening examination and ancillary services necessary to evaluate such injury or emergency medical condition and further medical examination and treatment as required to stabilize the patient.

In the event that you receive such emergency care services from an out-of-network provider and require an inpatient admission or observation immediately resulting from such injury or emergency medical condition and upon stabilization:

a. you are unable to travel using non-medical transportation or non-emergency medical transportation; or

b. you do not consent to be transferred,

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

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

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

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

Ambulance Service

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

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

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

Ambulance service includes an emergency medical services (EMS) agency licensed by the state.

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

Use of an ambulance as transportation to an emergency room for an injury or condition that does not satisfy the criteria of emergency care will not be covered as emergency ambulance services.

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

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

Therapy, Rehabilitative and Habilitative Services

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

- Chemotherapy
- Dialysis treatment

- Infusion therapy when performed by a facility provider or ancillary provider and for self-administration if the components are furnished and billed by a facility provider or ancillary provider
- Occupational therapy, rehabilitative and habilitative services
- Physical medicine, rehabilitative and habilitative services
- Radiation therapy
- Respiratory therapy (includes Pulmonary rehabilitation)
- Speech therapy, rehabilitative and habilitative services

Spinal Manipulations

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

Mental Health Care Services

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

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

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

Inpatient Facility Services

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

Inpatient Medical Services

Covered inpatient medical services provided by a professional provider:

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

Partial Hospitalization Program

Benefits are only available for mental health care services provided on a partial hospitalization basis when received through a partial hospitalization program. A mental health care service provided on a partial

hospitalization basis will be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.

Outpatient Mental Health Care Services

Inpatient facility service and inpatient medical benefits provided by a facility provider or professional provider as previously described, are also available when provided for the outpatient treatment of mental illness by a facility provider, or a professional provider. Benefits are also provided for mental health care services received through an Intensive Outpatient Program.

A virtual visit between you and a specialist (including a behavioral health specialist) via audio and video telecommunications. Benefits are provided for a virtual visit when you communicate with the specialist from any location, such as your home, office, or another mobile location, or if you travel to a provider-based location referred to as a provider originating site. If you communicate with the specialist from a provider originating site, you will be responsible for the virtual visit provider originating site fee.

Substance Abuse Services

Benefits are provided for detoxification services (withdrawal management services), individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance abuse when rendered by a facility provider or professional provider and include the following:

- Detoxification services rendered;
  - on an inpatient basis in a hospital or substance abuse treatment facility; or
  - on an outpatient basis
- Substance abuse treatment facility services for non-hospital inpatient residential treatment and rehabilitation services. Residential treatment and rehabilitation services include medically monitored high intensity inpatient services with twenty-four hour nursing care and physician availability and medically managed intensive inpatient services with twenty-four hour nursing care and daily physician oversight; and
- Outpatient services rendered in a hospital, substance abuse treatment facility or through an Intensive Outpatient Program or Partial Hospitalization Program, and outpatient substance abuse treatment facility services for rehabilitation therapy

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

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

Other Services

Allergy Extracts/Injections

Benefits are provided for allergy extract and allergy injections.

Anesthesia for Non-Covered Dental Procedures (Limited)

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

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

Assisted Fertilization Treatment

When such services are ordered by a physician and are determined to be medically necessary and appropriate, benefits will be provided for the following:

- Assisted reproductive technology, including pharmacological or hormonal treatments used in conjunction with Assisted Reproductive Technology in connection with the treatment of infertility.

Blue Distinction Specialty Care

The Blue Distinction Specialty Care Program is a nationwide quality designation program, awarded by the Blue Cross Blue Shield Association, recognizing health care providers that demonstrate expertise in delivering quality specialty care safely, effectively and cost-efficiently. The Blue Distinction Specialty Care Program offered by your group focuses on the following areas of specialty care provided at the designated health care providers.

Hospital, medical and surgical services rendered by a Blue Distinction Specialty Care designated facility provider for:

Transplants

Care includes comprehensive transplant services through a coordinated, streamlined referral management program. Facilities may be designated for one or more of the following types of transplants: heart, lung, liver (deceased and living donor), kidney (deceased and living donor) and bone marrow/stem cell.

Diabetes Treatment

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

- Prescription drugs: Insulin and pharmacological agents for controlling blood sugar
- Equipment and supplies: Blood glucose monitors, monitor supplies, and insulin infusion devices

- Diabetes Education Program*: When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through a diabetes education program:

  - Visits medically necessary and appropriate upon the diagnosis of diabetes
  - Subsequent visits under circumstances whereby your physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in your self-management, or b) identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to your treatment and/or management of diabetes

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

Diagnostic Services

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

Advanced Imaging Services

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

Basic Diagnostic Services

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

Durable Medical Equipment

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

Enteral Foods

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

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

- amino acid-based elemental medical formulae ordered by a physician for infants and children for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short bowel syndrome; and
- nutritional supplements administered under the direction of a physician for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.

Hearing Care Services

Benefits include coverage for diagnostic testing and an audiometric examination and purchase of hearing aid devices when prescribed by a professional provider.

The hearing aid must be purchased within six months of an audiometric examination and from a supplier who is a network provider.

Home Infusion and Suite Infusion Therapy Services

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

Home Health Care Services/Hospice Care Services

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

- Skilled nursing services of a registered nurse (RN) or licensed practical nurse (LPN), excluding private duty nursing services;
- Physical medicine, speech therapy and occupational therapy;
- Medical and surgical supplies provided by the home health care agency or hospital program for home health care or hospice care;
- Oxygen and its administration;
- Medical social service consultations;
- Health aide services when you are also receiving covered nursing services, rehabilitative or habilitative services or therapy services;
- Family counseling related to the member's terminal condition.

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

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

Infertility Counseling, Testing and Treatment

Benefits will be provided for covered services in connection with the counseling, testing and treatment of infertility when such services are ordered by a physician and are determined to be medically necessary and appropriate.

Orthotic Devices

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

Private Duty Nursing Services

Services of an actively practicing registered nurse (RN) or licensed practical nurse (LPN) when ordered by a physician, providing such nurse does not ordinarily reside in your home or is not a member of your immediate family. Benefits will be provided only when you are at home and only when Highmark determines that the nursing services require the skills of an RN or an LPN.

Prosthetic Appliances

Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues, or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered.

Skilled Nursing Facility Services

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

No benefits are payable:

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

Transplant Services

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

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

- when both the recipient and the donor are members, each is entitled to the benefits of their program;

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

Travel and Lodging for Transplant Services

Travel and lodging reimbursement is only available in connection with covered transplant services provided under this program. Specifically, travel and lodging reimbursement is available for the transplant recipient and one (1) other adult or, if the recipient is under eighteen (18) years of age, for the recipient and two (2) parents. If the facility provider is less than one hundred (100) miles from the recipient's home, standard automobile mileage and parking fees are reimbursable. No reimbursement is available for automobile maintenance or repair. Air travel on a commercial airline is reimbursable if the facility provider is further than one hundred (100) miles from the recipient's home. Reimbursement for air travel will be based on the cost of two (2) round trip coach tickets for the recipient and one (1) other adult or, if the recipient is under eighteen (18) years of age, for the recipient and two (2) parents. Travel and lodging costs are covered to the limits specified herein. Reimbursement will be provided upon submission of the eligible receipts to Highmark.

Travel and Lodging Expenses

Benefits will be provided for travel and lodging expenses Incurred by you when you travel at least 0 miles from your place of residence to obtain covered services, subject to the following conditions and limitations:

- You must verify there is no provider who can perform the covered service within 0 miles of your place of residence.
- Reimbursement of lodging expenses is limited to $50 per night per member, up to $100 total per night including your travel companion (including but not limited to a spouse or domestic partner).
- Reimbursement of ground travel is based on the mileage from your place of residence to the provider. Reimbursement is calculated using the Internal Revenue Service standard mileage rate.
- There is a $123 aggregate lifetime limit for all travel and lodging expenses.
- Highmark will reimburse you for travel and lodging expenses to the extent permitted by the law of the member's state of residence.
- Underlying covered services must be legally permissible in the state where the service is rendered.
- Claims for travel and lodging expenses cannot be processed until the claim for the underlying covered service is processed. You must submit a claim form for travel and lodging expense reimbursement. The claim form can be accessed on the member portal at www.myhighmark.com.
- Cost-sharing, such as deductible, copayments and coinsurance, will not apply to covered travel and lodging expenses.

Prescription Drugs (Outpatient)

Coverage will be provided for prescription and over-the-counter drugs that are set forth within the preventive schedule and that are prescribed for preventive purposes. Benefits will be provided for prescription drugs in the amounts specified in the Summary of Benefits of this booklet.

Injectable insulin and drugs that under Federal law may only be dispensed by written prescription and are approved for general use by the FDA. The drugs must be dispensed for your outpatient use by a pharmacy provider on or after your effective date.

What Is Not Covered

Except as specifically provided in this booklet or as Highmark is mandated or required to cover based on state or federal law, regulation or other directive, no benefits will be provided for services, supplies or charges:

Key Word	Exclusion
Acupuncture Therapy Services	• For acupuncture therapy services, except as otherwise set forth in the Covered Services - Medical Program section of this booklet.
Allergy Testing	• For allergy testing, except as provided herein.
Ambulance	• For ambulance services, except as provided herein.
Assisted Fertilization	• For artificial insemination including pharmacological or hormonal treatments used in conjunction with artificial insemination.
Comfort/Convenience Items	• For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider.
Cosmetic Surgery	• For a cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except: a) as otherwise provided herein; b) when required to correct a condition directly resulting from an accident; c) when necessary to correct a functional impairment which directly results from a covered disease or injury; or d) to correct a congenital birth defect.
Court Ordered Services	• For otherwise covered services ordered by a court or other tribunal unless medically necessary and appropriate or if the reimbursement of such services is required by law.
Custodial Care	• For custodial care, domiciliary care, protective and supportive care including educational services, rest cures and convalescent care.
Dental Care	• Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses otherwise covered because of accidental bodily injury to sound natural teeth and for orthodontic treatment for congenital cleft palates as provided herein.
Diabetes Prevention Program	• For a diabetes prevention program offered by other than a network diabetes prevention provider.
Educational Service and Testing	• For services that are primarily educational in nature, such as academic skills training or those for remedial education or vocational training, including tutorial services.

Effective Date	• Rendered prior to your effective date of coverage.
Enteral Foods	• For any food including, but not limited to, enteral foods, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis, except as provided herein.
Experimental/Investigational	• Which are experimental/investigational in nature, except as provided herein for Routine Patient Costs incurred in connection with an Approved Clinical Trial.
Eyeglasses/Contact Lenses	• For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses or sclera shells intended for use in the treatment of disease or injury).
Felonies	• For any illness or injury you suffer during your commission of a felony, as long as such illness or injuries are not the result of a medical condition or an act of domestic violence.
Foot Care	• For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
Health Care Management program	• For any care, treatment or service which has been disallowed under the provisions of Health Care Management program.
Illegal Services	• Services not permitted under applicable state law. Some state laws restrict the scope of health care services that a provider may render. In such cases, the plan will not cover such health care services. For detailed information about these excluded services, contact Member Services at the number on the back of your ID card.
Immunizations	• For immunizations required for foreign travel or employment, except as provided herein.
Inpatient Admissions	• For inpatient admissions which are primarily for diagnostic studies.
	• For inpatient admissions which are primarily for physical medicine services.
Legal Obligation	• For which you would have no legal obligation to pay.
Medically Necessary and Appropriate	• Which are not medically necessary and appropriate as determined by Highmark.

Medicare	• To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program.
Military Service	• To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.
Miscellaneous	• For any type of interaction made through unsecured and unstructured services, such as, but not limited to skype and instant messaging, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
	• For any other medical or dental service or treatment except as provided herein.
	• For any tests, screenings, examinations or any other services required by: (a) an employer or governmental body or agency in order to begin or to continue working or as a condition to performing the functions of any employment in a particular setting; (b) a school, college or university in order to enter onto school property or a particular location regardless of purpose, or; (c) a governmental body or agency for public surveillance purposes; and that does not relate to the furnishing or administration of an individualized test, screening or evaluation determined by the member's attending professional provider as being medically appropriate.
Motor Vehicle Accident	• For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law.
Neuropsychological/ Educational Testing	• For neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment.
Nutritional Counseling	• For nutritional counseling, except as provided herein, or as otherwise set forth in the preventive schedule.
Obesity	• For the treatment of obesity, except for medical surgical treatment of morbid obesity, or as otherwise set forth in the preventive schedule.
Oral Surgery	• For oral surgery procedures, except as provided herein.
Physical Examinations	• For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein.

	• For prescription drugs and medications, except those which are administered to an inpatient in a facility provider or as otherwise set forth in the preventive schedule.
Preventive Care Services	• For preventive care services, wellness services or programs, except as provided herein.
Provider of Service	• Which are not prescribed by or performed by or upon the direction of a professional provider. • Rendered by other than providers. • Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group. • Which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same member. • Rendered by a provider who is a member of your immediate family. • Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
Respite Care	• For respite care except as provided in connection with hospice care.
Sexual Dysfunction	• For treatment of sexual dysfunction that is not related to organic disease or injury.
Smoking (nicotine) Cessation	• For nicotine cessation support programs and/or classes, except as otherwise set forth in the preventive schedule.
Social or Environmental Change	• For services provided primarily for social or environmental change.
Sterilization	• For reversal of sterilization.
Termination Date	• Incurred after the date of termination of your coverage except as provided herein.
Therapy	• For outpatient therapy and rehabilitative and habilitative services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur.
TMJ	• For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.

Vision Correction Surgery	• For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.
War	• For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.
Weight Reduction	• For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
Workers' Compensation	• For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.

How Your Health Care Program Works

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

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

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

You can choose from two levels of network benefits coverage for eligible health care services.

Out-of-Network Care

There is no coverage for services received from out-of-network providers, except for urgent care, emergency care and emergency ambulance services. This is true even if you are directed to an out-of-network provider by a network provider. That is why it is critical - in all cases - that you check to see that your provider is in the network before you receive care.

Provider Reimbursement and Member Liability

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

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

Except for emergency care services provided in a hospital or freestanding emergency room and air ambulance services, in the event a member receives covered services from a provider that is not part of the network

without the required preauthorization, the member will be responsible for all charges associated with those services regardless of whether the services received were medically necessary and appropriate.

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

Please review the booklet's schedule of benefits for further details on cost sharing for Emergency Services.

No Prior Approval Requirement or Pre-Certification Requirement Applies When Members Receive Emergency Care services.

Out-of-Area Care

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

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

Inter-Plan Arrangements

Out-of-Area Services

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

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

BlueCard® Program

The BlueCard® Program is an inter-plan arrangement. Under this arrangement, when members access covered services outside Pennsylvania, the Host Blue will be responsible for contracting and handling all interactions with its participating health care providers.

The financial terms of the BlueCard Program are described generally below.

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

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

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

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

Special Cases: Value-Based Programs
If members receive covered services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Highmark through average pricing or fee schedule adjustments.

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

Inter-Plan Programs: Federal State Taxes/Surcharges/Fees
In some instances, federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, Highmark will include any such surcharge, tax or other fee in determining your premium.

Non-Participating Providers Outside Pennsylvania

Member Liability Calculation

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

Exceptions

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

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

Blue Cross Blue Shield Global Core Program

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

Inpatient Services

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

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

When members pay for covered services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, members should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center address on the form to initiate claims processing. The claim form is available from Highmark, the service center or online at www.bcbsglobalcore.com. If members need assistance with their claim submissions,

they should call the service center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

Your Provider Network

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

To determine if your physician is in the network, call the Quantum Health toll-free telephone number on the back of your ID card, or log onto RentokilBenefits.com.

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

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

Remember:
It is *your* responsibility to ensure that you receive network care. You may want to double-check any provider recommendations to make sure the doctor or facility is in the network. There is no coverage if you use a non-network provider unless it is for urgent care, emergency care, or emergency ambulance services.

How to Obtain Information Regarding Your Physician

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

- Name, address, telephone numbers
- Professional qualifications
- Specialty
- Medical school attended
- Residency completion
- Board certification status
- Hospital affiliations

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

Eligible Providers

Eligible network providers include facilities, general practitioners, internists, obstetricians/gynecologists and a wide range of specialists all licensed where required and performing within the scope of such licensure. Eligible Providers include:

Facility Providers:

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

Professional Providers:

- Audiologist;
- Certified registered nurse*;
- Chiropractor;
- Clinical social worker;
- Dentist;
- Dietitian-nutritionist;
- Licensed practical nurse;
- Marriage and family therapist;
- Nurse-midwife;
- Occupational therapist;
- Optometrist;
- Physical therapist;
- Physician;
- Podiatrist;
- Professional counselor;
- Psychologist;
- Pulmonologist;
- Registered nurse;
- Respiratory therapist;
- Speech-language pathologist;
- Teacher of hearing impaired.

Ancillary Providers:

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

- Suppliers.

Contracting Suppliers (for the sale or lease of):

- Durable medical equipment;
- Supplies;
- Hearing aids;
- Orthotics;
- Prosthetics.

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

Blue Distinction Centers

The Blue Cross Blue Shield Association recognizes health care facilities located nationwide that demonstrate expertise in delivering quality specialty care safely, effectively and cost-efficiently. Those facilities are designated as Blue Distinction Centers (BDC) or Blue Distinction Centers+ (BDC+).

BDC are hospitals recognized for their expertise in delivering specialty care. They meet quality-focused criteria that emphasizes patient safety and outcomes. BDC+ are hospitals recognized for their expertise and efficiency in delivering specialty care. To qualify as a BDC+, the facility must first meet quality-focused criteria that emphasizes patient safety and outcomes, as well as cost of care measures.

