## Unit 1 Highmark Blue Shield Indemnity Products

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Unit 1  Highmark Blue Shield Indemnity Products

Under **indemnity programs**, Highmark Blue Shield members can seek care directly from any participating provider, without coordination from a primary care physician. So long as the service is covered under the member’s benefit plan and all the necessary conditions are met, the facility is reimbursed according to the terms of its hospital contract. Indemnity programs offer the greatest degree of member choice among all Highmark Blue Shield products.

Highmark Blue Shield offers four indemnity products:

- **ClassicBlue** indemnity for group customers
- **ClassicBlue** indemnity for individual, direct-pay customers
- **MedigapBlue** Medicare supplemental coverage for individual, direct-pay customers
- **Signature 65** coverage for group customers also eligible for Medicare

The foundation of the Highmark Blue Shield indemnity programs is the **Participating Provider Network** of professional and ancillary providers, along with the Highmark Blue Shield network of contracted institutional providers.

- **Institutional providers** include hospitals, skilled nursing facilities, home health agencies, hospices, dialysis providers and other kinds of medical facilities.

- **Professional providers** include primary care physicians (such as internists and pediatricians) and specialty practitioners.

- **Ancillary providers** include suppliers of home infusion therapy, durable medical equipment, orthotics and prosthetics, ambulance transportation and other services which do not fall in one of the above categories.
Unit 1 ClassicBlue Indemnity

Components of ClassicBlue indemnity

The three components of ClassicBlue indemnity programs are:

- Hospital/institutional
- Medical/surgical
- Major Medical

An individual member’s benefit plan may provide any or all of these types of coverage.

What’s covered under each component

While the particulars of coverage may vary from one employer group to another, these generalizations can be made about the kinds of services covered under each component:

- The *hospital/institutional* portion of ClassicBlue indemnity benefit plans typically cover inpatient and outpatient care provided by a Highmark Blue Shield participating facility such as a hospital or a skilled nursing facility.

- The *medical/surgical* portion of ClassicBlue benefit plans typically covers the services of participating professional providers such as physicians.

- The *major medical* portion of ClassicBlue benefit plans typically considers eligible services such as durable medical equipment and professional office visits not covered by either of the other two components.
Unit 1 ClassicBlue: Traditional and Comprehensive Indemnity Programs

Two possible configurations of ClassicBlue

Employer groups (and individual direct-pay customers) can purchase ClassicBlue indemnity coverage in either of two configurations:

- ClassicBlue Traditional
- ClassicBlue Comprehensive

ClassicBlue Traditional

ClassicBlue Traditional differs from ClassicBlue Comprehensive primarily in the way it reimburses for covered services.

Under ClassicBlue Traditional programs, if a member receives hospital services, those charges are processed under the basic hospital/institutional portion of the benefit program, with covered services typically paid at 100% of the provider’s negotiated rate.

If the ClassicBlue Traditional member receives medical/surgical services, these charges are processed under the basic medical/surgical portion of the benefit program, with covered services typically paid at 100% of the provider’s reasonable charge.

The major medical component supplements these two coverage’s and typically provides coverage at 80% of the provider’s reasonable charge or negotiated rate, usually after an annual deductible.

ClassicBlue Comprehensive

Under ClassicBlue Comprehensive, the three components (basic hospital/institutional, basic medical/surgical and major medical) are combined into one product design. ClassicBlue Comprehensive typically provides coverage for the same types of services as ClassicBlue Traditional. However, an annual deductible and 20% member coinsurance typically apply to most services under this design.

Continued on next page
Unit 1 ClassicBlue: Traditional and Comprehensive Indemnity Programs, Continued

Reminder

If for any reason NaviNet is not available, eligibility and benefits information can be obtained by contacting Facility Customer Service at (866) 803-3708, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday.
Unit 1 Medical Management for ClassicBlue Indemnity

Medical management

Although ClassicBlue Traditional and Comprehensive plans do not include a “gatekeeper,” limited medical management processes do apply to these programs:

- All admissions to a hospital, rehabilitation hospital, skilled nursing facility or long-term acute-care hospital must be pre-certified by Healthcare Management Services (HMS), for both the Traditional and Comprehensive indemnity programs. For more information about pre-certifying admissions, please see page 1-2 of the Highmark Blue Shield Facility Manual for Care Management and Quality Improvement.

- All inpatient admissions for mental health and substance abuse must be authorized by Highmark Blue Shield Behavioral Health. Highmark Blue Shield Behavioral Health can be reached at (866) 803-3708, option 2, 24 hours a day, 7 days a week.

Provider-driven care management

Highmark Blue Shield’s network hospitals are responsible for initiating required pre-certifications and authorizations. If the pre-certification or authorization is not in place at the time of service, the claim will be denied, and the member cannot be billed for the services. This responsibility is known as provider-driven care management, and it applies to all Highmark Blue Shield products.

