

# PRODUCER MANUAL

For Highmark Blue Cross Blue Shield  
Medically Underwritten Health Coverage  
Programs Including Direct Blue, Advance Blue,  
PPO Blue and Short Term Blue



[HIGHMARKBCBS.COM](http://HIGHMARKBCBS.COM)

## WESTERN PRODUCER MANUAL

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

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

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

## Table of Contents

Topic	Page
Introduction	Page 4
Producer Network Quick Reference	Page 6
Service Centers	Page 8
Service Area	Page 9
Medicare Eligibility	Page 10
General Program Information	Page 10
Specific Program Information	Page 11
Benefits of Coverage	Page 15
Network Providers	Page 16
Inpatient Admissions	Page 17
Precertification for Inpatient Admissions	Page 18
Emergency and Delivery-Related Maternity Admissions	Page 18
Appeals and Grievances	Page 19
Application Process for Producers	Page 20
Family Deductible	Page 25
Enrollment	Page 26
Conversion from Highmark Group Coverage and HIPAA Options	Page 27
Medical Underwriting	Page 34
Code of Ethics	Page 40
Medical Underwriting Guidelines	Page 44

## Introduction

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

### **Direct Blue® Comprehensive Major Medical Preferred-Provider Program**

### **Advance Blue, Major Medical Preferred Provider Program.**

### **PPO Blue<sup>SM</sup> Individual Comprehensive Major Medical Preferred-Provider High-Deductible Program**

### **Short Term Blue<sup>SM</sup>, a Single-Term, Non-Renewable Comprehensive Major Medical Individual Preferred-Provider Program**

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

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

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

### **Complete Care<sup>SM</sup> Comprehensive Major Medical Program**

Effective September 1, 2009, Complete Care is no longer being marketed to new customers. Members currently enrolled under Complete Care are able to maintain their coverage. Complete Care is a grandfathered plan, which means that only certain health care reform changes apply, such as the elimination of lifetime dollar limits and the extension of dependent coverage to age 26.

Complete Care members are able to add eligible dependents to their existing coverage as long as they are underwritten to the same rate tier as the rest of the family members. If the dependent is underwritten to a different rate tier than the rest of the family, the dependent will be provided a counter-offer to PPO Blue and Direct Blue.

Complete Care deleted dependents are offered PPO Blue HDHP. If accepted within 30 days of deletion, no medical underwriting and no pre-existing condition exclusion period.

Members may decrease their deductible on their anniversary date after the member holds a Contract for two consecutive years. Notice must be received one month prior to the Contract Anniversary Date.

### **Keystone Blue<sup>SM</sup> Individual HMO, a product of Keystone Health Plan West**

Effective January 1, 2010, Keystone Blue Individual HMO is no longer being marketed to new customers. Members currently enrolled under Keystone Blue are able to maintain their coverage. Keystone Blue is a grandfathered plan, which means that only certain health care reform changes apply, such as the elimination of lifetime dollar limits and the extension of dependent coverage to age 26

Keystone Blue members are able to add eligible dependents to their existing coverage as long as they are underwritten to the same rate tier as the rest of the family members. If the dependent is underwritten to a different rate tier than the rest of the family, the dependent will be provided a counter-offer to PPO Blue and Direct Blue.

Keystone Blue deleted dependents are offered PPO Blue HDHP. If accepted within 30 days of deletion, no medical underwriting and no pre-existing condition exclusion period.

For questions regarding existing Complete Care and Keystone Blue individual coverage, members should call the Member Service number on the back of their identification card.

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

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

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

<b>Producer Network Quick Reference</b>	
Producer Information (For Producer Use Only)	
For questions about: Benefits and Claims	Highmark Blue Cross Blue Shield Producer Hotline: 1-866-602-1248 Monday – Friday 8:00 a.m. to 5:00 p.m.  Technical assistance with online applications via the Producer Portal at <a href="http://www.highmarkbcbs.com">www.highmarkbcbs.com</a> or contact your General Agency
For Guaranteed Issue Programs customers can call sales service	1-800-876-7639
Technical assistance with online applications via the Producer Portal	Highmark Blue Cross Blue Shield Producer Hotline: 1-866-602-1248 Monday – Friday 8:00 a.m. to 5:00 p.m.  Or contact your General Agency
Additional information or to order supplies	Access the Producer Portal at <a href="http://www.highmarkbcbs.com">www.highmarkbcbs.com</a> or contact your General Agency
Questions about Highmark Appointment and Portal Entitlements and Application Status	Contact your General Agency. General Agencies have access to Agency Activity Reports via the Producer Portal on the Highmark Blue Cross Blue Shield Web site. Agency Activity Reports reflect status of pending applications for all producers that report through the General Agencies. Active and Terminated Member Reports are also available to General Agencies on the Producer Portal.

## Producer Network Quick Reference

<p>Member Information Web Inquiries:</p>	<p>Claim forms, duplicate explanation of benefits, general inquiries and identification cards can also be handled on the Web: <a href="http://www.highmarkbcbs.com">www.highmarkbcbs.com</a>.</p>
<p>Submit appeals for member denials for coverage to:</p>	<p>Highmark Blue Cross Blue Shield Individual Product Appeals 120 Fifth Avenue, Suite 1720 Pittsburgh, PA 15222-3099 Fax: 412-544-4009</p>
<p>Telephone Inquiries: Benefits, claims and enrollment information about Under 65 Individual Programs:</p>	<p>Producers :     Call Producer Hotline at: 1-866-602-1248 Members     Call: 1-800-544-6679 Hearing impaired     Call 1-877-323-8480  Or, members can mail their inquiries to: Highmark Blue Cross Blue Shield P.O. Box 70 Pittsburgh, PA 15230-0070</p>

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

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

<b>Service Centers</b>	
Pittsburgh Service Center Penn Avenue Place 501 Penn Avenue Pittsburgh, PA 15222	Johnstown Service Center Crown American Building One Pasquerilla Plaza Franklin and Vine Street Johnstown, PA 15901
Erie Service Center 717 State Street Erie, PA 16501	State College Service Center 2040 Sandy Drive State College, PA 16803
Satellite Locations:  There are also a number of satellite locations. Please call 1-800-816-5527 for locations, days and times available, and to schedule an appointment.	Member service issues such as claims and identification cards can also be handled on the Web:  <a href="http://www.highmarkbcbs.com">www.highmarkbcbs.com</a> .

## SERVICE AREA

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



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

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

## Medicare Eligibility

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

MediGapBlue <sup>SM</sup>	1-800-789-9002
FreedomBlue <sup>SM</sup>	1-800-350-1973
SecurityBlue <sup>SM</sup>	1-800-576-6343

## General Program Information

The Direct Blue, Advance Blue, PPO Blue and Short Term Blue programs explained in this manual should not be represented as group programs. They are filed with the Pennsylvania Insurance Department as individual direct payment programs. These programs are designed specifically for individuals who are not covered by an employer group program and who are looking for reliable, affordable coverage. Following are general descriptions of the medically underwritten programs.

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

### All of these programs feature:

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

Short Term Blue is a medically underwritten program that provides temporary health insurance for individuals. Producers must screen applicants prior to applying for coverage using the two sets of medical questions on the application. Highmark reserves the right to deny, terminate or rescind coverage in the event of intentional misrepresentation of a material fact.

## Specific Program Information

### Direct Blue

Direct Blue covers most hospital and medical expenses, hospital care; women's care, emergency care and prescription drugs. Preventive care benefits, including adult and pediatric care, adult and pediatric immunizations, an annual gynecological exam and PAP test, and mammograms are covered at 100 percent when received from a network provider. These services are exempt from the deductible and any cost sharing. Preventive medications, including certain limited prescriptions and over-the-counter drugs prescribed for preventive purposes (based on a predefined Highmark schedule) are covered at 100 percent and are exempt from the prescription drug deductible. One routine vision exam every 24 months by a Davis Vision network provider is paid-in-full for Direct Blue members. Members also receive up to a 50 percent discount on eyewear purchased from Davis Vision providers.