Selection criteria are unique for each Blue Distinction Specialty Care Program reflecting that particular area of specialized care. A facility with proven expertise in one specialty area may or may not meet thresholds in other areas. For example, a BDC for one specialty may not necessarily meet the criteria for becoming a BDC for another specialty. A facility that has a BDC or BDC+ designation in multiple areas of care has met detailed criteria in each area.

Benefits after Provider Termination from the Network

If at the time you are receiving medical care from a network provider, notice is received from Highmark that: Highmark intends to terminate or has terminated all or portions of the contract of that network provider for reasons other than cause; or the contract of that network provider will not be renewed, or the participation status of that network provider is changing; you may, at your option, continue an active course of treatment with that network provider until the treatment is complete or for a period of up to ninety (90) days from the date the notification of the termination or pending termination is received, whichever is shorter. For purposes of this section, active course of treatment means: (i) an ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (ii) an ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring specialized medical treatment to avoid the reasonable possibility of death or permanent harm or complex ongoing care which you are currently receiving, such as chemotherapy, radiation therapy or post-operative visits; (iii) confirmed pregnancy, through the postpartum period; (iv) scheduled nonelective surgery, through postoperative care; (v) an ongoing course of treatment for a health condition that is life-threatening, degenerative, potentially disabling, or congenital and that requires specialized medical care over a prolonged period of time or for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes; or (vi) treatment for a terminal illness. If, however, the network provider is terminated for cause and you continue to seek treatment from that provider, then your plan will not cover payment for health care services provided to you following the date of termination. Any Services authorized under this section will be covered in accordance with the same terms and conditions as applicable to a network provider. Nothing in this section shall require payment of benefits for health care services that are not otherwise provided under the terms and conditions of your plan.

General Information

Who is Eligible for Coverage

The effective date for an individual member is the date specified by the group in writing or other documented communication received by Highmark, unless an earlier effective date is required by law.

The group is responsible for determining if a person is eligible for coverage and for reporting such eligibility to Highmark. Highmark reserves the right to request, at any time, documentation relative to eligibility for coverage of any individual enrolled for coverage.

*The following eligibility information applies **only** if your group provides coverage for dependents. Your group administrator can determine if you have dependent coverage.*

You may enroll your:

- Spouse under a legally valid existing marriage
- Children under 26 years of age, unless otherwise extended pursuant to applicable state or federal law, including:

    - Newborn children
    - Stepchildren
    - Children legally placed for adoption
    - Legally adopted children and children for whom the employee or the employee's spouse is the child's legal guardian
    - Children awarded coverage pursuant to an order of court

  An eligible dependent child's coverage automatically terminates and all benefits hereunder cease on the day following the date the dependent reaches the limiting age or ceases to be an eligible dependent as indicated above, whether or not notice to terminate is received by Highmark.

- Unmarried children over age 26 who are not able to support themselves due to intellectual disability, physical disability, mental illness or developmental disability that started before age 26. Coverage automatically terminates and all benefits hereunder cease, except as otherwise indicated, on the day following the date on which the disability ceases, whether or not notice to terminate is received by Highmark.

Your "domestic partner" means a same-sex or opposite-sex domestic partner of a Rentokil North America, Inc. employee. An individual will be considered by the Plan to be your domestic partner if you complete an Affidavit of Domestic Partnership and you both have a dedicated relationship characterized by all of the following:

- You are both at least 18 years old,
- You share a common residence for at least 12 months immediately preceding enrollment and intend to do so indefinitely,
- You are each other's sole Domestic Partner,
- Neither of you has had another Domestic Partner within the prior 12 months,
- You are economically interdependent and can provide proof of financial interdependence as determined by Rentokil North America, Inc.
- Neither of you is legally married to anyone, and
- You are not related by blood in a way that would prevent you from being married in the state where you both reside.
- You are not in the relationship solely for the purpose of obtaining health care coverage

To be eligible for dependent coverage, proof that dependents meet the above criteria may be required.

Changes in Membership Status

In order for there to be consistent coverage for you and your dependents, you must keep the RTX Benefits team timely informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage. Please consult with your RTX Benefits at (800) 901-9025 or MyHR@Rentokil-Terminix.com regarding all applicable deadlines for enrollment.

Medicare

If you or a dependent are entitled to Medicare (either due to age or disability) benefits your program will not duplicate payments or benefits provided under Medicare. However, your program may supplement the Medicare benefits, including the deductible and coinsurance not covered by Medicare, provided the services are eligible under your group's program. Contact your plan administrator for specific details.

Covered Active Employees Age 65 or Over

If you are age sixty-five (65) or over and actively employed in a group with twenty (20) or more members, you will remain covered under the program for the same benefits available to employees under age sixty-five (65). As a result:

- the program will pay all eligible expenses first.
- Medicare will then pay for Medicare eligible expenses, if any, not paid for by the program.

- or -

Non-Covered Active Employees Age 65 or Over

If you are age sixty-five (65) or over and actively employed, you may elect not to be covered under your program. In such a case, Medicare will be your only coverage. If you choose this option, you will not be eligible for any benefits under the program. Contact your plan administrator for specific details.

Spouses Age 65 or Over of Active Employees

If you are actively employed in a group with twenty (20) or more employees, your spouse has the same choices for benefit coverage as indicated above for the employee age sixty-five (65) and over.

Regardless of the choice made by you or your spouse, each one of you should apply for Medicare Part A coverage about three months prior to becoming age sixty-five (65). If you elect to be covered under the program, you may wait to enroll for Medicare Part B. You will be able to enroll for Part B later during special enrollment periods without penalty.

Leave of Absence or Layoff

Upon your return to work following a leave of absence or layoff, you may be eligible to participate in the Plan and make new benefit elections, provided you satisfy the eligibility requirements and make your benefit elections within the 30-day qualified life event enrollment period.

Continuation of Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that covers group health plans sponsored by an employer (private sector or state/local government) that employed at least twenty (20) employees on more than fifty percent (50%) of its typical business days in the previous calendar year. Employers that are subject to COBRA must temporarily extend their health care coverage to certain categories of employees and their covered dependents when, due to certain "qualifying events," they are no longer eligible for group coverage.

Contact your employer for more information about COBRA and the events that may allow you or your dependents to temporarily extend health care coverage.

Termination of Your Coverage Under the Group Contract

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

No Benefits after Termination of Coverage

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

Coordination of Benefits

Most health care programs, including your health care program, contain a coordination of benefits provision. This provision is used when you, your spouse or your covered dependents are eligible for payment under more than one health care program. The object of coordination of benefits is to ensure that your covered expenses will be paid, while preventing duplicate benefit payments. Highmark has the right to decide when to apply the below Coordination of Benefits provisions and shall not be required to determine the existence of any other health care program providing coverage to you or your dependents. In order to administer these provisions, Highmark may need to obtain information related to other health care coverage and may release such information to any organization or person as necessary. You must provide information related to other health care coverage through the completion of any questionnaires, surveys or other methods as requested by Highmark. Failure to timely provide the required information may result in claims processing delays or the denial of payment for covered services. You must also timely notify Highmark of any changes to any other health care coverage.

Here is how the coordination of benefits provision works:

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your program.
- When the person who received care is covered as an employee under one contract, and as a dependent under another, then the employee coverage pays first.
- When a dependent child is covered under two contracts whose parents are married or are living together, whether or not they have ever been married, the contract which covers the person as a

dependent of the parent whose birthday (month and day) falls earliest in the calendar year will be primary. But, if both parents have the same birthday, the program which covered the parent longer will be the primary program.

- If the dependent child's parents are divorced or separated or not living together, whether or not they have ever been married, the following applies:

    - if a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage, that contract is the primary program;
    - if a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provision for married or living together above shall determine the order of benefits;
    - if a court decree states the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provision for married or living together above shall determine the order of benefits; or
    - if there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

        i. the contract covering the custodial parent;

        ii. the contract covering the spouse of custodial parent;

        iii. the contract covering the non-custodial parent; and then

        iv. the contract covering the spouse of the non-custodial parent

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

    - the benefits of a program covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a program covering the person as a laid-off or retired employee or as a dependent of such person and if
    - the other program does not have this provision regarding laid-off or retired employees, and, as a result, plans do not agree on the order of benefits, then this rule is ignored.

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

Force Majeure

No failure, delay or default in performance of any obligation of Highmark shall constitute an event of default or breach to the extent that such failure to perform, delay or default arises out of a cause, existing or future, that is beyond the reasonable control and not the result of the negligence of Highmark. Such events include, by way of illustration and not limitation, Acts of God, war (declared or undeclared), government regulation, acts or inaction of governmental authority, civil or military authority, unforeseen disruptions caused by suppliers, subcontractors, vendors or carriers, terrorism, disaster, strikes, civil disorder, curtailment of transportation facilities, fire, floods, blizzards, epidemics, pandemics, viral or communicable disease outbreaks, National Emergency, quarantines, disruption of the labor force and/or any other cause which is beyond the reasonable control of Highmark (hereinafter a "Force Majeure Event"), that makes it impossible, illegal or commercially impracticable for Highmark to perform its obligations in whole or in part.

Upon the occurrence of a Force Majeure Event, Highmark shall take action to minimize the consequences of the Force Majeure Event. If Highmark relies on any of the foregoing as an excuse for failure, default or delay in performance, it shall give prompt written notice to the group of the facts that constitute such Force Majeure Event, when it arose and when it is expected to cease.

Subrogation

As used in this booklet, "subrogation" refers to the Plan's right to seek payment and/or reimbursement from a person or organization responsible, or potentially responsible, for the Plan's payment of health care expenses you incurred in connection with an injury.

The Plan also has the right to seek payment and/or reimbursement from you if you receive a payment, settlement, judgment or award from a person, organization or insurance company in connection with an injury caused or alleged to be caused by the person or organization. The Plan has this right regardless of whether:

- liability is admitted by any potentially responsible person or organization;
- the payment, settlement, judgment or award you received identifies medical benefits provided by the Plan; or
- the payment, settlement, judgment or award is otherwise designated as "pain and suffering" or "non-economic damages" only.

The Plan shall have a first priority lien on the proceeds of any payment, settlement or award you receive in connection with an injury caused by a person or organization. The lien shall be in the amount of benefits paid on your behalf regardless of whether you are made-whole for your loss or because you have incurred attorney fees or costs.

The Plan will provide eligible benefits when needed, but you may be asked to show, execute and/or deliver documents, or take other necessary actions to support the Plan in any subrogation efforts. Neither you nor any of your dependents shall do anything to prejudice the right given to the Plan by this Subrogation section without the Plan's consent.

A Recognized Identification Card

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

If your card is lost or stolen, please contact Member Service immediately. You can also request additional or replacement cards online by logging onto the website located on the back of your member ID card. It’s illegal to lend your ID card to anyone who is not eligible to use your benefits.

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

- Member name
- Member Identification number
- Group number
- Copayment for physician office visits and emergency room visits (if applicable)
- Plan deductible (if applicable)
- Out-of-pocket limit (if applicable)
- Total maximum out-of-pocket (if applicable)
- Pharmacy network logo (when applicable)
- Member Service toll-free number (on back of card)
- Member website (on back of card)

How to File a Claim

Notice of Claim and Proofs of Loss

(Applies to Post-service Claims Only)

Network providers have entered into an agreement with Highmark pertaining to the payment for covered services that they provide to you. When you receive covered services from a network provider, it is the responsibility of the network provider to submit its claim to Highmark in accordance with the terms of its participation agreement. Should the network provider fail to submit its claim in a timely manner or otherwise satisfy Highmark's requirements as they relate to the filing of claims, you will not be liable, and the network provider shall hold you harmless relative to payment of the covered services that you received.

When covered services are received from other than a network provider, you are responsible for submitting the claim to Highmark. In such instances, you must submit the claim in accordance with the following procedures:

Notice of Claim
Highmark will not be liable for any claims unless proper notice is furnished to Highmark that you have received covered services. Written notice of a claim must be given to Highmark within twenty (20) days or as soon as reasonably possible after you have received covered services. Notice given by you or on your behalf to Highmark that includes information sufficient to identify you shall constitute sufficient notice of a claim to Highmark. You can give notice to Highmark by writing to the Member Service Department. The address of the Member Service Department can be found on your ID card. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Claim Forms
Proofs of loss for covered services must be submitted to Highmark on the appropriate claim form. Highmark, upon receipt of a notice of a claim will, within fifteen (15) days following the date a notice of a claim is received, furnish you with claim forms for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of such notice, you shall be deemed to have complied with the requirements of this subsection as to filing proofs of loss upon submitting, within the time fixed in this subsection for filing proofs of loss, itemized bills for covered services as described below. The proofs of loss may be submitted to Highmark at the address appearing on your ID card.

Proofs of Loss
Claims cannot be paid until written proofs of loss are submitted to Highmark. Written proofs of loss must be provided to Highmark within twelve (12) months after the date of such loss. Proofs of loss must include all data necessary for Highmark to determine benefits. Failure to submit proofs of loss to Highmark within the time specified will not invalidate or reduce any claim if it is shown that the proofs of loss were submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will Highmark be required to accept proofs of loss later than 1 year from the time proof is otherwise required.

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

To avoid delay in handling claims that you submit, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing:

Person or organization providing the service or supply
Type of service or supply
Date of service or supply
Amount charged
Name of patient

In addition to the above, private duty nursing bills must contain the shifts worked, the charge per day, the professional status of the nurse, and the signature of the professional provider prescribing the service. Professional provider bills must show specific treatment dates. Your attending professional provider must include a signature on all bills as certification that services have been prescribed, except for doctor bills or hospital bills. (Some bills requiring a signature of the professional provider include ambulance, prosthetic devices, rental of durable medical equipment, private duty nursing, etc.). Itemized bills cannot be returned.

A request for payment of a claim will not be reviewed and no payment will be made unless all of the information and evidence of payment required on the claim form has been submitted in the manner described above. Highmark reserves the right to require additional information and documents as needed to support a claim that a covered service has been rendered.

Notice of Highmark's claim determination will be issued within a reasonable period of time not to exceed thirty (30) days following the receipt of proper proofs of loss. This period of time may be extended one (1) time by Highmark for an additional period of time not to exceed fifteen (15) days provided the extension is due to matters outside the control of Highmark and a written explanation for the delay is provided to you.

In the event that Highmark renders an adverse decision on the claim, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement describing your right to file an appeal.

Time of Payment of Claims
Claim payments for benefits payable under this program will be processed immediately upon receipt of proper proofs of loss.

Authorized Representative
Nothing in this section shall preclude your duly authorized representative from filing or otherwise pursuing a claim on behalf of you. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

Limitation on Legal Actions

After a notice of claim has been given, you may not take legal action for sixty days. You may not take legal action later than three years after the expiration of the time within which a notice of claim is required.

Physical Examinations and Autopsy

Highmark, at its own expense, shall have the right and opportunity to examine the person of the member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Your Explanation of Benefits Statement

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

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

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

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

How to Voice a Complaint

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

Highmark
P.O. Box 226
Pittsburgh, PA 15222

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

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

Fraud or Provider Abuse

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

Additional Information on How to File a Claim

Member Inquiries

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

Filing Benefit Claims

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

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

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

Determinations on Benefit Claims

- ***Notice of Benefit Determinations Involving Requests for Precertification and Other Pre-Service Claims***
  For a description of the time frames in which requests for precertification or other pre-service claims will be determined by Highmark and the notice you will receive concerning its decision, whether adverse or not, see the Precertification, Preauthorization and Pre-Service Claims Review Processes subsection in the Health Care Management section of this benefit booklet.

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

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

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

Appeal Procedure

Your benefit program maintains an appeal process involving two levels of review with the exception of urgent care claims (which involve a single level of review). At any time during the appeal process, you may choose to designate a representative to participate in the appeal process on your behalf. You or your representative shall notify Highmark in writing of the designation.

For purposes of the appeal process, "you" includes designees, legal representatives and, in the case of a minor, parent(s) entitled or authorized to act on your behalf.

Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by Highmark shall, in the case of an urgent care claim, permit your physician or other provider of health care with knowledge of your medical condition to act as your representative.

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

Initial Review

If you receive notification that a claim has been denied by Highmark, in whole or in part, or is not subject to legal prohibitions against balance billing, you may appeal the decision. Your appeal must be submitted not later than one hundred-eighty (180) days from the date you received notice from Highmark of the adverse benefit determination.

Upon request to Highmark, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit or present additional evidence or testimony, which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of your appeal.

A representative from the Appeal Review Department will review the initial appeal. The representative will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on your appeal, the Appeal Review Department will take into account all evidence, comments, testimony, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Highmark. The Appeal Review Department will also afford no deference to any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigational, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal.

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

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

In the event Highmark renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, the procedure for appealing the decision and, in the case of an adverse benefit determination involving a pre-service claim, a statement regarding your right to request an external review or pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Your decision to proceed with a second level review of a pre-service claim (other than an urgent care claim, which involves one level of review) is voluntary. In other words, you are not required to pursue the second level review of a pre-service claim before pursuing a claim for benefits in court under §502 of ERISA. Should you elect to pursue the second level review before filing a claim for benefits in court, your benefit program:

- Will not later assert in a court action under §502 of ERISA that you failed to exhaust administrative remedies (i.e. that you failed to proceed with a second level review) prior to the filing of the lawsuit;
- Agrees that any statute of limitations applicable to the claim for benefits under §502 of ERISA will not commence (i.e. run) during the second level review; and
- Will not impose any additional fee or cost in connection with the second level review.

