

BLUE EDGE DENTAL BENEFITS

Dental Program

Blue Edge Dental
Carnegie Mellon University Student Plan - Dental
Group 10566602
Effective August 01, 2024

This booklet relates to a Limited Policy - Read it Carefully

Highmark Inc.
d/b/a Highmark Blue Cross Blue Shield
An independent licensee of the Blue Cross and Blue Shield Association

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myhighmark.com

Discrimination is Against the Law

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

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languagesIf a Member needs these services, the Member should contact the Civil Rights Coordinator.

If a Member believes that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, the Member can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. The Member can file a grievance in person or by mail, fax, or email. If the Member needs help filing a grievance, the Civil Rights Coordinator is available to help the Member. The Member can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

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

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

LANGUAGE ASSISTANCE SERVICES

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyon sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

Highmark Blue Cross Blue Shield is very pleased to provide this information about your dental care program. Read it carefully and keep it in a safe place with your other valuable documents. Review it to become familiar with your benefits and when you have a specific question regarding your coverage.

This booklet does not constitute a contract of benefits and provisions. The complete set of terms of coverage are set forth in the group contract issued by Highmark Blue Cross Blue Shield, an Independent Licensee of the Blue Cross and Blue Shield Association. Should the information in this booklet differ from the information contained in the group contract, the terms of the group contract shall govern. This booklet is merely a description of the principal features of your BlueEdge Dental program.

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Non-Assignment

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

How Your Benefits Are Applied - Dental Program

Benefit Period

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

Your benefit period is 12 consecutive months beginning on August 1.

Coinsurance

Those remaining percentages or dollar amounts of the maximum allowable charge for a covered service that are your responsibility after Highmark pays the percentages or dollar amounts shown on the Summary of Benefits for a covered service.

Deductible

A specified amount of expenses set forth in the Summary of Benefits for covered services that you must be pay before Highmark will pay any benefit.

Member Liability

In order to keep the program affordable for you, Highmark includes certain cost-sharing features. If the class or service grouping is not covered under the program, the Summary of Benefits will indicate either “not covered” or “Plan Pays -- 0%”. You will be responsible to pay your dentist the full charge for these uncovered services.

Classes or service groupings shown with “Plan Pays” percentages greater than 0% but less than 100% require you to pay a portion of the cost for the covered service. For example, if the program pays 80%, your share or coinsurance is 20% of the maximum allowable charge. You are also responsible to pay any deductibles, charges exceeding the program maximums or charges for covered services performed before satisfaction of any applicable waiting periods or which are not eligible for payment following the application of program benefit limitations. If you receive covered services from an out-of network provider, the plan will apply the percentages shown in the Summary of Benefits and you will be responsible for the difference, up to the provider’s charge.

Maximum

The greatest amount Highmark is obligated to pay for all covered services rendered during a specified period as shown in the Summary of Benefits.

Limitations

Certain services on the Summary of Benefits are subject to frequency or age limitations See the section Covered Services for any limitations. Before reviewing the limitations, you must first check the Summary of Benefits to see which services are covered.

Payment For Network Covered Expenses

If you have services performed by a network dentist, Highmark will pay covered benefits directly to the network dentist. Both you and the dentist will be notified of benefits covered, the plan's payment and any amounts you owe for coinsurance, deductibles, charges exceeding annual maximums or charges for services not covered. Payment will be based on the maximum allowable charge (MAC) that the treating network dentist has contracted to accept. MAC charges may vary depending on the geographical area of the dental office and the contract between Highmark or its designated agent and the particular network dentist rendering the service. Network dentists agree by contract to accept MAC as payment in full for covered services rendered to you. You shall be held harmless if, after receiving services from a network dentist, such services are determined not to be dentally necessary.

Payment For Out-of-Network Covered Expenses

If you receive services from an out-of-network dentist, Highmark will send payment for covered benefits to you, unless the claim submitted by you indicates that payment should be sent directly to the dentist that performed the services. This is called assignment of benefits, and is available for care delivered by out-of-network dentists outside of Pennsylvania. You will still be notified whether the services you received are covered, the plan payment and any amounts that you owe for coinsurance, deductibles, charges exceeding annual maximums, services not covered due to benefit frequency limitations or charges for services not covered by your program. Highmark's payment will be based on the maximum allowable charges (MAC) for the services. Out-of-Network MAC is determined as a percentile of dentist charges for Covered Services by grouping the 90th percentile of dentist charges into different geographical areas which are used to calculate Highmark's payment. You will be responsible to pay the dentist any difference between the plan's payment and the out-of-network dentist's full charge for the services. Out-of-network dentists are not obligated to limit their fees to the plan's MAC. Dental emergency services performed by an out-of-network dentist will be reimbursed by the plan so that you are not liable for a greater out of pocket expense than if you were treated by a network dentist.

Description of Benefits

The general descriptions below explain the services on the Summary of Benefits. The descriptions are not all-inclusive – they include only the most common dental procedures in a class or service grouping. Specific dental procedures may be shifted among groupings or classes or may not be covered depending on your program.

Check the Summary of Benefits section to see which services are covered (“Plan Pays percentage greater than “0%”). Also, have your provider call Highmark to verify coverage of specific dental procedures or log on to www.myHighmark.com to check coverage.

Covered services are limited as detailed below. ***Limitations may differ by the state in which you receive services. Some limitations may be waived depending on your medical condition. Only American Dental Association procedure codes are covered.***

Also, be sure to review the section, What is Not Covered for exclusion information.

