

# PRN

## Policy Review & News

Important information about Highmark Blue Shield  
www.highmarkblueshield.com

February 2004

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### News

#### Blue Shield extends HIPAA transaction and code set contingency plans deadline

Highmark Blue Shield will continue to accept and process electronic claims that are not in the HIPAA-compliant 4010A1 formats.

Blue Shield had announced in the December 2003 **PRN** that as of Feb. 29, 2004, it would no longer accept electronic claims in non-HIPAA-compliant formats. Blue Shield has decided to extend its HIPAA contingency plans because less than 70 percent of the electronic claims it receives are in the HIPAA-compliant format.

Watch for more information about Blue Shield’s HIPAA contingency plans in future issues of **PRN**.

If you have questions about how to submit your electronic claims, call EDI Operations at (800) 992-0246, or the Validator™ help desk at (866) 727-4941.



*Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. Blue Shield and the Shield symbol are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.*

## HIPAA claims submission tips

Here are some hints to help you submit HIPAA-compliant claims transactions:

- When you transmit a HIPAA-compliant claims transaction (837) to Highmark Blue Shield, you should retrieve a Functional Acknowledgment transaction (997). The 997 transaction will tell you if the transaction file was accepted or rejected. An accepted 997 only indicates that the transactions were structurally correct.

Within 24 hours of receiving an accepted 997 transaction, you should retrieve a Claim Acknowledgment transaction (277). A 277 transaction provides acceptance or rejection of claims by the payer on an individual claim basis. If individual claims are rejected, you must correct them and resubmit them.

If your claim transmission files receive a rejected 997 transaction, you must correct the files and retransmit them.

If you use a billing service, clearinghouse or software vendor, contact them about the retrieval of the 277 Claim Acknowledgment report.

Please continue to direct any inquiries about connectivity or the receipt of 997 transactions to EDI Operations at (800) 992-0246.

- When you report a Highmark Blue Shield provider number on an 837 HIPAA-compliant claims transaction, do not add leading zeros or alpha characters to the provider number.
- Batch claims for Independence Blue Cross, AmeriHealth New Jersey and AmeriHealth Delaware in their own functional group (GS to GE segments) with the appropriate payer (NAIC) code.

Here are the appropriate payer codes and member identification alphabetical prefixes for each of these payers. Do not submit claims with these alphabetical prefixes under payer code 54771. Please see Section 8, Professional Claim (837P), of the **Provider EDI Reference Guide** for more specific reporting information.

<b>Insurer</b>	<b>Payer or NAIC code</b>	<b>Member alphabetical prefixes</b>
Independence Blue Cross	54704	QCA, QCB, QCM This does not include members with Comp Select.
AmeriHealth New Jersey	60061	Q1 Includes all non-HMO and Comprehensive Major Medical members.
AmeriHealth Delaware	93688	Q2 Includes all non-HMO and Comprehensive Major Medical members.

Please call the Highmark Blue Shield HIPAA help desk at (866) 727-4941 or write to them at [HMhipaatst@highmark.com](mailto:HMhipaatst@highmark.com) if you have questions about how to submit HIPAA-compliant claims.

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## BlueCard reminders



Follow these helpful hints to simplify your BlueCard claim submissions:

- Always ask the patient for their current identification card. The identification card will carry a three-character alphabetical prefix at the beginning of the member's identification number. The alphabetical prefix is the key element used to identify and correctly route out-of-area BlueCard claims. Make sure that you always enter the alphabetical prefix along with the member's identification number on the claim.
- Now you can request online eligibility and benefit information for out-of-area members in NaviNet through BlueExchange. The BlueExchange transaction uses the standard HIPAA format for sharing member information across participating Blue Cross and Blue Shield plans.

Highmark Blue Shield will always acknowledge your inquiry. It will answer your questions as soon as the member's home plan sends a response to Highmark Blue Shield. The response times, as well as the amount of information returned, varies by plan. These variances arise from the flexibility allowed by HIPAA in the health plan compliance alternatives.

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You can continue to call BlueCard *Eligibility* at (800) 676-BLUE (2583). Be sure you have the member's current identification card before calling BlueCard *Eligibility* since the operator will ask you for the member's alphabetical prefix. The alphabetical prefix will help the operator to direct your call to the appropriate plan. Operators are available to assist you with membership and coverage questions Monday through Friday, 7 a.m.-10 p.m. EST.