If you have further questions regarding second level reviews of pre-service claims, you should contact Member Service using the telephone number on your ID card.

Second Level Review

If you are dissatisfied with the decision following the initial review of your appeal (other than the review of an urgent care claim), you may request to have the decision reviewed by Highmark. The request to have the decision reviewed must be submitted in writing (or communicated orally under special circumstances) within forty-five (45) days from the date of an adverse benefit determination.

Upon request to Highmark, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit or present additional evidence or testimony, which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of your appeal.

A representative from the Appeal Review Department will review your second level appeal. The representative will be an individual who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the matter under review.

In rendering a decision on the second level appeal, the Appeal Review Department will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Highmark. The Appeal Review Department will also afford no deference to any previous adverse benefit determination regarding the matter under review.

In rendering a decision on a second level appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigational, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the matter under review.

Your second level appeal will be promptly investigated and Highmark will provide you with written notification of its decision within the following time frames:

- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed thirty (30) business days following receipt of the appeal; or

- When the appeal involves a post-service claim, within a reasonable period of time not to exceed thirty (30) days following receipt of the appeal.

In the event Highmark renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination and, in the case of an adverse benefit determination involving a post-service claim, a statement regarding your right to request an external review or pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

External Review

You have four (4) months from the date you receive notice of a final Highmark adverse benefit determination to file a request for an external review with Highmark. Note that for pre-service claims, the four (4) month period begins to run from the date you received Highmark's first-level adverse benefit determination.

To be eligible for external review, the decision of Highmark must have involved (i) a claim that was denied involving medical judgment, including, application of Highmark's requirements as to medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered service or a determination that the treatment is experimental or investigational; (ii) a claim that Highmark has concluded is not subject to legal prohibitions against balance billing; or (iii) a determination made by your plan administrator to rescind your coverage.

In the case of a denied claim, the request for external review may be filed by either you or a health care provider with your written consent in the format required by or acceptable to Highmark. The request for external review should include any reasons, material justification and all reasonably necessary supporting information as part of the external review filing.

Preliminary Review

Highmark will conduct a preliminary review of your external review request within five (5) business days following the date on which Highmark receives the request. Highmark's preliminary review will determine whether:

- You were covered by your plan at all relevant times;
- The adverse benefit determination relates to your failure to meet your plan’s eligibility requirements;
- You exhausted the above-described appeal process; and
- You submitted all required information or forms necessary for processing the external review.

Highmark will notify you of the results of its preliminary review within one (1) business day following its completion of the review. This will include our reasons regarding the ineligibility of your request, if applicable,

and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not complete, Highmark's notification will describe the information or materials needed to make the request complete. You will then have the balance of the four (4) month filing period or, if later, forty eight (48) hours from receipt of the notice, to perfect your request for external review; whichever is later.

In the event that the external review request is complete but not eligible for external review, notification by Highmark will include the reasons why the request is ineligible for external review and contact information that you may use to receive additional information and assistance.

Referral to an Independent Review Organization (IRO)
Highmark will, randomly or by rotation, select an IRO to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Within five (5) business days thereafter, Highmark will provide the IRO with documents and information we considered when making our final adverse benefit determination. The IRO may reverse Highmark's final adverse benefit determination if the documents and information are not provided to the IRO within the five-day time frame.

The IRO will timely notify you in writing of your eligibility for the external review and will provide you with at least ten (10) business days following receipt of the notice to provide additional information.

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim *de novo*. In other words, the IRO will not be bound by any decisions or conclusions reached during the above described appeal process.

The assigned IRO must provide written notice of its final external review decision within forty-five (45) days after the IRO received the request for the external review. The IRO will deliver its notice of final external review decision to you and Highmark. The IRO's notice will inform you of:

- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Coverage or payment for the requested benefits will be paid immediately upon Highmark's receipt of the IRO's notice of a final external review decision from the IRO that reverses Highmark's prior final internal adverse benefit determination.

Expedited External Review (Applies to Urgent Care Claims Only)
You are entitled to the same procedural rights to an external review as described above on an expedited basis:

- If the final adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or your health or would jeopardize your ability to regain maximum function and you filed a request for an expedited internal appeal; or
- Following a final internal adverse benefit determination, if you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or

health or would jeopardize your ability to regain maximum function, or the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from the facility rendering the emergency services.

In the above circumstances, Highmark will immediately conduct a preliminary review and will immediately notify you of our reasons regarding the ineligibility of your request, if applicable, and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not complete, Highmark's notification will describe the information or materials needed to make the request complete. You will then have forty-eight (48) hours from receipt of the notice, to perfect your request for external review.

Referral to an Independent Review Organization (IRO) (Applies to Urgent Care Claims Only)
Highmark will, randomly or by rotation, select an IRO to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Thereafter, Highmark will immediately provide the IRO with documents and information we considered when making our final adverse benefit determination via the most expeditious method (e.g., electronic, facsimile, etc.).

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim *de novo*. In other words, the IRO will not be bound by any decisions or conclusions reached during the above described appeal process.

The assigned IRO must provide notice of its final external review decision as expeditiously as possible, but in no event more than seventy-two (72) hours from the time the IRO received the request for the external review. The IRO must provide written notice of its final external review decision to you and to Highmark, if not originally in writing, within forty-eight (48) hours of its original decision. The IRO's written notice will inform you of:

- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Coverage or payment for the requested benefits will be paid immediately upon Highmark's receipt of the IRO's notice of a final external review decision from the IRO that reverses Highmark's prior final internal adverse benefit determination.

Member Rights and Responsibilities

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

You have the right to:

1. Receive information about your group health plan, its practitioners and providers, and your rights and responsibilities.

2. Be treated with respect and recognition of your dignity and right to privacy.

3. Participate with practitioners in decision-making regarding your health care. This includes the right to be informed of your diagnosis and treatment plan in terms that you understand and participate in decisions about your care.

4. Have a candid discussion of appropriate and/or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Highmark does not restrict the information shared between practitioners and patients and has policies in place, directing practitioners to openly communicate information with their patients regarding all treatment options regardless of benefit coverage.

5. Voice a complaint or file an appeal about Highmark or the care provided and receive a reply within a reasonable period of time.

6. Make recommendations regarding the Highmark Members' Rights and Responsibilities policies.

You have a responsibility to:

1. Supply to the extent possible, information that the organization needs in order to make care available to you, and that its practitioners and providers need in order to care for you.

2. Follow the plans and instructions for care that you have agreed on with your practitioners.

3. Communicate openly with the physician you choose. Ask questions and make sure you understand the explanations and instructions you are given and participate in developing mutually agreed upon treatment goals. Develop a relationship with your doctor based on trust and cooperation.

How We Protect Your Right to Confidentiality

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

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

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

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

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

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

Terms You Should Know

*The following terms apply **only** if your group provides coverage for this benefit. Depending on your health care program not all terms may apply. Your group administrator can determine if you are eligible for this coverage. Please refer to the Summary of Benefits section of this booklet.*

Affordable Care Act (ACA) - The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) and its implementing regulations.

Ambulance Service - An ancillary provider licensed by the state which, for compensation from its patients, provides local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured. Ambulance service includes an emergency medical services (EMS) agency licensed by the state.

Ambulatory Surgical Facility - A facility provider, with an organized staff of physicians, which is licensed as required by the state and which, for compensation from its patients:

a. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;

b. provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility;

c. does not provide inpatient accommodations; and

d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a professional provider.

Ancillary Provider - A person or entity licensed where required and performing services within the scope of such licensure.

Ambulance Service
Clinical Laboratory
Diabetes Prevention Provider
Home Infusion Therapy Provider
Independent Diagnostic Testing Facility (IDTF)
Suite Infusion Therapy Provider
Suppliers

Anesthesia - The administration of a regional or rectal anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, induce an altered state, loss of sensation or loss of consciousness.

Approved Clinical Trial - A Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that has been federally funded, authorized or approved by one of the following:

a. The National Institutes of Health (NIH), including the National Cancer Institute (NCI);

b. The United States Food and Drug Administration (FDA) in the form of an investigational new drug (IND) exemption;

c. The United States Department of Defense (DOD);

d. The United States Department of Veterans Affairs (VA);

e. The Centers for Disease Control and Prevention (CDC);

f. The Agency for Healthcare Research and Quality (AHRQ);

g. The Centers for Medicare and Medicaid Services (CMS);

h. The Department of Energy; or

i. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support.

Highmark may, at its discretion, approve other clinical trials that do not satisfy the above criteria.

Assisted Reproductive Technology - Includes all treatments or procedures that involve the in vitro (i.e., outside of the living body) handling of both human oocytes (eggs) and sperm, or embryos, for the purpose of establishing a pregnancy. This includes, but is not limited to, in vitro fertilization (IVF) and embryo transfer, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), tubal embryo transfer (TET), peritoneal ovum sperm transfer, zona drilling, sperm microinjection, gamete and embryo cryopreservation (freezing), oocyte and embryo donation, and gestational surrogacy or carrier, but does not include artificial insemination in which sperm are placed directly into the vagina, cervix or uterus.

Bariatric Surgery - An operation on the stomach and/or intestines intended to help promote weight loss including, but not limited to, vertical banded gastroplasty, gastric stapling, laparoscopic adjustable gastric banding, mini-gastric bypass, gastric bypass with Roux-en-Y, biliopancreatic diversion, biliopancreatic diversion with duodenal switch, long-limb gastric bypass, intestinal gastric bypass, or any other surgical procedure designed to restrict an individual's ability to assimilate food.

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

Birthing Facility - A facility provider licensed by the state which, for compensation from its patients, is primarily organized and staffed to provide maternity care and is under the supervision of a nurse-midwife.

Blue Distinction Center - A provider designated by the Blue Cross Blue Shield Association for meeting certain quality focused criteria in a particular area of specialized care. The provider may be recognized as a Blue Distinction Center in one or more areas of specialized care.

Blue Distinction Center+ - A provider designated by the Blue Cross Blue Shield Association for meeting certain quality focused criteria as well as cost of care measures in a particular area of specialized care. The provider may be recognized as a Blue Distinction Center+ in one or more areas of specialized care.

Blue Distinction Specialty Care Program - A national designation program identifying providers that demonstrate expertise in delivering quality specialty care safely, effectively and cost efficiently relative to specific services. Providers that choose to participate in the Blue Distinction Specialty Care Program may be recognized as either Blue Distinction Centers or Blue Distinction Centers+.

Blue High Performance Network - Provides in-network access to the industry's most expansive HPN footprint—more than 55+ major U.S. markets—and is the only HPN with presence in all top 10 U.S. cities. This national network uses local market expertise, deep data and strong provider relationship which means it includes the right primary care physicians, hospital and specialist in each market to enhance care quality and lower cost. Network coverage includes all provider types (PCP's, specialties and hospitals) with market specific exceptions (such as renal dialysis, behavioral health, Children's Hospitals, etc.).

Blues On Call (Health Education and Support Program) - A program administered by the designated agent through which you receive health education and support services, including assistance in the self-management of certain health conditions.

Board-Certified - A designation given to those physicians who, after meeting strict standards of knowledge and practices, are certified by the professional board representing their specialty.

Certified Registered Nurse - A certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any registered professional nurses employed by a health care facility, as defined in the Pennsylvania Health Care Facilities Act or by an anesthesiology group.

Claim - A request for precertification, preauthorization or prior approval of a covered service or for the payment or reimbursement of the charges or costs associated with a covered service. Claims include:

- **Pre-Service Claim** - A request for precertification, preauthorization or prior approval of a covered service which under the terms of your coverage must be approved before you receive the covered service.
- **Urgent Care Claim** - A pre-service claim which, if decided within the time periods established for making non-urgent care pre-service claim decisions, could seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service. Whether a request involves an urgent care claim will be determined by your attending physician or provider.
- **Post-Service Claim** - A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

For purposes of the claim determination and appeal procedure provisions, whether a claim or an appeal of a denied claim involves a pre-service claim, an urgent care claim or a post-service claim will be determined at the time that the claim or appeal is filed with Highmark in accordance with its procedures for filing claims and appeals.

Clinical Laboratory - A medical laboratory licensed where required, performing within the scope of such licensure, and is not affiliated or associated with a hospital or physician.

Clinical Social Worker - A licensed clinical social worker performing within the scope of such licensure. Where there is no licensure law, the clinical social worker must be certified by the appropriate professional body.

Coinsurance - The percentage of the plan allowance for covered services that is your responsibility. The remaining percentage is the responsibility of Highmark subject to the provisions of this program.

Copayment - A specified dollar amount of eligible expenses which you are required to pay for a specified covered service and which will be deducted from the plan allowance before the determination of the benefits payable under this program is made.

Covered Service - A service or supply specified by your program which is eligible for payment when rendered by a provider.

Custodial Care - Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting the activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Multiple non-skilled nursing services/non-skilled rehabilitation services in the aggregate do not constitute skilled nursing services/skilled rehabilitation services. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparing special diets and supervising the administration of medications not requiring skilled nursing services/skilled rehabilitation services provided by trained and licensed medical personnel.

Deductible - A specified dollar amount of liability for covered services that must be incurred by you before your program will assume any liability for all or part of the remaining covered services.

Dentist - A person who is a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.), licensed where required and performing services within the scope of such licensure.

Dependent - A member other than the employee as specified herein.

Designated Agent - An entity that has contracted, either directly or indirectly, with your health care program to perform a function and/or service in the administration of this program. Such function and/or service may include, but is not limited to, medical management and provider referral.

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

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

Diabetes Prevention Program - A 12-month program using curriculum approved by the Centers for Disease Control to deliver a prevention lifestyle intervention for those at high risk of developing type 2 diabetes. The program includes behavioral and motivational content focusing on moderate changes in both diet and physical activity.

Diabetes Prevention Provider - An entity that offers a diabetes prevention program.

Diagnostic Service - A testing procedure ordered by a professional provider because of specific symptoms to determine a definite condition or disease.

Dietitian-Nutritionist - A licensed dietitian-nutritionist performing within the scope of such licensure. Where there is no licensure law, the dietitian-nutritionist must be certified by the appropriate professional body.

Domestic Partner - Your "domestic partner" means a same-sex or opposite-sex domestic partner of a Rentokil North America, Inc. employee. An individual will be considered by the Plan to be your domestic partner if you complete an Affidavit of Domestic Partnership and you both have a dedicated relationship characterized by all of the following:

- You are both at least 18 years old,
- You share a common residence for at least 12 months immediately preceding enrollment and intend to do so indefinitely,
- You are each other's sole Domestic Partner,
- Neither of you has had another Domestic Partner within the prior 12 months,
- You are economically interdependent and can provide proof of financial interdependence as determined by Rentokil North America, Inc.
- Neither of you is legally married to anyone, and
- You are not related by blood in a way that would prevent you from being married in the state where you both reside.
- You are not in the relationship solely for the purpose of obtaining health care coverage

Domestic Partnership - A voluntary relationship between two (2) domestic partners.

Durable Medical Equipment - Items which can withstand repeated use; are primarily and customarily used to serve a productive medical purpose; are generally not useful to a person in the absence of illness, injury or disease; are appropriate for use in the home and do not serve as comfort or convenience items.

Effective Date - The date when your coverage begins.

Emergency Care Services - The treatment of bodily injuries resulting from an accident, or following the sudden onset of a medical condition, or following, in the case of a chronic condition, a sudden and unexpected medical event that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- placing your health or, with respect to a pregnant member, the health of the member or the unborn child in serious jeopardy;
- causing serious impairment to bodily functions; and/or
- causing serious dysfunction of any bodily organ or part

and for which care is sought as soon as possible after the medical condition becomes evident to you.

Employee - An individual who meets the eligibility requirements specified herein.

Enteral Foods - A liquid source of nutrition equivalent to a prescription drug that is administered orally or enterally and which may contain some or all nutrients necessary to meet minimum daily nutritional

requirements. Enteral foods are intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are identified through medical evaluation.

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

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

Facility Provider - An entity which is licensed, where required, to render covered services. Facility providers include:

- Ambulatory Surgical Facility
- Birthing Facility
- Freestanding Dialysis Facility
- Freestanding Nuclear Magnetic Resonance Facility/Magnetic Resonance Imaging Facility
- Home Health Care Agency
- Hospice
- Hospital
- Outpatient Physical Rehabilitation Facility
- Outpatient Psychiatric Facility
- Outpatient Substance Abuse Treatment Facility
- Psychiatric Hospital
- Rehabilitation Hospital
- Residential Treatment Facility
- Skilled Nursing Facility
- State-Owned Psychiatric Hospital
- Substance Abuse Treatment Facility

Family Counseling - Counseling with family members in the assessment of the patient's diagnosis and treatment. Such counseling may assist family members to gain insight into the patient's illness and serve as an adjunct of the treatment regimen. Nevertheless, the services must primarily relate to the management of the patient's illness.

Family Coverage - Coverage for the employee and one (1) or more of the employee's dependents.

Family Deductible - A specified dollar amount of liability for covered services that must be incurred by one (1) or more covered family members before Highmark will assume any liability for all or part of the remaining covered services. Once the family deductible is met, no further deductible amounts must be satisfied by any covered family member.

Freestanding Dialysis Facility - A facility provider licensed and approved by the appropriate governmental agency which, for compensation from its patients, is primarily engaged in providing dialysis treatment, maintenance or training to patients on an outpatient or home-care basis.

Freestanding Nuclear Magnetic Resonance Facility/Magnetic Resonance Imaging Facility - A facility provider which, for compensation from its patients, is primarily engaged in providing, through an organized professional staff, nuclear magnetic resonance/magnetic resonance imaging scanning. These facilities do not include Inpatient beds, medical or health-related services.