Exams (oral evaluations)

Oral examination and evaluation of the member by a provider. Examinations may be comprehensive and periodic, limited problem focused and consultations and detailed problem focused.

- Benefits for Oral Evaluations are limited to:
 - Comprehensive and periodic – Two of these services per 12 months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three or more years.
 - Limited problem focused and consultations – One of these services per dentist per patient per 12 months.
 - Detailed problem focused – One per dentist per patient 12 months per eligible diagnosis.

X-rays (full mouth, bitewing and occlusal)

Bitewings, periapical and full-mouth x-rays. Benefits are limited to:

- Full mouth x-rays – One set every 5 years.
- Bitewing x-rays – One set per 12 months under age 19 and One set per 18 months age 19 and older.
- Periapical intraoral films - 4 set(s) every 12 months per dental provider if not performed in conjunction with definitive procedures and occlusal intraoral films are limited to 2 set(s) every 24 months.

Cleanings, Fluoride Treatments, Sealants for prevention

Benefits are limited to:

- Prophylaxis – Two per 12 months. One additional if you are under the care of a medical professional during pregnancy.
- Fluoride treatment – One per 12 months for members under age 14.
- Sealants – One per tooth every 3 years between ages 6 and 16 on permanent first and second molars.

Palliative Treatment for relief of pain for dental emergencies.

Space Maintainers to prevent tooth movement.

- Space maintainers – One per 5 years period for members under age 14 when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.

Basic Restorative to treat caries (cavities, tooth decay) – amalgam and anterior composite resin fillings, stainless steel crowns, crown build-ups and posts and cores.

- Replacement of restorative services only when they are not, and cannot be made, serviceable:
 - Basic restorations – not within 24 months of previous placement.
 - Single crowns, inlays, onlays, buildups, and post and cores – not within Five year(s) of previous placement.
 - Replacement of natural tooth/teeth in an arch – not within Five years of a fixed partial denture, full denture or partial removable denture.

Endodontics to treat the dental pulp, pulp chamber and root canal – root canal treatment and retreatment, pulpotomy, pulpal therapy, apicoectomy, and apexification.

- Pulpal therapy – one per eligible primary tooth per lifetime only when there is no secondary tooth to replace it.
- Root canal retreatment – One per tooth per lifetime.

Non-surgical Periodontics for non-surgical treatment of diseases of the gums and bones supporting the teeth – periodontal scaling and root planing, periodontal maintenance.

Repairs of Crowns, Inlays, Onlays, Bridges– repair, recementation, re-lining, re-basing and adjustment.

Denture Repairs

- Denture relining, rebasing or adjustments are considered part of the denture charges if provided within Six months of insertion by the same dentist. Subsequent denture relining or rebasing limited to One every Three years thereafter.

Simple Extractions – non-surgical removal of teeth and roots.

Periodontics and Surgical Periodontics for surgical treatment of the tissues supporting and surrounding the teeth (gums and bone) – gingivectomy, gingivoplasty, gingival curettage, osseous surgery, crown lengthening, bone and tissue replacement grafts.

- Periodontal Services:
 - Full mouth debridement – One per lifetime.
 - Periodontal maintenance following active periodontal therapy – Two per 12 in addition to routine prophylaxis.
 - Periodontal scaling and root planing – One per 36 month(s) per area of the mouth.
 - Surgical periodontal procedures – One per 36 months per area of the mouth.

- Guided tissue regeneration – One per tooth per lifetime.

Complex Oral Surgery for surgical treatment of the hard and soft tissues of the mouth – surgical extractions, impactions, excisions, exposure, root removal; alveoplasty and vestibuloplasty.

Anesthesia for elimination of pain during treatment – general or nitrous oxide or IV sedation. Limited to 60 minutes per session.

Crowns, Inlays and Onlays/Prefabricated stainless steel crowns when the teeth cannot be restored by fillings.

- Prefabricated stainless steel crowns – One per tooth per lifetime for members under age 14.

Prosthetics – fixed bridges, partial and complete dentures.

Recementation

- Recementation – One per 3 Calendar Year(s). Recementation during the first 12 months following insertion of the crown or bridge by the same dentist is included in the crown or bridge benefit.

Other Benefit Limitations

- An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit you to the less costly treatment. However, if you and the dentist choose the more expensive treatment, you are responsible for the additional charges beyond those allowed under this ABP.

Smile for Health Benefits

Pregnancy - Covers 1 additional cleaning during pregnancy in addition to the benefits listed for Smile for Health.

What Is Not Covered - Dental Program

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

- started prior to your effective date or after the termination of coverage under the group program (e.g. multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
- for house or hospital calls for dental services and for hospitalization costs (e.g. facility-use fees).
- for prescription and non-prescription drugs, vitamins or dietary supplements.
- administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Summary of Benefits.
- which are cosmetic in nature as determined by Highmark (e.g. bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).
- elective procedures (e.g. the prophylactic extraction of third molars).
- for congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment). This exclusion does not apply to the treatment of medically diagnosed congenital defects or birth abnormalities of a newborn dependent child or newly adopted children, regardless of age.
- for dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the program.
- diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the program. Examples of these jaw joint problems include, but are not limited to, temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
- for treatment of fractures and dislocations of the jaw.
- for treatment of malignancies or neoplasms.
- services and/or appliances that alter the vertical dimension (e.g. full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
- replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
- preventive restorations.
- periodontal splinting of teeth by any method.
- for duplicate dentures, prosthetic devices or any other duplicative device.
- for which in the absence of insurance, you would incur no charge.
- for plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
- for any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.
- for treatment and appliances for bruxism (e.g. night grinding of teeth).
- for any claims you submit or which are submitted on your behalf to Highmark in excess of 12 months after the date of service.
- incomplete treatment (e.g. patient does not return to complete treatment) and temporary services (e.g. temporary restorations).
- procedures that are part of a service but are reported as separate services; reported in a treatment sequence that is not appropriate; or misreported or that represent a procedure other than the one reported.
- specialized procedures and techniques (e.g. precision attachments, copings and intentional root canal treatment).
- those not dentally necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of Highmark will apply.
- not prescribed by or performed by or upon the direction of a provider.
- rendered by other than a provider.
- rendered by a provider who is a member of your immediate family.

