

PRODUCER MANUAL

For Highmark Blue Shield Medically Underwritten Health Coverage Programs



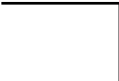
This manual, which is being provided to you by Highmark Blue Shield as a courtesy, is intended to provide useful information and is not intended to be complete or exhaustive. The guidelines governing the offering of health insurance and Highmark's policies may change from time to time. Please check for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

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

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

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INTRODUCTION

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

DirectBlue® Comprehensive Major Medical Preferred-Provider Program

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

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

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

These programs are available only to persons living in the 21-county area served by Highmark Blue Shield. If an individual enrolled in one of these programs moves out of the 21-county service area, his/her agreement will be terminated.

If the individual moves to the 29-county service area of the Western Region, he/she has the option of picking up the same program, if offered in the Western Region, and medical underwriting is waived. If the same program is not offered in the Western Region, he/she can pick up another medically underwritten program. Pre-existing condition limitations are credited for the time spent in the Highmark Central Region program.

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

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

PRODUCER NETWORK QUICK REFERENCE

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

PRODUCER INFORMATION *(For Producer Use Only)*

Questions about Highmark Appointment and Portal Entitlements	1-717-302-2469
Producer Portal Access Requests	Producer Affairs Central@highmark.com
Questions about benefits, claims, etc.	Highmark Blue Shield Producer Hotline 1-866-602-1248 Monday – Friday 8:00 a.m. to 5:00 p.m. <ul style="list-style-type: none"> • For password reset, press 1 • For Web technical/portal issues, press 2 • To speak with a service representative for all other issues, including benefits, claims, direct pay applications' status, etc., press 3
Guaranteed issue programs sales service	1-888-269-8412 Monday through Friday, 8:00 a.m. to 9:00 p.m.; Saturday, 8:00 a.m. to 8:00 p.m.
Technical assistance with online applications via the Producer Portal on the Highmark Blue Shield Web site	1-866-306-1059
For additional information or to order supplies	Access the Producer Portal at www.highmarkblueshield.com or contact your Preferred Agency

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

MEMBER INFORMATION

Web Inquiries:

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

Submit appeals for member denials for coverage to:

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

Telephone Inquiries:

Benefits, claims and enrollment information about

Under 65 Individual Programs:1-877-986-4571

Medicare and Over-65 Programs1-877-987-4876

Hearing impaired may call1-800-562-0591

Or, members can mail their inquiries to:

Highmark Blue Shield
P.O. Box 890171
Camp Hill, PA 17089-0171

SERVICE CENTERS

The following Highmark Blue Shield walk-in Service Centers are located in convenient areas for members living in the 21-county Highmark Blue Shield service area:

<i>Camp Hill Service Center</i>	<i>Allentown Service Center</i>	<i>State College Service Center</i>
1800 Center Street	7248 Tilghman Street	2040 Sandy Drive
Building 1, Level 1A	Allentown, PA 18106	State College, PA 16803
Camp Hill, PA 17089		

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

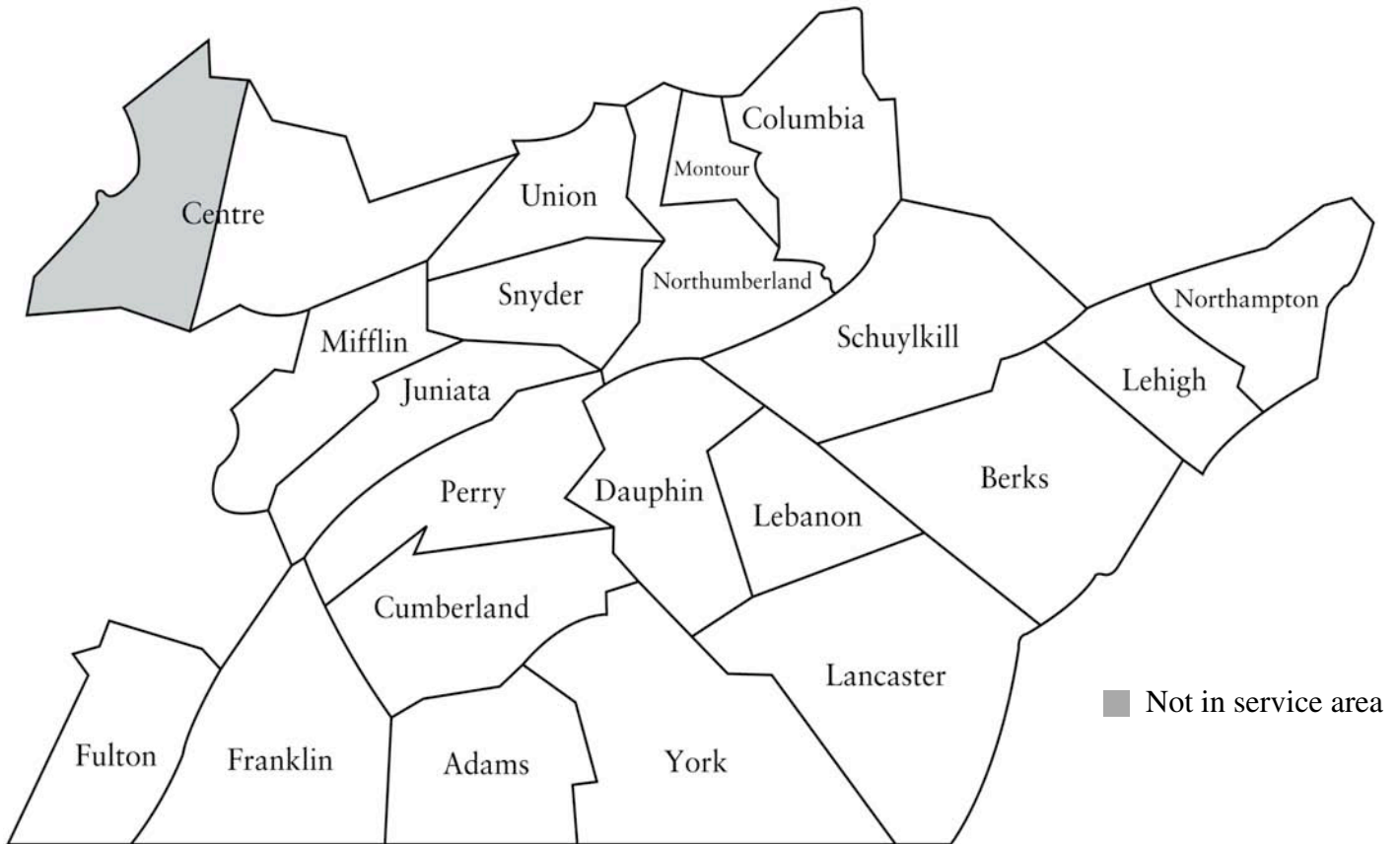
To make an appointment with a Service Representative, please call:

Allentown.....	1-610-573-5400
Camp Hill.....	1-717-302-4697
State College.....	1-814-321-9509

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

SERVICE AREA

21 counties where Highmark Blue Shield medically underwritten programs are available



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

- | | |
|-----------------------|------------------------|
| 16801 State College | 16844 Julian |
| 16802 University Park | 16851 Lemont |
| 16803 State College | 16852 Madisonburg |
| 16804 State College | 16853 Milesburg |
| 16805 State College | 16854 Millheim |
| 16820 Aaronsburg | 16856 Mingoville |
| 16823 Bellefonte | 16864 Orviston |
| 16826 Blanchard | 16868 Pine Grove Mills |
| 16827 Boalsburg | 16870 Port Matilda |
| 16828 Centre Hall | 16872 Rebersburg |
| 16832 Coburn | 16875 Spring Mills |
| 16835 Fleming | 16882 Woodward |
| 16841 Howard | |

MEDICARE ELIGIBILITY

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

Highmark Blue Shield
P.O. Box 890171
Camp Hill, PA 17089-0171
Phone: 1-877-549-5642

GENERAL PROGRAM INFORMATION

The programs explained in this manual should not be represented as group programs. They are filed with the Pennsylvania Insurance Department as individual direct payment programs.