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

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

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

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

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

Health Care Management Services - A program which integrates all activity related to managing your medical care from the time that an admission, surgical or diagnostic procedure, or certain services become necessary. The program consists of any applicable pre-admission certification, admission certification of emergency admissions, continued stay review, discharge planning, procedure or covered service precertification, case management, home health care precertification and skilled nursing facility precertification.

Highmark Blue Cross Blue Shield - An independent licensee of the Blue Cross Blue Shield Association. Any reference to Highmark Blue Cross Blue Shield may also include its Designated Agents with whom Highmark Blue Cross Blue Shield has contracted to perform a function or service.

Highmark Blue Shield - An independent licensee of the Blue Cross Blue Shield Association. Any reference to Highmark Blue Shield may also include its designated agents with whom Highmark Blue Shield has contracted to perform a function or service.

Highmark Blue Shield Participating Facility Provider - A facility provider, licensed where required and performing within the scope of such licensure, that has an agreement, either directly or indirectly with Highmark Blue Shield, operating as a hospital plan corporation, pertaining to payment for covered services rendered to you.

Highmark Blue Shield Participating Facility Provider Network - All Highmark Blue Shield participating facility providers, approved as a network by the Pennsylvania Department of Health, that have entered into a network agreement, either directly or indirectly with Highmark Blue Shield to provide health care services to you.

Highmark Managed Care Facility Provider - A facility provider, licensed where required and performing within the scope of its license, that has entered into a Highmark Managed Care Network agreement, either directly or indirectly, with Highmark Inc. pertaining to payment as a participant in a managed care network for covered services rendered to you.

Highmark Managed Care Network - All Highmark managed care facility providers and professional providers, approved as a network by the Pennsylvania Department of Health, that have entered into a network agreement, either directly or indirectly, with Highmark Inc. pertaining to payment as a participant in a managed care network for covered services rendered to you.

Highmark Managed Care Professional Provider - A professional provider, licensed where required and performing within the scope of its license, that has entered into a Highmark Managed Care Network agreement, either directly or indirectly, with Highmark Inc. pertaining to payment as a participant in a managed care network for covered services rendered to you.

Highmark NE Participating Facility Provider - A facility provider, located in the Plan Service Area, licensed where required and performing within the scope of such licensure, that has an agreement, either directly or indirectly, with Highmark pertaining to payment for covered services rendered to you.

Highmark NE Participating Facility Provider Network - All Highmark NE participating facility providers, approved as a network by the Pennsylvania Department of Health, that have entered into an agreement, either directly or indirectly with Highmark Blue Cross Blue Shield to provide health care services to you.

Highmark Northeastern Pennsylvania Service Area - The geographic area within northeastern Pennsylvania consisting of the following counties in Pennsylvania:

Bradford
Carbon
Clinton
Lackawanna
Luzerne
Lycoming
Monroe
Pike
Sullivan
Susquehanna
Tioga
Wayne
Wyoming

Highmark Southeastern Pennsylvania Service Area - The geographic area within southeastern Pennsylvania consisting of the following counties in Pennsylvania:

Bucks
Chester
Delaware
Montgomery
Philadelphia

Highmark Western Pennsylvania Service Area - The geographic area, within western Pennsylvania, consisting of the following counties in Pennsylvania:

Allegheny
Armstrong
Beaver
Bedford
Blair
Butler
Cambria
Cameron
Centre (part)
Clarion
Clearfield
Crawford
Elk
Erie
Fayette
Forest
Greene
Huntingdon
Indiana
Jefferson
Lawrence
McKean
Mercer
Potter
Somerset
Venango
Warren
Washington
Westmoreland

Home Health Care Agency - A facility provider program for home health care, licensed by the state and certified by Medicare which, for compensation from its patients:

a. provides skilled nursing and other services on a visiting basis in the Member's home, and

b. is responsible for supervising the delivery of such services under a plan prescribed by the attending physician.

Home Infusion Therapy Provider - An ancillary provider licensed by the state, accredited by The Joint Commission, if appropriate, and organized to provide infusion therapy to patients at their place of residence.

Hospice - A facility provider, licensed by the state which, for compensation from its patients, is primarily engaged in providing palliative care to terminally ill individuals.

Hospice Care - A program which provides an integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients and their families. Hospice services are centrally coordinated through an interdisciplinary team directed by a physician.

Hospital - A duly licensed facility provider that is a general or special hospital which has been approved by Medicare, The Joint Commission or the American Osteopathic Hospital Association which, for compensation from its patients:

a. is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment and care of injured and sick persons, and

b. provides twenty-four hour nursing services by or under the supervision of registered nurses.

Identification Card (ID Card) - The currently effective card issued to you by Highmark.

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

In-Area - The geographic area covering Pennsylvania.

Incurred - A charge is considered incurred on the date the Member received the service or supply for which the charge is made. For purposes of this definition and this booklet, a "charge" encompasses the contracted unit/case rate based on a diagnosis related grouping (DRG) or other payment methodology for a service or supply (including any applicable outlier days incurred up to the date on which the Member is terminated from coverage) except as may otherwise be provided under the applicable Provider agreement and applicable Blue Cross Blue Shield Association policies.

Independent Diagnostic Testing Facility - An ancillary provider operating from a fixed or mobile location, which performs diagnostic testing services, other than clinical laboratory or pathology testing, using diagnostic testing and imaging equipment including, but not limited to, sleep centers/home sleep testing providers, mobile x-ray providers and cardiac event monitoring providers, and other diagnostic imaging providers. Such technical services do not include the interpretation of test results by a professional provider.

Infertility - An interruption, cessation, or disorder of body functions, systems, or organs of the reproductive tract which prevents an individual or couple from the conception of a child or the ability to carry a pregnancy to delivery after regular, unprotected sexual intercourse without medical intervention or as diagnosed by a licensed physician based on the individual’s medical, sexual, and reproductive history, age, physical findings, and/or diagnostic testing.

Infusion Therapy - The administration of medically necessary and appropriate fluid or medication via a central or peripheral vein to patients.

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

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

Local PPO Network - All providers who have entered into an agreement, either directly or indirectly, with any licensee of the Blue Cross Blue Shield Association located out-of-area pertaining to payment as a participant in that licensee's PPO network for covered services rendered to you.

Marriage and Family Therapist - A licensed marriage and family therapist performing within the scope of such licensure. Where there is no licensure law, the marriage and family therapist must be certified by the appropriate professional body.

Maximum - The greatest amount for which your program may be liable for covered services within a set amount of time. This could be expressed in dollars, number of days or number of services. In connection with such day and/or visit limits, all services received by a member during a benefit period will reduce the remaining number of days and/or visits available under that benefit, regardless of whether the member has satisfied the deductible. There are two types of maximums:

> **Program Maximum** - The greatest amount payable by the program for all covered services.
>
> **Benefit Maximum** - The greatest amount payable by the program for a specific covered service.

Medical Care - Professional services rendered by a professional provider for the treatment of an illness or injury.

Medically Necessary and Appropriate (Medical Necessity and Appropriateness) - Services, medications or supplies that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (iii) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service, sequence of services or site of service at least as likely to produce equivalent therapeutic or diagnostic results given the nature of the patient's diagnosis, treatment, illness, injury or disease, the severity of the patient's symptoms, or other clinical criteria.

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

Medicare - The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Member - An individual who meets the eligibility requirements specified in General Information section provided herein.

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

Network Diabetes Prevention Provider - A diabetes prevention provider that contracts with:

a. Highmark to offer a diabetes prevention program based on a digital model; or

b. Highmark or the local licensee of the Blue Cross Blue Shield Association to offer a diabetes prevention program based on an in-person/onsite model.

Network Facility Provider - A facility provider that has an agreement, either directly or indirectly, with Highmark pertaining to payment as a network participant for covered services rendered to a member.

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

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

Network Service Area - The geographic area consisting of the following counties in Pennsylvania:

Allegheny	Erie	Luzerne	Northampton	Washington
Beaver	Fayette	McKean	Schuylkill	Westmoreland
Bedford	Lawrence	Mercer	Somerset	
Blair	Lehigh	Monroe	Venango	

Nurse-Midwife - A licensed nurse-midwife. Where there is no licensure law, the nurse-midwife must be certified by the appropriate professional body.

Occupational Therapist - A licensed occupational therapist performing within the scope of such licensure. Where there is no licensure law, the occupational therapist must be certified by the appropriate professional body.

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

Open Enrollment Period - The period during which you and your eligible dependents may enroll for coverage.

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

Out-of-Area - The geographic area outside of Pennsylvania.

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

Out-of-Network Service - A service, treatment or care that is provided by an out-of-network provider.

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

Outpatient - A member who receives services or supplies while not an inpatient.

Outpatient Psychiatric Facility - A facility provider which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the treatment of mental illness on an outpatient basis.

Outpatient Substance Abuse Treatment Facility - A facility provider which, for compensation from its patients, is primarily engaged in providing detoxification services (withdrawal management services) and/or rehabilitative counseling services for the treatment of substance abuse and diagnostic and therapeutic services for the treatment of substance abuse on an outpatient basis. This facility must also meet the minimum standards set by the Pennsylvania Department of Health, the Pennsylvania Office of Drug and Alcohol Programs, or another appropriate governmental agency.

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

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

Physical Therapist - A licensed physical therapist. Where there is no licensure law, the physical therapist must be certified by the appropriate professional body.

Physician - A person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed and legally entitled to practice medicine in all of its branches, perform Surgery and dispense drugs.

Plan Allowance - The amount used to determine payment by your program for covered services provided to you and to determine your liability. Plan allowance is based on the type of provider who renders such services or as required by law.

In-Network Benefits
When covered medical services are received from a network provider, then the plan allowance is determined in accordance with the provider's contract with Highmark or on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your health care program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

Out-of-Network Benefits
When covered medical services are received from an out-of-network provider as described below, the plan allowance is determined as follows:

Non-Emergency Services Received at Certain In-Network Facilities from Out-of-Network Physicians
For non-emergency covered medical services received at certain in-network facilities from out-of-network physicians when such services are either ancillary, or non-ancillary that have not satisfied the notice and consent criteria required by federal law, the plan allowance may be based on the (i) the reference price (as defined below) if out of area; (ii) the recognized amount (as defined below); (iii) the amount agreed to by the out-of-network provider and Highmark; or (iv) the amount determined by Independent Dispute Resolution (IDR).

For the purpose of this preceding, "certain In-network facilities" are limited to a hospital, a hospital outpatient department, a critical access hospital, an ambulatory surgical center, and any other facility specified under federal law and regulation.

Emergency Services Provided by an Out-of-Network Provider
For emergency services provided by an out-of-network provider, the plan allowance is based on one of the following in the order listed below as applicable: (i) the reference price (as defined below) if out-of-area; (ii) recognized amount (as defined below) if out of area; (iii) the amount agreed to by the out-of-network provider and Highmark; or (iv) the amount determined by Independent Dispute Resolution (IDR).

Air Ambulance Transportation Provided by an Out-of-Network Provider
For Air Ambulance transportation provided by an out-of-network provider, the plan allowance is based on one of the following in the order listed below as applicable: (i) the recognized amount (as defined below); (ii) the amount subsequently agreed to by the out-of-network provider and Highmark; or (iii) the amount determined by Independent Dispute Resolution (IDR).

In All Other Cases
If you receive covered medical services from an out-of-network provider, the plan allowance for an out-of-network provider located in the Highmark service area is based on an adjusted contractual allowance for like services rendered by a network provider in the same geographic region. You will be responsible for any difference between the provider's billed charges and your program's payment. Reminder, there is no out-of-network coverage except for urgent care, emergency care, and emergency ambulance services.

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

When covered medical services are received from an out-of-network provider outside of the Highmark service area, the plan allowance may be determined on the basis of the reference price (as defined below) or on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your health care program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

Recognized Amount - Except as otherwise provided, the plan allowance and the amount which coinsurance and applicable deductible is based on for covered medical services when provided by: (i) out-of-network emergency service providers; and (ii) non-emergency service received at certain in-network facilities by non-network providers, when such services are either ancillary or non-ancillary provider services that have not satisfied the notice and consent criteria under federal law and regulation. For the purpose of this definition, "certain facilities" are limited to a hospital (a hospital outpatient department, a critical access hospital, an ambulatory surgical center), as defined in federal law and regulation. The Recognized Amount is based on: (i) an all-payer model agreement, if adopted; (ii) state law; or (iii) the lesser of the qualifying payment amount as determined by Highmark (or the local licensee of the Blue Cross Blue Shield Association when the claim is incurred outside of the Highmark service area) under applicable law and regulation, or the amount billed by the provider or facility.

The recognized amount for air ambulance services provided by an out-of-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law and regulation or the amount billed by the air ambulance service provider.

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

Plan Service Area - The geographic area consisting of the Highmark Blue Shield Service Area.

Precertification (Preauthorization/Certification) - The process through which medical necessity and appropriateness of inpatient admissions, services or place of services is determined by Highmark prior to or after an admission or the performance of a procedure or service.

PremierBlue Shield Preferred Professional Provider - A professional provider who has an agreement, either directly or indirectly, with Highmark or Highmark Blue Shield pertaining to payment as a participant in the PremierBlue Shield Professional Provider Network for covered service rendered to you.

PremierBlue Shield Preferred Professional Provider Network - All PremierBlue Shield Preferred Providers approved as a network by the Pennsylvania Department of Health, who have an agreement, either directly or indirectly, with Highmark to provide health care services to you.

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

Primary Care Provider (PCP) - A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics, or a certified registered nurse practitioner each of whom has an agreement with Highmark pertaining to payment as a network participant and has specifically contracted with Highmark to: a) be designated as a PCP; b) supervise, coordinate and provide specific basic medical services to you; and c) maintain continuity of patient care.

Professional Counselor - A licensed professional counselor performing within the scope of such licensure. Where there is no licensure law, the professional counselor must be certified by the appropriate professional body.

Professional Provider - A person or practitioner licensed where required and performing services within the scope of such licensure.

Audiologist
Behavioral Specialist
Certified Registered Nurse
Chiropractor
Clinical Social Worker
Dietitian-Nutritionists
Dentist
Licensed Practical Nurse
Marriage and Family Therapist
Nurse-Midwife
Occupational Therapist
Optometrist
Physical Therapist
Physician
Podiatrist
Professional Counselor
Psychologist
Registered Nurse
Respiratory Therapist
Speech-Language Pathologist
Teacher of the Hearing Impaired

Provider - An ancillary provider, facility provider or professional provider, licensed where required and performing within the scope of such licensure.

Provider Directory - A listing of network providers, which is updated periodically. The provider directory contains a description of network providers, including contact information, areas of expertise and whether the network provider is accepting new patients. Your plan's provider directory can be accessed at the website appearing on the back of your ID card or by calling the number on the back of your ID card.

Psychiatric Hospital - A facility provider approved by The Joint Commission, the American Osteopathic Hospital Association, Council on Accreditation or Commission on Accreditation of Rehabilitation Facilities which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the inpatient treatment of mental illness. Such services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Psychologist - A licensed psychologist. When there is no licensure law, the psychologist must be certified by the appropriate professional body.

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

Rehabilitation Hospital - A facility provider approved by The Joint Commission or by the Commission on Accreditation of Rehabilitation Facilities or certified by Medicare which, for compensation from its patients, is primarily engaged in providing skilled rehabilitation services on an inpatient basis.

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

A residential treatment program must provide the following:

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

b. Clinical assessment at least once a day;

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

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

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

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

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

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

i. Discharge planning initiated within twenty-four hours;

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

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

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

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

Respite Care - Short-term care for a terminally ill member provided by a facility provider when necessary to relieve a person (caregiver) who is caring for the member at home free of charge.

Retail Clinic - A retail-based clinic that provides basic and preventive health care services seven days a week, including evenings and weekends. A retail clinic is generally staffed by certified registered nurses that diagnose and treat minor health problems and triage patients to appropriate levels of care.

Routine Patient Costs - Costs associated with covered services furnished when participating in an Approved Clinical Trial and that Highmark has determined are medically necessary and appropriate. Such costs do not include:

- the costs of investigational drugs or devices themselves;
- the costs of non-health services required by you when receiving treatments or interventions in the course of participating in an Approved Clinical Trial (e.g. transportation, lodging, meals and other travel expenses);
- items or services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of you; and
- a service clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Service - Each treatment rendered by a provider to you for a covered service.

Skilled Nursing Facility - A facility provider approved by the state and certified by Medicare, which, for compensation from its patients, is primarily engaged in providing skilled nursing services on an inpatient basis to patients requiring twenty-four (24) hour skilled nursing Services but not requiring confinement in an acute care general hospital. Such care is rendered by or under the supervision of physicians. A skilled nursing facility is not, other than incidentally, a place that provides:

a. minimal care, custodial care, ambulatory care, or part-time care services; or

b. care or treatment of mental illness, substance abuse or pulmonary tuberculosis.

Skilled Nursing Services/Skilled Rehabilitation Services - Services which have been ordered by and under the direction of a physician and are provided either directly by or under the supervision of a medical professional, e.g., registered nurse, physical therapist, licensed practical nurse, occupational therapist, speech pathologist or audiologist with the treatment described and documented in the patient's medical records. Unless otherwise determined in the sole discretion of Highmark, skilled nursing services/skilled rehabilitation services shall be subject to the following:

a. the skilled nursing services/skilled rehabilitation services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified licensed medical professional and must be such that the care could not be performed by a non-medical individual instructed to deliver such services.

b. the skilled rehabilitation services must be provided with the expectation that the patient has restorative potential and the condition will improve materially in a reasonable and generally predictable period of time. Once a maintenance level has been established or no further progress is attained, the services are no longer classified as skilled rehabilitation and will be considered to be custodial care.