- experimental/investigative in nature.
- to the extent benefits are provided to members of the armed forces while on active duty or to patients in veteran's administration facilities for service-connected illness or injury, unless you have a legal obligation to pay.
- for any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease, or similar type legislation. This exclusion applies whether or not the member files a claim for said benefits or compensation.
- for treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.
- for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
- for otherwise covered services ordered by a court or other tribunal as part of your or your dependent's sentence.
- for any tests, screenings, examinations or any other services required by: a) an employer or governmental body or agency in order to begin or to continue working or as a condition to performing the functions of any employment in a particular setting; b) a school, college or university in order to enter onto school property or a particular location regardless of purpose; or c) a governmental body or agency for public surveillance purposes; and that does not relate to the furnishing or administration of an individualized test, screening or evaluation determined by your attending professional provider as being medically appropriate.
- For any other medical or dental service or treatment except as provided herein.

How Your Program Works - Dental Program

Choice of Provider

You may choose any licensed dentist for services. However, if you choose a network dentist, you limit your out of pocket costs. Network dentists limit their fees to their contracted maximum allowable charges for covered services. Also, if agreed by the provider, network dentists limit their charges for all services delivered to you, even if the service is not covered for any reason and a benefit is not paid under your dental program. Network dentists also complete and send claims for the covered services you receive directly to Highmark for processing. To find a network dentist, visit Highmark's Web site at www.myHighmark.com or call the toll-free number on the back of your dental identification card.

If you go to a dentist who is an out-of-network dentist, you may have to pay the dentist at the time of service and complete and submit your own claims to Highmark for reimbursement. You will be responsible for the dentist's full charge which may exceed Highmark's maximum allowable charge and result in higher out of pocket costs.

General Information - Dental Program

Who is Eligible for Coverage

You may enroll your:

- Spouse under a legally valid existing marriage
- Unmarried children under 26 years of age, including:
 - Newborn children
 - Stepchildren
 - Children legally placed for adoption
 - Legally adopted children or children for whom the employee or the employee's spouse is the child's legal guardian
 - Children awarded coverage pursuant to an order of court

provided they do not have dental benefits available to them through their own employment.

Unless the period of eligibility for the dependent child is otherwise extended pursuant to applicable state or federal law, coverage automatically terminates and all benefits hereunder cease at the end of the month the dependent reaches the limiting age, whether or not notice to terminate is received by Highmark.

- Unmarried children over age 26 who are not able to support themselves due to intellectual disability, physical disability, mental illness or developmental disability. Highmark may require proof of such disability from time to time.

NOTE: To the extent mandated by the requirements of Pennsylvania Act 83 of 2005, eligibility will be continued past the limiting age for unmarried children who are enrolled as dependents under their parent's coverage at the time they are called or ordered into active military duty. They must be a member of the Pennsylvania National Guard or any reserve component of the armed forces of the United States, who is called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days, or be a member of the Pennsylvania National Guard ordered to active state duty for a period of 30 or more consecutive days. If they become a full-time student for the first term or semester starting 60 or more days after their release from active duty, they shall be eligible for coverage as a dependent past the limiting age for a period equal to the duration of their service on active duty or active state duty.

For the purposes of this note, full-time student shall mean a dependent who is enrolled in, and regularly attending, an accredited school, college or university, or a licensed technical or specialized school for 15 or more credit hours per semester, or, if less than 15 credit hours per semester, the number of credit hours deemed by the school to constitute full-time student status.

- A domestic partner* shall be considered for eligibility as long as a domestic partnership (a voluntary relationship between two domestic partners) exists with you. In addition, the children of the domestic partner shall be considered for eligibility as if they were your children as long as the domestic partnership exists. Furthermore, to be considered an eligible dependent, the domestic partner must demonstrate financial interdependence with you by submitting proof to the group of three or more of the following:

- A domestic partner agreement or proof of registry with a domestic partner registry
- A joint mortgage or lease
- A designation of one of the partners as beneficiary in the other partner's will
- A durable property and health care powers of attorney
- Joint title to an automobile, or joint bank account or credit account
- Such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case

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

*"Domestic Partner" means a member of a domestic partnership consisting of two partners, each of whom has registered with a domestic partner registry in effect in the municipality/governmental entity within which the domestic partner currently resides, or who meets the definition of a domestic partner as defined by the state or local government where the individual currently resides or meets all of the following:

- Is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time
- Is not related to the other partner by adoption or blood
- Is the sole domestic partner of the other partner and has been a member of this domestic partnership for the last six months
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner
- Meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for domestic partnerships which are currently enacted, or which may be enacted in the future

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

Changes in Membership Status

For Highmark to administer coverage for you and your dependents, you must keep your plan sponsor informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage.

Your newborn child may be covered under your program for a maximum of 31 days from the moment of birth. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within such period.