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

The medically underwritten programs feature:

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

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

These programs are designed specifically for individuals who are not covered by an employer group program and who are looking for reliable, affordable coverage. Following are general descriptions of the three medically underwritten programs – DirectBlue, PPOBlue and ShortTermBlue.

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

SPECIFIC PROGRAM INFORMATION

DirectBlue® Comprehensive Major Medical Preferred-Provider Program

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

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

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

Family Deductible for DirectBlue

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

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

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

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

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

Family Deductible for PPOBlue

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

BlueAccountSM Health Savings Account (HSA)

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

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

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

ShortTermBlue Comprehensive Major Medical Preferred-Provider Program

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

Members have the choice of using providers in the PremierBlueSM Shield professional provider network and the Highmark participating facility network, where eligible services are covered at the higher benefits level. If out-of-network providers are used, eligible services are covered at the lower benefits level. After the deductible is met, payment is made at 80 percent for network services and 60 percent for out-of-network services (drugs are not covered out of the network). Balance billing may occur if the member uses an out-of-network provider. When a member reaches their coinsurance percentage limit (out-of-pocket maximum) for coverage in the network or out of the network, ShortTermBlue pays 100 percent of eligible expenses for the remainder of the contract period.

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

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

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

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

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

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

BENEFITS OF COVERAGE

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

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

Covered Inpatient Services

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

Covered Outpatient Services

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

Therapy Service Benefits

Radiation Therapy
Chemotherapy
Dialysis Treatment
Physical Medicine
Occupational Therapy
Speech Therapy
Spinal Manipulation*

Note: These medically underwritten programs exclude coverage for mental health and substance abuse services and prescription drugs related to these services.

Reference the relevant outline of coverage for additional program exclusions and limitations.

*Does not apply to ShortTermBlue.

IN-AREA AND OUT-OF-AREA SERVICES

DirectBlue, PPOBlue and ShortTermBlue In-Area Services versus Out-of-Area Services

DirectBlue, PPOBlue and ShortTermBlue utilize the PremierBlue Shield professional provider network and the Highmark participating facility network.

In-Area Network Coverage

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

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

Out-of-Network Coverage

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

DirectBlue, PPOBlue and ShortTermBlue Out-of-Area Services

Network, Out-of-Area Coverage through BlueCard®

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

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

Out-of-Network Out-of-Area Coverage

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

Coverage Out of the United States through BlueCard Worldwide

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

AUTHORIZATION OR PREADMISSION CERTIFICATION

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

Inpatient Admissions

Network and Participating Facility Providers

In the event of a proposed inpatient admission, for other than an emergency or delivery-related maternity condition, the provider is responsible for contacting the Highmark Blue Shield Healthcare Management Services (HMS) division prior to the proposed admission to determine if the admission is medically necessary and appropriate. When prior written notice that the admission or services will not be covered, the member will be held financially responsible.

Out-of-Network and Non-Participating Facility Providers

For a proposed inpatient admission to a non-participating or out-of-network hospital or facility, the member is responsible for contacting HMS at our toll-free number noted on the back of the member’s identification card, 1-877-986-4571, or assuring that the provider contacts HMS prior to the proposed admission to determine medical necessity and appropriateness.

Precertification for Inpatient Admissions

Precertification obtained

If precertification has been obtained as required for a medically necessary and appropriate inpatient admission, benefits will be paid in accordance with the member's agreement.

Precertification not obtained

The member is financially responsible for the out-of-network payment level in addition to the difference between the Highmark Blue Shield allowance and the non-participating provider’s actual charges.

Emergency and Delivery-Related Maternity Admissions

Network and Participating Facility Providers

In the event of an emergency or delivery-related maternity admission to a hospital or a rehabilitation hospital, it is the responsibility of the provider to contact HMS within 24 hours to determine if the admission is medically necessary and appropriate.

Out-of-Network and Non-Participating Facility Providers

In the event of an emergency or delivery-related maternity admission to an out-of-network or non-participating hospital or rehabilitation hospital, it is the responsibility of the member to contact HMS at our toll-free number, 1-877-986-4571, within 48 hours to determine if the admission is medically necessary and appropriate.

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

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

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

Benefits Appeal Procedure

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

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

Highmark Blue Shield
P. O. Box 890178
Camp Hill, PA 17089-0178
Attention: Review Committee

APPLICATION PROCESS FOR PRODUCERS

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

Exceptions to Submitting an Online Application

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

- For ShortTermBlue, if the customer wants to submit a check, a Producer's Certificate must accompany the paper application to ensure proper processing of commission payments.
- When the system does not accept the zip code and you have proof that the zip code is within the service area. Zip codes split between in-area and out-of-area counties include the following: 17002, 17229, 17756, 18041, 18070, 18240, 18635, 18655, 19310, 19344, 19362, 19363 and 19520.
- If the Social Security number for the applicant subscriber is not available
- When the existing member moves from another Highmark medically underwritten program to the PPOBlue High-Deductible program (use the change form and follow the directions on the form)*
- When changing a contract from husband/wife coverage to separate coverage or to add a spouse/dependent to an existing policy (use the change form and follow the directions on the form)*
- For enrollment in a guaranteed issue program

The online application is very easy to access...

1. Log onto the Highmark Blue Shield Web site at www.highmarkblueshield.com.
2. Select the "Producers" blue tab at the top of the page.
3. Enter your login ID and password.

*Does not apply to ShortTermBlue.

4. On the Welcome page, scroll down to “Key Site Features” and next to the New Business link click “Go.”
5. On the “New Business” page, scroll down to “Individual and Family Coverage” and click “Generate Quote and Apply.”
6. Enter a “Quote/Application Name” along with the applicant’s zip code and date generated. That way, you can save and access the information later.

The online system walks you through the process...