The mere fact that a physician has ordered or prescribed a therapeutic regimen does not, in itself, determine whether a service is a skilled nursing service or a skilled rehabilitation service.

Specialist - A physician, other than a primary care provider, whose practice is limited to a particular branch of medicine or surgery.

State-Owned Psychiatric Hospital - A facility provider, that is owned and operated by the Commonwealth of Pennsylvania, which is primarily engaged in providing treatment and/or care for the Inpatient treatment of mental illness for individuals aged eighteen and older whose hospitalization is ordered by a court of competent jurisdiction through a civil commitment proceeding.

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

Substance Abuse Treatment Facility - A facility provider licensed by the state and approved by an external accreditation body (i.e., The Joint Commission, Commission on Accreditation of Rehabilitation Facilities, Council on Accreditation) which, for compensation from its patients, is primarily engaged in providing detoxification (withdrawal management) and/or rehabilitation treatment for alcohol and/or drug use/misuse. This facility must also meet the minimum standards set by the Pennsylvania Department of Health, the Pennsylvania Office of Drug and Alcohol Programs, or another appropriate governmental agency.

Suite Infusion Therapy Provider - An ancillary provider licensed by the state, accredited by The Joint Commission, if appropriate, and organized to provide infusion therapy to patients at an infusion suite.

Supplier - An individual or entity that is in the business of leasing and selling durable medical equipment and supplies. Suppliers include, but are not limited to, the following:

- durable medical equipment suppliers,
- hearing aid device vendors,
- vendors/fitters,
- orthotic and prosthetic suppliers,
- pharmacy/durable medical equipment suppliers.

Surgery - a.) The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures; b.) the correction of fractures and dislocations; and c.) usual and related inpatient pre-operative and post-operative care.

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

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

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

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

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

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

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

Total Maximum Out-of-Pocket - The total maximum out-of-pocket, as mandated by the federal government, is **the most you have to pay for covered services in a benefit period**. After you spend this amount on deductibles, copayments, and coinsurance for network care and services, your program pays 100% of the costs of covered services. See How Your Benefits are Applied and the Summary of Benefits for the total maximum out-of-pocket applicable to you.

Urgent Care Center - A formally structured hospital-based or freestanding full-service, walk-in health care clinic, outside of a hospital-based emergency room, that is open twelve hours a day, Monday through Friday and eight hours a day on Saturdays and Sundays, that primarily treats patients who have an injury or illness that requires immediate care, but is not serious enough to warrant a visit to an emergency room. An urgent care center can also provide the same services as a family physician or primary care provider, such as treatment of minor illnesses and injuries, physicals, x-rays and immunizations.

Virtual Visit Provider Originating Site - An outpatient facility provider or professional provider's medical site where a real-time office visit with a professional provider at a remote location is conducted.

Visit - An interaction between you and a professional provider for the purpose of providing covered services. This may include seeking advice for the purpose of determining what medical examinations, procedures, or treatment if any, are appropriate for your condition. A visit may be performed in-person or via telephone, internet or other electronic communication.

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

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Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association.

Blue Distinction, Blue Distinction Centers, BlueCard, Blue Shield and the Shield symbol are registered service marks of the Blue Cross and Blue Shield Association.

The Blue Cross Blue Shield Association is an independent company that does not provide Highmark Blue Shield products and services. It is solely responsible for the services described in this booklet.

You are hereby notified that Highmark Blue Shield provides administrative services only on behalf of your self-funded group health plan. Highmark Blue Shield is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield companies throughout the United States. Although all of these independent Blue Cross and Blue Shield companies

operate from a license with the Association, each of them is a separate and distinct operation. The Association allows Highmark Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Highmark Blue Shield is neither the insurer nor the guarantor of benefits under your group health plan. Your Group remains fully responsible for the payment of group health plan benefits.

HIGHMARK

Blue High Performance Network

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). On the chart below, you'll see what your plan pays for specific services. You are responsible for paying non-urgent care center services and non-emergency services received from an out-of-network provider. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital. This plan does not provide Out-of-Network coverage except for in cases of true emergencies. You must seek care from an In-Network provider.

Rentokil North America CDHP 2250 HPN — Effective 01/01/2026

Benefit	In-Network Coverage Only
General Provisions	
Calendar year (1)	Calendar Year
Deductible (per calendar year) (non-embedded)	
Individual	$2,250
Family	$4,500
Plan Pays – payment based on the plan allowance	80% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period) (embedded)	
Individual	$4,500
Individual in Family Plan	$8,500
Family	$9,000
Total Maximum Out-of-Pocket (includes deductible, coinsurance, copayments, prescription drug, and other qualified medical expenses. Once met, plan pays 100% for the rest of the benefit period. Excludes amounts over UCR.) (embedded) (2)	
Individual	$4,500
Individual in Family Plan	$8,500
Family	$9,000
Office/Clinic/Urgent Care Visits	
Retail Clinic Visits	80% after deductible
Primary Care Provider Office Visits	80% after deductible
Specialist Office Visits/Outpatient/	80% after deductible
Urgent Care Center Visits	80% after deductible
Telemedicine (3) Services provided by CirrusMD	100% (deductible does not apply)
Preventive Care	
Routine Adult	
Physical exams	100% (deductible does not apply)
Adult immunizations	100% (deductible does not apply)
Colorectal cancer screening	100% (deductible does not apply)
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)
Routine Pediatric	
Physical exams	100% (deductible does not apply)
Pediatric immunizations	100% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)
Hospital and Medical/Surgical Expenses (including Maternity)	
Hospital Inpatient	80% after deductible
Hospital Outpatient	80% after deductible
Maternity (non-preventive facility & professional services)	80% after deductible
Medical/Surgical Expenses (except office visits)	80% after deductible Certain procedures may be required to be performed through Carrum Health, or enhanced benefits may be available when using Carrum Health. More details about the Carrum Health Benefit can be found later in this chart.

Benefit	In-Network Coverage Only
Emergency Services	
Emergency Room Services (includes emergency medical and emergency accident)	80% after deductible
Ambulance	80% after deductible
Therapy and Rehabilitation Services	
Physical Medicine	80% after deductible Limit: 60 visits combined with Occupational Therapy and Speech Therapy
Occupational Therapy	80% after deductible Limit: 60 visits combined with Physical Medicine and Speech Therapy
Speech Therapy	80% after deductible Limit: 60 visits combined with Physical Medicine and Occupational Therapy
Spinal Manipulations	80% after deductible Limit: 30 visits per benefit period
Other Therapy Services (Cardiac Rehabilitation, Infusion Therapy, Pulmonary Rehabilitation, Chemotherapy, Radiation Therapy, and Dialysis)	80% after deductible
Mental Health/Substance Abuse	
Inpatient Inpatient Detoxification/Rehabilitation	80% after deductible
Outpatient	80% after deductible
Autism (Includes ABA Coverage)	80% after deductible
Prescription Drugs (6)	
Generic drugs	80% after deductible
Preferred brand drugs	80% after deductible
Non-preferred brand drugs	80% after deductible
Specialty drugs	80% after deductible
Other Services Available through Highmark	
Acupuncture (when used in lieu of anesthesia)	80% after deductible
Allergy Extracts and Injections	80% after deductible
Assisted Fertilization Procedures	80% after deductible
Includes Comprehensive Infertility and ART Services	Benefit Maximum: $25,000 combined with prescription drugs
Dental Services Related to Accidental Injury	80% after deductible
Diagnostic Services Standard and Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible
Wigs	80% after deductible
Hearing Aids	80% after deductible Limit: $1,250 per hearing aid per ear every 36 months
Hearing Exams (Non-routine/Diagnostic)	80% after deductible
Home Health Care/Visiting Nurse	80% after deductible Limit: 90 Visits per benefit period
Hospice	80% after deductible
Infertility Counseling, Testing and Treatment (4)	80% after deductible
Nutritional Counseling	80% after deductible
Podiatry Care	80% after deductible Limit: 30 Visits per benefit period
Private Duty Nursing	80% after deductible Limit: 30 Days per benefit period
Skilled Nursing Facility Care	80% after deductible Limit: 100 Days per benefit period
Transplants	80% after deductible
Travel and Lodging Expenses (Transplants)	100% after deductible Must be Performed in a BDC/BDC+ $10,000 maximum Per diem rate of $50 per day for patient or $100 for patient plus one or more companions
Travel and Loging Expenses (Cancer and Congenital Heart Disease)	100% after deductible $10,000 maximum Per diem rate of $50 per day for patient or $100 for patient plus one or more companions

Benefit	In-Network Coverage Only
Precertification Requirements (5)	Yes
Carrum Health Benefit (Mandatory Centers of Excellence) (7)	
Bariatric surgery	100% after meeting the Federal Minimum Annual Deductible for QHDHPs ($1,700 for 2026). Services must be provided through Carrum Health (7).
Major joint replacement – hip and knee only	100% after meeting the Federal Minimum Annual Deductible for QHDHPs ($1,700 for 2026). Services must be provided through Carrum Health (7).
Spinal surgery	100% after meeting the Federal Minimum Annual Deductible for QHDHPs ($1,700 for 2026). Services must be provided through Carrum Health (7).
CAR T-Cell Therapy (Chimeric antigen receptor (CAR) T-cell therapy)	100% after meeting the Federal Minimum Annual Deductible for QHDHPs ($1,700 for 2026). Services must be provided through Carrum Health (7).
Medical/Surgical Expenses (8)	
Major joint replacement – ankle and shoulder only	100% after meeting the Federal Minimum Annual Deductible for QHDHPs ($1,700 for 2026) if services are provided through Carrum Health (8). 80% after deductible if services are provided through a Highmark In-Network provider (8).
Minor orthopedic surgery	100% after meeting the Federal Minimum Annual Deductible for QHDHPs ($1,700 for 2026) if services are provided through Carrum Health (8). 80% after deductible if services are provided through a Highmark In-Network provider (8).
Cardiac surgery	100% after meeting the Federal Minimum Annual Deductible for QHDHPs ($1,700 for 2026) if services are provided through Carrum Health (8). 80% after deductible if services are provided through a Highmark In-Network provider (8).
Gynecologic	100% after meeting the Federal Minimum Annual Deductible for QHDHPs ($1,700 for 2026) if services are provided through Carrum Health (8). 80% after deductible if services are provided through a Highmark In-Network provider (8).
General surgery	100% after meeting the Federal Minimum Annual Deductible for QHDHPs ($1,700 for 2026) if services are provided through Carrum Health (8). 80% after deductible if services are provided through a Highmark In-Network provider (8).
Ear, nose, and throat surgery	100% after meeting the Federal Minimum Annual Deductible for QHDHPs ($1,700 for 2026) if services are provided through Carrum Health (8). 80% after deductible if services are provided through a Highmark In-Network provider (8).
Urologic surgery	100% after meeting the Federal Minimum Annual Deductible for QHDHPs ($1,700 for 2026) if services are provided through Carrum Health (8). 80% after deductible if services are provided through a Highmark In-Network provider (8).
Pain management surgery	100% after meeting the Federal Minimum Annual Deductible for QHDHPs ($1,700 for 2026) if services are provided through Carrum Health (8). 80% after deductible if services are provided through a Highmark In-Network provider (8).
Gastroenterology surgery	100% after meeting the Federal Minimum Annual Deductible for QHDHPs ($1,700 for 2026) if services are provided through Carrum Health (8). 80% after deductible if services are provided through a Highmark In-Network provider (8).
Substance Use Disorder	100% after meeting the Federal Minimum Annual Deductible for QHDHPs ($1,700 for 2026) if services are provided through Carrum Health (8). 80% after deductible if services are provided through a Highmark In-Network provider (8).
Cancer care (9)	100% after meeting the Federal Minimum Annual Deductible for QHDHPs ($1,700 for 2026) if services are provided through Carrum Health (8). 80% after deductible if services are provided through a Highmark In-Network provider (8).

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

*Out-of-Network urgent care pays at the benefit level. The plan's out-of-network allowance is used for payment when the provider does not participate with either the BlueHPN or the local Highmark PPO network. The provider can balance bill the member.

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) The In-Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expenses. If you are enrolled in a "Family" plan, with your non-embedded deductible, the entire family deductible must be satisfied before claims reimbursement begins. In addition, with your embedded out-of-pocket limit, once an individual family member's out-of-pocket limit is satisfied, additional claims reimbursement begins for that person. Finally, with your embedded TMOOP, once any eligible family member satisfies his/her individual TMOOP, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family TMOOP amount is met.
(3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be obtained through CirrusMD. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
(4) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(5) Quantum Health must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting Quantum for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered. (6) Prescription drug coverage is administered by Express Scripts, covering up to a 30-day supply at retail pharmacies, and a 90-day supply through mail order. Certain preventive medications are covered with no charge or deductible. Specialty drugs must be obtained through the designated specialty pharmacy network. Additional restrictions may apply. For more details, visit www.express-scripts.com.
(7) These services must be obtained exclusively through Carrum Health; these services are not covered if received through the Highmark network. Plan participants have access to the Carrum Health Benefit, which offers enhanced coverage for select planned procedures performed at designated Centers of Excellence. These Centers of Excellence are specialized providers and facilities chosen for their expertise in high-risk or high-cost procedures. Under the Carrum Health Benefit, all medically necessary costs related to the covered procedure at the Center of Excellence are covered with no Copay, Deductible, or Coinsurance—except for participants enrolled in an HSA-eligible plan, who remain subject to the Federal Minimum Annual Deductible. Additionally, the benefit covers travel expenses to the Center of Excellence, including transportation, lodging, meals, and incidentals, based on the participant’s distance from the facility and the procedure type. To qualify for travel coverage, all transportation and lodging arrangements must be coordinated and booked by Carrum Health’s Patient Care Team. Exceptions may apply. Please refer to the policy/plan document for more information.
(8) Certain services may be obtained through Carrum Health, but use of Carrum is optional for these services. Participants may choose to receive care from a provider within the Highmark network, in which case standard cost-sharing will apply. Alternatively, participants can elect to use a Carrum Health provider and receive enhanced coverage through the Carrum Health Benefit. This benefit covers select planned procedures at designated Centers of Excellence—specialized providers and facilities recognized for their expertise in high-risk or high-cost procedures. When using the Carrum Health Benefit, all medically necessary costs related to the covered procedure at the Center of Excellence are covered with no Copay, Deductible, or Coinsurance—except for participants enrolled in an HSA-eligible plan, who remain subject to the Federal Minimum Annual Deductible. The benefit also includes coverage for travel expenses to the Center of Excellence, such as transportation, lodging, meals, and incidentals, based on the participant’s distance from the facility and the procedure type. To qualify for travel coverage, all transportation and lodging must be arranged and booked by Carrum Health’s Patient Care Team. Exceptions may apply. Please refer to the policy or plan document for full details.
(9) Cancer care covered through the Carrum Health Benefit includes the Cancer Advisory Program and ongoing support for all cancer diagnoses, as well as treatment provided by a Carrum Health Center of Excellence for the following cancers: Bone, Breast, Colorectal, Endocrine, Esophageal, Gynecologic, Head & Neck, Hematologic, Kidney, Liver, Lung, Neurologic, Prostate, Melanoma (skin), other cancers, and CAR (chimeric antigen receptor)-T cell therapy for specific hematologic cancers. Except for CAR-T cell therapy, all other cancer treatments are voluntary and not required to be obtained through the Carrum Health Benefit. You may choose to use an In-Network provider instead, in which case regular cost-sharing will apply. If you elect to use the Carrum Health Benefit for cancer treatment, all medically necessary costs related to the covered procedure at the Center of Excellence are covered with no Copay, Deductible, or Coinsurance—except for participants enrolled in an HSA-eligible plan, who remain subject to the Federal Minimum Annual Deductible. The benefit also includes coverage for travel expenses to the Center of Excellence, including transportation, lodging, meals, and incidentals, based on the participant’s distance from the facility and the type of procedure. To qualify for travel coverage, all transportation and lodging arrangements must be coordinated and booked by Carrum Health’s Patient Care Team. Exceptions may apply. Please refer to the policy or plan document for full details.

Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.

If you receive services from an out-of-area provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.

Highmark Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

NOTICE OF PRIVACY PRACTICES

Highmark Inc.

Your Information. Your Rights. Our Responsibilities.

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

Our responsibilities

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

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

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

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

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

How we protect your privacy

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

How we use and share your information

We use and share PHI and other non-public personal information we collect only as necessary to deliver products and services to our members, to operate our business, or to comply with legal requirements. For example, we may use your PHI and non-public personal information internally to manage enrollment, process claims, or audit our operations. We share PHI and non-public personal information with our affiliated companies and non-affiliated third parties, as permitted

by law, who assist us in administering our programs, coordinating care, and delivering products and services to our members. We may also share PHI and non-public personal information with other third-party service providers that cooperate with us to jointly promote or administer health insurance products or services. Our contracts with all such service providers require them to protect the confidentiality of our members' information.

