All these benefits.
All for you.

With a great plan, it’s all in the details.

That’s why whoever you are, we make it easy to find affordable, quality care.

HIGHMARK

PPO Blue
County of Allegheny

Hi there,

We know choosing coverage is about more than just your health care. It's about peace of mind. That's why when you choose Highmark for your coverage, you get a plan that's simple to understand, easy to use, and easy to love.

With Highmark, you get access to personalized wellness programs, handy online tools, and 24/7 support for any questions you might have along the way.

We look forward to making it easier for you to feel your best.

Deborah L. Rice-Johnson
President, Highmark Health Plans

Contents

Why Highmark

BLUES ON CALL℠

Answers from a health pro, 24/7.

Medical concerns during off hours? Just call the phone number on the back of your ID card or from the Highmark app to get support from a registered nurse or a health coach any time and put your worries to bed.

MY CARE NAVIGATOR

Your appointments, booked for you.

It's as simple as calling the phone number on the back of your ID card or from the Highmark app. We'll help you find the in-network doctor you need and reserve some space on their calendar for a checkup. Which means less on-hold music for you.

TELEMEDICINE

Face-to-face with a doctor, 24/7.

Need to see a doctor but can't get to their office? Get a diagnosis, treatment plan, or prescription any time, right from your phone or computer. You can register at **amwell.com or doctorondemand.com** via the mobile app, or over the phone using the number on the back of your member ID card. That's laid-back-in-a-recliner easy.

EMERGENCY CARE

When you need it most, you're covered.

Emergency care is always covered at the in-network level of benefits, wherever you get it. So don't hesitate. If it's an emergency, go straight to the nearest emergency room or dial 911.

WORLDWIDE CARE

Support around the globe.

No matter where you travel, the Blue Cross Blue Shield Global® Core Program gives you access to providers for your health care needs. For worldwide help, just call 1-800-810-BLUE.

MENTAL HEALTH CARE

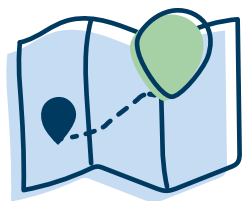
Get care for your mind, too.

Highmark covers a wide range of mental health services, including counseling and treatment. You get a choice of providers so the level and type of care fits your situation best.

SUBSTANCE ABUSE CARE

Guidance to keep you on track.

Highmark covers a spectrum of substance abuse services. Pick the substance abuse professional you feel will give you the necessary care from our list of providers.



AHN LOCAL ACCESS

Expert care, close to home.

Allegheny Health Network (AHN), an in-network provider, invests big in a patient-first approach to care. Between new construction and hospital expansions, you've got easy access to high-quality, affordable health care services. Visit ahn.org.

JOHNS HOPKINS COLLABORATION

Expert teamwork for advanced care.

Highmark collaborates with some of the best minds, like Johns Hopkins, for cancer research. That lets us bring the latest medical breakthroughs right to your neighborhood.

MATERNITY CARE

Caring for moms is about so much more than labor and delivery.

With Highmark, you get access to numerous facilities designed around comprehensive women's care, personal attention, and a family-centered approach during this special time.

You also have access to programs focused on advanced technology and expertise in neonatal care and OB-GYN specialty care.

- OB-GYNs specializing in high-risk pregnancy, maternal fetal medicine, and fertility
- Board-certified pediatricians and pediatric subspecialists
- Childbirth and certified lactation experts
- Behavioral health specialists for emotional support such as the Alexis Joy D'Achille Center for Perinatal Mental Health at Allegheny Health Network's West Penn Hospital

Alexis Joy D'Achille Center for Perinatal Mental Health

The first of its kind in western Pennsylvania and one of only a handful in the nation, the center provides research, information, and specialized treatment around perinatal depression, anxiety, bipolar disorder, and infant loss. The center's main focus is keeping mothers physically and emotionally connected to their children throughout the healing process.