1. Search for “Saved Information” (or enter new application name).
2. Enter Individual Information.
 - Enter the information for each person applying for coverage. (For ShortTermBlue, only individuals can apply for coverage.)
 - Use the pulldown box next to the “Add” button in order to enter additional family members.*
 - Click on “Submit” when all the information is completed.
 - If certain required information is missing, edits will show in red to let you know what needs to be added or corrected.
3. Select Plan
 - You can check the programs for which you want to view benefit grids and standard rates. Select “Indemnity” and/or “PPO.”
 - Indemnity programs are our Guaranteed Issue Programs – ClassicBlue® Comprehensive (\$750 or \$1,500 deductible), including HIPAA and HCTC programs, and the SpecialCareSM Program.
 - PPO programs include our Medically Underwritten Programs – DirectBlue (\$0, \$250 or \$500 deductible), PPOBlue HDHP (\$1,200, \$2,600 or \$3,500 deductible) and ShortTermBlue (\$250, \$500 or \$1,000 deductible) and the Guaranteed Issue Program PPOBlue HDHP (\$1,200, \$2,600 or \$3,500 deductible).

*Does not apply to ShortTermBlue.

4. View Quote

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

5. Confirm Quote

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

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

6. Gather Information

- This section confirms the application type and premium.

*Does not apply to ShortTermBlue.

- For ShortTermBlue, two sets of medical eligibility questions are asked relative to pre-existing conditions. If the applicant answers “yes” to one or more of these questions, they are not eligible for coverage. Highmark reserves the right to terminate coverage for misrepresentation of medical facts.
- Click on “Sample Outline of Coverage” to print the comprehensive outline of benefits. The Pennsylvania Insurance Department requires that a copy of the Outline of Coverage be provided to each individual/family applying for coverage. (Copies of the Outlines of Coverage for each of the Medically Underwritten Programs can also be ordered from Highmark. Standard Producers can request copies from their Preferred Producer.)
- This section also provides important information regarding the Direct Pay Medically Underwritten Programs. Please read carefully.

7. Complete Application

- This section outlines Underwriting Guidelines and the Appeal Process.*
- Information needed to complete the processing of the application is entered in this section. Enter complete and accurate information for each person applying for coverage.
- If certain required information is missing, edits will show in red to let you know what needs to be added or corrected.

8. Make a Payment and Submit Application

- For all programs except ShortTermBlue, two payment options are available: Credit Card or Bill Me Later. If the Credit Card option is selected, one month’s premium will be charged to the applicant’s account upon receipt of the application. If the application is approved, coverage will begin on the assigned effective date. If the applicant or any family members are denied coverage, a refund check will be generated and mailed to them. If the Bill Me Later option is selected, the application can be submitted without making the first month’s payment. If approved, the assigned effective date will not be delayed; however, no claims will finalize until the first month’s premium has been received.
- For ShortTermBlue, credit card payment is the only option for online applications. The full premium for the coverage period selected is charged to the applicant.
- “Pay-It-Easy”* is the automatic monthly premium payment program or Electronic Funds Transfer (EFT) process. Information on the Pay-It-Easy program will be sent in the member welcome packet. Members can enroll in Pay-It-Easy and have their monthly payments automatically deducted from their bank account. Otherwise, monthly invoices will be mailed to the member.

*Does not apply to ShortTermBlue.

- Enter the information completely and accurately to finalize the online application process.
- When you complete the payment screen, your application has been submitted.
- When confirmation is received, a copy of the completed application can be printed.

NOTE: If at any time during the application process you want to go back to a previous section, click on the gray navigation tools section in the left-hand column to return there.

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

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

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

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

*Does not apply to ShortTermBlue.

Important Information Pertaining to the Application Process

- Verify the accuracy of all information prior to submission. Numerical data is particularly error-prone, so double-check Social Security numbers, height, weight, date of birth, etc.
- The writing producer must be properly licensed and appointed with Highmark to sell individual products prior to acting on Highmark's behalf or as Highmark's representative.
- Applicants must not be eligible for Medicare and must reside within the 21-county area serviced by Highmark Blue Shield to apply for any of these programs. Applicants must use their correct home address. Do not use a business address.
- In order to receive commission, all producers must submit online applications through the Highmark Web site via the Producer Portal.
- When submitting online applications, the producer must enter the application via the Producer Portal (not the Consumer Portal) to receive commissions on approved applications. Use your Portal login ID and password to enter the Producer Portal, and enter your Agency and producer numbers on the producer information page on the application. The exception is ShortTermBlue, when accompanied by a producer certificate.
- All application information must be completed accurately and in detail to help avoid processing and approval delays.
- The writing producer must complete all questions in the producer section of the application. Incomplete or missing information will result in no commission for the writing producer.
- Producers must provide applicants with an Outline of Coverage.
- Print and maintain a copy of the application for your files.
- Producers must abide by the code of ethics included in this manual on page 65.
- To ensure that applicants submit complete and accurate applications, Highmark has implemented several mechanisms for our medically underwritten programs to detect fraud.
- Any repeated submission by producers of applications for individuals whose applications are determined to be fraudulent will result in termination of their appointment with Highmark and the possible pursuit of legal actions and remedies.

PPOBlue and DirectBlue

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

Family Deductible

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

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

PPOBlue Annual Family Deductible

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

DirectBlue Annual Family Deductibles

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

ShortTermBlue

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

Identification Cards and Subscription Agreements

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

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

*Does not apply to ShortTermBlue.

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

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

Free-look Enrollment Period

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

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

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

This cancellation information should be mailed to:

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

OR

Fax to: 412-544-4176

CANCELLING POLICIES

DirectBlue and PPO Blue

Members should notify Highmark Blue Shield 30 days prior to the requested effective date of cancellation by calling Member Service at 1-877-986-4571, or by mailing written notification to:

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

OR

Fax to: 412-544-4176

ShortTermBlue

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

CONVERSION FROM HIGHMARK GROUP COVERAGE AND HIPAA OPTIONS

Conversion and HIPAA Options

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

Conversion

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

Individuals interested in applying for a conversion should:

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

HIPAA Program and Eligibility Checklist

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

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

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

Individuals interested in applying for HIPAA coverage should:

- 1) Obtain a Certificate of Prior Creditable Coverage from all previous employers with whom they had coverage during the past 18 months.
- 2) Determine if he/she meets the government-mandated guidelines for the HIPAA program (see the HIPAA Eligibility Checklist below).
- 3) Once eligibility is determined, call 1-800-876-7639 to request a Highmark HIPAA enrollment kit.
- 4) Submit the HIPAA application to Highmark within 63 days of the group cancellation date.

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

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

- Applicant is a resident of the 21-county geographical area of central Pennsylvania served by Highmark Blue Shield.
- Applicant is not eligible for or enrolled in Medicare, Medicaid or any group health insurance plan.

- Applicant does not have any other health insurance coverage, either group or individual.
- Applicant has elected and exhausted all "COBRA" or similar continuation of coverage benefits available through his/her former employer or group benefits plan.
- Applicant has had a minimum of 18 months of health care coverage (without any breaks in coverage of more than 63 days) prior to applying for this new coverage.
- Applicant's most recent health care coverage was provided through a group, governmental or church plan.
- Applicant's most recent health care coverage is no longer in effect and ended within the last 63 days.
- Applicant's most recent health care coverage was not terminated due to non-payment of premiums (including contributions) or fraud.
- Applicant is attaching a copy of his/her "Certificate of Prior Creditable Coverage" to the application. Or, if applicant does not have a certificate, applicant is attaching a statement describing his/her prior coverage, including the name of the plan(s) and the time during which he/she was covered, together with additional evidence of that coverage, such as copies of identification cards, explanation of benefits (EOB) forms, etc.