Termination of Your Coverage Under the Group Contract

Your coverage can be terminated in the following instances:

- When you cease to be a student, your coverage will terminate at the end of the last month for which payment was made.
- When you fail to pay the required contribution, coverage will terminate at the end of the last month for which payment was made.
- Termination of the employer contract automatically terminates the coverage of all the members. It is the responsibility of the employer to notify you of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given to you by the employer.
- If it is proven that you obtained or attempted to obtain benefits or payment for benefits through fraud or intentional misrepresentation of a material fact, Highmark may, upon notice to you, terminate your coverage under the program.

- It is understood that you have an affirmative obligation to notify the group or Highmark as soon as the domestic partnership has been terminated. Upon termination of the domestic partnership, coverage of the former domestic partner and the children of the former domestic partner will terminate at the end of the last month for which payment was made.

Benefits After Coverage Terminates

Highmark is not liable to pay any benefits for dental services which are started after the termination date of your coverage or of the group program. However, coverage for completion of a dental procedure requiring two or more visits on separate days will be extended for a short period of 90 days after the termination date in order for the procedure to be finished. The procedure must be started prior to the termination date. The procedure is considered started when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. For orthodontic treatment, if covered under your plan, coverage will be extended through the end of the month of the member's termination date. This extension does not apply if the program terminates for failure to pay premium.

College Tuition Reward Program

1. Highmark provides access to a College Tuition Reward Program ("Program") made available by SAGE CTB LLC ("Sage"). Sage represents and has agreements with a consortium of private colleges and universities that participate in the Program.
2. Participation in the Program is at the sole option of the member.
3. Members who wish to participate in the Program can earn college tuition reward points that can be converted into equivalent cash credits which may be applied to the tuition expenses that eligible students incur when attending Sage participating colleges and universities. Credits are earned and accumulate during the period in which the member is enrolled under this plan.
4. Information regarding Program details including a listing of participating colleges and universities will be provided by Sage.
5. Highmark makes no representations and assumes no liability in connection with the Program or its administration.

Coordination of Benefits

If you or your dependents are covered by any other dental program and receive a service covered by this program and the other dental program, benefits will be coordinated. This means that one program will be primary and determine its benefits before those of the other program and without considering the other program's benefits. The other program will be secondary and determine its benefits after the primary program. The secondary program's benefits may be reduced because of the primary program's payment. Each program will provide only that portion of its benefit that is required to cover expenses. This prevents duplicate payments and overpayments. Upon determination of primary or secondary liability, this program will determine payment.

The following words and phrases regarding the Coordination of Benefits ("COB") provision are defined as set forth below:

- **Allowable Amount** is the program allowance for items of expense, when the care is covered at least in part by one or more programs covering the member for whom the claim is made.

- **Claim Determination Period** means a benefit year. However, it does not include any part of a year during which a person has no coverage under this program.
- **Other Dental Plan** is any form of coverage which is separate from this program with which coordination is allowed. **Other Dental Plan** will be any of the following which provides dental benefits, or services, for the following: group insurance or group type coverage, whether insured or uninsured. It also includes coverage other than school accident type coverage (including grammar, high school and college student coverages) for accidents only, including athletic injury, either on a 24-hour basis or on a "to and from school basis," or group or group type hospital indemnity benefits of \$100 per day or less.
- **Primary Plan** is the program which determines its benefits first and without considering the other program's benefits. A program that does not include a COB provision may not take the benefits of another program into account when it determines its benefits.
- **Secondary Plan** is the program which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other program's (Primary Plan) benefits.
- **Plan** means this document, providing dental care benefits to which this COB provision applies and which may be reduced as a result of the benefits of other dental plans.

The fair value of services provided by the Company will be considered to be the amount of benefits paid by the Company. The Company will be fully discharged from liability to the extent of such payment under this provision.

In order to determine which plan is primary, this Plan will use the following rules.

- If the other plan does not have a provision similar to this one, then that plan will be primary.
- If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent.
- Dependent Child/Parents Not Separated or Divorced -- The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are:
 - The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
 - If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
 - The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
 - If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
- Dependent Child/Separated or Divorced Parents -- If two or more plans cover a person as Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - First, the plan of the parent with custody of the child.
 - Then, the plan of the spouse of the parent with the custody of the child; and
 - Finally, the plan of the parent not having custody of the child.
 - If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan.
 - If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in the above paragraph, titled Dependent Child/Parents Not Separated or Divorced.

- Active/Inactive Member
 - For actively employed Members and their spouses over the age of 65 who are covered by Medicare, the plan will be primary.
 - When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.
- If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time will be primary.
- The plan covering an individual as a COBRA continuee will be secondary to a plan covering that individual as a Member or a Dependent.

Right to Receive and Release Needed Information -- Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Any health information furnished to a third party will be released in accordance with federal law. Each person claiming benefits under this Plan must give any facts needed to pay the claim.

Facility of Payment -- A payment made under another plan may include an amount which should have been paid under this plan. If it does, the Plan may pay the amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan, and the Plan will not pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the services prepaid by the Plan.

Right of Recovery -- If the payment made by the Plan is more than it should have paid under this COB provision, the Plan may recover the excess from one or more of the following: (1) persons it has paid or for whom it has paid; or (2) insurance companies; or (3) other organization. Members are required to assist the Company to implement this section.

Force Majeure

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

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

How to File a Claim - Dental Program

NOTICE OF CLAIM AND PROOF OF LOSS

Network Providers have directly or indirectly entered into an agreement with the Plan pertaining to the payment for Covered Services rendered to a Member. When a Member receives Covered Services from a Network Provider, it is the responsibility of the Network Provider to submit its claim to the Plan in accordance with the terms of its participation agreement. Should the Network Provider fail to submit its claim in a timely manner or otherwise satisfy the Plan's requirements as they relate to the filing of claims, the Member will not be liable and the Network Provider shall hold the Member harmless relative to payment of the Covered Services received by the Member.