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

Uses of PHI without your authorization.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your personal information

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

Your choices

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

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

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

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

Your individual rights

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

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

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

Changes to the terms of this Notice

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

Complaints

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

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

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

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

Effective date

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

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

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

When we can use and share your SUD records

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

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

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

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

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

Opt-out for fundraising

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

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

Disclosures:

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

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

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

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

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

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

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

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

Care Coordination Program

To best assist covered individuals with navigation of the healthcare system, the Plan includes a "Care Coordination Program" provided by Quantum Health. The Care Coordination Program is intended to help Members better understand their available health and welfare benefits, obtain quality healthcare and services in the most appropriate setting, reduce unnecessary medical costs, and allow early identification of complex medical conditions using "Care Coordinators," "Medical Management Standards" and "Care Management." The Care Coordinators are available to Covered Members and their providers for information, help, and guidance, and can be reached toll-free by calling Quantum Health's **Care Coordinators at 1-866-317-6103.**

The Care Coordinators

Quantum Health provides a single point of contact through "Care Coordinators" or "Patient Service Representatives" for Members and providers to help with Member navigation through their individual healthcare journey, including, but not limited to:

- Answering questions about eligibility, Plan benefits and coverage levels,
- Locating providers based on network status and individual Member needs,
- Outreaching to Members and educating them about the benefits of using in-network providers and other resources available under the Plan,
- Identifying and educating Members about availability of community resources,
- Initiating and coordinating referrals,
- Identifying Members who may benefit from Care Management,
- Facilitating Prior Authorization determinations as "Pre-service" and "Concurrent" Claims in accordance with the Plan's Claim and Appeal Procedures*;
- Advising on Claim and appeal status, how-to-understand explanations of benefits ("EOBs") and health care bills, and
- Other general customer service functions on behalf of the Plan.

*As an added courtesy, if a Member or provider inquires about coverage for a service that would generally be subject to a medical judgment review in a "Post-service" Claim as defined under the Plan, the Care Coordinators will offer an opportunity for a "Pre-determination." Pre-determinations are not considered "Claims" under the Plan's Claim and Appeal Procedures and are generally suggested for services being rendered in an office or in outpatient setting where medical judgment may be involved and there is no prior authorization requirement under the Plan. This allows the Member and provider to better estimate coverage levels for services under the Plan prior to incurring the expense and to provide the Member with an opportunity to seek and receive care from an in-network provider or facility and maximize benefits under the Plan. To find out if a potential service requires Prior Authorization or is eligible for a Pre-determination, you should reach out to **the Care Coordinators at 1-866-317-6103**

If you have any questions about your benefits under the Plan, you should reach out to the Care Coordinators at 1-866-317-6103

The Member's Role in Care Coordination

Members play a vital role in the Care Coordination process. To maximize benefits available under the Plan, you should familiarize yourself with and follow the Care Coordination processes outlined below and any other applicable Plan provisions. **Please note that failure to comply with requirements under the Plan can result in significant benefit reductions, which may include penalties, higher co-payments and cost-sharing, balance billing or denials of coverage for certain services. When in doubt, contact the Care Coordinators at 1-866-317-6103.**

1. Use In-Network Providers where Possible to Reduce Your Out-of-Pocket Costs.

   The Plan offers a narrow network of providers (aka, "in-network") and there is no coverage for out-of-network providers except for urgent care, emergency care, and emergency ambulance services. **To find in-network providers, please visit the Plan's website at rentokilbenefits.com or call the Care Coordinators at 1-866-317-6103.** The Schedule of Benefits provided in the SPD and in the Summary of Benefits and Coverage ("SBC") provided by the Plan identifies the coverage differences between services provided in-network and out-of-network. Receiving services from out-of-network providers will result in increased Member financial responsibility and could result in balance billing by the provider for many non-emergency services as otherwise explained in the SPD.

2. Designate an In-Network Primary Care Provider.

   While not required, to maximize benefits under the Plan and streamline the coordination of care, all Members are strongly encouraged to designate an in-network Primary Care Provider (PCP). A successful healthcare journey generally begins with a PCP who maintains a relationship with the Member, coordinates with the Plan and other providers and supplies ongoing general healthcare evaluation, guidance, and care management.

   Members are encouraged to begin all healthcare events or inquiries with a call or visit to their designated PCP. Because the PCP takes part in Care Coordination, they will help with submission of Prior Authorization requests and may receive updates from the Plan to enable the PCP to supply ongoing healthcare guidance.

   If you have trouble finding a PCP, the Care Coordinators can supply a list of in-network PCPs based on your individual needs. **Care Coordinators: 1-866-317-6103.**

3. Understand what Services Require Prior Authorization.

To provide Care Coordination and to maximize benefits payable under the Plan, the following care, services, and procedures must be authorized before they are provided ("Prior Authorization or Pre-certification") under the Plan's Medical Management Standards (also commonly referred to as utilization review).

Services Requiring Prior Authorization (In-Network Only; no coverage for Out-of-Network care except for emergencies and urgent care)	
Medical/Surgical Services	**Mental Health/Substance Use Disorder Services**
• Inpatient Hospital Admissions (Inpatient) • Skilled Nursing Facility Admissions (Inpatient) • Hospice Care (Inpatient and Outpatient) • Organ, Tissue and Bone Marrow Transplants (Inpatient) • Outpatient Surgeries provided in a Hospital Setting (Outpatient) • Home Health (Outpatient) • Diagnostics MRI/MRA/PET (Outpatient) • Genetic Testing (Outpatient) • Oncology Services – Chemotherapy, Radiation and Clinical Trials (Outpatient) • Dialysis (Outpatient) • Durable Medical Equipment over $1,500 and all Rentals	• Inpatient Hospital Admissions (Inpatient) • Residential Treatment Facility Admissions (Inpatient) • Partial Hospitalization (Outpatient) • Intensive Outpatient Services (Outpatient)

4. Understand the Prior Authorization Process.

A. Timing of Request.

Prior Authorization requests should be made to the Care Coordinators at least **three business days** before a scheduled service, treatment, procedure, inpatient admission or any other service requiring Prior Authorization except in the following circumstances:

- For an “emergency” hospital admission or outpatient procedure, notification to the Care Coordinators should be made on or before the next business day after the admission or procedure. For the purposes of this subsection only, “emergency” is defined as a procedure that has not been previously scheduled and cannot be delayed without harming the Member’s health.
- Notification should be made upon Member identification as a potential organ or tissue transplant recipient.
- Maternity admission notifications should be submitted thirty (30) days before the expected delivery date.

B. Submission of a Request.

Members are ultimately responsible for ensuring that all Prior Authorizations are approved and on file prior to the provision of service to maximize benefits under the Plan. Most Prior Authorization requests are submitted to the Care Coordinators by a designated PCP, other PCP, or other healthcare provider via the Plan's provider portal, facsimile or by calling the **Care Coordinators: 1-866-374-2457** as listed on the back of the Member identification card.

C. Evaluation of the Request.

Submitted Prior Authorization requests considered Pre-service Claims and are reviewed to determine if the requested service is: (a) specifically covered or excluded under the terms of the Plan or (b) considered experimental or investigative **and** (c) is medically necessary under the Plan's Medical Management Standards discussed below. Depending on the request, the Care Coordinators may contact the requesting provider and/or treating provider to obtain additional clinical information to support the request and will suspend the claim for 45 days to allow the provider to send the information. At the end of the 45-day period, the claim will be denied as an administrative denial if the information is not provided.

D. Ongoing Courses of Treatment.

Quantum Health will regularly monitor inpatient hospital stays, other institutional admissions, or ongoing courses of treatment for a Member receiving ongoing care and will examine the use of alternative levels of care or facilities, if necessary, under the Medical Management Standards discussed below. Quantum Health will communicate regularly with attending providers, discharge planners of facilities, the Member and/or Member's family to monitor the Member's progress and expect and initiate planning for discharge needs.

If Quantum Health reduces or terminates an already approved courses of treatment or is reviewing an ongoing course of treatment in a Claim involving urgent care, the Claim shall be treated as a Concurrent care Claim under the Plan's Claim and Appeal Procedures. Otherwise, it shall be treated as a Pre-service or Post-service Claim as applicable.

5. Understand the Impact of Failure to Request Prior Authorization.

Failure to timely submit a Prior Authorization request may result in a reduction of benefits, a denial of coverage, or assessment of penalties as reflected in in the Plan's Schedule of Benefits and/or SBC. Any penalty charges assessed during Claim processing are not applied toward the Member's satisfaction of the Deductible, Co-insurance amounts, or Out-of-Pocket limits under the Plan.

However, a Member will not be penalized for failure to obtain Prior Authorization if a prudent layperson, who has an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. Members who receive care on this basis should

contact the Care Coordinators no later than two (2) business days after receiving care or a hospital admittance.

6. Understand that Participation in the Program is not a Guarantee of Benefits.

   Quantum Health strives to supply accurate and up-to-date information about provider network status, benefit estimates and Plan coverage through the Program. However, engagement with the Care Coordinators for any reason, including Pre-determinations, is not a guarantee of benefits. Members are still responsible for educating themselves on the benefits available to them (under the Plan and as otherwise provided by the Plan Sponsor or community resources).

   Further, Prior Authorization approvals issued by Quantum Health mean that the medical condition, services, and care settings meet the Medical Management Standards adopted by the Plan. The approvals do not guarantee that the service will be a covered benefit at the time the Claim is submitted for processing as a Post-Service Claim, that the Member is eligible for such benefits, that other benefit conditions such as Co-payments, Deductibles, Co-insurance, or Out-of-Pocket limits have been satisfied or that the Member will not be subject to balance billing where services are provided by an out-of-network provider. Final determinations of coverage and eligibility for benefits are made by the Plan when the Claim is submitted for payment.

The Plan's Medical Management Standards

Determinations involving medical judgment (i.e., experimental/investigative and medical necessity) that require interpretation of clinical information are reviewed by a clinician under the terms of the Plan and the clinical review criteria approved by the Plan Administrator. If the clinician is not able to justify coverage based on the established criteria or no applicable criteria is available, it is referred to a medical director for review using the general clinical review criteria, medical director criteria or is referred to a "Peer Reviewer." A Peer Reviewer is a staff medical director or an independent reviewer but will be a Doctor of Medicine or a Doctor of Osteopathic Medicine or in the same licensure category as the ordering provider.

If an initial adverse determination is pending or issued by Quantum Health based on medical judgment, the ordering provider may request a peer-to-peer conversation with the Peer Reviewer to discuss the determination and supply more information that may support coverage. The peer-to-peer must be requested by the ordering provider prior to the Member (or Authorized Representative) filing an appeal under the Plan's Claim and Appeal procedures.

Compliance with the Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act and regulations issued thereunder ("MHPAEA") generally require that the Plan may not impose a financial requirement or treatment limitation on any mental health/substance use disorder benefits offered under the Plan unless the requirement or treatment limitation meets certain requirements, as documented by a comparative analysis.

Certain components of the Care Coordination Program, including the Prior Authorization and Concurrent review requirements and the use of other "Medical Management Standards" (medical

judgment determinations of medical necessity, medical appropriateness and designation as experimental or investigative treatment to make benefit determinations) are generally considered NQTL's under MHPAEA.

The Care Coordination Program is intended to be compliant with the MHAEA in its design and application because:

- The Plan's Prior Authorization and Concurrent review and Medical Management Standards are reasonably designed to detect or prevent fraud, waste and abuse.
- The processes, strategies, evidentiary standards and other factors used to design the Prior Authorization, Concurrent review and Medical Management Standards requirements for mental health or substance use disorder benefits in each classification are comparable to and no more restrictive than those processes, strategies, evidentiary standards, or other factors used to design the Prior Authorization, Concurrent review and Medical Management Standards to substantially all of the medical and surgical benefits in the same classification as reflected above.
- The clinical criteria applied by the Plan under the Medical Management Standards as written and in operation for medical/surgical and mental health/substance use disorder benefits are generally recognized independent professional medical or clinical standards (generally, InterQual, the TPA's medical criteria and Quantum Health medical director criteria consistent with generally accepted standards of care).
- The Plan's Prior Authorization, Concurrent review and Medical Management Standards, as written and in operation, are not applied to mental health or substance use disorder benefits in any classification more restrictively or more stringently than and are impartially applied comparably to the Prior Authorization, Concurrent review and Medical Management Standards applied to substantially all medical/surgical benefits in the same classification.

Care Management

Quantum Health's Approach to Care Management

Quantum Health uses a primary nurse model for chronic condition as well as acute condition management. This enhanced approach supplies one nurse to address clinical needs for all chronic and acute issues.

Our primary nurse model has three foundational drivers for change:

- Humanistic: Help Members with acute and chronic needs by assigning a single nurse (PCG) to the Member and their family and a heightened attention to psychosocial issues that can negatively affect health, quality of life and financial outcomes.

- Clinical: Identify and prioritize Members in need of clinical outreach. Improve adherence to quality measures for preventive health and management of chronic conditions.

- Financial: Identify and outreach to Members at risk for future high costs while encouraging preventive care and chronic condition management to improve health and reduce costs.

Initial Outreach and Intake

During outreach, the PCG will discuss the Member's treatment, perform a physical assessment, perform a medication reconciliation to ensure there are no duplications or interactions, perform a depression screening with subsequent referrals to EAP or in-network providers, as well as focus on the physical and emotional needs of the Member.

The PCG will look at the Member’s barriers to care and individual needs. In addition to the depression screening, they will evaluate the Member’s financial issues, knowledge deficits, and any cultural barriers.

The PCG nurse will consult with the Member, their family (if requested), the attending Physician, and other members of the Member’s treatment team to aid in facilitating/implementing proactive plans of care which supply the most appropriate health care and services in a prompt, efficient and cost-effective manner. They help with benefits, incidental health care issues, becoming healthier, finding resources or navigating an unexpected healthcare journey.

Ongoing Support

Conversations with the Member would occur at least monthly, if not more often, and continue until the Member’s health goals and needs are met.

The primary PCG nurse will align with the Member and be the single point of contact them, their family and caregivers, and providers. Each Member journey is different, and the types of services provided by the PCG will differ based on the condition managed and the needs of the individual Member, but generally the PCG nurse will:

- Provide comprehensive benefit education/utilization support
- Drive PCP designation and steerage to in-network providers
- Encourage provider involvement
- Deliver pre-certification help
- Perform pre-admission, pre-discharge, and post-discharge engagement
- Coordinate for utilization review and discharge planning
- Identify gaps in care and alleviate clinical, financial, and humanistic barriers
- Coordinate second opinions, drive utilization to other third-party vendor tools, and introduce community resources
- Perform behavioral health screening

Employee Assistance Program through Resources for Living

The Employee Assistance Program (EAP") is a program separate and independent from the Plan. The Plan Sponsor pays a fee to the EAP vendor to make its EAP services available to employees regardless of medical plan enrollment. All members of your household, including children up to the age of 26, whether they live at home or not can access services.

The EAP provides short-term counseling and consultations services to assist employees, all members of your household and dependents with a wide range of issues, including, but not limited to:

- Family problems
- Marital problems
- Emotional difficulties
- Stress management
- Anxiety
- Depression
- Grief and loss
- Substance misuse
- Legal problems
- Financial problems and more

The EAP provides 6 counseling sessions per issue each year, available via face-to-face, telehealth and chat therapy. Access the benefit:

- www.resourcesforliving.com Username: Rentokil Password: EAP
- Mobile app "Resources for Living"
- Member phone number: 1-833-721-2317, available 24 hours a day, 7 days a week

The benefits provided through the EAP are fully paid for by your Employer and cover the employee as well as their household members and dependents. For detailed information with respect to the actual benefits provided under the EAP and any conditions, limitations and exclusions that may apply to those benefits, please refer to the EAP materials distributed to you by your Employer and/or the EAP Administrator. If you do not have a copy of these materials, please contact your Employer or the EAP Administrator. Your personal information will be kept strictly confidential by the EAP Program Administrator.

If you do not have a copy of these materials, please contact your Employer or the EAP Administrator, identified on the General Plan Information page for additional information. Any login information may be customized per the Employer.

CirrusMD: Virtual Medicine Provider

CirrusMD is a "chat-first" virtual care provider offering 24/7/365, on-demand access to board-certified physicians in under 60 seconds. It specializes in immediate, text-based, physician-led care for urgent, acute, and primary health needs, allowing patients to connect via chat, voice, or video to manage conditions, receive prescriptions, and get referrals without appointments.

CirrusMD gives you instant access to a licensed doctor through secure text messaging—anytime, anywhere. No waiting rooms, no scheduling hassles, and no fees.

What this means for you:

- Unlimited access to doctors 24/7/365
- Text-based care for everyday health concerns
- No cost—100% covered by Rentokil

You can register by downloading the CirrusMD app on your smart device, or by navigating to the website at MyCirrusMD.com. You can also connect via telephone at (866) 305-0409.

Livongo by Teladoc: Whole Person Solution

Personalized Support for Managing Your Health - Living with a chronic condition can feel overwhelming—but you don't have to manage it alone. **Livongo by Teladoc Health** offers personalized support, simple tools, and real human guidance to help you manage conditions like diabetes, prediabetes, high blood pressure, weight, and stress. Everything works together in one connected experience designed to fit into your everyday life. Whether you're newly diagnosed or working to stay on track, Livongo helps you understand your numbers, build healthier habits, and feel more confident taking care of your health. Best of all, the program and devices are **available at no cost to you**.

What Livongo supports

- Diabetes & Prediabetes
- High blood pressure (hypertension)
- Weight management
- Mental and emotional well-being

What's included

- **Connected devices shipped to you** (such as a blood glucose meter, blood pressure monitor, or scale), with no complicated setup
- **Personalized insights and goal-setting** that turn readings into clear next steps
- **1:1 health coaching** with experts who understand your condition
- **24/7 support** if a reading is too high or too low
- **Mental health and wellness tools** to support stress, sleep, and overall well-being

Why enroll?

Livongo makes managing your health simpler, more supportive, and more personal—so you can focus on feeling your best, one step at a time.

Ready to get started?