Call the Highmark Blue Shield Producer Hotline at 1-866-602-1248 if you need more information.

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

ENROLLMENT GUIDELINES

Effective Date of Coverage*

A producer can never guarantee an effective date.

- If an application is approved on or before the last day of the month, coverage will become effective the first of the following month.
- If an application is approved after the last day of the month, coverage will become effective the first of the second month following approval.
- Example: Applications approved on or before May 31st will become effective June 1.
- For ShortTermBlue, an eligible applicant can choose that their coverage becomes effective the next day after the signature date of the application.
- The effective date of coverage for newborns is the 32nd day after birth.

Dependents*

Under these programs, a "child" is defined as the:

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

Adding Newborns/Infants to Medically Underwritten Coverage*

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

*Does not apply to ShortTermBlue.

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

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

Newborn Coverage in ShortTermBlue

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

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

Adding Children*

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

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

*Does not apply to ShortTermBlue.

Deleting Children*

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

Disabled Dependents

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

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

Adding a Spouse*

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

- 1) A dependent spouse may be added on the first of the month following the medical underwriting approval date, providing that contact was made within 60 days of the marriage date, or
- 2) If more than 60 days have elapsed from the marriage date, the dependent spouse may be added on the anniversary date of the agreement, providing contact is made and medical underwriting approval is received within 60 days prior to the anniversary date of the agreement. (A spouse can enroll in their own policy at any point in time.)
- 3) A change form should be completed and submitted with the spouse's application.

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

*Does not apply to ShortTermBlue.

Changes in Eligibility

Have the member notify Member Service at 1-877-986-4571 as soon as they experience a change in the following:

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

Medical Underwriting Waived for Members Who Switch to PPOBlue HDHP*

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

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

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

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

*Does not apply to ShortTermBlue.

To make the change, simply:

- 1) Complete a change form (CC-040), indicating the contract holder's name, Social Security number, group number and the desired PPOBlue deductible amount. The member's signature, date of signature and phone numbers must be completed on the back of the change form.
- 2) Complete the General Information section (name, address, county, phone number, and e-mail address) on the first page of an accompanying PPOBlue application (ENR-078).
- 3) Indicate the desired deductible amount in the Enrollment Information section of the PPOBlue application. There is no need to complete any further information in the Enrollment Information or the Medical Information sections of the application.
- 4) Sign and date the application in the Conditions of Enrollment section. Applying members should also indicate the date they would like the PPOBlue membership to be effective. PPOBlue membership can take effect on the first day of the month following submission of the change form and application.
- 5) Producers should complete the agency information, producer information, telephone number and signature on the last page of the application.
- 6) Submit the change form and application. No payment is required at the time of application submission.

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

*Does not apply to ShortTermBlue.

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

MEDICAL UNDERWRITING FOR DIRECTBLUE AND PPOBLUE

General Information

An evaluation of the applicant's medical history will determine acceptance for coverage. To help you assist applicants, underwriting guidelines are included in this manual* (see page 38).

Medical Records Submission

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

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

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

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

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

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

Medical information regarding denials will only be released to the applicant. You may call the Producer Hotline at 1-866-306-1056 to determine if an applicant was denied. No medical information will be discussed with a producer without a signed authorization form.

*Underwriting guidelines are current as of the publication date of this manual. Highmark reserves the right to modify its guidelines from time to time. Please contact the Highmark Producer Line at 1-866-602-1248 for any updated information. The decision to accept an individual applicant is made by Highmark upon receipt of all required information. No producer should make any representation to an applicant.

Incomplete Applications

If clarification or additional medical information is necessary to process the application, our medical underwriting staff may contact the applicant directly. The applicant will be asked to submit the appropriate information to Highmark Blue Shield within 30 days. If, after 30 days, additional information is still not received, processing of the application will be cancelled and the premium will be refunded. Any fees requested in the procurement of medical records are the responsibility of the applicant. Medical records are not returned. Evaluation of the applicant's medical history will determine acceptance for coverage. To help you assist applicants, underwriting guidelines are included in this manual.*

*Underwriting guidelines are current as of the publication date of this manual. Highmark reserves the right to modify its guidelines from time to time. Please contact the Highmark Producer Line at 1-866-602-1248 for any updated information. The decision to accept an individual applicant is made by Highmark upon receipt of all required information. No producer should make any representation to an applicant.

MEDICAL UNDERWRITING GUIDELINES

Underwriting Practices and Disclaimer

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

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

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

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

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

Body System	You Should Ask	Possible Action by Highmark
Behavioral Health Psychiatric/Substance Abuse		
Addiction/substance abuse	<ul style="list-style-type: none"> • Name of drug or substance • Current treatment • Inpatient/outpatient • Medical records recommended 	<p>Consider for tiering with physician documentation of abstinence for past five years and no significant concurrent problems</p> <p>Deny for active problem within past five years</p>
Tobacco use	<ul style="list-style-type: none"> • Type of tobacco • Cigarettes/cigars/chew/pinches/number per day • Date range of tobacco use 	<p>Approve if tobacco-free for over one year</p> <p>Consider for tiering for current or recent user</p> <p>Deny for heavy or long-term use</p>
Attention deficit disorder/attention deficit hyperactivity disorder	<ul style="list-style-type: none"> • Current medications • Current non-pharmaceutical treatment 	<p>Standard every time to standard approval, if no treatment required in the past year and no concurrent problems</p> <p>Consider for tiering if undergoing current treatment or treated in past year</p> <p>Deny for unstable, multiple treatments</p>
Psychiatric/psychological counseling/ medications for any condition	<ul style="list-style-type: none"> • Diagnosis required • Current medications • Current treatments/ counseling • Length of time/number of sessions 	<p>Standard if treatment ended over five years ago</p> <p>Consider for tiering if problem active one to five years ago, for a situational diagnosis, or for medication used for non-psychiatric diagnosis</p> <p>Deny for major psychological/nervous diagnosis, current medication, medication within the past year, frequent or recent counseling or suicide attempt</p>