- When a BlueCard member receives services in your office, Highmark Blue Shield will pay you directly, subject to the terms of your contract, for covered services. Therefore, you should not seek payment from the BlueCard member until you receive your final claim disposition from Highmark Blue Shield. As with any local member, you must accept Highmark Blue Shield's allowance as payment in full for covered services. You may ask for payment for any medically necessary non-covered services, copayments, deductibles or coinsurances from a BlueCard member prior to submission of a claim.
- If you are a participating provider with Highmark Blue Shield and you have signed a participation agreement with another Blue plan, please submit claims for members with coverage through that other Blue plan directly to that plan.

For example, if your office is in Pennsylvania and you participate with Highmark Blue Shield and with Horizon Blue Cross Blue Shield of New Jersey, send all claims for members with coverage through Horizon Blue Cross Blue Shield to Horizon Blue Cross Blue Shield. If you do not have an agreement with Horizon Blue Cross Blue Shield, then send all claims for Horizon Blue Cross Blue Shield members to:

Highmark Blue Shield  
PO Box 890062  
Camp Hill, Pa. 17089-0062

- Highmark Blue Shield requires you to file a claim directly with the Blue plan providing coverage to a member when:
  - you have a contract with the member's Blue plan, or
  - the member's identification card does not have an alphabetical prefix.

To find out more information about the BlueCard program visit the Blue Cross Blue Shield Association's Web site at [www.bcbs.com](http://www.bcbs.com).

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## **Report diagnosis codes to highest degree of specificity to avoid claim denials**

If you do not report diagnosis codes to the highest degree of specificity, according to the most current ICD-9-CM coding manual, Highmark Blue Shield will deny your claim. This requirement applies to electronic and paper claims. It also pertains to all Blue Shield products.

Report ICD-9-CM diagnosis codes to the fourth or fifth digit, when applicable. For example, when you submit a claim with a diagnosis of reflux esophagitis, you must report 530.11. Do not report code 530 (diseases of the esophagus) or 530.1 (esophagitis)—they are not acceptable.

For more information about reporting ICD-9-CM codes, see “Blue Shield to require most specific ICD-9-CM coding in 2002” in the December 2001 PRN and “Report diagnosis codes to the highest degree of specificity on all claims” in the April 2002 PRN.

## Policy

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### **Physical therapy, occupational therapy and athletic training evaluations guidelines clarified**

Highmark Blue Shield considers certain evaluation and management services an inherent part of a physical therapy evaluation (97001-97002), occupational therapy evaluation (97003-97004), or athletic training evaluation (97005-97006).

Blue Shield will not allow separate payment for these evaluation and management services when they're reported on the same day as a physical therapy, occupational therapy, or athletic training evaluation by the same or an affiliated health care professional:

99201-99205

99211-99215

99221-99223

99231-99233

99238-99239

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99301-99303

99311-99313

99315-99316

99321-99323

99331-99333

99341-99350

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## **How to report epidural anesthesia provided during labor and vaginal delivery**

Report code 01967—neuraxial labor analgesia for planned vaginal delivery—when you provide epidural anesthesia care during:

- labor only, or
- labor and vaginal delivery

The total time you report should reflect your actual time in personal attendance, that is, “face time” with the patient.

Highmark Blue Shield will base its payment for code 01967 on the appropriate number of anesthesia base units and the units for total time in attendance with the patient, either during labor or labor with vaginal delivery.

Report code 01960—anesthesia for vaginal delivery only—only when you provide anesthesia care for a vaginal delivery not including labor. Do not report code 01960 in addition to code 01967.

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## **Fetal nuchal translucency considered investigational**

Highmark Blue Shield does not cover fetal nuchal translucency for any use, including first trimester screening for chromosomal abnormalities such as Down syndrome. Blue Shield considers this procedure investigational. A participating, preferred or network provider can bill the member for services denied as investigational.

The technique for measuring nuchal translucency and the criteria for defining increased nuchal translucency have not yet been standardized in the clinical setting. Additional supporting short and long term studies involving larger numbers of patients are needed to confirm the effectiveness of first trimester nuchal translucency, with or without serum markers, before this modality can be accepted for routine clinical use.