Visit **go.livongo.com**, text **GO RTX** to **85240**, or call **(800) 945-4355,** Registration code: **RTX**

Hinge Health

Through the Hinge Health Digital Musculoskeletal (MSK) Clinic, participants have access to personalized MSK care programs depending on their specific MSK needs. Participants will register online through the Hinge Health website or app, complete a clinically validated screener to determine which program best fits their MSK needs. The programs include:

(a) Prevention - This is a software only program (no coaching, sensors or other hardware). This Program is designed to increase education regarding key strengthening and stretching activities around healthy habits.
(b) Chronic - evidence-based care for joint pain in a program that includes the following: personalized exercise therapy sessions guided by motion tracking technology, 1:1 access to personal health coach, personalized educational content, and behavioral health support. The Chronic Program consists of (i) the Hinge Health proprietary exercise band systems and technologies; (ii) coaching and alert features; and (iii) Cloud-based data capture and reporting capabilities; and (iv) personalized analytics capabilities. Participants in the Chronic Program may also be offered the non-invasive ENSO High Frequency Impulse Therapy™ pain treatment device and service, as appropriate, for symptomatic relief and management of pain.
(c) Acute - Program designed to address recent injuries which includes live virtual sessions with a dedicated licensed Physical Therapist along with software guided rehabilitation and education.
(d) Surgery - Program provides members with access to a physical therapist, a health coach, and motion-guided exercise therapy, and covers both pre-and post-surgical rehabilitation for the most common MSK surgeries and is designed as a continuation of the Chronic Program.
(e) Expert Medical Opinion - Service offering second opinions focused on elective MSK procedures.
For applicable programs a participant may obtain up to six virtual physical therapy sessions per episode prior to in-person healthcare provider or physical therapy care (additionally, other state laws may limit access without a physician's referral).

Eligibility
To be eligible for the Hinge Health programs, you, and your eligible dependents must meet each of the following requirements: (i) be enrolled in a Rentokil Highmark medical plan (ii) be age 18 or older (iii) be located in the United States, and (iiii) be approved through the clinical suitability evaluation performed by Hinge Health prior to enrollment.

Cost
If you are eligible, Hinge Health is offered at no cost to you.

Hinge Health Contact Information
To get started with Hinge Health, visit https://www.hingehealth.com/for/rentokil/ to enroll. If you have any questions regarding Hinge Health, email help@hingehealth.com or call (855) 902-2777.

Oshi Health

Oshi Health offers virtual-first, gastrointestinal (GI) care for the whole you—available at no additional cost. Work with a team of GI specialists, including GI providers, registered dietitians, and gut-brain specialists, to get to the root cause of your symptoms.

Oshi Health is a different approach to GI care that gives you access to:

- Clinically-proven, quality care from leading GI experts
- A team working together to treat you, not just your symptoms
- Convenient virtual appointments with next-day and weekend availability

Members who may benefit:
Oshi treats many GI symptoms and conditions, whether or not there is a diagnosis. Common conditions include:

- Irritable bowel syndrome (IBS);
- Crohn's disease;
- Undiagnosed digestive symptoms including abdominal pain, bloating, constipation and diarrhea;
- Gastritis;
- Gastroesophageal reflux disease (GERD);
- Small intestinal bacterial overgrowth (SIBO);
- Ulcerative colitis

Accessing Oshi:
Members can visit https://oshihealth.com/rentokil/ to sign up and schedule their first appointment. Members can also call Oshi's care coordination team at 646-876-8455 or email carecoordinator@oshihealth.com for any assistance

Eligibility
Employees and adult dependents (age 18+) enrolled in the Rentokil-sponsored medical plan are eligible for Oshi Health services.

Cost
Oshi Health services are available to eligible Rentokil members at no additional cost.

Carrum Health

Participants in the Plan have access to the Carrum Health Benefit, which provides enhanced coverage for certain planned procedures at participating Centers of Excellence. Through the Carrum Health Benefit, participants have access to specialized providers and facilities selected for their expertise in certain high-risk or high-cost procedures, referred to as “Centers of Excellence”.

Subject to limited exceptions described below, the Plan only provides coverage for the following procedures if they are provided by a Center of Excellence through the Carrum Health Benefit:

- Surgery
    - Total and partial, major joint replacement surgery (e.g., **knee and hip)** (requirement excludes revisions)
    - Spinal (back and neck) surgery (e.g. fusion and decompression)
    - Bariatric (weight loss) surgery (requirement excludes revisions)
    - CAR (chimeric antigen receptor) T-cell therapy for specific hematologic cancers

Participants may, but are not required to, use the Carrum Health Benefit for the following procedures or conditions:

- Surgery
    - Total, partial, and revision major joint replacement surgery (e.g., **shoulder, ankle**) and revisions for knee and hip
    - Spinal (back and neck) surgery (other than fusion and decompression)
    - Bariatric revisions
    - Minor orthopedic procedures (e.g., surgeries of the hand, wrist, elbow, shoulder, ankle, foot) other than major joint replacements*
    - Cardiac (heart) surgery (e.g., bypass, valve repair and replacement)
    - Gynecologic surgery (e.g., hysterectomy)
    - General surgery (e.g., gallbladder removal, hernia repair)*
    - Ear Nose Throat surgery (e.g., tonsillectomy, ear drum repairs, septum repairs)*
    - Urologic surgery (e.g., cystourethroscopy - bladder scope)*
- Non-surgical procedures
    - Pain Management (e.g., major joint steroid injections, spinal injections, ablations)*
    - Gastroenterology (e.g., colonoscopies, upper endoscopies/EGDs)*
- Substance Use Disorder treatment (e.g., alcohol, opioids, stimulants, cannabis, sedatives, hypnotics, and anxiolytics)
    - Detox
    - Residential treatment
    - Partial hospitalization (PHP)
    - Intensive outpatient (IOP)
    - Outpatient including virtual
- Cancer care
    - Advisory Program (virtual second opinions / expert reviews and support)
    - Treatment (e.g., excision surgery, chemotherapy, radiation treatment, supportive care such as psychosocial, nutrition and family support; excludes CAR T-cell therapy for certain hematologic cancers)**

* Only available for participants who reside within 150 miles of the nearest COE
** Some treatment may only be available for participants who reside within 150 miles of the nearest COE; please contact Carrum Health to learn more

This section describes the Carrum Health Benefit, including important conditions and restrictions. The Summary of Benefits Coverage table below summarizes coverage of the medical services available through the Carrum Health Benefit. As shown below, certain eligible services performed through the Carrum Health Benefit are covered at 100%, meaning there is no out-of-pocket spend for the participant such as copays or coinsurance, except that a participant in an HSA-eligible plan must meet their Federal Minimum deductible.

About Carrum Health

Carrum Health provides access to Centers of Excellence for planned medical care and coordinates the delivery of care with travel, communication and other non-medical aspects of the program. Carrum Health itself does not render any medical care or advice and does not recommend any particular medical providers or course of treatment.

To learn more about the Carrum Health Benefit or request a consultation with a Center of Excellence, please contact Carrum Health at 1-888-855-7806, Monday-Friday 9am-8pm EST, or visit carrum.me/rentokil. The 'Carrum Health' app is available to download on both iPhone and Android devices.

How It Works

Plan participants can contact Carrum Health at 1-888-855-7806, Monday-Friday 9am-8pm EST, online at carrum.me/rentokil, or by downloading the 'Carrum Health' app on iPhone and Android devices to search for and compare participating Centers of Excellence.

After contacting Carrum Health, a participant is assigned a Care Specialist to determine if the participant may be referred to a Center of Excellence and provide non-medical coordination throughout the entire episode of care. Care Specialist services can include assistance with selection of a Center of Excellence, medical records collection, appointment scheduling, and travel reservations and logistics management. The Care Specialist can also assist the participant with registration for the Carrum Health Benefit through the Carrum Health app and completion of required forms.

Participants are required to agree to Carrum Health's Terms of Service and Member Registration Agreement and must also agree to provide their medical records and any other relevant information to their selected Center of Excellence as needed to schedule a consultation. Medical records and images may be collected on behalf of participants by their assigned Care Specialists. During the consultation, the Center of Excellence will determine if the participant is an appropriate candidate for the requested procedure. Receiving this consultation does not commit a participant to proceed with the procedure or to use the Carrum Health Benefit.

Covered Expenses

Medical

The Carrum Health Benefit covers all medical costs charged by the Center of Excellence that are related to the covered procedure with no Copay, Deductible, or Coinsurance (except those enrolled in an HSA-eligible plan will still be subject to the Federal Minimum Deductible).

Cancer Care

Cancer care covered through the Carrum Health Benefit includes:

- Cancer Advisory Program and ongoing support for all cancer diagnoses
- Treatment for cancer provided by Center of Excellence including:
    - Bone
    - Breast
    - Colorectal
    - Endocrine
    - Esophageal
    - Gynecologic
    - Head & Neck
    - Hematologic
    - Kidney
    - Liver
    - Lung
    - Neurologic
    - Prostate
    - Melanoma (skin)
    - Other cancers
- CAR (chimeric antigen receptor) T-cell therapy for specific hematologic cancers

Travel

The Carrum Health Benefit covers the cost of travel to the Center of Excellence, including transportation, lodging, meals and incidentals, depending on the distance of the participant from the Center of Excellence and the type of procedure requested. Please contact your Care Specialist or Carrum Health at 1-888-855-7806 or via the Carrum Health app for details regarding what travel benefits may be available with respect to your requested treatment.

For transportation and lodging to be covered under the Carrum Health Benefit, it must be booked by Carrum Health's Patient Care Team. Generally, the Patient Care Team will book travel on behalf of the participant for:

- Roundtrip transportation for an in-person consultation with a Center of Excellence, to the extent requested by the Center of Excellence, for the participant only
- Roundtrip transportation and hotel stay to receive the procedure at a Center of Excellence, for the participant and adult travel companion

Any stipend for meals and incidentals is provided via PayPal or prepaid Mastercard.
A participant will receive a Form 1099 reflecting any taxable travel benefits, such as lodging costs over federal tax limits and daily stipends.

Coverage Limitations and Disclosures

- To receive coverage under the Carrum Health Benefit, a Center of Excellence must determine that it will provide the requested procedure to the participant. A Center of Excellence may decline to treat a participant as it determines in its discretion, including, but not limited to, for failure to:
    1. identify a designated adult companion who is willing and able to meet caregiver requirements;
    2. be safe to travel to the Center of Excellence for medical care and not requiring emergency care at the time of travel;
    3. follow preoperative and postoperative instructions;
    4. provide all required medical history, labs, and diagnostic tests;
    5. make lifestyle changes required by the Center of Excellence as a condition of obtaining the covered procedure (e.g., stop smoking or lose weight); or
    6. refrain from committing an act of physical or verbal abuse or other threatening behavior to the staff of the Center of Excellence.
- To receive coverage under the Carrum Health Benefit, services MUST be scheduled and authorized by Carrum Health. If the participant does not use the Carrum Health Benefit, their care will be covered as outlined in the Summary of Benefits Coverage table above under "In-Network" and "Out-of-Network", as applicable.
- Emergency medical services that are rendered by a Center of Excellence are not covered under the Carrum Health Benefit and are subject to the coverage limits, cost-sharing, and other terms of the Plan.
- Certain examinations, tests, or other medical services may be required before or after the participant visits the Center of Excellence under the Carrum Health Benefit. Any medical services not performed by a participating Center of Excellence facility or physician, including necessary pre-and post-acute care, are not covered under the Carrum Health Benefit and are subject to the coverage limits, cost-sharing, and other terms of the Plan.
- The Carrum Health Benefit applies toward any benefit maximums on the covered procedures under the Plan. Any cost-sharing paid by the participant will count towards the Plan's annual deductible and out-of-pocket maximum.
- Carrum Health will provide appropriate documentation for any non-medical benefits paid under the program, which may be subject to taxation as income to the participant, such as the allowance paid for meals and incidentals.
- Coverage under the Carrum Health Benefit may be denied by Carrum Health if:
    1. The participant refuses to complete documentation required to participate in the Carrum Health Benefit, including the Terms of Service and Member Registration Agreement;
    2. A participant requests to be referred to another Center of Excellence after the initial Center of Excellence has determined the participant is not an appropriate candidate for the requested treatment. Note this does not apply when the initial referral is to an outpatient facility or ambulatory surgical center (ASC) that cannot treat the participant because their condition is too complex, in which case the participant may be referred to an acute care Center of Excellence. This also does not apply when the consulting COE agrees treatment is necessary, however there are medically related circumstances prohibiting the member from utilizing the initial COE. In this case the participant may be referred to one alternative Center of Excellence;

3. The treatment is being sought to satisfy a court order;
4. The participant violates the Carrum Health Terms of Service or Member Registration Agreement; or
5. The participant is on probation and does not provide written approval from their probation officer that they are allowed to travel for treatment.

- If the Plan would pay secondary in accordance with its coordination of benefits provisions, such secondary coverage will be determined in accordance with the Plan's standard terms and cost-sharing provisions and not under this Carrum Health Benefit.

Coverage and Exceptions for Hip and Knee Replacement Surgery, Spinal Fusion Surgery, and Bariatric Surgery

- Unless an exception has been approved as described below, the Plan only provides coverage for hip and knee replacement surgery, spinal fusion surgery, and bariatric surgery if the participant receives such treatment through the Carrum Health Benefit using a Center of Excellence. If treatment is not received through the Carrum Health Benefit and no exception has been approved, the participant will be responsible for the entire cost of their treatment.
- Participants may request an exception to the requirement that they use the Carrum Health Benefit. If an exception is approved, treatment may be covered in accordance with the terms of the Plan, which may include prior authorization requirements, cost-sharing, and other conditions and exclusions.
- An exception will be approved for any of the following reasons:
    - Grace Period: Surgery was secured on or before 02/28/2026.
    - Urgent Surgery: As stated on a doctor's note on official letterhead, either (i) the participant already received surgery due to a medical emergency, with details of the surgery and the nature of the medical emergency, or (ii) the participant has an urgent need for surgery, detailing the reason for the urgency, and confirmation that the scheduled date of surgery and the actual date of surgery shall occur within a period not to exceed 15 calendar days of one another.
    - Medically Unsafe to Travel: The participant lives more than 60 miles from the nearest Center of Excellence and a doctor's note on official letterhead documents the participant's medical condition and the reason such medical condition makes travel medically unsafe or physically impossible. "Medically unsafe" means travel would result in (i) placing the participant's health in serious jeopardy, (ii) serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) injury, and "physically impossible" means the individual has physical limitations that prevent travel to the nearest Center of Excellence.
    - Surgical Candidacy: As stated on a doctor's note on official letterhead, the reason the participant's doctor disagrees with the Center of Excellence's determination that the participant is not an appropriate candidate for surgery and why the doctor believes that the participant is an appropriate surgical candidate. The Center of Excellence's determination that the participant is not an appropriate surgical candidate may be made (i) after consultation with the participant or (ii) prior to consultation, based on the participant's failure to meet clinical criteria required by the Center of Excellence.
    - Severe Financial Hardship: The participant lives more than 150 miles from the nearest Center of Excellence and provides documentation showing the reason

why having surgery at a Center of Excellence through the Carrum Health Benefit would cause severe financial hardship. Examples of financial hardship include: (i) inability to work or loss of hours due to the condition that the surgery is intended to fix without the ability to receive disability coverage, (ii) loss of insurance prior to earliest possible surgery date, or (iii) disability leave cannot be moved to accommodate a surgery date approved through the Carrum Health Benefit (iv) Existing obligations as a primary caregiver and travel to a Carrum COE would result in unreasonable disruption to caregiver obligations. "Unreasonable disruption" means having to hire a caregiver for 24hrs+ over and above caregiver needs if staying with a local surgeon, resulting in a severe financial hardship.

An example of documentation could include, but is not limited to, providing documentation of disability leave approval, plus documentation (i.e., email communication) showing that such disability leave cannot be moved.

- ○ Inability to Secure Travel Companion (post consultation and established surgery date): The participant lives more than 150 miles from the nearest Center of Excellence and provides documentation showing a good faith effort to secure an adult travel companion, including documenting steps taken to find an adult travel companion, describing any roadblocks, and providing supporting materials.
- ○ Non-Required Surgery: The participant is redirected to Carrum Health for a non-required surgery and provides a doctor's note on official letterhead that provides a detailed description of the intended surgery.