When Covered Services are received from other than a Network Provider, the Member is responsible for submitting the claim to the Plan. In such instances, the Member must submit the claim in accordance with the following procedures:

1. Notice of Claim

The Plan will not be liable for any claims under this Contract unless proper notice is furnished to the Plan that Covered Services in this Contract have been rendered to a Member. Written notice of a claim must be given to the Plan within twenty (20) days or as soon as reasonably possible after Covered Services have been rendered to the Member. Notice given by or on behalf of the Member to the Plan that includes information sufficient to identify the Member that received the Covered Services shall constitute sufficient notice of a claim to the Plan. The Member can give notice to the Plan by writing to the Member Service Department. The address of the Member Service Department can be found on the Member's Identification Card. A charge shall be considered Incurred on the date a Member receives the Service for which the Charge is made.

2. Claim Forms

Proof of loss for benefits under this Contract must be submitted to the Plan on the appropriate claim form. The Plan, upon receipt of a notice of a Claim will, within fifteen (15) days following the date a notice of a claim is received, furnish to the Member claim forms for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of such notice, the Member shall be deemed to have complied with the requirements of this Subsection as to filing a proof of loss upon submitting, within the time fixed in this Subsection for filing proofs of loss, itemized bills for Covered Services as described below. The proof of loss may be submitted to the Plan at the address appearing on the Member's Identification Card.

3. Proof of Loss

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

4. Submission of Claim Forms

The completed claim form, with all itemized bills attached, must be forwarded to the Plan at the address appearing on the Member's Identification Card in order to satisfy the requirement of submitting a written proof of loss and to receive payment for benefits provided under this Contract.

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

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

Itemized bills cannot be returned.

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

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

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

5. Time of Payment of Claims

Claim payments for benefits payable under this Contract will be processed immediately upon receipt of a proper proof of loss.

6. Authorized Representative

Nothing in this Subsection shall preclude a duly authorized representative of the Member from filing or otherwise pursuing a Claim on behalf of the Member. The Plan reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of the Member.

Predetermination

A predetermination is a review in advance of treatment by Highmark to determine patient eligibility and coverage for planned services. Predetermination is not required to receive a benefit for any service under the program. However, it is recommended for extensive, more costly treatment such as crowns and bridges. A predetermination gives you and your dentist an estimate of your coverage and how much your share of the cost will be for the treatment being considered.

To have services predetermined, you or your dentist should submit a claim showing the planned procedures but leaving out the dates of services. Be sure to sign the predetermination request. Substantiating material such as radiographs and periodontal charting may be requested by Highmark to estimate benefits and coverage. We will determine benefits payable, taking into account exclusions and limitations including alternate treatment options based upon the provisions of the program. We will notify you of the estimated benefits.

When the services are performed, simply have your dentist contact us or fill in the dates of service for the completed procedures on the predetermination notification and re-submit it to Highmark for processing. Any

predetermination amount estimated is subject to continued eligibility of the patient. We may also make adjustments at the time of final payment to correct any mathematical errors, apply coordination of benefits, and comply with your plan in effect and remaining program maximum dollars on the date of service.

Your Explanation of Benefits Statement

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

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

Review of Claim Determination

If you are not satisfied with a claim determination or payment, please contact member service at the toll-free telephone number on your dental identification card. If, after speaking with a member service representative, you are still dissatisfied then please see the Appeal Procedure subsection below.

Filing Benefit Claims

- ***Authorized Representatives***

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

- ***Requests for Reimbursement and Other Claims***

When you receive services from a network provider, the provider will report the services to Highmark and payment will be made directly to the provider. Highmark will also notify the provider of any amounts that you are required to pay in the form of a copayment. If you believe that the determination of the copayment amount is not correct or that any portion of those amounts are covered under your benefit program, you may file a claim to have that amount paid.

Determinations on Benefit Claims

Notice of Adverse Benefit Determinations Involving Requests for Reimbursement and Other Claims

If you have submitted a claim for services of an out-of-network provider, Highmark will notify you in writing of its determination on your request for reimbursement or other claim within a reasonable period of time following receipt of your claim. That period of time will not exceed 30 days from the date your claim was received. However, this 30-day period of time may be extended one time for an additional 15 days, provided that Highmark determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day claim determination period. If an extension of time is necessary because you failed to submit information necessary for Highmark to make a decision on your claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your claim.

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

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

Appeal Procedure

This appeal procedure is effective on the effective date of your program. If you are dissatisfied with our benefit determination on a claim, you may appeal our decision by following the steps outlined in this procedure. We will resolve your appeal in a thorough, appropriate, and timely manner to ensure that you are afforded a full and fair review of claims for benefits. Benefit determinations will be made in accordance with the plan documents and consistently among claimants. You or your authorized representative may submit written comments, documents, records and other information relating to claims or appeals. We will provide a review that takes into account all information submitted whether or not it was considered with its first determination on the claim. Any notifications by Highmark required under these procedures will be supplied to you or your authorized representative.

The following terms when used in this document have the following meaning:

- "Adverse benefit determination" is a denial, reduction, or termination of or failure to make payment (in whole or in part) based on a determination of eligibility to participate in a plan or the application of any utilization review; or a determination that an item or service otherwise covered is experimental or investigational or not dentally necessary or appropriate.
- "Authorized representative" is a person granted authority by you to act on your behalf regarding a claim for benefits or an appeal of an adverse benefit determination. An assignment of benefits is not a grant of authority to act on your behalf in pursuing and appealing a benefit determination.