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

There is a required 12-month waiting period before a policy will pay benefits for a pre-existing condition. Direct Blue applicants who are age 19 and older are subject to this pre-existing condition clause regardless of any prior Highmark Blue Cross Blue Shield affiliation. For the first 12 months of coverage, Direct Blue will not pay for expenses related to a condition for which medical advice or treatment was recommended by, or received from, a physician or other professional provider within a five-year period immediately preceding the effective date of the member's coverage.

### Family Deductible for Direct Blue

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

## **Advance Blue**

Advance Blue is a PPO program designed for consumers who anticipate needing some basic services throughout the year but still would like the benefit of a lower premium. Advance Blue covers hospital and medical expenses, hospital care, women's care, emergency care and prescription drugs. A high medical deductible applies to most hospital and injury care services. Office visits, basic diagnostic services and prescription drugs are covered at 100% after a low copayment amount and do not count towards the deductible or out-of-pocket limit. Preventive benefits, including adult and pediatric care, adult and pediatric immunizations, an annual gynecological exam and PAP test, and mammograms are covered at 100% when received from a network provider. These services are exempt from the deductible and any cost sharing. Preventive medications, including certain limited prescriptions and over-the-counter drugs prescribed for preventive purposes (based on a predefined Highmark Preventive Schedule) are covered at 100 percent and are exempt from the prescription drug deductible.

Members have the choice of using providers in or out of the Keystone Health Plan West network. After members meet the contract year deductible and when they use network providers and facilities, Advance Blue pays 90 percent of most eligible hospital and medical expenses. When out-of-network providers are used, Advance Blue pays 70% of most eligible expenses after the member meets the annual deductible. Balance billing may occur if the member uses an out-of-network provider (except for emergency room services). When a member reaches their network/out of network out-of-pocket maximums, Advance Blue pays 100% of eligible expenses for the remainder of the contract year. The (either individual or family) deductible must be met before Advance Blue pays for eligible expenses.

There is a required 12-month waiting period before Advance Blue will pay benefits for a pre-existing condition. Advance Blue applicants who are age 19 or older are subject to this pre-existing condition clause regardless of any prior Highmark Blue Cross Blue Shield affiliation. For the first 12 months of coverage, Advance Blue will not pay for expenses related to a condition for which medical advice or treatment was recommended by, or received from, a physician or other professional provider within a five-year period immediately preceding the effective date of the member's coverage.

A new Advance Blue member will receive three mailings: (1) a welcome letter with a notice of their premium and effective date; (2) an ID card and (3) Subscriber agreement, preventive schedule and Member Handbook.

### **Family Deductible for Advance Blue**

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

## **PPO Blue High-Deductible Program**

A qualified high-deductible health plan with lower premiums designed for use with a Health Savings Account (HSA) as defined by the Internal Revenue Service. PPO Blue covers most hospital and medical expenses, hospital care; women's care, emergency care and prescription drugs. Preventive care benefits, including adult and pediatric care, adult and pediatric immunizations, an annual gynecological exam and PAP test, and mammograms are covered at 100 percent when received from a network provider. These services are exempt from the deductible and any cost sharing. Preventive medications, including certain limited prescriptions and over-the-counter drugs prescribed for preventive purposes (based on a predefined Highmark schedule are covered at 100 percent and are exempt from the prescription drug deductible).

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

There is a required 12-month waiting period before PPO Blue will pay benefits for a pre-existing condition. PPO Blue applicants who are age 19 or older are subject to this pre-existing condition clause regardless of any prior Highmark Blue Cross Blue Shield affiliation. For the first 12 months of coverage, PPO Blue will not pay for expenses related to a condition for which medical advice or treatment was recommended by, or received from, a physician or other professional provider within a five-year period immediately preceding the effective date of the member's coverage.

### **Family Deductible for PPO Blue**

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

### **BlueAccount<sup>SM</sup> Health Savings Account (HSA)**

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

- Investment Choice – BlueAccount HSA offers a variety of mutual fund investment options. This means that your client can choose how to invest his account dollars – either for immediate access to pay his expenses or for longer-term growth potential. The account is administered by Bank of New York Mellon.
- Highmark Online Convenience Makes It Easy – To establish a BlueAccount HSA through Highmark, members simply log onto the Highmark Web site [www.highmarkbcbs.com](http://www.highmarkbcbs.com) and click on

“Establish a BlueAccount HSA.” Both the Highmark health care coverage and the HSA can be managed through this single Web site. Your customers can elect to have Highmark automatically send unpaid claims to the HSA directly, submit only certain claims using the Highmark Blue Cross Blue Shield Web site, pay out-of-pocket expenses using the HSA debit card, or submit a paper claim form. They even can choose how reimbursements are made – via check sent to them or automatic deposit into a bank account.

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

## **Short Term Blue**

Short Term Blue is a Preferred-Provider Program (PPO) designed to provide individuals with temporary, non-renewable short term coverage. Short Term Blue is medically underwritten. Eligibility is determined based on the applicant’s responses on a short medical questionnaire. Highmark reserves the right to deny, terminate or rescind coverage in the event of intentional misrepresentation of a material fact. Members have the choice of using providers in the Keystone Health Plan West network, where eligible services are covered at the higher benefits level. If out-of-network providers are used, eligible services are covered at the lower benefits level. After the deductible is met, payment is made at 80 percent for network services and 60 percent for out-of-network services. Balance billing may occur if the member uses an out-of-network provider. When a member reaches their coinsurance percentage limit (out-of-pocket maximum) for coverage in the network or out of the network, Short Term Blue pays 100 percent of eligible expenses for the remainder of the contract period.

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

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

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

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

To obtain additional coverage after a coverage period ends, a member must submit a new application. The member may enroll for two consecutive coverage periods. Coverage periods are

considered consecutive only if there are 60 days or less between the end of one coverage period and the beginning of the next coverage period. The member must wait 90 days, after enrolling in consecutive coverage periods, before applying for a third coverage period.

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

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

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

<b>Benefits of coverage</b>	
Covered Inpatient Services	Covered Outpatient Services
Hospital Room and Board Fees	Doctors' Fees
Doctors' Fees	Surgeons' Fees
Surgery	Anesthesia
Prescription Drugs (subject to pre-existing condition limitations for Short Term Blue)	Maternity Care*
Newborn Care	Emergency Accident Care
Pregnancy Complications*	Emergency Medical Care
Skilled Nursing Care	Prescription Drugs
Office Visits for Preventive Care* according to the Highmark Preventive Schedule	Durable Medical Equipment
Prosthetic Appliances	Office Visits for Illness and Injury
Orthotic Devices	Annual Mammogram for Women- beginning at age 40
Transplant Services	Surgery
Routine Gynecological Examination and Pap Test	Dental Services Related to Accidental Injury
Pediatric Immunizations	Therapy Service Benefits
Radiation Therapy	Chemotherapy

\*Does not apply to Short Term Blue

<b>Benefits of coverage</b>	
Dialysis Treatment	Physical Medicine
Occupational Therapy	Speech Therapy
Spinal Manipulation (not covered by Short Term Blue)	

**Direct Blue, Advance Blue, PPO Blue and Short Term Blue exclude coverage for mental health and substance abuse services and prescription drugs related to these services**

## **Network Providers**

### **Direct Blue, Advance Blue, PPO Blue and Short Term Blue In-Area Services utilizing the Keystone Health Plan West Network.**

#### **In-Area Network Coverage**

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

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

#### **Out-of-Network Coverage**

When members in Direct Blue, Advance Blue and PPO Blue use out-of-network providers, the Plan pays 70 percent of most eligible services after the member reaches the deductible obligation. When members in Short Term Blue use out-of-network providers, the Plan pays 60 percent of most eligible services after the member reaches the deductible obligation. Balance billing may occur if a member uses an out-of-network provider.