Body System	You Should Ask	Possible Action by Highmark
Behavioral Health Psychiatric/Substance Abuse (continued)		
Sleep disorders/sleeping medications	<ul style="list-style-type: none"> • Diagnosis • Sleep study done/date • Durable medical equipment required, such as continuous positive airway pressure or bi-level positive airway pressure • Medications/frequency 	<p>Standard if surgical correction was more than six months ago and released</p> <p>Consider for tiering for current medications or additional conditions</p> <p>Deny for more severe diagnoses or if durable medical equipment required</p>
Antidepressants or anti-anxiety treatment for smoking cessation/restless legs/hot flashes/ pre-menstrual dysphoric syndrome/ situational adjustment disorder	<ul style="list-style-type: none"> • Medications/frequency 	Consider for tiering
Mental retardation		Deny
Heart/Blood/Circulation		
High cholesterol	<ul style="list-style-type: none"> • Recent lab results • Medications 	<p>Cholesterol level required for decision</p> <p>Approve if well-controlled</p> <p>Deny if unstable or requires multiple medications</p>
Anemia blood disorders	<ul style="list-style-type: none"> • Kind of anemia • Diagnosis 	Standard for simple iron deficiency or oral treatment only and stable
Angina/chest pain	<ul style="list-style-type: none"> • Diagnosis • Medications/medication changes • Recent ER/doctor visit/hospitalization/results • Diagnostic tests/date/results • Medical records strongly recommended 	<p>Individual consideration</p> <p>Deny if unstable, medications required, heart attack in past five years, heart surgery in past five years or enlarged heart</p>

Body System	You Should Ask	Possible Action by Highmark
Heart/Blood/Circulation (continued)		
Vein/artery problems/deep vein thrombosis/blood clots	<ul style="list-style-type: none"> • Diagnosis • Describe problems with blood clotting/kinds of disorders 	Individual consideration Deny for embolism, phlebitis, significant associated conditions or blood thinners
Hypertension/hypotension	<ul style="list-style-type: none"> • Average blood pressure/ recent blood pressure <p>DO NOT ENTER “STABLE” OR “UNDER CONTROL”</p> <ul style="list-style-type: none"> • All medications/frequency 	Blood pressure reading required for decision Approve if well-controlled Deny if unstable, blood pressure elevated, associated with kidney or neurological problems, recent hospitalization, multiple medications for blood pressure or blood thinners
Irregular heart beat	<ul style="list-style-type: none"> • Diagnosis, if known • Medications and/or changes to medications/diet • Medical records and/or statement strongly recommended 	Individual consideration Deny if unstable, history of heart attack or surgery, artificial valve, pacemaker or defibrillator, functional limitations or heart block
Pacemaker/defibrillator		Deny
Stroke/cerebrovascular accident		Deny
Enlarged heart/cardiomyopathy		Deny
Heart surgery/valve replacement		Deny
Hemophilia/blood clotting disorders		Deny
Peripheral vascular disease/ bypass surgery/ implanted filters		Deny

Body System	You Should Ask	Possible Action by Highmark
Eyes/Ears/Nose/Throat		
EYES		
Glaucoma	<ul style="list-style-type: none"> • Surgery, anticipated or recently performed • Medications 	Standard if stable on one to two medications or no recent or planned procedures
Macular degeneration	<ul style="list-style-type: none"> • Medications 	<p>Consider for tiering if no prescription or over-the-counter medications</p> <p>Deny for prescription medications or treatments</p>
Cataract(s)	<ul style="list-style-type: none"> • Status of both eyes required • Past surgery/date/which eye • Anticipated surgery/which eye 	<p>Standard if surgery is completed and applicant is released from care</p> <p>Deny if surgery is planned or performed less than six months ago</p>
Visual impairment	<ul style="list-style-type: none"> • Impact activities of daily living (No or yes answer required) • Lasik surgery date 	<p>Standard if no associated complications or major functional deficit</p> <p>Consider for tiering for recent Lasik surgery or concurrent problems</p>
Enucleated/removed eye	<ul style="list-style-type: none"> • Date of enucleation, reason, infection, complications, problems with prosthesis 	<p>Consider for tiering</p> <p>Deny for current infection, problems with prosthesis or significant underlying condition</p>
Iritis	<ul style="list-style-type: none"> • Diagnosis/date • Last episode • Frequency of episodes • Doctor's statement strongly recommended 	Consider for tiering

Body System	You Should Ask	Possible Action by Highmark
Eyes/Ears/Nose/Throat (continued)		
EYES (CONTINUED)		
Retinal/corneal conditions	<ul style="list-style-type: none"> • Diagnosis • Specify problem • Past or future surgery • Surgery date 	Individual consideration
EARS		
Infections	<ul style="list-style-type: none"> • Average number of infections per year • Past or future surgery • Surgery date • Medication/frequency 	Standard Consider for tiering with multiple episodes
Cochlear implants	<ul style="list-style-type: none"> • Reason • Date of surgery 	Consider for tiering
NOSE		
Deviated septum	<ul style="list-style-type: none"> • Surgery/date 	Standard if no surgery is planned or applicant is released from care Deny if surgery is anticipated or occurred less than three months ago
THROAT/JAW/MOUTH		
Jaw/temporo-mandibular joint problems	<ul style="list-style-type: none"> • Diagnosis • Specify surgery, splints, treatment 	Consider for tiering
Infections	<ul style="list-style-type: none"> • Type • Frequency • Diagnosis • Medications 	Standard if fully resolved and not recurrent

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

Body System	You Should Ask	Possible Action by Highmark
GI – Gastro-intestinal/Stomach/Intestines (continued)		
Diverticulitis/diverticulosis/ frequent abdominal pain	<ul style="list-style-type: none"> • Diagnosis: diverticulitis/osis • Medications • Rectal bleeding episode(s)/ date(s) • Hospitalization/date • ER/date 	<p>Standard if well-controlled with diet</p> <p>Deny for recent prescription, hospitalization or treatment</p>
Nutritional disorder	<ul style="list-style-type: none"> • Medical records or doctor’s statement strongly recommended 	Individual consideration
Fistula/fissure	<ul style="list-style-type: none"> • Location • Diagnosis/date • Symptoms and treatment plan within the past year • Surgery 	<p>Consider for tiering if resolved over six months</p> <p>Deny if symptomatic or for surgery within six months</p>
Bariatric surgery/gastrectomy/ gastroplasty		Deny
Hemorrhoids	<ul style="list-style-type: none"> • Surgery type/date 	<p>Standard if well-controlled or no need for recent treatment</p> <p>Consider for tiering for recent surgery, multiple or bleeding</p> <p>Deny for anticipated surgery or surgery less than three months ago</p>
Hernia	<ul style="list-style-type: none"> • Type/diagnosis • Surgery/date • Released from care/date 	<p>Standard for surgery more than six months ago</p> <p>Individual consideration for surgery less than six months ago</p>
Hepatitis	<ul style="list-style-type: none"> • Specify Type: A/B/C/D/E, etc. • Date of diagnosis • Treatment/medications • Medical statement recommended 	<p>Individual consideration</p> <p>Deny for Hepatitis B, C, D, E</p>

Body System	You Should Ask	Possible Action by Highmark
GI – Gastro-intestinal/Stomach/Intestines (continued)		
Irritable bowel syndrome	<ul style="list-style-type: none"> • Medications • Medical records with treatment plan strongly recommended • Current symptoms 	<p>Standard if no medications or hospitalization needed in past year</p> <p>Deny for prescription medications or recent hospitalization</p>
Pancreatitis	<ul style="list-style-type: none"> • Acute or chronic • Number of episodes • Treatment plan/release from care 	<p>Consider for tiering</p> <p>Deny if chronic, treatment in the past two years, abnormal lab results</p>
Gastritis/ulcer/esophagitis/gastroesophageal reflux disease	<ul style="list-style-type: none"> • Medications • Surgery/date/release • Hospitalization 	<p>Standard on over-the-counter drugs</p> <p>Tiering if on proton pump inhibitor (PPI) drugs.</p> <p>Deny for H. Pylori, Barrett’s Esophagus, recent surgery or hospitalization</p>
Polyps	<ul style="list-style-type: none"> • Biopsy results/date • Pathology reports recommended 	Individual consideration
Colorectal cancer	<ul style="list-style-type: none"> • Medical records required for consideration 	Automatic denial if treated within past five years or with additional risk factors
Esophageal varices		Deny