Use code 76999—unlisted ultrasound procedure—to report fetal nuchal translucency. When you report unlisted code 76999, please include a complete description of the procedure in the narrative field of the electronic or paper claim.

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## **Deep brain stimulation eligible for treatment of dystonia**

Highmark Blue Shield now covers deep brain stimulation when it's used to treat chronic, intractable (drug refractory) primary dystonia (diagnosis code 333.6). This coverage includes generalized and/or segmental dystonia, hemidystonia and cervical dystonia (torticollis) in patients seven years of age or older.

Before, Blue Shield covered deep brain stimulation only when it was used to control tremors due to essential tremor (diagnosis code 333.1) or Parkinson's disease (diagnosis code 332.0).

Use code 61863, 61864, 61867 or 61868 to report deep brain stimulation.

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## **Blue Shield revises coverage guidelines for antiembolism stockings and elastic stockings**

Highmark Blue Shield pays for antiembolism stockings and elastic stockings when they're medically necessary for the treatment of an illness or injury. A health care professional must prescribe the stockings.

Beginning April 13, 2004, Blue Shield will limit coverage for antiembolism stockings to three pairs in a six-month period. As a result, Blue Shield will only pay for three pairs of elastic stockings in a six-month period.

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## **Bravo pH monitoring system not covered**

Highmark Blue Shield considers 48-hour catheter-free, wireless esophageal pH monitoring, that is, Bravo pH monitoring system, investigational. There is a lack of published data about the Bravo pH monitoring system in peer reviewed medical journals. It is also unclear as to whether this service provides any additional health benefits in comparison to conventional 24-hour monitoring systems.

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When Blue Shield denies this monitoring system, a participating, preferred or network provider can bill the member for the denied service.

Use procedure code 91299 to report 48-hour catheter-free, wireless esophageal pH monitoring. When you report unlisted code 91299, please provide a complete description of the service in the narrative field of the electronic or paper claim.

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## **Reporting guidelines for mammography with computer aided detection revised**

As of Jan. 1, 2004, you can use procedure code 76082 or 76083 to report computer aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of the film radiographic images.

Highmark Blue Shield considers 76082 and 76083 “add-on” codes. Do not report these codes as unique or separate services. Report code 76082 or 76083, as appropriate, in addition to the primary mammography service or procedure.

### **How to report mammography procedures with CAD**

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Use code 76082 to report CAD with an appropriate diagnostic mammography code, either 76090 or 76091.

Report code 76083 for CAD with screening mammography, code 76092.

A new procedure code, S8075, is now available for reporting CAD of full field digital mammograms with further health care professional review. Report code S8075 only with an appropriate code for full field digital mammography studies—G0202, G0204 or G0206.

Report code 76082, 76083 or S8075 with the primary mammography procedure with which it is performed. If you report code 76082, 76083 or S8075 without the appropriate mammography code, Blue Shield will deny the service. In this case, a participating, preferred or network provider cannot bill the member for the denied service.



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## **Endoscopic injectable and bulk-forming agents for treating GERD considered experimental**

Highmark Blue Shield considers these procedures experimental or investigational when they're used to treat gastroesophageal reflux disease:

- implantation of a biocompatible polymer, for example, Enteryx
- endoscopic submucosal implantation of polymethylmethacrylate (PMMA) beads into the LES folds

There is a lack of published data in peer-reviewed journals to determine the safety and effectiveness of these procedures. More studies are needed to determine their long-term effectiveness.

When Blue Shield denies these procedures, a participating, preferred or network provider can bill the member for the denied procedure.

To report either of these procedures, use code 43201—esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance.

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## **Blue Shield changes billable status for certain services**

Highmark Blue Shield considers these services not medically necessary. A participating, preferred or network provider cannot bill the member for these denied services.