## **Direct Blue, Advance Blue, PPO Blue and Short Term Blue Out-of-Area Services Network Out-of-Area Coverage through BlueCard®**

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

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

### **Out-of-Network Out-of-Area Coverage**

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

## **Coverage Out of the United States through BlueCard Worldwide**

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

## **Authorization or Preadmission Certification**

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

### **Inpatient Admissions**

#### **Network and Participating Facility Providers**

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

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

## **Out-of-Network and Non-Participating Facility Providers**

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

## **Precertification for Inpatient Admissions**

### **Precertification obtained**

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

- Direct Blue, Advance Blue, PPO Blue and Short Term Blue – The member will be financially responsible for out-of-network payment level, in addition to the difference between the Highmark Blue Cross Blue Shield allowance and the non-participating provider's actual charges

### **Precertification not obtained**

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

## **Emergency and Delivery-Related Maternity Admissions**

### **Network and Participating Facility Providers**

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

### **Out-of-Network and Non-Participating Facility Providers**

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

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

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

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

## **Appeals and Grievances**

Benefits Appeal Procedure for Direct Blue, Advance Blue, PPO Blue and Short Term Blue

In the event that the Plan or its designated agent has determined in accordance with procedures established by the Plan denies your claim for benefits, the member may submit an appeal in writing to the Plan or verbally by contacting Member Service at 1-800-544-6679. Such appeal must be submitted not later than 180 days from the date the Plan or its designated agent notifies the member and should include specific information in support of the claim for benefits. The Plan or its designated agent will review the information and make a final decision concerning the member's claim for benefits and notify the member, in writing, following receipt of the appeal.

The member will have 15 days from receipt of the notice to appeal the decision by requesting an external review. The member can initiate the appeal with a call to Member Service at the number located on the back of their ID card. Their written appeal should be submitted to the following address:

Highmark Blue Cross Blue Shield  
Attention: Appeals Committee  
P. O. Box 535095  
Pittsburgh, PA 15253-5095

## **Application Process for Producers**

All producers must submit online applications in order to receive commissions. You must have Internet Explorer 7.0 or above or FireFox 2.0 or above in order to submit online applications. Do not use the back button of your Internet browser to move to previous pages in the application. Use the navigation bar at the top of the page. View the progress bar to track an applications progress.

### **Exceptions to Submitting an Online Application**

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

- For Short Term Blue, if the customer wants to submit a check, a Producer's Certificate must accompany the paper application to ensure proper processing of commission payments.
- When the system does not accept the zip code and you have proof that the zip code is within the service area
- When the existing member moves from another Highmark medically underwritten program to the PPO Blue High-Deductible program (use the Medically Underwritten Change Form and follow the directions on the form)\*
- When changing a contract from husband/wife coverage to separate coverage or to add a spouse/dependent to an existing policy (use the Medically Underwritten Change Form and follow the directions on the form) Does not apply to Short Term Blue.
- For enrollment in a guaranteed issue program or a program based on income

### **The online application is very easy to access**

1. Log onto the Highmark Blue Cross Blue Shield Web site at [www.highmarkbcbs.com](http://www.highmarkbcbs.com).
2. Select the "Producers" blue tab at the top of the page.
3. Enter your login ID and password.

Two options are available to apply for medically underwritten coverage. From the Welcome page, go to the New Business tab and within the Individual and Family Coverage section, select "Generate Quote and Apply" or Generate Email to Customer.

- The Generate Quote and Apply option is used when a producer enters the applicant information online for a client.
- The Generate Email to Customer option is used when clients complete the application online. With this option, the producer is prompted to enter their producer number and in order for an email to be generated to the client. Within the email is a link to the medically underwritten application on the Highmark website. Only after a client submits an application, it is reviewed and approved by Highmark, and the client accepts an offer of coverage, will commissions be assigned for payment. In addition, emails confirming the submission of the application will be sent to the client and producer.

## **The online system walks you through the process.**

### **1. Retrieving saved applications/quotes.**

- If you have already saved a quote or application, click on the “Retrieve Quote/Application” link in the Quotes & Applications box on the right side of the Individuals & Families page. Log in to use the search feature to find your saved quote/application.

### **2. Select Plan**

- You can check the programs for which you want to view benefit grids and rates by selecting Indemnity and/or PPO.
- Indemnity programs include the SpecialCareSM Program.
- PPO programs include our Medically Underwritten Programs – Direct Blue (\$250 or \$500 deductible), Advance Blue (\$1,200, \$2,600 or \$3,500), PPO Blue HDHP (\$1,200, \$2,600 or \$3,500 deductible) and Short Term Blue (\$250, \$500 or \$1,000 deductible) and the Guaranteed Issue Programs – PPO Blue HDHP (\$1,200, \$2,600 or \$3,500 deductible) and Preferred Blue® (\$500 or \$1,000 deductible).

### **3. Gather Information**

- This section confirms the application type and premium.
- For Short Term Blue, two sets of medical eligibility questions are asked relative to pre-existing conditions. If the applicant answers “yes” to one or more of these questions, they are not eligible for coverage. Highmark reserves the right to terminate or rescind coverage for misrepresentation of medical facts.
- Click on “Outline of Coverage” to print the comprehensive outline of benefits. The Pennsylvania Insurance Department requires that a copy of the Outline of Coverage be provided to each individual/family applying for coverage. (Copies of the Outlines of Coverage for each of the Medically Underwritten Programs can also be ordered from Highmark. Producers can request copies from their General Agency.)

This section also provides important information regarding the Individual Market Medically Underwritten Programs. Please read carefully.

### **4. Enter Individual Information**

Enter all requested information on the application pages for each person applying for coverage. Make sure the information is complete and accurate.

- A message will prompt correction to add any missing information or if a field needs to be edited.
- Read the *Notice to Applicant Regarding Replacement of Accident and Sickness Insurance*. Choose “I Accept” or “I Do Not Accept” to indicate your intent for purchasing new coverage. The Pennsylvania Insurance Department requires that you are provided with this notice.

- Read the Conditions of Enrollment statements. Provide the applicable electronic signature(s) to indicate that all applicants/dependents age 18 and older understand and accept the Conditions of Enrollment Statements. Selecting the appropriate check box will create an electronic signature.

The application is almost complete. To submit the application, select NEXT at the bottom of the page to move on to select a payment method.

## 5. View Quote

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

## 6. Confirm Quote

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

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

## 7. Make a Payment

- You must arrange payment for the first month of coverage before the application can be processed. For all plans *except Short Term Blue*:
  - Online credit card or debit card payments are accepted for the first month’s premium payment.

- There is an option to be billed later for the first month's premium payment only. This allows for applying online without making the first month's payment.
- Ongoing monthly billing:
  - If approved, the applicant will receive information with their ID cards about online billing options.
- For Short Term Blue – Online credit card or debit card payments are the only payments accepted, and you must pay the full premium for the coverage period selected.
- Enter the information completely and accurately to finalize the online application process.
- When you complete the "Payment" screen, your application has been submitted.

## **8. Edit the Application Prior to Submission**

- To edit the application, return to the previous pages using the navigation bar at the top of the page. Continue through the application to make changes. Save the application and submit.

## **9. Confirmation and Tracking of Submitted Application**

- Print a copy of the application and payment confirmation upon completion.
- You will receive an email confirmation that the application has been submitted along with instructions for tracking the status of the application.
- You will be given an Application Name, Tracking ID and Primary Applicant Name that will assist you in tracking your application online.

## **10. Medical Records\***

- Please use the Highmark fax cover sheet and complete all the information so that we can correctly match the medical records to the online application.
- If you do not clarify the above-requested information on the online application and the faxed medical records, the application will be processed without the medical records.
- Remember that only medical records will be accepted on this fax line. Applications, changes to applications and inquiries will not be accepted.

### **Important Information Pertaining to the Application Process**

- Verify the accuracy of all information prior to submission. Numerical data is particularly error-prone, so double-check Social Security numbers, height, weight, date of birth, etc.
- The writing producer must be properly licensed and appointed with Highmark to sell individual products prior to acting on Highmark's behalf or as Highmark's representative.
- Applicants must not be eligible for Medicare and must reside within the 29-county area serviced by Highmark Blue Cross Blue Shield to apply for any of these programs. Applicants must use their correct home address. Do not use a business address.