Baby Blueprints® Program

Pregnancy can be exciting and overwhelming all at once. That's why Highmark's Baby Blueprints® program guides you every step of the way. It's a no-cost program that provides you with educational resources and personalized attention from your own specially trained health coach.

Call 1-866-918-5267 to take advantage of Baby Blueprints today.

Product Information /Benefit Summary

PPOBlue

Here's how Highmark makes it simple for you:

Nationwide access to providers through the BlueCard® program.

Access to the largest physician and hospital networks in the U.S. with over 1.7 million providers, including 95% of all hospitals.*

And when you travel globally, you're covered in 190 countries through the Blue Cross Blue Shield Global® Core program.

Easy access to top-performing specialists.

Many of our network specialists have earned Blue Distinction status for their exceptional safety and results. That means great specialty care for you, across the board. Easy-peasy.

Total support, day or night.

Whether it's 24/7 answers from registered nurses, a diagnosis or prescription over video visit, or just some help booking your doctor visits, when you need us, we're there.

And you're covered close to home, too.

Our network covers western Pennsylvania with easy access to more than 50 hospitals and more than 11,400 doctors. From behavioral health to cancer care to cardiology, children's health to neuroscience to women's care, we've got you covered for local specialty care, too. From behavioral health to cancer care to cardiology, children's health to neuroscience to women's care, we've got you covered for local specialty care, too.

Need help finding top-quality doctors and hospitals?

To search for in-network providers:

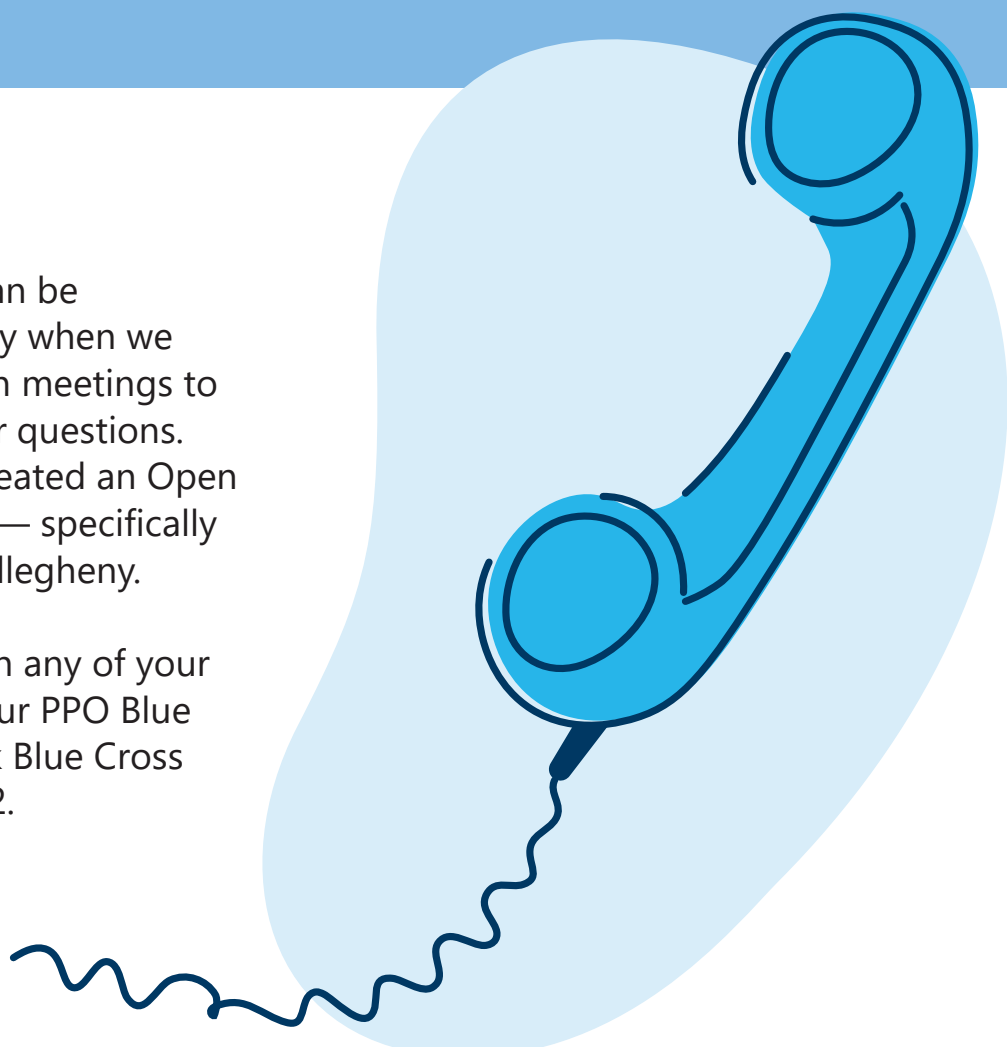
1. Go to **highmarkbcbs.com/find-a-doctor**.
2. Choose **Medical** and select **Continue**.
3. Select **Continue** to browse.
4. Enter your ZIP code.
5. Choose a plan from the list.
6. Type a name or specialty into the search window.