<b>Code</b>	<b>Terminology</b>
93760	thermogram; cephalic
93762	thermogram; peripheral
95999	electrodynogram
96000	comprehensive computer-based motion analysis by video-taping and 3-D kinematics
96001	comprehensive computer-based motion analysis by video-taping and 3-D kinematics; with dynamic plantar pressure measurements during walking
96002	dynamic surface electromyography, during walking or other functional activities, 1-12 muscles

<b>Code</b>	<b>Terminology</b>
96003	dynamic fine wire electromyography, during walking or other functional activities, 1 muscle
96004	physician review and interpretation of comprehensive computer based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography with written report
S9033	gait analysis

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## **Percutaneous neuromodulation therapy is investigational**

Highmark Blue Shield considers percutaneous neuromodulation therapy (PNT) investigational. Even though the FDA has approved PNT, adequate studies demonstrating the long term safety and effectiveness have not been performed. Because of this, Blue Shield will not provide coverage for PNT. A participating, preferred or network provider can bill the member for the denied therapy.

Use code 64999 to report percutaneous neuromodulation therapy. When you report code 64999, remember to include a complete description of the service in the narrative field of the electronic or paper claim.

Percutaneous neuromodulation therapy is a new modality developed for the treatment of chronic intractable low back pain. PNT delivers electrical stimulation percutaneously to the deep tissues near the spine through an anatomically defined array of temporarily placed electrodes. The electrodes help deliver electrical stimulation to peripheral nerve pathways.

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## **Blue Shield considers pneumatic compression devices to treat arterial insufficiency investigational**

Highmark Blue Shield does not provide coverage for a pneumatic compression device when it's used in the treatment of arterial insufficiency. Blue Shield considers the device investigational in this instance. When Blue Shield denies the device as investigational, a participating, preferred or network provider can bill the member for the device.

More studies are needed to determine the long-term effectiveness of the pneumatic compression device.

Use code E0675—pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)—to report a pneumatic compression device used in the treatment of arterial insufficiency.

For information about pneumatic compression devices used to treat lymphedema or chronic venous insufficiency, see “Coverage guidelines for intermittent pneumatic compression units explained” on Pages 16-17 in the August 2003 PRN.

## Codes

### Changes to 2004 HCPCS revision publication

The Centers for Medicare and Medicaid Services (CMS) has made changes to the 2004 HCPCS update. Please make these changes to your **2004 Revision Publication**:

<b>Code</b>	<b>Terminology</b>	<b>Action</b>
E1019	Wheelchair accessory, power seating system, heavy duty feature, patient weight capacity greater than 250 pounds and less than or equal to 400 pounds	Delete
E1021	Wheelchair accessory, power seating system, extra heavy duty feature, patient weight capacity greater than 400 pounds	Delete
E1065	Power attachment (to convert any wheelchair to motorized wheelchair; e.g., solo)	Delete
G0110	NETT pulm-rehab; education/skills training, individual	Reinstated
G0111	NETT pulm-rehab; education/skills training, group	Reinstated
G0112	NETT pulm-rehab; nutritional guidance, initial	Reinstated
G0113	NETT pulm-rehab; nutritional guidance, subsequent	Reinstated
G0114	NETT pulm-rehab; psychosocial consultation	Reinstated
G0115	NETT pulm-rehab; psychological testing	Reinstated
G0116	NETT pulm-rehab; psychosocial counseling	Reinstated
G0256	Prostate brachytherapy using permanently implanted palladium seeds, including transperitoneal placement of needles or catheters into the prostate, cystoscopy and application of permanent interstitial radiation source	Delete

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<b>Code</b>	<b>Terminology</b>	<b>Action</b>
G0261	Prostate brachytherapy using permanently implanted iodine seeds, including transperitoneal placement of needles or catheters into the prostate, cystoscopy and application of permanent interstitial radiation source	Delete
G0308	End stage renal disease (ESRD) related services full month, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month	Add
G0309	End stage renal disease (ESRD) related services per full month, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month	Add
G0310	End stage renal disease (ESRD) related services per full month, for patients under 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month	Add
G0311	End stage renal disease (ESRD) related services per full month, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month	Add
G0312	End stage renal disease (ESRD) related services per full month, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month	Add
G0313	End stage renal disease (ESRD) related services per full month, for patients between 2 and 11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month	Add
G0314	End stage renal disease (ESRD) related services per full month, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month	Add
G0315	End stage renal disease (ESRD) related services per full month, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month	Add