- The producer must review the HIPAA Eligibility Checklist with the customer to determine eligibility for the HIPAA product.
- When submitting online applications, the producer must enter the application via the Producer Portal (not the Consumer Portal) to receive commissions on approved applications. Use your Portal login ID and password to enter the Producer Portal, and enter your Agency and producer numbers on the producer information page of the application. The exception is Short Term Blue when accompanied by a provider certificate.
- All application information must be completed accurately and in detail to help avoid processing and approval delays.
- The writing producer must complete all questions in the producer section of the application. Incomplete or missing information will result in no commission for the writing producer.
- Producers must provide applicants with an Outline of Coverage.
- Print and maintain a copy of the application for your files.
- Producers must abide by the code of ethics included in this manual.
- To ensure that applicants submit complete and accurate applications, Highmark has implemented several mechanisms for our medically underwritten programs to detect fraud.
- Any repeated submission by producers of applications for individuals whose applications are determined to be fraudulent will result in termination of their appointment with Highmark and the possible pursuit of legal actions and remedies.

### **Direct Blue, Advance Blue and PPO Blue**

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

## **Short Term Blue**

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

## **Family Deductible**

### **Family Deductible**

If a family deductible applies, it is listed beside the individual deductible on the electronic application. Explanations of family deductibles are included in the Conditions of Enrollment (signature page) section of applications. The customer must read and understand the deductible for their chosen product.

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

### **PPO Blue Annual Family Deductible**

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

### **Family Deductible for Advance Blue**

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

### **Direct Blue Annual Family Deductibles**

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

## **Enrollment**

### **Identification Cards and Subscription Agreements**

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

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

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

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

### **Free-look Enrollment Period**

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

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

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

This cancellation information should be mailed to:

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

## **Cancelling Policies**

Direct Blue, Advance Blue, PPO Blue, Keystone Blue HMO and Complete Care

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

Highmark Blue Cross Blue Shield  
Membership  
Fifth Avenue Place  
120 Fifth Avenue, Suite 2318  
Pittsburgh, PA 15222-0399  
OR  
Fax to: 412-544-4176

## **Short Term Blue**

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

## **Conversion From Highmark Group coverage and HIPAA Options**

### **Conversion and HIPAA Options**

Customers who are losing their coverage in a group product may want options for individual and family coverage. If these individuals are not eligible for a Highmark Medically Underwritten products because of pre-existing conditions, they may be eligible for a Highmark Guaranteed Issue product.

If a person is terminated from Highmark group coverage, he may be offered **Conversion:**

- Fully insured Highmark groups offer Conversion into a guaranteed issue product with no lapse in coverage and no pre-existing condition limitations
- Certain Self-Insured (ASO/ASC) Highmark groups offer Conversion into a guaranteed issue product with no lapse in coverage, however, pre-existing condition limitations may apply

If a person is terminated from group coverage (from another insurance carrier) and meets HIPAA program guidelines, he may be offered the Highmark **HIPAA product**, PreferredBluePPO – in the Western region, or ClassicBlue Comprehensive - in the Central region). Neither HIPAA product includes a pre-existing condition waiting period.

### **Conversion Policies**

Conversion is the process in which a Highmark member goes from one policy type to another without a lapse in coverage, such as:

- Cancelled Highmark group to a Highmark Individual Product.
- Cancelled Highmark Health Insurance Company (HHIC) group member to

- Highmark Transition PPO. Note: Transition PPO is an individual product created specifically to be a conversion option for HHIC group members.
- Child(ren) removed from the CHIP Program because they reached age 19.
- Dependents who have reached the maximum age (26) on a Highmark individual product policy.

If Highmark member who is eligible for conversion wants to add additional family members, anyone age 19 or older has pre-existing condition limitations for the first 12 months of coverage.

### **Conversion Process**

If an individual is cancelled from a Highmark group, he or she may be eligible for a conversion to:

- ClassicBlue Comprehensive (Central),
- PreferredBlue PPO (Western),
- PPOBlue HDHP Guaranteed Issue, or
- SpecialCare (must meet income guidelines)

The customer can enroll in one of the conversion products with no pre-existing condition waiting period and no lapse in coverage between the group's cancel date and the date the new individual coverage begins\*\*.

The normal process for conversion offers and member application are:

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

### **ASO/ASC Group Conversions**

If a conversion-eligible member was enrolled in a fully-insured (Non-ASO) group, pre-existing condition limitations will be waived for his individual conversion policy.

Most ASO/ASC groups do not offer conversion. If a conversion-eligible member was enrolled in a self-insured (ASO/ASC) group:

- In **western region**, pre-existing condition limitations will apply for anyone age 19 or older on his individual conversion policy
- In **central region**, pre-existing condition limitations may apply for anyone age 19 or older on his individual conversion policy. (There are certain ASO/ASC groups that

have designated that their converting members will have a waiver of pre-existing condition limitations.)

If Highmark member who is eligible for conversion wants to add additional family members, anyone age 19 or older has pre-existing condition limitations for the first 12 months of coverage.

### **HIPAA Program and Eligibility Checklist**

It's a requirement of the Pennsylvania Insurance Department that producers advise customers of their rights under The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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

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

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

#### **Individuals interested in applying for HIPAA coverage should:**

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

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

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

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

- Applicant is not eligible for or enrolled in Medicare, Medical Disability (except if the applicant is under age 26) or any group health insurance plan.

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

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

## **Enrollment Guidelines**

### **Effective Date of Coverage\***

A producer can never guarantee an effective date.

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

### **Dependents\***

Under all of these programs except Short Term Blue\*, a "child" is defined as the:

- Applicant's son or daughter, or
- A stepchild dependent upon the applicant, or
- A legally adopted child (including the child during a probationary period), or

- A child for whom the applicant is legal guardian
- Children may be considered for coverage on the applicant's agreement if the following additional standards are met:
- They are under the age of 26, regardless of student or marital status
- They are not eligible for Medicare Part A and/or Part B

#### Adding Dependents to Medically Underwritten Coverage\*

Based on Pennsylvania Act 81 of 1975, a newborn child will automatically be covered for a maximum of 31 days from the moment of birth, adoption or placement for adoption. The following guidelines apply when adding a dependent to existing coverage:

#### **Continuing coverage for a newborn child beyond the first 31 days of life**

A child is considered to be a *newborn* from birth through the first 31 days of life. To add a natural *newborn* to existing coverage, the member must contact Highmark within 31 days of the date of birth in order to continue the child's coverage beyond the first 31 days. To add an adopted or placed for adoption *newborn* (less than 32 days old) to existing coverage, the member must contact Highmark within 31 days of the date of adoption or placement for adoption.

#### **Adding an eligible child who is between 32 and 90 days old**

To add a natural child, an adopted child or a child placed for adoption who is between 32 and 90 days old, the member must contact Highmark to complete an application for the child. The child will not be denied coverage, but will be subject to medical underwriting for the purpose of determining the appropriate premium rate.

#### **Adding a spouse or other eligible dependent who is over 90 days old**

To add a spouse or other eligible dependent to existing coverage, the member must contact Highmark within 60 days after marriage or a life event or prior to the member's coverage anniversary date. The member must complete an application and include medical information for each new dependent to determine premium rates and/or eligibility for coverage. A dependent who is less than 19 years old who is applying for a non-grandfathered program will not be denied coverage, but will be subject to medical underwriting for the purpose of determining the appropriate premium rate. A dependent who is 19 years or older who is applying for a non-grandfathered program will be subject to the pre-existing condition limitation.

#### **Newborn Coverage in Short Term Blue**

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

If notification is not received until 31 days from birth, the newborn is treated as a new applicant, and medical underwriting applies.

### **Adding Children\***

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

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

### **Deleting Children\***

Dependent children can be deleted from their medically underwritten program by completing a change form. Dependents are automatically deleted from their parents' agreements the first of the month following their 26th birthday. They will receive a letter and an application for the same program their parent(s) or legal guardian are enrolled in prior to their deletion date. If the deleted dependent wants to continue being covered under the program, medical underwriting is not required if the application is received within 30 days of the deletion date.

### **Disabled Dependents\***

Disabled dependents reaching age 26 can remain as eligible dependents on a policy if they are certified by a physician to be incapable of self-support by reason of physical or mental disability, if they became incapable of self-support before reaching age 26, and if they were an active dependent on the contract.