Body System	You Should Ask	Possible Action by Highmark
GU - Kidney/Bladder		
Benign prostatic hyperplasia/ enlarged prostate	<ul style="list-style-type: none"> • Surgery/date/outcome • Medications • Treatment plan • Release from care 	<p>Standard if no medications, surgical history or plan, or biopsy</p> <p>Consider for tiering with any medication</p> <p>Deny for recent surgery</p>
Incontinence	<ul style="list-style-type: none"> • Diagnosis/date • Surgery/date/outcome • Medications 	<p>Standard for surgery and if released from care</p> <p>Consider for tiering for medications on chronic basis</p> <p>Deny for anticipated or recent surgery</p>
Kidney cysts		<p>Standard if stable for two years with no medications or treatment</p> <p>Deny for anticipated surgery, if symptomatic or unstable</p>
Kidney failure/renal failure/ chronic renal failure/end-stage renal disease		Deny
Kidney stones	<ul style="list-style-type: none"> • Number of episodes in past five years • Date of last episode 	<p>Standard for infrequent episodes and more than three years since treatment</p> <p>Consider for tiering for repeat or recent episodes</p> <p>Deny for urinary abnormalities, episodes within the past year or frequent episodes</p>

Body System	You Should Ask	Possible Action by Highmark
GU - Kidney/Bladder (continued)		
Kidney surgery/nephrectomy/ prostrate and testicular cancers/pyelonephritis/cystitis	<ul style="list-style-type: none"> • Type/date of surgery • Diagnosis/date • Treatment plan/release from care required • Specify number of episodes per year/date/treatment 	Individual consideration
Urethral strictures/narrowing	<ul style="list-style-type: none"> • Frequency • Surgery/type/date/release • Medications • Physician statement or records strongly recommended 	<p>Standard if fully resolved and no concurrent problems</p> <p>Deny for ongoing/recent surgery/repetitive treatments</p>
Immune System/Infections		
AIDS/HIV		Deny
Allergies (specify)	<ul style="list-style-type: none"> • Medication/frequency of use • Allergy shots for desensitization/ treatment date range • Associated conditions/ asthma/rashes 	<p>Standard for minimal oral/nasal medications</p> <p>Consider for tiering if steroids by mouth are required, for two or more daily medications, or if allergy shots ended recently</p> <p>Deny for current testing or desensitization, if associated with asthma or other respiratory problems, if multiple daily medications are required</p>
Lupus		Deny
Scleroderma		Deny

Body System	You Should Ask	Possible Action by Highmark
Immune System/Infections (continued)		
Lyme disease	<ul style="list-style-type: none"> • Diagnosis/date • Treatment plan • Medications 	Consider for tiering if treated within past year
Viral infections	<ul style="list-style-type: none"> • Diagnosis/date • Treatment plan • Medications/frequency of use/episodic or daily 	Standard if resolved/infrequent Consider for tiering for active, recent or frequent infections
Epstein-Barr virus/ mononucleosis	<ul style="list-style-type: none"> • Diagnosis/date • Treatment plan • Medications/frequency 	Individual consideration Deny for active treatment
Other/comments: Methicillin Resistant Staff (MRSA)	<ul style="list-style-type: none"> • Diagnosis/location/date • Number of episodes • Treatment plan • Medications/frequency 	Consider for tiering if released for more than one year Deny for active/frequent treatment or treatment within past year
Skin/Nails/Hair/Cosmetic		
Cellulitis	<ul style="list-style-type: none"> • Onset date • Site of infection • Treatment plan/released • Associated conditions • Medical records and/or statement recommended, if less than three months ago 	Standard if resolved Consider for tiering if recent, required hospitalization, is recurrent, or for underlying conditions Deny for current or frequent treatment
Hair loss	<ul style="list-style-type: none"> • Treatment plan • Associated medical condition • Medical records recommended 	Individual consideration
Psoriasis	<ul style="list-style-type: none"> • Treatment plan/physician statement required • Medications/frequency of use 	Individual consideration

Body System	You Should Ask	Possible Action by Highmark
Skin/Nails/Hair/Cosmetic (continued)		
Skin lesions/skin cancer/ pre-cancer	<ul style="list-style-type: none"> • Frequency • Site • Onset/treatment dates • Treatment plan • Pathology reports strongly recommended 	<p>Individual consideration</p> <p>Standard for squamous cell pathology and if resolved and infrequent</p> <p>Consider for tiering based on cell type and frequency of follow up needed</p> <p>Deny for melanoma, if inconclusive, or for recent/frequent intervention</p>
Other skin conditions requiring treatment: acne/fungal infections/rosacea/rashes/dermatitis/warts/eczema/keratosis	<ul style="list-style-type: none"> • Specify diagnosis/date • Medications/frequency of use • Treatment type/surgery/date • Treatment plan/physician statement recommended 	<p>Standard for minor treatment or treatment complete for more than six months and/or if clinical statement indicates release without complications</p> <p>Consider for tiering for multiple or costly medications</p> <p>Deny if severe, or for phototherapy, laser treatment, prescription accutane</p>
Cosmetic problems	<ul style="list-style-type: none"> • Full description/diagnosis/dates 	Individual consideration
Wounds	<ul style="list-style-type: none"> • Surgery type/date • Wound date • Treatment plan/physician statement recommended, if less than three months ago or long term 	Standard if resolved
Sarcoidosis/scleroderma		Deny

Body System	You Should Ask	Possible Action by Highmark
Muscles/Bones		
Amputations	<ul style="list-style-type: none"> • Exact site • Underlying condition/trauma • Durable medical equipment needed • Prosthetics in use or planned 	<p>Standard if traumatic amputation of minor appendage with no prosthesis needed</p> <p>Otherwise, individual consideration</p>
Arthritis	<ul style="list-style-type: none"> • Specify type • Therapy • Medications/frequency of use • Steroids/oral or injections • Treatment plan 	<p>Individual consideration</p> <p>Deny for rheumatoid disease</p>
Fractures/joint replacement/pins/screws	<ul style="list-style-type: none"> • Specify underlying condition • Surgery/treatment and date • Rehabilitation plan • Current range of motion • Release from care or follow-up visits • Hardware replacement/removal schedule 	<p>Standard if healed and released from care with full function</p> <p>Individual consideration if criteria not met</p>
Bunion/foot conditions/plantar fasciitis	<ul style="list-style-type: none"> • Specify diagnosis/type • Therapy/number/date range of visits • Surgery/date • Durable medical equipment/treatment • Release from care/date 	<p>Approved if treatment completed and released</p> <p>Deny for surgery or recent or ongoing treatment, or if durable medical equipment is required</p>
Carpal tunnel syndrome	<ul style="list-style-type: none"> • Medications/pain management • Surgery/treatment/therapy/date • Splint/durable medical equipment • Release from care/date 	<p>Standard if resolved and released from care</p> <p>Individual consideration if criteria not met</p>