Coverage and Exceptions for CAR T-Cell Therapy for Certain Hematologic Cancers

- Unless an exception has been approved as described below, the Plan only provides coverage for CAR T-Cell Therapy if the participant receives such treatment through the Carrum Health Benefit using a Center of Excellence. If treatment is not received through the Carrum Health Benefit and no exception has been approved, the participant will be responsible for the entire cost of their treatment.
- Participants may request an exception to the requirement that they use the Carrum Health Benefit. If an exception is approved, treatment may be covered in accordance with the terms of the Plan, which may include prior authorization requirements, cost-sharing, and other conditions and exclusions.
- An exception will be approved for any of the following reasons:
  - ○ Grace Period: Treatment authorized (prior to authorization approved) by the health plan before the requirement to use Carrum went into effect, or treatment date is scheduled to be completed on or before 02/28/2026.
  - Inability to Secure Travel Companion: The participant lives more than 150 miles from the nearest Center of Excellence and provides documentation showing a good faith effort to secure an adult travel companion, including documenting steps taken to find an adult travel companion, describing any roadblocks, and providing supporting materials.
  - Existing Provider Relationship at local CAR T-Cell Therapy Certified Cancer Center: Accommodates existing patient-provider relationship if established at a local (within 60 miles of the patient) certified CAR T-Cell Therapy center and the participant provides a doctor's note on official letterhead documenting scheduled treatment date.
  - Surgical Candidacy: Participant's doctor disagrees that the participant is not an

appropriate CAR T-Cell Therapy candidate. The COE's determination

- To request an exception, a participant must complete the Exception Initiation Form or CAR T-Cell Therapy Exception Initiation Form and send it, along with the required supporting documentation listed in the Exception Initiation Form, to Carrum Health. A participant may request an Exception Initiation Form by contacting Carrum Health at 1-888-855-7806. Please complete the form and submit it via fax to Carrum Health at 650-539-0777, via the Carrum app, or via secure email or U.S. mail. Your Care Specialist, who can be reached at 1-888-855-7806, can walk you through the process of submitting the Exception Initiation Form via the app, secure email, or U.S. mail.
    - Carrum Health will review the Exception Initiation Form to determine whether the submitted information and documentation meets the criteria to approve an exception.
    - Depending on whether the participant has already received treatment when they make their exception request, it will be treated as either a pre-service claim or post-service claim, as described in the Claims and Appeals section of this Summary Plan Description.
    - If the participant's exception request is approved, coverage of the treatment will be subject to the standard Plan terms, including any deductibles, coinsurance, or limitations, and the participant must comply with the Plan's standard protocols for authorizing and receiving care including utilization management. The exception request is not a request for prior authorization for coverage of the treatment under the Plan. The participant may still need to receive prior authorization under the Plan for the desired procedure after their exception is approved. If the exception request is denied, no benefits will be payable for services performed outside the Carrum Health Benefit, as outlined earlier. Participants can file an appeal with Carrum Health if they are denied an exception, as described in the Claims and Appeals section of this Summary Plan Description.

Initial Claims and Denials under the Carrum Health Benefit

Plan participants can contact Carrum Health at 1-888-855-7806, Monday-Friday 9am-8pm EST, online at carrum.me/rentokil, or by downloading the 'Carrum Health' app on iPhone and Android devices to search for and compare participating Centers of Excellence. After contacting Carrum Health, a participant is assigned a Care Specialist to determine if the participant may be referred to a Center of Excellence and provide non-medical coordination throughout the entire episode of care. To receive coverage under the Carrum Health Benefit, services must be scheduled and authorized by Carrum Health.

Participants are required to agree to Carrum Health's Terms of Service and Member Registration Agreement and must also agree to provide their medical records and any other relevant information to their selected Center of Excellence as needed to schedule a consultative evaluation. During the consultation, the Center of Excellence will determine if the participant is an appropriate candidate for the requested procedure. To receive coverage under the Carrum Health Benefit, a Center of Excellence must determine that it will provide the requested procedure to the participant. A Center of Excellence may decline to treat a participant as it determines in its discretion.

In the case of a failure by a participant (or the participant's authorized representative) to follow the Plan's procedures for requesting authorization to participate in the Carrum Health Benefit, the participant or representative shall be notified of the failure and the proper procedures to be followed. This notification shall be provided to the participant or authorized representative, as appropriate, as soon as possible, but not later than five days following the failure. Notification may be oral, unless written notification is requested by the participant or authorized representative.

Coverage under the Carrum Health Benefit may be denied, in whole or in part, by Carrum Health in the following circumstances:

Refusal to complete required documentation

Coverage under the Carrum Health Benefit may be denied by Carrum Health if a participant refuses to complete documentation required to participate in the Carrum Health Benefit, including the Terms of Service and Member Registration Agreement.

Carrum Health will notify the participant (or the participant's authorized representative) within 15 days of the participant's request to participate in the Carrum Health Benefit if the participant has failed to submit any documentation that must be submitted to approve participation in the Carrum Health Benefit. The participant will be given additional time, without a deadline, to submit those forms. If the participant responds without providing the required documentation, Carrum Health will notify the participant that requested participation in the Carrum Health Benefit has been denied within 15 days after receipt by Carrum Health of the participant's response.

Request for referral to another Center of Excellence

Coverage under the Carrum Health Benefit may be denied by Carrum Health if a participant requests to be referred to another Center of Excellence after the initial Center of Excellence has determined the participant is not an appropriate candidate for the requested treatment. Note this does not apply when the initial referral is to an outpatient facility or ambulatory surgical center (ASC) that cannot treat the participant because their condition is too complex, in which case the participant may be referred to an acute care Center of Excellence. This also does not apply when the consulting COE agrees surgery is necessary, however there are medically related circumstances prohibiting the member from utilizing the initial COE. In this case the participant may be referred to one alternative Center of Excellence.

Carrum Health will notify the participant (or the participant's authorized representative) within 15 days of the participant's request that this request has been denied. This period may be extended one time for up to 15 days, provided that Carrum Health both determines that such an extension is necessary due to matters beyond the control of Carrum Health and notifies the participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which Carrum Health expects to render a decision. If such an extension is necessary due to a failure of the participant to submit information necessary to decide the claim, the notice of extension will specifically describe the required information, and the participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

The Treatment is Being Sought to Satisfy a Court Order

Coverage under the Carrum Health Benefit may be denied by Carrum Health if a participant's treatment is sought for purposes of satisfying a court order.

Carrum Health will notify the participant (or the participant's authorized representative) within 15 days of the participant's violation of the Carrum Health Terms of Service or Member Registration Agreement that the participant's requested participation in the Carrum Health Benefit has been denied. This period may be extended one time for up to 15 days, provided that Carrum Health both determines that such an extension is necessary due to matters beyond the control of Carrum Health and notifies the participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which Carrum Health expects to render a decision. If such an extension is necessary due to a failure of the participant to submit information necessary to decide the claim, the notice of extension will specifically describe the required information, and the participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Violation of Terms of Service or Member Registration Agreement

Coverage under the Carrum Health Benefit may be denied by Carrum Health if a participant violates the Carrum Health Terms of Service or Member Registration Agreement.

Carrum Health will notify the participant (or the participant's authorized representative) within 15 days of learning of the participant's violation of the Carrum Health Terms of Service or Member Registration Agreement that the participant's requested participation in the Carrum Health Benefit has been denied. This period may be extended one time for up to 15 days, provided that Carrum Health both determines that such an extension is necessary due to matters beyond the control of Carrum Health and notifies the participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which Carrum Health expects to render a decision. If such an extension is necessary due to a failure of the participant to submit information necessary to decide the claim, the notice of extension will specifically describe the required information, and the participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Participant does not provide written approval from their probation officer that they are allowed to travel for treatment.

Coverage under the Carrum Health Benefit may be denied by Carrum Health if a participant on probation does not provide written approval from their probation officer to travel to an out of state COE to obtain treatment.

Carrum Health will notify the participant (or the participant's authorized representative) within 15 days of the participant's violation of the Carrum Health Terms of Service or Member Registration Agreement that the participant's requested participation in the Carrum Health Benefit has been denied. This period may be extended one time for up to 15 days, provided that Carrum Health both determines that such an extension is necessary due to matters beyond the control of Carrum Health and notifies the participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which Carrum Health expects to render a decision. If such an extension is necessary due to a failure of the participant to submit information necessary to decide the claim, the notice of extension will specifically describe the required information, and the participant shall be afforded at least 45

days from receipt of the notice within which to provide the specified information.

Denial of an Exception Request

To request an exception, a participant must complete the Exception Initiation Form and fax it, along with the required supporting documentation listed in the Exception Initiation Form, to Carrum Health at 1-650-539-0777. A participant may request an Exception Initiation Form by contacting Carrum Health at 1-888-855-7806 or by registering for the Carrum Health Program at carrum.me/rentokil.

Carrum Health will review the Exception Initiation Form to determine whether the submitted information and documentation meets the criteria to approve an exception, as listed in the Exception Initiation Form.

In the case of a failure by a participant (or the participant's authorized representative) to follow the Plan's procedures for requesting an exception and the participant has not yet received treatment, the participant or representative shall be notified of the failure and the proper procedures to be followed. This notification shall be provided to the participant or authorized representative, as appropriate, as soon as possible, but not later than five days following the failure. Notification may be oral, unless written notification is requested by the participant or authorized representative.

If the participant has not yet received the requested treatment, Carrum Health will notify the participant (or the participant's authorized representative) of the exception determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt by Carrum Health of the exception request. This period may be extended one time for up to 15 days, provided that Carrum Health both determines that such an extension is necessary due to matters beyond the control of Carrum Health and notifies the participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which Carrum Health expects to render a decision. If such an extension is necessary due to a failure of the participant to submit the information necessary to decide whether the exception should be approved, the notice of extension will specifically describe the required information, and the participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

If the participant has already received treatment when they make their exception request, Carrum Health will notify the participant (or the participant's authorized representative) of the denial of an exception request within a reasonable period of time, but not later than 30 days after receipt of the exception request. This period may be extended one time for up to 15 days, provided that Carrum Health both determines that such an extension is necessary due to matters beyond the control of Carrum Health and notifies the participant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which Carrum Health expects to render a decision. If such an extension is necessary due to a failure of the participant to submit the information necessary to decide the exception request, the notice of extension shall specifically describe the required information, and the participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Benefit Notifications

Carrum Health will provide a participant with written or electronic notification of any adverse

benefit determination. The notification will include:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the participant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the appeal procedures and the time limits applicable to such procedures, including a statement of the participant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination of a second-level appeal;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;
- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- The reason or reasons for the adverse benefit determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim;
- A description of available internal appeals and external review processes, if any, including information regarding how to initiate an appeal; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Appeals

Denials for Non-Exception and Exceptions Requests

The Plan requires two levels of appeal with respect to the Carrum Health Benefit. The request for a first-level appeal must be made within 180 days following receipt of the adverse benefit determination, by submitting such request to Carrum Health at appeals@carrumhealth.com. The request for a second-level appeal must be made within 60 days following receipt of the adverse benefit determination on review, by submitting such request to Carrum Health at appeals@carrumhealth.com.

As part of the appeal process, a participant may submit written comments, documents, records, and other information relating to the claim for benefits. The review will take into account all comments, documents, records, and other information submitted by the participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

A participant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for

benefits.

A participant will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by Carrum Health in connection with the claim or any new or additional rationale for an adverse benefit determination as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the participant a reasonable opportunity to respond prior to that date.

When the requested treatment has not yet been provided, Carrum Health will notify the participant of a benefit determination on review no later than 15 days after receipt by Carrum Health of the participant's request for a first-level appeal or second-level appeal, as applicable. When requested treatment has already been provided, Carrum Health will notify the participant of benefit determination on review no later than 30 days after receipt by Carrum Health of the participant's request for a first-level appeal or a second-level appeal, as applicable.

Carrum Health will provide a participant with written or electronic notification of an appeal determination. In the case of an adverse benefit determination, the notification will include:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits;
- A statement of the participant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination of a second-level appeal;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- The reason or reasons for the adverse benefit determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim, including a discussion of the decision;
- A description of available internal appeals and external review processes, if any, including information regarding how to initiate an appeal; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

No action at law or in equity may be brought to recover under the Carrum Health Benefit under

the Plan until all administrative remedies have been exhausted (including the two levels of appeal). If a participant fails to file a timely claim, or if the participant fails to request a review in accordance with the Plan's claim procedures outlined herein, such participant will have no right of review and will have no right to bring any action in any court. The denial of the claim will become final and binding on all persons for all purposes.

Any action at law or in equity with respect to any and all claims relating to the Carrum Health Benefit under the Plan must be brought for recovery within one year from the earlier of (1) the date of an adverse benefit determination on a second-level appeal, if applicable, or (2) the accrual of any claim under or relating to the Carrum Health Benefit that does not result in an adverse benefit determination on a second-level appeal.

Carrum Health Benefit: Substance Use Disorder Treatment
The Carrum Health Benefit also covers treatment for certain substance use disorders* at participating Centers of Excellence. The Summary of Benefits Coverage table below summarizes coverage of the substance use disorder services available through the Carrum Health Benefit.

Summary of Benefits Coverage

	Carrum Health Benefit
Detoxification: medically managed with medication	100% covered; No Deductible**
Residential Treatment	100% covered; No Deductible**
Partial Hospitalization	100% covered; No Deductible**
Intensive Outpatient Treatment	100% covered; No Deductible**
Outpatient Treatment, including Virtual Support	100% covered; No Deductible**

*Substance use disorders covered under the Carrum Health benefit include: alcohol, opioids, stimulants, cannabis, sedatives, hypnotics and anxiolytics. Excludes hallucinogens/psychedelics, inhalants and nicotine.
**Due to federal tax law, participants enrolled in HSA-eligible plans must meet the Federal Minimum deductible before 100% coverage can be provided.

Covered Expenses

Medical

Participants may, but are not required to, use the Carrum Health Benefit for the following treatments for certain substance use disorders:

- Detoxification: medically managed with medication
- Residential Treatment
- Partial Hospitalization
- Intensive Outpatient Treatment
- Outpatient Treatment, including Virtual Support

The Carrum Health Benefit covers all medical costs charged by the Center of Excellence for such treatments with no Copay, Deductible, or Coinsurance (except those enrolled in an HSA-eligible plan will still be subject to the Federal Minimum Deductible).
Coverage under the Carrum Health Benefit does not include costs associated with other medical conditions, which may be covered under the Plan outside of the Carrum Health Benefit. For example, prescription drugs required for heart conditions would not be covered under the Carrum Health Benefit but may be covered under the Plan's prescription drug benefit.

Coverage under the Carrum Health Program for these treatments may be limited in duration. To the extent that a participant seeks continued treatment after exhausting the coverage available under the Carrum Health Program, their care will be covered as outlined in the Summary of Benefits Coverage table above under "In-Network" and "Out-of-Network", as applicable, and as described elsewhere in this Plan Document.

Travel

For transportation to be covered under the Carrum Health Benefit, it must be booked by Carrum Health's Patient Care Team. Generally, the Patient Care Team will book and pay for travel on behalf of the participant for:

- Transportation for inpatient treatment at a Center of Excellence for the participant (and adult travel companion if deemed necessary by the Center of Excellence).
- Transportation for the participant to move from a Center of Excellence to a different level of care provided outside the Carrum Health Benefit for the participant (and adult travel companion if deemed necessary by the Center of Excellence).
- Transportation home from a Center of Excellence for the participant (and adult travel companion if deemed necessary by the Center of Excellence).

A stipend may also be provided to cover travel and other expenses, such as daily stipends during outpatient treatment and stipends for parking and mileage. Any stipend is provided via PayPal or prepaid Mastercard.

The cost of sober living arrangements may also be covered up to $3,500 per month for a participant who is receiving treatment through the Carrum Health Benefit.

Travel coverage and any stipend amount will vary based on the distance of the participant's home from the Center of Excellence and the type of treatment to be received.

Travel benefits do not include any travel-related expenses not specified in this Plan Document,

such as expenses related to a family member's lodging or travel to participate in the participant's treatment.

Please contact your Care Specialist or Carrum Health at 1-855-729-3511 or via the Carrum Health app for details regarding what travel benefits may be available with respect to your requested treatment.

A participant will receive a Form 1099 reflecting any taxable travel benefits.

Coverage Limitations and Disclosures

- To receive coverage under the Carrum Health Benefit, a Center of Excellence must determine that it will provide the requested treatment to the participant. Generally, a Center of Excellence may require a participant to meet American Society of Addiction Medicine (ASAM) criteria for treatment. A Center of Excellence may decline to treat a participant, or discontinue treatment, as it determines in its discretion. For example, a Center of Excellence may determine that it will discontinue treatment if the participant has a relapse while in treatment.
- To receive coverage under the Carrum Health Benefit, services MUST be scheduled and authorized by Carrum Health. If the participant does not use the Carrum Health Benefit, their care will be covered as outlined in the Summary of Benefits Coverage table above under "In-Network" and "Out-of-Network", as applicable, and as described elsewhere in this Plan Document.
- Services rendered by a Center of Excellence that are not covered under the Carrum Health Benefit are subject to the coverage limits, cost-sharing, and other terms of the Plan.
- Any cost-sharing paid by the participant for services provided under the Carrum Health Benefit will count towards the Plan's annual deductible and out-of-pocket maximum.
- Coverage under the Carrum Health Benefit may be denied by Carrum Health if:
    1. The participant refuses to complete documentation required to participate in the Carrum Health Benefit, including the Terms of Service and Member Registration Agreement;
    2. The participant violates the Carrum Health Terms of Service or Member Registration Agreement;
    3. The participant leaves treatment at a Center of Excellence against medical advice twice within six months, measured from the start date of the initial treatment. In that case, the participant will not be approved to participate in the substance use disorder benefits under the Carrum Health Program for six months measured from their last discharge date;
    4. The treatment is being sought to satisfy a court order;
    5. The participant is on probation and does not provide written approval from their probation officer that they are allowed to travel for treatment; or
    6. A participant requests to be referred to another Center of Excellence after the initial Center of Excellence has declined to provide the participant the requested treatment. Note this does not apply when the initial referral is to a Center of Excellence that cannot treat the participant because their condition is too complex or requires treatment that the Center of Excellence does not provide, in which case the participant may be referred to another Center of Excellence.
- If coverage under the Carrum Health Benefit is denied by Carrum Health for any of the foregoing reasons, the participant may still receive coverage for treatment as outlined in

the Summary of Benefits Coverage table above under “In-Network” and “Out-of-Network”, as applicable, and as described elsewhere in this Plan Document

- If the Plan would pay secondary in accordance with its coordination of benefits provisions, such secondary coverage will be determined in accordance with the Plan’s standard terms and cost-sharing provisions and not under this Carrum Health Benefit.