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

### **Adding a Spouse\***

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

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

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

## **Changes in Eligibility**

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

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

### **Medical Underwriting Waived for Direct Blue, Keystone Blue and Complete Care Members Who Switch to PPO Blue HDHP\***

Existing Complete Care, Direct Blue and Keystone Blue members may switch to the Highmark PPO Blue High Deductible Health Plan (HDHP), which will allow them to take advantage of lower premiums and the tax savings associated with a Health Savings Account (HSA).\*\* Complete Care, Direct Blue and Keystone Blue members may make this switch without undergoing new medical underwriting.

In addition, members age 19 and older who have met the 12-month pre-existing condition waiting period under their original coverage will not be required to meet a new waiting period under PPO Blue.

Individuals age 19 and older who have not yet met the full 12-month pre-existing condition waiting period will be credited with the portion of the waiting period they have met, but must complete the remainder of the waiting period under the PPO Blue coverage. For example, if a member has been enrolled in Direct Blue for nine months and switches to PPO Blue, he/she will only have three months of the pre-existing condition waiting period remaining under PPO Blue.

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

To make the change, current members simply:

- 1) Complete a Change Form (CC-043), indicating the contract holder's name, Social Security number, group number and the PPO Blue deductible level they want. The member's signature, date of signature and phone numbers must be included on the back of the Change Form.
- 2) On the first page of an accompanying PPO Blue application (ENR-070), complete the General Information section (name, address, county, phone number, e-mail address).
- 3) In the Enrollment Information section of the PPO Blue application, indicate the deductible selected. There is no need to complete anything else in the Enrollment Information section on the first page or the Medical Information section starting on the second page of the application.
- 4) Sign and date the application on the second to the last page (Conditions of Enrollment) of the application. Applying members should also indicate on the last page of the application the date

they would like the PPO Blue membership to take effect. PPO Blue membership can take effect on the first day of the month following submission of the Change Form and application.

- 5) On the last page of the application, Producers should fill in Agency, Producer and telephone numbers and sign the application.
- 6) Submit the Change Form and application. No payment is required at the time of application submission.

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

## **Medical Underwriting For Direct Blue, Advance Blue and PPO Blue**

### **General Information**

An evaluation of the applicant's medical history will determine acceptance for coverage.

To help you assist applicants, field underwriting guidelines are included at the end of this manual.

### **Medical Record Submission**

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

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

When you have pertinent medical records to submit with an online application, fax the records to 1-412-544-4009 within 31 days using the designated Highmark fax cover sheet. Indicate on the application – either in the space next to the pertinent medical condition or in the last question that asks for “Other” information – that you will be faxing medical records.

The records must be received in three days or the application will be processed without them. Please use the Highmark fax cover sheet and complete all the information so that we can correctly match the medical records to the online application.

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

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

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

### **Incomplete Applications**

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

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

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

### **Medical Advice or Treatment Received after Application is Submitted**

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

How to Appeal a Denial -- Applicants denied enrollment in a Highmark Blue Shield medically underwritten program have the right to appeal the decision not later than 180 days from the date the Plan or its designated agent notifies the applicant. The following guidelines may be used to expedite the process.

- 1) The applicant should ask the attending physician to write a letter providing additional medical information about all condition(s). The doctor should include any pertinent clinical information to support the appeal. The statement should be a summary of the applicant's current health status for all medical conditions, including, for example, all medications being taken, recent medical visits, diagnostic tests that were performed or proposed, and a tentative course of treatments for the future.
- 2) If someone other than the applicant is filing the appeal, a signed consent form is required authorizing the representative to submit the appeal on the applicants behalf. This form is an attachment to the applicant's denial letter.
- 3) If the appeal is related to a sensitive diagnosis, the Authorization of Disclosure of Health Information form, which is also attached to the applicants denial letter must be signed and submitted with the appeal request.

The appeal will be reviewed, a decision made and notification of the decision will be sent within 30 days from receipt of the appeal request.

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

- 4) The applicant must send the physician's letter, clinical information and a copy of the denial letter to:

Highmark Blue Shield  
Individual Product Appeals  
120 Fifth Avenue, Suite 1720  
Pittsburgh, PA 15222-3099

OR

Fax to: 412-544-4009

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

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

- 5) The applicant should not submit a payment with the appeal.

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

### **Reconsideration for a Tier Rate Offer**

Any applicant who is offered a tier rate will be entitled to a one-time reconsideration, if requested within 60 days from the date of their decision letter. A reconsideration can be sent to the above address or fax number with additional clinical information.

### **How to Respond to an Offer Letter**

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

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

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

- 1) To accept the offer for Tier I, Tier II, Tier III or Tier IV rating, an individual should sign the offer letter and return it in the envelope provided along with a check for one month's premium. To determine the premium, the individual should refer to the rate sheet provided based on gender and age.
- 2) To accept the offer for a husband/wife or family application, the applicant(s) should sign for each tier offered, and return in the envelope provided along with a check for one month's

premium. The premium can be calculated based on the tiers being offered and the rate sheet(s) attached.

- 3) If the family offer is split between different tiers, the family has the option of either accepting the separate offers being made or choosing to enroll the husband/wife or family under one contract at the highest tier offered. The acceptance of separate offers will create separate contracts for each tier offered. Separate contracts will generate separate monthly invoices.
- 4) The individual, husband/wife or families accepting the offer made should return the signed offer letter and first month's premium in the envelope provided within 14 days. If they do not return the information within 14 days, Highmark Blue Cross Blue Shield will assume they are no longer interested in coverage. Applicants will need to complete a new application to be considered for any future enrollment.

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

## **Payments**

### **Rates for Direct Blue, Advance Blue, PPO Blue, Keystone Blue HMO and Complete Care\***

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

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

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

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

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

## **Rates for Short Term Blue**

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

## **Payment Information**

No discounts will be given for advance payments.

### Initial Payment Options

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

#### **1) Credit Card Payment**

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

#### **2) Check for Short Term Blue Only**

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

#### **3) Bill Me Later\***

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

## **Ongoing Payments**

#### **1) Automatic Deduction from a Bank Account\***

Monthly payments also can be made through automatic deduction from a bank account or Bill online payment available through the secure web site, [www.highmarkbcbs.com](http://www.highmarkbcbs.com). Members can have their premium automatically deducted from their checking account *on the date they choose*. Members will receive information on how to apply for this service in their Welcome Kits.

#### **2) Billing\***

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

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

### **3) Remitting Payment\***

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

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

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

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

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

### **Grace Period and Reinstatement\***

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

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

Agency/Producer Network

## Code of Ethics

Any person selling insurance shall:

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

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

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

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

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

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

7. Obey all laws governing business and professional activities and honestly represent products in an ethical manner without fraud, misrepresentation, exaggeration, coercion, scare tactics or concealment of pertinent facts. Do so without taking advantage of the customer or potential customer, which could lead to the customer's detriment in insurance choices based on need and financial capability.
8. Accept no gifts, entertainment or favors of more than nominal value from customers or potential customers, which may be deemed professionally questionable.
9. Use only authorized promotional materials unless prior written approval has been obtained from an authorized Highmark representative, and fairly focus presentation on positive benefit comparisons rather than disparaging remarks about the competition.

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

Blue Cross, Blue Shield and the Cross and Shield symbols, Away from Home Care, PreferredBlue, BlueCard, BlueCard Worldwide and Direct Blue are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

PPO Blue, Advance Blue, Keystone Blue , Short Term Blue, MedigapBlue, FreedomBlue, SecurityBlue and BlueAccount are service marks of the Blue Cross and Blue Shield Association.

Keystone Health Plan West is an independent licensee of the Blue Cross and Blue Shield Association.

Highmark is a registered mark of Highmark Inc.

Complete Care and SpecialCare are service marks of Highmark Inc.

## MEDICAL UNDERWRITING GUIDELINES

Property of Highmark, Inc.