Body System	You Should Ask	Possible Action by Highmark
Muscles/Bones (continued)		
Fibromyalgia	<ul style="list-style-type: none"> • Diagnosis/date • Treatment plan required for consideration • Medications/frequency 	Individual consideration
Osteopenia/osteoporosis	<ul style="list-style-type: none"> • Diagnosis/date • T-scores with dates required for consideration • Physician statement of height loss/fracture history/treatment plan recommended • Medications/schedule 	<p>Approve if minor/preventive</p> <p>Consider for tiering for moderate T-score</p> <p>Deny for T-score below minus 2.5</p>
Recurrent pain	<ul style="list-style-type: none"> • Diagnosis/date • Associated conditions • Workers-compensation related • Site/onset factors/control • Treatment <ul style="list-style-type: none"> • Medication schedule • Therapy • Surgery • Durable medical equipment 	Individual consideration
Spine problems/disc problems/scoliosis/kyphosis	<ul style="list-style-type: none"> • Diagnosis/date • Evaluation/treatment/surgery dates • Therapy/spinal manipulation • Durable medical equipment • Medication/frequency of use • Physician statement recommended for consideration 	Individual consideration
Tendonitis/bursitis/myositis	<ul style="list-style-type: none"> • Specify diagnosis/date • Treatment or surgery/date • Durable medical equipment • Medications/frequency of use/oral or injections • Therapy/spinal manipulations • Recommend physician statement and treatment plan 	<p>Individual consideration</p> <p>Deny if severe or if treatment or durable medical equipment required recently or frequently</p>

Body System	You Should Ask	Possible Action by Highmark
Brain/Spine/Nervous System		
Neuro/muscular disorders/Guillain Barre/ multiple sclerosis/ muscular dystrophy/myasthenia gravis/ALS/Lou Gehrig's disease/Alzheimer's/dementia/ senility/hemiplegia/ ahemiparesis/Tourette's syndrome		Deny
Headaches/migraines (Specify type)	<ul style="list-style-type: none"> • Diagnosis • Frequency • Medications/frequency of use • ER/hospitalization/dates • Other treatment and dates 	Individual consideration
Memory loss/cognitive problems	<ul style="list-style-type: none"> • Diagnosis/date • Treatment plan 	Individual consideration
Developmental delays	<ul style="list-style-type: none"> • Diagnosis/date • Treatment plan 	Individual consideration
Narcolepsy		Deny
Parkinson's disease		Deny
Seizure disorder	<ul style="list-style-type: none"> • Diagnosis/date • Last seizure date • Medications • Related conditions 	<p>Approve if no medications, seizure free at least one year and no underlying conditions</p> <p>Consider for tiering if no recent seizures</p> <p>Deny for unstable seizure within the past year, other conditions</p>

Body System	You Should Ask	Possible Action by Highmark
Brain/Spine/Nervous System		
Dizziness/Meuniere's disease/fainting	<ul style="list-style-type: none"> • Diagnosis/date • Associated conditions • Medications and frequency of use • Current symptoms • Activity limitations • ER/hospital admission/date 	<p>Consider for tiering if well controlled or for minor treatment</p> <p>Deny for severe, active treatment, current associated conditions</p>
Tremors/essential or familial/restless leg syndrome	<ul style="list-style-type: none"> • Diagnosis/date • Medications/frequency of use • Associated conditions 	Individual consideration
Stroke/cerebral vascular accident/transient ischemic attack		Deny
Mental retardation/Down's syndrome		Deny
Reproductive System – Female		
Breast augmentation	<ul style="list-style-type: none"> • Date of augmentation • Removal/replacement of prosthesis/date 	<p>Deny for surgery within past year</p> <p>Consider for tiering if more than one year</p>
Breast problems/fibrocystic breasts/mastitis/lumps/lumpectomy/mastectomy	<ul style="list-style-type: none"> • Diagnosis/date • Treatment/surgery/date • Medications/schedule • Therapy • Release from care • Pathology reports recommended for biopsy/surgery 	Individual consideration
Childbirth (most recent)	<ul style="list-style-type: none"> • Date of birth • Postpartum office release date required 	Standard if released from care

Body System	You Should Ask	Possible Action by Highmark
Reproductive System – Female (continued)		
Miscarriage/date/complications	<ul style="list-style-type: none"> • Dates • Treatments/surgery • Complications • Medication • Ongoing treatment plan 	Standard if more than one month and no complications
Female fertility	<ul style="list-style-type: none"> • Last menstrual period required for all females ages 18 to 50 • Reason for no period in past month • Diagnosis/date • Medications/intervention • Infertility/fertility treatment • Pregnancies/delivery dates 	Standard if successful and no longer seeking fertility treatment Deny for active treatment
PAP test (females age 18 and older)	<ul style="list-style-type: none"> • PAP test results/dates recommended for all females 18 and older • Treatment/monitoring plan required for all abnormal results • Treatment follow-up results required 	Individual consideration
Infectious disease/sexually transmitted disease/genital warts/chlamydia/human papilloma virus/syphilis/gonorrhea/herpes	<ul style="list-style-type: none"> • Diagnosis/date • Treatment plan 	Standard if treatment completed and no complications
Menstrual problems/fibroids/endometriosis	<ul style="list-style-type: none"> • Diagnosis/date • Treatments • Surgery • Medication • Residual complications 	Individual consideration
Ovarian cysts	<ul style="list-style-type: none"> • Diagnosis/date • Treatment • Surgery • Medication 	Standard for surgical correction more than six months ago and released Deny if recently diagnosed, pending surgery, or for drugs other than birth control pills

Body System	You Should Ask	Possible Action by Highmark
Reproductive System – Female (continued)		
Sexual issues/transgender/dysfunction	<ul style="list-style-type: none"> • Treatment • Prosthesis • Sexual alterations 	Individual consideration
Reproductive System – Male		
Prostate cancer	<ul style="list-style-type: none"> • Diagnosis/date • Medications • Surgery/radiation/date 	Approve if disease-free and no treatment in past five years
Prostate problems/benign prostatic hypertrophy	<ul style="list-style-type: none"> • Diagnosis/dates • Treatments • Medications • Surgery • PSA level 	<p>Standard if mild and does not require treatment</p> <p>Consider for tiering for active treatment</p> <p>Deny for recent or planned surgery</p>
Epididymitis	<ul style="list-style-type: none"> • Dates • Treatments • Medications • Number of episode(s) 	Standard if acute, single episode, full recovery, released from care
Erectile dysfunction	<ul style="list-style-type: none"> • Associated conditions 	Individual consideration
Sexual issues/transgender/dysfunction	<ul style="list-style-type: none"> • Diagnosis/dates • Treatment • Medications • Prosthesis • Sexual alterations 	Individual consideration
Testicular cancer	<ul style="list-style-type: none"> • Diagnosis/dates 	<p>Standard if disease-free and without treatment for past three years</p> <p>Consider tiering for complications, other conditions</p>
Infectious disease/sexually transmitted diseases)/genital warts/chlamydia/human papilloma virus/syphilis/gonorrhea/herpes	<ul style="list-style-type: none"> • Diagnosis/date • Treatment 	Standard if treatment completed and no complications