Receiving or verifying the authorization or pre-certification

Providers not electronically connected to Highmark Blue Shield ordinarily receive pre-certification or authorization information via a designated fax machine or through telephone contact with Healthcare Management Services. Healthcare Management Services can be reached at (866) 803-3708, option 1, between the hours of 8:30 a.m. and 7:00 p.m., Monday through Friday, and 8:30 a.m. to 4:30 p.m. on Saturdays and Sundays. The admitting or ordering physician may also be able to supply the authorization number for the admission or the service.

Continued on next page
Unit 1  Medical Management for ClassicBlue Indemnity, Continued

Hospitals can verify that the authorization has been provided for a scheduled admission by checking the NaviNet Referral/Authorization Inquiry function. If for any reason NaviNet is not available, authorization information may be available from the admitting/ordering physician or by contacting Healthcare Management Services at (866) 803-3708, option 1, during the hours of 8:30 a.m. to 7:00 p.m., Monday through Friday, and 8:30 a.m. to 4:30 p.m. on Saturdays and Sundays.

Authorization is not a guarantee of payment
When an authorization number is provided to the hospital, it serves as a statement about medical necessity and appropriateness; it is not a guarantee of payment. Payment is dependent upon whether the patient has coverage at the time the service is rendered and the type of coverage available under the member’s benefit plan. Some benefit plans may also impose deductibles, coinsurance, co-payments and/or maximums which may impact the payment provided. Consult the NaviNet Eligibility and Benefits function to obtain this information. If for any reason NaviNet is not available, eligibility and benefits information can be obtained by a number of electronic means, or by contacting Facility Customer Service at (866) 803-3708, during the hours of 8:00 a.m. through 4:30 p.m., Monday through Friday. For more information on electronic means for accessing eligibility or benefits information, please see Appendix A.

Criteria are available
The criteria which Healthcare Management Services uses to make its determinations are available upon request from Healthcare Management Services. For more information about these criteria, please see page 3-1 of the Highmark Blue Shield Facility Manual for Care Management and Quality Improvement.
Unit 1 Benefits for Members with ClassicBlue

The appropriate benefit is required

In all cases, the ClassicBlue member’s benefit program will pay for a service only if the appropriate benefits are available for that service. If the benefit does not exist, the claim will be denied, and the member is financially responsible for the service.

If no benefit exists

It is in the facility’s best interest to verify the member’s benefits before providing the service. If the ClassicBlue member’s benefit plan does not include the specific benefits needed for the service received, Highmark Blue Shield will not issue payment. If the member insists on receiving such a non-covered service, the hospital may have him or her sign a waiver formally accepting financial responsibility for it. With the signed waiver in hand, the hospital may then bill the member for the service.
Unit 1 MedigapBlue

MedigapBlue, Highmark Blue Shield’s Medicare supplemental product, is designed to assist beneficiaries by paying certain amounts not covered by the Medicare program. Depending upon the design of the program, a supplemental product can pay Medicare deductibles, coinsurances and/or other specific kinds of expenses.

Individual, direct-pay

MedigapBlue is Highmark Blue Shield’s Medicare supplemental product for individual, direct-pay customers.

Standardization among Medigap plans

1990’s Omnibus Budget Reconciliation Act required insurers throughout the United States to standardize the benefits available under their direct-pay Medigap products. The purpose of this standardization was to simplify seniors’ purchasing decisions for Medicare supplemental coverage. All “Plan A” products, for example, must provide the same benefits. Therefore, the only real points of comparison among the contenders would be price and customer service.

The legislation provided for a maximum of ten standardized benefit plans. States were permitted to limit these plans further, and the Commonwealth of Pennsylvania chose to eliminate three of the originally proposed benefit packages. All Pennsylvania insurers in the Medigap market are required to offer Plan A and Plan B; they may also offer Plans C, D, E, H and I.

Highmark Blue Shield has opted to offer Plans A, B, C, E, H and I.

Core benefits for all MedigapBlue plans

All six of the MedigapBlue benefit packages offered by Highmark Blue Shield provide the following core benefits:

- Hospital coinsurance for days 61 through 90
- Hospital coinsurance for Lifetime Reserve Days (days 91 through 150)
- 365 additional hospital days after Lifetime Reserve Days have been exhausted
- First three pints of blood (not covered by Medicare)
- Medicare Part B coinsurance

Continued on next page
Plan A offers only the core benefits described on the previous page. The table below compares the benefits available under the other five plans offered by Highmark Blue Shield:

### Standardized Benefits

<table>
<thead>
<tr>
<th>Item</th>
<th>Plan B</th>
<th>Plan C</th>
<th>Plan E</th>
<th>Plan H</th>
<th>Plan I</th>
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<tbody>
<tr>
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<td>Basic Drugs ($1250 annual maximum limit)</td>
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### Highmark Special Services

<table>
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<tr>
<th>Service</th>
<th>Plan B</th>
<th>Plan C</th>
<th>Plan E</th>
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Unit 1 Signature 65

Signature 65 is a Highmark Blue Shield group product, which provides coverage to supplement Medicare. Signature 65 includes the following core benefits:

- Medicare Part A deductible
- Hospital coinsurance for approved Medicare benefits
- 365 additional hospital days, of which up to 30 can be used for inpatient mental health or substance abuse treatment
- The first 3 pints of blood per calendar year
- Medicare Part B coinsurance