Confidential and Proprietary

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

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

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

**Note: Due to the Genetic Information Nondiscrimination Act of 2008 (GINA), decisions regarding eligibility for the medically underwritten products, determination of premium level, or determinations upon appeal cannot be based on genetic information, genetic testing or family medical history. This type of genetic information and/or family history is not requested or**

Body System	You Should Ask	Possible Action by Highmark - see page 1
-------------	----------------	--

Behavioral Health Psychiatric/ Substance Abuse		
Addiction/substance abuse	<ul style="list-style-type: none"> <li>• Name of drug or alcohol</li> <li>• Current treatment</li> <li>• Inpatient/outpatient</li> <li>• Medical records recommended</li> </ul>	<p>Consider tiering with physician documentation of abstinence for past five years and no significant concurrent problems</p> <p>Deny adults for active problem within past five years</p>
Tobacco use	<ul style="list-style-type: none"> <li>• Type of tobacco</li> <li>• Enter number per day Cigarettes/cigars/pinches (1 can =15 pinches)</li> <li>• Date range of tobacco use</li> </ul>	<p>Approve if tobacco-free for over one year</p> <p>Tiering for current or recent user</p> <p>Deny adults for heavy or long-term use</p>
Attention deficit disorder/attention deficit hyperactivity disorder	<ul style="list-style-type: none"> <li>• Current medications</li> <li>• Current non-pharmaceutical treatment</li> </ul>	<p>Standard approval, if no treatment required in the past year and no concurrent problems</p> <p>Consider for tiering if undergoing current treatment or treated in past year</p> <p>Deny adults for unstable, multiple treatments</p>
Psychiatric/psychological counseling/ medications for any condition	<ul style="list-style-type: none"> <li>• Diagnosis required</li> <li>• Current medications</li> <li>• Current treatments/counseling</li> <li>• Length of time/number of sessions</li> </ul>	<p>Standard if treatment ended over five years ago</p> <p>Consider for tiering for problem active one to five years ago, for a situational diagnosis, or for medication used for non-psychiatric diagnosis</p> <p>Deny adults for major psychological/nervous diagnosis, current medication, medication within the past year, frequent or recent counseling or suicide attempt</p>

Body System	You Should Ask	Possible Action by Highmark - see page 1
-------------	----------------	--

Behavioral Health Psychiatric/ Substance Abuse		
Sleep disorders/sleeping medications	<ul style="list-style-type: none"> <li>• Diagnosis</li> <li>• Sleep study done/date</li> <li>• Durable medical equipment required, such as continuous positive airway pressure or bi-level positive airway pressure</li> <li>• Medications/frequency</li> </ul>	<p>Standard if surgical correction was more than six months ago and released</p> <p>Consider for tiering for current medications or additional conditions</p> <p>Deny adults for more severe diagnoses or if durable medical equipment required</p>
Antidepressants or anti-anxiety treatment for smoking cessation/restless legs/hot flashes/ pre-menstrual dysphoric syndrome/ situational adjustment disorder	<ul style="list-style-type: none"> <li>• Medications/frequency</li> </ul>	Consider for tiering
Mental retardation		Deny adults

Heart/Blood/Circulation		
High cholesterol	<ul style="list-style-type: none"> <li>• Recent lab results</li> <li>• Medications</li> </ul>	<p>Approve if well controlled</p> <p>Deny adults if unstable or requires multiple medications</p>
Anemia blood disorders	<ul style="list-style-type: none"> <li>• Kind of anemia</li> <li>• Diagnosis</li> </ul>	Standard for simple iron deficiency or oral treatment only and stable
Angina/chest pain	<ul style="list-style-type: none"> <li>• Diagnosis</li> <li>• Medications/medication changes</li> <li>• Recent ER/doctor visit/hospitalization/results</li> <li>• Diagnostic tests/date/results</li> <li>• Medical records strongly recommended</li> </ul>	<p>Individual consideration</p> <p>Deny adults if unstable, medications required, heart attack in past five years, heart surgery in past five years, CHF or enlarged heart</p>

Body System	You Should Ask	Possible Action by Highmark - see page 1
-------------	----------------	--

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

Body System	You Should Ask	Possible Action by Highmark - see page 1
-------------	----------------	--

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

Body System	You Should Ask	Possible Action by Highmark - see page 1
-------------	----------------	--

Eyes/Ears/Nose/Throat (cont.)		
<b>Ears</b>		
Infections	<ul style="list-style-type: none"> <li>• Average number of infections per year</li> <li>• Past or future surgery</li> <li>• Surgery date</li> <li>• Medication/frequency</li> </ul>	<p>Standard</p> <p>Consider for tiering with multiple episodes</p>
Cochlear implants	<ul style="list-style-type: none"> <li>• Reason</li> <li>• Date of surgery</li> </ul>	Consider for tiering
<b>Nose</b>		
Deviated septum	<ul style="list-style-type: none"> <li>• Surgery/date</li> </ul>	<p>Standard if no surgery is planned or applicant is released from care</p> <p>Deny adults if surgery is anticipated or occurred less than three months ago</p>
<b>Throat/Jaw/Mouth</b>		
Jaw/temporo-mandibular joint problems	<ul style="list-style-type: none"> <li>• Diagnosis</li> <li>• Specify surgery, splints, treatment</li> </ul>	Consider for tiering
Infections	<ul style="list-style-type: none"> <li>• Type</li> <li>• Frequency</li> <li>• Diagnosis</li> <li>• Medications</li> </ul>	Standard if fully resolved and not recurrent

<b>Body System</b>	<b>• You Should Ask</b>	<b>Possible Action by Highmark - see page 1</b>
--------------------	-------------------------	---

<b>Endocrine/Hormones/Metabolic/Glandular</b>		
Adrenal gland		Automatic denial
Diabetes	<ul style="list-style-type: none"> <li>• Type: juvenile/adult onset/ pregnancy related (gestational)</li> <li>• Treatment: none/diet-controlled/ medications</li> <li>• Medications: daily/coverage</li> <li>• Labwork: FBS/A1C</li> <li>• Medical records and/or statement highly recommended.</li> </ul>	Individual consideration for diet-controlled  Deny adults for insulin or medication dependency
Thyroid	<ul style="list-style-type: none"> <li>• Type: hypo/hyper</li> <li>• Treatment: medications/ surgery and date/ radiation and number of treatments, date, additional planned</li> <li>• Cancer related diagnosis</li> </ul>	Standard if hypo and controlled
		Individual consideration for hyper
Goiter/nodules/other	<ul style="list-style-type: none"> <li>• Medications</li> </ul>	Standard if stable
Pituitary/pineal gland problems		Deny adults
Chronic fatigue	<ul style="list-style-type: none"> <li>• Date diagnosed</li> <li>• Medications</li> <li>• Current treatment plan</li> </ul>	Individual consideration
Marfan's syndrome		Deny adults

<b>Body System</b>	<b>You Should Ask</b>	<b>Possible Action by Highmark - see page 1</b>
--------------------	-----------------------	---

<b>GI – Gastro-intestinal/Stomach/Intestines</b>		
Abscess/infection	<ul style="list-style-type: none"> <li>• Location of abscess or infection</li> <li>• Diagnosis/date</li> <li>• Symptoms/treatment plan within the past year</li> <li>• Past/future surgery</li> </ul>	Deny adults if symptomatic or treated in the past year
Cirrhosis/liver disease	<ul style="list-style-type: none"> <li>• Diagnosis date</li> <li>• Status</li> </ul>	Deny adults
Ulcerative colitis/Crohn's disease	<ul style="list-style-type: none"> <li>• Diagnosis date</li> <li>• Status</li> </ul>	Deny adults
Diverticulitis/diverticulosis/frequent abdominal pain	<ul style="list-style-type: none"> <li>• Diagnosis: diverticulitis/osis</li> <li>• Medications</li> <li>• Rectal bleeding episode(s)/date(s)</li> <li>• Hospitalization/date</li> <li>• ER/date</li> </ul>	Standard if well controlled with diet  Deny adults for recent prescription, hospitalization or treatment
Nutritional disorder	<ul style="list-style-type: none"> <li>• Medical records or doctor's statement strongly recommended</li> </ul>	Individual consideration
Fistula/fissure	<ul style="list-style-type: none"> <li>• Location</li> <li>• Diagnosis/date</li> <li>• Symptoms and treatment plan within the past year</li> <li>• Surgery</li> </ul>	Consider for tiering if resolved over six months  Deny adults if symptomatic or for surgery within six months
Bariatric surgery/gastrectomy/gastroplasty		Deny adults
Hemorrhoids	<ul style="list-style-type: none"> <li>• Surgery type/date</li> </ul>	Standard if well controlled or no need for recent treatment  Consider for tiering for recent surgery, multiple or bleeding  Deny adults for anticipated surgery or surgery less than three months ago