Body System	You Should Ask	Possible Action by Highmark
Respiratory		
Asthma	<ul style="list-style-type: none"> • Diagnosis • Causative factors/triggers/allergies • All medications • Treatment • Last ER visit 	<p>Standard if stable on two or less medications and no ER visits in past year</p> <p>Consider for tiering for steroid therapy by mouth or nasal spray, using two or more medications, or allergy shots ended more than three months to one year</p> <p>Deny if steroid dependent, frequent ER/hospital/intervention</p>
Bronchitis/pneumonia/upper respiratory infections	<ul style="list-style-type: none"> • Diagnosis/date • Treatment • Medications 	<p>Standard if fully resolved, non-recurrent</p> <p>Deny for active/recent infection</p>
Chronic cough	<ul style="list-style-type: none"> • Diagnosis/date • Causative factors 	Individual consideration
Shortness of breath	<ul style="list-style-type: none"> • Diagnosis/date • Causative factors 	Individual consideration
Pleurisy/pneumothorax	<ul style="list-style-type: none"> • Diagnosis/date • Episode(s)/date(s) • Treatment • Release from care • Medications 	Standard for episode(s) more than six months ago and if released from care
Pulmonary embolism/blood clots	<ul style="list-style-type: none"> • Diagnosis/date • Associated diagnoses • Medications and anticoagulation therapy or filter 	<p>Consider for tiering if more than three years since diagnosis, not receiving anticoagulation therapy, no associated peripheral vascular disease, phlebitis, arrhythmia or coronary artery disease</p> <p>Deny if active treatment continues</p>

Body System	You Should Ask	Possible Action by Highmark
Respiratory (continued)		
Tuberculosis	<ul style="list-style-type: none"> • Active/inactive • Diagnosis/date • Specify treatment • Medications and dates 	Standard if treatment complete
Emphysema/chronic obstructive pulmonary disease/other lung disease or work-related breathing problems	<ul style="list-style-type: none"> • Diagnosis/date 	Deny
Cystic fibrosis/pulmonary fibrosis		Deny
Other Conditions		
Accident/injury	<ul style="list-style-type: none"> • Specify/describe • Dates • Treatment/dates 	Individual consideration
Birth conditions/congenital abnormalities	<ul style="list-style-type: none"> • Specify/describe • Dates • Treatment/dates 	Individual consideration
Organ transplant recipient		Deny

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

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

1. If the applicant has not already determined the reason for denial or offer to a higher tier rating, they can call Highmark Blue Shield Member Service at 1-877-986-4571, Monday through Friday, between 8:00 a.m. and 4:30 p.m.
2. The applicant should ask the attending physician to write a letter providing additional medical information about the condition(s). The doctor should include any pertinent clinical information to support the appeal. The statement should be a summary of the applicant's current health status for all medical conditions, including, for example, all medications being taken, recent medical visits, diagnostic tests that were performed or proposed, and a tentative course of treatments for the future.

Note: Fees charged by the physician for this service are the responsibility of the APPLICANT.

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

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

OR

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

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

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

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

How to Respond to an Offer Letter

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

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

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

1. To accept the offer for Tier II or Tier III rating, an individual should sign the offer letter and return it in the envelope provided along with a check for one month's premium. To determine the premium, the individual should refer to the rate sheet provided based on gender and age.
2. To accept the offer for a husband/wife or family application, the applicant(s) should sign for each tier offered, and return in the envelope provided along with a check for one month's premium. The premium can be calculated based on the tiers being offered and the rate sheet(s) attached.
3. If the family offer is split between different tiers, the family has the option of either accepting the separate offers being made or choosing to enroll the husband/wife or family under one contract at the highest tier offered. The acceptance of separate offers will create separate contracts for each tier offered. Separate contracts will generate separate monthly invoices.
4. The individual, husband/wife or families accepting the offer made should return the signed offer letter and first month's premium in the envelope provided within 14 days. If they do not return the information within 14 days, Highmark Blue Shield will assume they are no longer interested in coverage. Applicants will need to complete a new application to be considered for any future enrollment.

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

PAYMENTS

Rates for DirectBlue and PPOBlue*

Rates for these programs are determined by the following criteria:

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

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

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

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

*Does not apply to ShortTermBlue.

Rates for ShortTermBlue

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

Payment Information

No discounts will be given for advance payments.

Initial Payment Options

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

1) Credit card payment

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

2) Check for ShortTermBlue Only

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

3) Bill me later*

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

*Does not apply to ShortTermBlue.

Ongoing Payments

1) Automatic Deduction from a Bank Account*

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

2) Billing*

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

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

3) Remitting Payment*

To make it more convenient for members to remit payments, Highmark Blue Shield provides several options. Checks, money orders or certified checks can be dropped off at a Highmark Blue Shield Service Center. See page 3 for these locations. Members may mail their payments to:

Highmark Blue Shield
P.O. Box 382102
Pittsburgh, PA 15250-8102

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

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

*Does not apply to ShortTermBlue.

AGENCY/PRODUCER NETWORK CODE OF ETHICS



Any person selling insurance shall:

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

Honestly try to discover any adverse factors that a reasonably competent and diligent investigation would likely disclose.

5. Have in-depth, sound command of products in order to honestly, openly and effectively portray coverages in a clear and concise fashion; to determine a customer's true understanding and grasp of key benefits, limitations and exclusions, such as waiting periods, inflationary impact on benefits or premiums, and causes for cancellation.

After said exchange and questioning, to clarify and verify the customer's grasp of information and, if necessary, review pertinent issues.

6. Uphold a customer's right to confidentiality and use personal information with professional integrity solely for making sound insurance recommendations to the customer.

Under no circumstances reveal information, directly or indirectly, for the purpose of personal advantage, beyond fair and reasonable commission, or for personal advantage to others.

7. Obey all laws governing business and professional activities and honestly represent products in an ethical manner without fraud, misrepresentation, exaggeration, coercion, scare tactics or concealment of pertinent facts. Do so without taking advantage of the customer or potential customer, which could lead to the customer's detriment in insurance choices based on need and financial capability.

8. Accept no gifts, entertainment or favors of more than nominal value from customers or potential customers, which may be deemed professionally questionable.

9. Use only authorized promotional materials unless prior written approval has been obtained from an authorized Highmark representative, and fairly focus presentation on positive benefit comparisons rather than disparaging remarks about the competition.

10. Treat a customer or potential customer with due courtesy, respect and priority in accordance with thoughtful, ethical and legal business practices.



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PPOBlue, ShortTermBlue, PremierBlue, and BlueAccount are service marks of the Blue Cross and Blue Shield Association.

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