Procedure

You or your authorized representative may file an appeal with Highmark within 180 days of receipt of an adverse benefit determination. To file an appeal, telephone the toll-free number listed on your dental ID card. We will review the claim and notify you of our decision within 60 days of the request for appeal. Any dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the dentist advisor involved in the initial benefit determination. Notice of the appeal decision will include the following in written or electronic form:

- the specific reason for the appeal decision;
- reference to specific plan provisions on which the decision was based;
- a statement that you are entitled to receive upon request and free of charge, reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts;
- a statement of your right to bring a civil action under ERISA; and
- the following statement: "You and Highmark may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Member Service - Dental Program

Whether it's for help with a claim or a question about your benefits, you can call your Member Service toll-free telephone number on the back of your dental ID card or log onto Highmark's Web site, www.myHighmark.com. A Member Service representative can also help you with any coverage inquiry. Representatives are trained to answer your questions quickly, politely and accurately.

You can get the following information:

- Find network providers and where to access them
- Verify eligibility for yourself or your dependents
- Request an out-of-network provider reimbursement form
- Speak with a Member Service representative
- Initiate an appeal of a benefit denial
- Ask any questions about your dental benefits

How We Protect Your Right to Confidentiality

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

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

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

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

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

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

Terms You Should Know - Dental Program

Claim - A request for payment or reimbursement of the charges or costs associated with a covered service.

Cosmetic - Those procedures which are undertaken primarily to improve or otherwise modify your appearance.

Dentist - A person licensed to practice dentistry in the state in which dental services are provided. Dentist will include other duly licensed dental practitioners under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

Dentally Necessary - A dental service or procedure is determined by a dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the dentist and the prevailing standards of care in the professional community. The determination will be made by the dentist in accordance with guidelines established by Highmark.

Designated Agent - An entity that has contracted with Highmark, either directly or indirectly, to perform a function and/or service in the administration of this program.

Experimental or Investigative - The use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which Highmark determines is not acceptable standard dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval which was not granted at the time the services were rendered. Highmark will rely on the advice of the general dental community including, but not limited to dental consultants, dental journals and/or governmental regulations, to make this determination.

Limitations - The maximum frequency or age limit that applies to a covered service.

Maximum Allowable Charge - The greatest amount Highmark will allow for a specific service. Maximum allowable charges may vary depending upon the contract between Highmark or its designated agent and the particular network dentist rendering the service. Depending upon your program, maximum allowable charges for covered services rendered by out-of-network dentists may be the same or higher than such charges for covered services rendered by network dentists in order to help limit your out-of-pocket costs when you choose out-of-network dentists.

Member(s) - The policyholder and dependent eligible and enrolled for coverage under this program.

Network Dentist - A dentist who has executed a Participating Dentist Agreement with Highmark or its designated agent, under which the dentist agrees to accept Highmark's maximum allowable charge as payment in full for covered services. Network dentists separately agree to limit their charges for any other services delivered to you.

Out-of-Network Dentist - A dentist who has not entered into an agreement, directly or indirectly, with Highmark or its designated agent pertaining to payment for covered services rendered to a member.

Plan - Refers to Highmark Blue Cross Blue Shield, a wholly-owned subsidiary of Highmark Inc., which is an independent licensee of the Blue Cross Blue Shield Association. Any reference to the plan may also include its designated agent as defined herein and with whom Highmark has contracted either directly or indirectly, to perform a function or service in the administration of this program.

Service - A service, treatment or supply rendered by a dentist to you.

Waiting Period - The period of time, if applicable, that you must be enrolled under the program before benefits will be paid for certain covered services.

Summary of Benefits: Blue Edge Dental Preferred

Blue Edge Dental Preferred plan options provide you maximum cost savings. Benefits are increased when participating dentists are utilized. The listed percentages represent the portion of the maximum allowable charge (MAC) for which the plan is responsible. Network providers agree to accept the MAC as payment in full and agree to file your claims. **If you receive covered services from an out-of-network provider, the plan will apply the percentages shown to the 90th percentile for covered services and you will be responsible for the difference, up to the provider's charge.** Standard deductibles, exclusions and limitations apply. Network dentists may elect to discount non-covered services and services above the annual maximum. Discounts vary by service and region and when agreed to by the provider; not permitted in all jurisdictions.

Carnegie Mellon University Student Health Plan - Blue Edge Dental Preferred 10W - CUSTOM

	In-Network	Out-of-Network
Network	Elite Plus	90th
Deductible – Individual/Family (waived for In-network & Out of network Class I services)	\$100 / \$300	\$125 / \$375
Benefit Period Maximum per member	\$1,000	
Class I Services		
Exams	100%	80%
X-rays (bite-wing and panoramic)	100%	80%
Cleanings	100%	80%
Fluoride Treatment	100%	80%
Sealants	100%	80%
Class II Services		
Basic Restorative (Fillings), Posterior Resins	80%	70%
Periodontics (Surgical and Nonsurgical) (No osseus surgery)	80%	70%
Oral Surgery (including Simple and Surgical Extractions) (No bony impacted extractions)	80%	70%
X-rays (all other)	80%	70%
Palliative Treatment (Emergency)	80%	70%
Endodontics (root canals on anterior and bicuspid only)	80%	70%
Class III Services		
Inlays, Onlays, Crowns	50%	50%
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures	50%	50%
Prosthetics (Bridges, Dentures)	50%	50%
Endodontics (root canals on molars)	50%	50%
Periodontics (osseus surgery)	50%	50%
Oral Surgery (partial and full bony impactions)	50%	50%
General Anesthesia	50%	50%
Space Maintainers	50%	50%
Orthodontics (dependents to age 19)		
Diagnostic, Active, Retention Treatment	Not Covered	Not Covered
Orthodontic Lifetime Maximum per covered dependent	Not Applicable	
Implants		
Implant Surgery, Supported Restoration	Not Covered	
Additional Features		
<input type="checkbox"/> TMD/TMJ*	<input type="checkbox"/> Smile for Health®--Wellness	<input checked="" type="checkbox"/> Pregnancy
<input type="checkbox"/> Annual Maximum Rollover*	<input type="checkbox"/> College Tuition Benefit	<input type="checkbox"/> Preventive Incentive*
<input checked="" type="checkbox"/> Occlusal Guard* (class III coverage)		