Body System	• You Should Ask	Possible Action by Highmark - see page 1
-------------	------------------	--

GI – Gastro-intestinal/Stomach/Intestines (cont.)		
Hernia	<ul style="list-style-type: none"> <li>Type/diagnosis</li> <li>Surgery/date</li> <li>Released from care/date</li> </ul>	<p>Standard for surgery more than six months ago</p> <p>Individual consideration for surgery less than six months ago</p>
Hepatitis	<ul style="list-style-type: none"> <li>Specify Type: A/B/C/D/E, etc.</li> <li>Date of diagnosis</li> <li>Treatment/medications</li> <li>Medical statement recommended</li> </ul>	<p>Individual consideration</p> <p>Deny adults for Hepatitis B, C, D, E</p>
Irritable bowel syndrome	<ul style="list-style-type: none"> <li>Medications</li> <li>Medical records with treatment plan strongly recommended</li> <li>Current symptoms</li> </ul>	<p>Standard if no medications or hospitalization needed in past year</p> <p>Deny adults for prescription medications or recent hospitalization</p>
Pancreatitis	<ul style="list-style-type: none"> <li>Acute or chronic</li> <li>Number of episodes</li> <li>Treatment plan/release from care</li> </ul>	<p>Consider for tiering</p> <p>Deny adults if chronic, treatment in the past two years, abnormal lab results</p>
Gastritis/ulcer/esophagitis/gastroesophageal reflux disease	<ul style="list-style-type: none"> <li>Medications</li> <li>Surgery/date/release</li> <li>Hospitalization</li> </ul>	<p>Standard on over-the-counter drugs</p> <p>Tiering if on proton pump inhibitor (PPI) drugs.</p> <p>Deny adults for H. Pylori, Barrett's Esophagus, recent surgery or hospitalization</p>
Polyps	<ul style="list-style-type: none"> <li>Biopsy results/date</li> <li>Pathology reports recommended</li> </ul>	<p>Individual consideration</p>
Colorectal cancer	<ul style="list-style-type: none"> <li>Medical records required for consideration</li> </ul>	<p>Automatic denial if treated within past five years or with additional risk factors</p>
Esophageal varices		<p>Deny adults</p>

Body System	You Should Ask	Possible Action by Highmark - see page 1
-------------	----------------	--

GU - Kidney/Bladder		
Benign prostatic hyperplasia/enlarged prostate	<ul style="list-style-type: none"> <li>• Surgery/date/outcome</li> <li>• Medications</li> <li>• Treatment plan</li> <li>• Release from care</li> </ul>	<p>Standard if no medications, surgical history or plan, or biopsy</p> <p>Tiering with any medication</p> <p>Deny adults for recent surgery</p>
Incontinence	<ul style="list-style-type: none"> <li>• Diagnosis/date</li> <li>• Surgery/date/outcome</li> <li>• Medications</li> </ul>	<p>Standard for surgery and if released from care</p> <p>Tiering for medications on chronic basis</p> <p>Deny adults for anticipated or recent surgery</p>
Kidney cysts		<p>Standard if stable for two years with no medications or treatment</p> <p>Deny adults for anticipated surgery, if symptomatic or unstable</p>
Kidney failure/renal failure/chronic renal failure/end-stage renal disease		Deny adults
Kidney stones	<ul style="list-style-type: none"> <li>• Number of episodes in past five years</li> <li>• Date of last episode</li> </ul>	<p>Standard for Infrequent episodes and more than three years since treatment</p> <p>Tiering for repeat or recent episodes</p> <p>Deny adults for urinary abnormalities, episodes within the past year or frequent episodes</p>
Kidney surgery/nephrectomy/prostate and testicular cancers/pyelonephritis/cystitis	<ul style="list-style-type: none"> <li>• Type/date of surgery</li> <li>• Diagnosis/date</li> <li>• Treatment plan/release from care required</li> <li>• Specify number of episodes per year/date/treatment</li> </ul>	Individual consideration
Urethral strictures/narrowing	<ul style="list-style-type: none"> <li>• Frequency</li> <li>• Surgery/type/date/release</li> <li>• Medications</li> <li>• Physician statement or records strongly recommended</li> </ul>	<p>Standard if fully resolved and no concurrent problems.</p> <p>Deny adults for ongoing/recent surgery/repetitive treatments</p>

Body System	You Should Ask	Possible Action by Highmark - see page 1
-------------	----------------	--

Immune System/Infections		
AIDS/HIV		Deny adults
Allergies (specify)	<ul style="list-style-type: none"> <li>• Medication/frequency of use</li> <li>• Allergy shots for desensitization/ treatment date range</li> <li>• Associated conditions/asthma/ rashes</li> </ul>	<p>Standard for minimal oral/nasal medications</p> <p>Consider for tiering if steroids by mouth are required, for two or more daily medications, or if allergy shots ended recently</p> <p>Deny adults for current testing or desensitization, if associated with asthma or other respiratory problems, if multiple daily medications are required</p>
Lupus		Deny adults
Scleroderma		Deny adults
Lyme disease	<ul style="list-style-type: none"> <li>• Diagnosis/date</li> <li>• Treatment plan</li> <li>• Medications</li> </ul>	Consider for tiering if treated within past year
Viral infections	<ul style="list-style-type: none"> <li>• Diagnosis/date</li> <li>• Treatment plan</li> <li>• Medications/frequency of use/episodic or daily</li> </ul>	<p>Standard if resolved/infrequent</p> <p>Consider for tiering for active, recent or frequent infections</p>
Epstein-Barr virus/mononucleosis	<ul style="list-style-type: none"> <li>• Diagnosis/date</li> <li>• Treatment plan</li> <li>• Medications/frequency</li> </ul>	<p>Individual consideration</p> <p>Deny adults for active treatment</p>
Other/comments: Methicillin Resistant Staff (MRSA)/Chronic Infections of any type	<ul style="list-style-type: none"> <li>• Diagnosis/location/date</li> <li>• Number of episodes</li> <li>• Treatment plan</li> <li>• Medications/frequency</li> <li>•</li> </ul>	<p>Consider for tiering if released for more than one year</p> <p>Deny adults for active/frequent treatment or treatment within past year</p>

Body System	You Should Ask	Possible Action by Highmark - see page 1
-------------	----------------	--

Skin/Nails/Nair/Cosmetic		
Cellulitis	<ul style="list-style-type: none"> <li>Onset date</li> <li>Site of infection</li> <li>Treatment plan/released</li> <li>Associated conditions</li> <li>Medical records and/or statement recommended, if less than three months ago</li> </ul>	<p>Standard if resolved</p> <p>Consider tiering if recent, required hospitalization, is recurrent, or for underlying conditions</p> <p>Deny adults for current or frequent treatment</p>
Hair loss	<ul style="list-style-type: none"> <li>Treatment plan</li> <li>Associated medical condition</li> <li>Medical records recommended</li> </ul>	Individual consideration
Psoriasis	<ul style="list-style-type: none"> <li>Treatment plan/physician statement required</li> <li>Medications/frequency of use</li> </ul>	Individual consideration
Skin lesions/skin cancer/pre-cancer	<ul style="list-style-type: none"> <li>Frequency</li> <li>Site</li> <li>Onset/treatment dates</li> <li>Treatment plan</li> <li>Pathology reports strongly recommended</li> </ul>	<p>Individual consideration</p> <p>Standard for squamous cell pathology and if resolved and infrequent</p> <p>Consider for tiering based on cell type and frequency of follow up needed</p> <p>Deny adults for melanoma, if inconclusive, or for recent/frequent intervention</p>
Other skin conditions requiring treatment : acne/fungal infections/rosacea/rashes/dermatitis/warts/eczema/keratosis	<p>Specify diagnosis/date</p> <p>Medications/frequency of use</p> <p>Treatment type/surgery/date</p> <p>Treatment plan/physician statement recommended</p>	<p>Standard for minor treatment or treatment complete for more than six months and/or if clinical statement indicates release without complications</p> <p>Consider for tiering for multiple or costly medications</p> <p>Deny adults if severe, or for phototherapy, laser treatment, prescription accutane</p>
Cosmetic problems	<ul style="list-style-type: none"> <li>Full description/diagnosis/dates</li> </ul>	Individual consideration