<b>Code</b>	<b>Terminology</b>	<b>Action</b>
G0316	End stage renal disease (ESRD) related services per full month, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month	Add
G0317	End stage renal disease (ESRD) related services per full month, for patients 20 years of age and over; with 4 or more face-to-face physician visits per month	Add
G0318	End stage renal disease (ESRD) related services per full month, for patients 20 years of age and over; with 2 or 3 face-to-face physician visits per month	Add
G0319	End stage renal disease (ESRD) related services per full month, for patients 20 years of age and over; with 1 face-to-face physician visit per month	Add
G0320	End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients under two years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents	Add
G0321	End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients two to eleven years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents	Add
G0322	End stage renal disease (ESRD) related services for home dialysis patients per full month; for patients twelve to nineteen years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents	Add
G0323	End stage renal disease (ESRD) related services for home dialysis per full month; for patients twenty years of age and older	Add
G0324	End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients under two years of age	Add
G0325	End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between two and eleven years of age	Add
G0326	End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients between twelve and nineteen years of age	Add

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<b>Code</b>	<b>Terminology</b>	<b>Action</b>
G0327	End stage renal disease (ESRD) related services for home dialysis (less than full month), per day; for patients twenty years of age and over	Add
G0338	Linear-accelerator-based stereotactic radiosurgery plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment	Add
G0339	Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment	Add
G0340	Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment	Add

Note: Highmark Blue Shield reimburses health care professionals' services provided to dialysis patients on a fee-for-service basis, rather than a capitated payment rate. This applies to codes G0308, G0309, G0310, G0311, G0312, G0313, G0314, G0315, G0316, G0317, G0318, G0319, G0320, G0321, G0322, G0323, G0324, G0325, G0326 and G0327.

## Patient News – Information about your patients who are Highmark Blue Shield customers

### Central and Eastern Region

#### **SelectBlue requires authorization for out-of-network facility services**

Highmark Blue Shield's facility network supports Blue Shield's SelectBlue product in the 21 counties of central Pennsylvania and the Lehigh Valley.

If your Highmark Blue Shield SelectBlue patient requires services at a facility outside of these 21 counties, you must request an out-of-network authorization from Blue Shield's Healthcare Management Services. To obtain authorization, contact Healthcare Management Services through NaviNet or call them at (866) 731-8080.

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## Line Construction Benefit Fund selects PPO BlueCard



Beginning Sept. 1, 2003, Line Construction Benefit Fund (LCBF) switched to a BlueCard PPO processing arrangement. Before Sept. 1, 2003, claims for LCBF members were filed directly with the Labor Group. Now you can submit claims for LCBF members through BlueCard.

You can identify an LCBF member by the LCB alphabetical prefix on their identification card. Always include the LCB alphabetical prefix with the member's identification number on their claims.

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## Need to change your provider information?

### **Fax the information to us!**

You can fax us changes about your practice information, such as the information listed on the coupon below. The fax number is (866) 731-2896. You may also continue to send information by completing the coupon below.

### **Coupon for changes to provider information**

Please clip and mail this coupon, leaving the PRN mailing label attached to the reverse side, to:

Highmark Blue Shield  
Provider Data Services  
PO Box 898842  
Camp Hill, Pa. 17089-8842

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Name \_\_\_\_\_ Provider ID number \_\_\_\_\_

Electronic media claims source number \_\_\_\_\_

Please make the following changes to my provider records:

Practice name \_\_\_\_\_

Practice address \_\_\_\_\_

Mailing address \_\_\_\_\_

Telephone number ( ) \_\_\_\_\_ Fax number ( ) \_\_\_\_\_

E-mail address \_\_\_\_\_

Tax ID number \_\_\_\_\_

Specialty \_\_\_\_\_

Provider's signature \_\_\_\_\_ Date signed \_\_\_\_\_

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### Acknowledgement

The five-digit numeric codes that appear in **PRN** were obtained from the Current Procedural Terminology, as contained in CPT-2004, Copyright 2003, by the American Medical Association. **PRN** includes CPT descriptive terms and numeric procedure codes and modifiers that are copyrighted by the American Medical Association. These procedure codes and modifiers are used for reporting medical services and procedures.

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