Insurance may be provided by Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage, First Priority Life Insurance Company or First Priority Health, all of which are independent licensees of the Blue Cross and Blue Shield Association. United Concordia is a separate company that administers Highmark dental benefits.

Smile for Health--Wellness is a registered service mark of United Concordia Companies, Inc.

*These features are for Large Group only. Additional fees may apply.

Summary of Limitations:

Blue Edge Dental

This is an abbreviated list of Highmark's Standard Limitations.
Please refer to your specific benefit design as to what services are covered.

Blue Edge Dental

Benefit Category	Highmark's Standard Frequency Limitations
Exams	2 every 12 months
X-rays (Bitewings Only)	1 set every 12 months under age 19 and one set every 18 months age 19 and over
X-rays (All Others)	1 every 5 years for Full Mouth and Panoramic X-rays Limitations may apply to other types of X-rays
Cleanings; Fluoride Treatment	2 every 12 months; 1 every 12 months under age 14
Sealants	1 per tooth every 3 years to age 16 on permanent first and second molars
Space Maintainers	1 every 5 years under age 14
Palliative Treatment (Emergency)	2 per 12 months in combination with pulpal debridement
Basic Restorative	Not within 24 months of previous placement. Includes coverage for posterior resins
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures	1 per 36 months
Simple Extractions	Any frequency (no limitations)
General Anesthesia	Limited to 60 minutes per session
Endodontics	Pulpal therapy: primary teeth that have no permanent tooth to replace it Root canal treatment: 1 per tooth per lifetime
Periodontics (Nonsurgical)	Full mouth debridement: 1 per lifetime Scaling and root planing: 1 per 36 months (per area of mouth) Periodontal maintenance: 2 every 12 months (in addition to routine prophylaxis following active periodontal therapy)
Periodontics (Surgical)	Surgical periodontal procedures: 1 per 36 months (per area of mouth) Guided tissue regeneration: 1 per tooth per lifetime
Complex Oral Surgery	May vary by procedure
Inlays, Onlays, Crowns	Not within 5 years of previous placement
Prosthetics (Bridges, Dentures)	Not within 5 years of previous placement
Orthodontics (dependents to age 19) Diagnostic, Active, Retention Treatment	Payment for orthodontic services, if covered, shall cease at the end of the month after termination by the Company.
Alternative Benefit Provision	An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.
Smile for Health®--Wellness <i>Provides periodontal care for people with certain chronic medical conditions: diabetes, heart disease, lupus, oral cancer, organ transplant, rheumatoid arthritis and stroke</i>	<ul style="list-style-type: none"> Covers 1 additional periodontal maintenance per year and all are covered at 100% Scaling and root planing are covered at 100% 4 periodontal surgery procedures are covered at 100%
Pregnancy Benefit	<ul style="list-style-type: none"> Covers 1 additional cleaning during pregnancy Covers 1 additional periodontal maintenance Scaling and root planing 4 periodontal surgery procedures
Preventive Incentive	Class I services do not count toward your annual program maximum
Annual Maximum Rollover	Members can roll over \$300 of unused benefit dollars to the following plan year
College Tuition Benefit	<ul style="list-style-type: none"> Earn Tuition Rewards® points redeemable for tuition discounts Receive 2,000 points/year Each child enrolled receives a one-time bonus of 500 Tuition Rewards points One Tuition Rewards point = \$1 reduction in full tuition Use Tuition Rewards points at participating private colleges and universities
Occlusal Guard	<ul style="list-style-type: none"> 1 per 60 months for members 22 years and older after a 6 month waiting period Covered at 50% \$1,000 Lifetime maximum

**HIGHMARK INC.
NOTICE OF PRIVACY PRACTICES**

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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

THIS NOTICE ALSO DESCRIBES HOW WE COLLECT, USE AND DISCLOSE NON-PUBLIC PERSONAL FINANCIAL INFORMATION.

Our Legal Duties

At Highmark Inc. (“Highmark”), we are committed to protecting the privacy of your “Protected Health Information” (PHI). PHI is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members’ protected health information. We are required by applicable federal and state laws to maintain the privacy of your protected health information. We also are required by the HIPAA Privacy Rule (45 C.F.R. parts 160 and 164, as amended) to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We are also required to notify affected individuals following a breach of unsecured health information.

We will inform you of these practices the first time you become a Highmark customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice becomes effective September 23, 2013, and will remain in effect unless we replace it.

On an ongoing basis, we will review and monitor our privacy practices to ensure the privacy of our members’ protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this Notice. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will become effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. Before we make a material change in our privacy practices, we will change this Notice and notify all affected members in writing in advance of the change. Any change to this notice will be posted on our website and we will further notify you of any changes in our annual mailing.