Body System	You Should Ask	Possible Action by Highmark - see page 1
-------------	----------------	--

Skin/Nails/Nair/Cosmetic Cont.		
Wounds	<ul style="list-style-type: none"> <li>• Surgery type/date</li> <li>• Wound date</li> </ul> Treatment plan/physician statement recommended, if less than three months ago or long term	Standard if resolved
Sarcoidosis/scleroderma		Deny adults
Muscles/Bones		
Amputations	<ul style="list-style-type: none"> <li>• Exact site</li> <li>• Underlying condition/trauma</li> <li>• Durable medical equipment needed</li> <li>• Prosthetics in use or planned</li> </ul>	Standard if traumatic amputation of minor appendage with no prosthesis needed  Otherwise, individual consideration
Arthritis	<ul style="list-style-type: none"> <li>• Specify type</li> <li>• Therapy</li> <li>• Medications/frequency of use</li> <li>• Steroids/oral or injections</li> <li>• Treatment plan</li> </ul>	Individual consideration  Deny adults for rheumatoid disease
Fractures/joint replacement/pins/screws	<ul style="list-style-type: none"> <li>• Specify underlying condition</li> <li>• Surgery/treatment and date</li> <li>• Rehabilitation plan</li> <li>• Current range of motion</li> <li>• Release from care or follow-up visits</li> <li>• Hardware replacement/removal schedule</li> </ul>	Standard if healed and released from care with full function  Individual consideration if criteria not met
Bunion/foot conditions/plantar fasciitis	<ul style="list-style-type: none"> <li>• Specify diagnosis/type</li> <li>• Therapy/number/date range of visits</li> <li>• Surgery/date</li> <li>• Durable medical equipment/treatment</li> <li>• Release from care/date</li> </ul>	Approved if treatment completed and released  Deny adults for surgery or recent or ongoing treatment, or if durable medical equipment is required
Carpal tunnel syndrome	<ul style="list-style-type: none"> <li>• Medications/pain management</li> <li>• Surgery/treatment/therapy/date</li> <li>• Splint/durable medical equipment</li> <li>• Release from care/date</li> </ul>	Standard if resolved and released from care  Individual consideration if criteria not met

Body System	You Should Ask	Possible Action by Highmark - see page 1
-------------	----------------	--

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

<b>Body System</b>	<b>• You Should Ask</b>	<b>Possible Action by Highmark - see page 1</b>
--------------------	-------------------------	---

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

Body System	You Should Ask	Possible Action by Highmark - see page 1
-------------	----------------	--

Brain/Spine/Nervous System Cont.		
Dizziness/Meuniere's disease/fainting	<ul style="list-style-type: none"> <li>• Diagnosis/date</li> <li>• Associated conditions</li> <li>• Medications and frequency of use</li> <li>• Current symptoms</li> <li>• Activity limitations</li> <li>• ER/hospital admission/date</li> </ul>	<p>Consider for tiering if well controlled or for minor treatment</p> <p>Deny adults for severe, active treatment, current associated conditions</p>
Tremors/essential or familial/restless leg syndrome	<ul style="list-style-type: none"> <li>• Diagnosis/date</li> <li>• Medications/frequency of use</li> <li>• Associated conditions</li> </ul>	Individual consideration
Stroke/cerebral vascular accident/transient ischemic attack		Deny adults
Mental retardation/Down's syndrome		Deny adults

Reproductive System - Female		
Breast augmentation	<ul style="list-style-type: none"> <li>• Date of augmentation</li> <li>• Removal/replacement of prosthesis/date</li> </ul>	<p>Deny adults for surgery within past year</p> <p>Consider for tiering if more than one year</p>
Breast problems/fibrocystic breasts/mastitis/lumps/lumpectomy/mastectomy	<ul style="list-style-type: none"> <li>• Diagnosis/date</li> <li>• Treatment/surgery/date</li> <li>• Medications/schedule</li> <li>• Therapy</li> <li>• Release from care</li> <li>• Pathology reports recommended for biopsy/surgery</li> </ul>	Individual consideration

<b>Body System</b>	<b>• You Should Ask</b>	<b>Possible Action by Highmark - see page 1</b>
--------------------	-------------------------	---

<b>Reproductive System – Female Cont.</b>		
Childbirth (most recent)	<ul style="list-style-type: none"> <li>• Date of birth</li> <li>• Postpartum office release date required</li> </ul>	Standard if released from care
Miscarriage/date/complications	<ul style="list-style-type: none"> <li>• Dates</li> <li>• Treatments/surgery</li> <li>• Complications</li> <li>• Medication</li> <li>• Ongoing treatment plan</li> </ul>	Standard if more than one month and no complications
Female fertility	<ul style="list-style-type: none"> <li>• Last menstrual period required for all females ages 18 to 50</li> <li>• Reason for no period in past month</li> <li>• Diagnosis/date</li> <li>• Medications/intervention</li> <li>• Infertility/fertility treatment</li> <li>• Pregnancies/delivery dates</li> </ul>	<p>Standard if successful and no longer seeking fertility treatment</p> <p>Deny for pregnancy, planned adoption or surrogacy</p> <p>Deny adults for active or anticipated fertility treatment</p>
PAP test (females age 18 and older)	<ul style="list-style-type: none"> <li>• PAP test results/dates recommended for all females 18 and older</li> <li>• Treatment/monitoring plan required for all abnormal results</li> <li>• Treatment follow-up results required</li> </ul>	Individual consideration
Infectious disease/sexually transmitted disease/genital warts/chlamydia/human papilloma virus/syphilis/gonorrhea/herpes	<ul style="list-style-type: none"> <li>• Diagnosis/date</li> <li>• Treatment plan</li> </ul>	Standard if treatment completed and no complications.
Menstrual problems/fibroids/endometriosis	<ul style="list-style-type: none"> <li>• Diagnosis/date</li> <li>• Treatments</li> <li>• Surgery</li> <li>• Medication</li> <li>• Residual complications</li> </ul>	Individual consideration

Body System	You Should Ask	Possible Action by Highmark - see page 1
-------------	----------------	--

Reproductive System – Female Cont.		
Ovarian cysts	<ul style="list-style-type: none"> <li>• Diagnosis/date</li> <li>• Treatment</li> <li>• Surgery</li> <li>• Medications</li> </ul>	<p>Standard for surgical correction more than six months ago and released</p> <p>Deny adults if recently diagnosed, pending surgery, or for drugs other than birth control pills</p>
Sexual issues/transgender/dysfunction	<ul style="list-style-type: none"> <li>• Treatment</li> <li>• Prosthesis</li> <li>• Sexual alterations</li> </ul>	Deny adults

Body System	You Should Ask	Possible Action by Highmark - see page 1
-------------	----------------	--

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

Body System	You Should Ask	Possible Action by Highmark - see page 1
-------------	----------------	--

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

<b>Body System</b>	<b>• You Should Ask</b>	<b>Possible Action by Highmark - see page 1</b>
--------------------	-------------------------	---

<b>Respiratory Cont.</b>		
Emphysema/chronic obstructive pulmonary disease/other lung disease or work-related breathing problems	<ul style="list-style-type: none"> <li>• Diagnosis/date</li> </ul>	Deny adults
Cystic fibrosis/pulmonary fibrosis		Deny adults

<b>Other Conditions</b>		
Accident/injury	<ul style="list-style-type: none"> <li>• Specify/describe</li> <li>• Dates</li> <li>• Treatment/dates</li> </ul>	Individual consideration
Birth conditions/congenital abnormalities	<ul style="list-style-type: none"> <li>• Specify/describe</li> <li>• Dates</li> <li>• Treatment/dates</li> </ul>	Individual consideration
Organ transplant recipient		Deny adults