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

I. Uses and Disclosures of Protected Health Information

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

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

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

Payment

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

► **For example:**

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

Health Care Operations

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

► **For example:**

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

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

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

(i) Business Associates.

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

(ii) Other Covered Entities.

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

II. Other Possible Uses and Disclosures of Protected Health Information

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

A. To Plan Sponsors

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

B. Required by Law

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

C. Public Health Activities

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

D. Health Oversight Activities

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

E. Abuse or Neglect

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

F. Legal Proceedings

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

G. Law Enforcement

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

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

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

I. Research

We may disclose your protected health information to researchers when an institutional review board or privacy board has:

(1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

J. To Prevent a Serious Threat to Health or Safety

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

K. Military Activity and National Security, Protective Services

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

L. Inmates

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

M. Workers' Compensation

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

N. Others Involved in Your Health Care

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

O. Underwriting

We may disclose your protected health information for underwriting purposes; however, we are prohibited from using or disclosing your genetic information for these purposes.

P. Health Information Exchange

We will participate in a Health Information Exchange (HIE). An HIE is primarily a secure electronic data sharing network. In accordance with federal and state privacy regulations, regional health care providers participate in the HIE to exchange patient information in order to facilitate health care, avoid duplication of services, such as tests, and to reduce the likelihood that medical errors will occur.

The HIE allows your health information to be shared among authorized participating healthcare providers, such as health systems, hospitals and physicians, for the purposes of Treatment, Payment or Healthcare Operations purposes. Examples of this health information may include:

- General laboratory, pathology, transcribed radiology reports and EKG Images.
- Results of outpatient diagnostic testing (GI testing, cardiac testing, neurological testing, etc.)
- Health Maintenance documentation/Medication
- Allergy documentation/Immunization profiles
- Progress notes/Urgent Care visit progress notes
- Consultation notes
- Inpatient operative reports
- Discharge summary/Emergency room visit discharge summary notes

All participating providers who provide services to you will have the ability to access your information. Providers that do not provide services to you will not have access to your information. Information may be provided to others as necessary for referral, consultation, treatment or the provision of other healthcare services, such as pharmacy or laboratory services. All participating providers have agreed to a set of standards relating to their use and disclosure of the information available through the HIE. Your health information shall be available to all participating providers through the HIE.

You cannot choose to have only certain providers access your information. Patients who do not want their health information to be accessible through the HIE may choose not to participate or may “opt-out.”

In order to opt-out, you must call the customer service number located on the back of your membership card. You should be aware, if you choose to opt-out, your health care providers will not be able to access your health information through the HIE. Even if you chose to opt-out, your information will be sent to the HIE, but providers will not be able to access this information. Additionally, your opt-out does not affect the ability of participating providers to access health information entered into the HIE prior to your opt-out submission.

III. Required Disclosures of Your Protected Health Information

The following is a description of disclosures that we are required by law to make:

A. Disclosures to the Secretary of the U.S. Department of Health and Human Services

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

B. Disclosures to You

We are required to disclose to you most of your protected health information that is in a “designated record set” (defined below) when you request access to this information. We also are required to provide, upon your request, an accounting of many disclosures of your protected health information that are for reasons other than payment and health care operations.

IV. Other Uses and Disclosures of Your Protected Health Information

Sometimes we are required to obtain your written authorization for use or disclosure of your health information. The uses and disclosures that require an authorization under 45 C.F.R. § 164.508(a) are:

1. For marketing purposes
2. If we intend to sell your PHI
3. For use of Psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. An Authorization for use of psychotherapy notes is required unless:
 - a. Used by the person who created the psychotherapy note for treatment purposes, or
 - b. Used or disclosed for the following purposes:
 - (i) the provider’s own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;
 - (ii) for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;
 - (iii) if required for enforcement purposes;
 - (iv) if mandated by law;
 - (v) if permitted for oversight of the provider that created the note,
 - (vi) to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or
 - (vi) if needed to avert a serious and imminent threat to health or safety.

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

V. Your Individual Rights

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

A. Right to Access

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

You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so, if you request the information in an electronic format that is not readily producible, we will provide the information in a readable electronic format as mutually agreed upon. You must make a request in writing to obtain access to your protected health information.

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

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

B. Right to an Accounting

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

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

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or submitting your request in writing to the Highmark Privacy Department, 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

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

C. Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing. We have a right to terminate this restriction, however if we do so, we must inform you of this restriction.

You may request a restriction by contacting us at the Customer Service phone number on the back of your identification card, or writing to the Highmark Privacy Department, 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222. In your request tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

D. Right to Request Confidential Communications

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

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

In the event that a Confidential Communication is placed against you, then you will no longer have the ability to access any of your health and/or policy information online.

E. Right to Request Amendment

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

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

F. Right to a Paper Copy of this Notice

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

VI. Questions and Complaints

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

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

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

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

Contact Office: Highmark Privacy Department
Telephone: 1-866-228-9424 (toll free) Fax: 1-412-544-4320
Address: 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222

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

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

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

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

- We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.
- We collect and create information about our members' transactions with Highmark, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits/payments (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

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

- We use personal information internally to manage enrollment, process claims, monitor the quality of the health services provided to our members, prevent fraud, audit our own performance or to respond to members' requests for information, products or services.

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

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

For questions about this Privacy Notice, please contact:

Contact Office: Highmark Privacy Department

Telephone: 1-866-228-9424 (toll free) Fax: 1-412-544-4320

Address: 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222