You can still use out-of-network providers, but it may cost you more. So, check that a provider is in network before you get care.

For over-the-phone help, call Member Service at the number on the back of your ID card.

*According to the Blue Cross Blue Shield Association.

We have the answers to your Open Enrollment questions.



Open Enrollment can be confusing, especially when we can't hold in-person meetings to help with all of your questions. That's why we've created an Open Enrollment hotline — specifically for the County of Allegheny.

Call this hotline with any of your questions about your PPO Blue plan with Highmark Blue Cross Blue Shield for 2022.

Just call **1-800-215-7865** and provide the reference code: **P0020920**.

We're ready to answer your questions, Monday – Friday, 8 a.m. – 8 p.m., October 25 through November 19.

Flip this flyer over to see a quick list of what our representatives can help you with.

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ALLEGHENY COUNTY
ALWAYS INSPIRING

Call 1-800-215-7865 and provide the reference code P0020920 for any questions about:

Our website, highmarkbcbs.com

- Navigational tips
- How to find providers
- Member discounts
- Cost comparisons
- Password resets

Provider information

- How to find a provider
- Verifying a provider's network participation
- Verifying pharmacy participation

Information on your benefits

- Differences between deductibles, coinsurance, and out-of-pocket expenses
- Explanation of accumulations
- Copay costs for primary care physicians, specialists, emergency room, urgent care, and retail clinics
- Telemedicine services
- Eligibility and member cost sharing for specific prescription drugs
- Requirements for authorization

10/20 MX235153

HIGHMARK

As you are probably aware, Highmark and UPMC reached a 10-year agreement that ensures broad access to UPMC hospitals and physicians for many Highmark members.

This is great news for health care consumers in western Pennsylvania like you. You now have an even larger range of high-quality health care options to choose from.

We've been able to deliver on our commitment to preserve access to quality health care in our communities. Today and in the future, we remain dedicated to making sure all of our members have access to the highest-quality health care.

These UPMC hospitals and other providers listed below are **in-network** for you since July 1, 2019.

Magee-Women's Hospital of UPMC	UPMC Hamot	UPMC Northwest
UPMC East	UPMC Altoona	UPMC Somerset
UPMC Mercy	UPMC Bedford	Western Psychiatric Institute and Clinic of UPMC
UPMC McKeesport	UPMC Cole	Children's Hospital of Pittsburgh of UPMC (including oncology and all affiliated pediatric practices)
UPMC Passavant	UPMC Horizon	Over 20 additional UPMC and other community hospital cancer centers
UPMC Presbyterian Shadyside	UPMC Jameson	Doctors affiliated with hospitals listed
UPMC St. Margaret	UPMC Kane	

- **Should you have any questions, please call My Care Navigator at 1-888-258-3428 (TTY users may call 711) between 8 a.m. and 8 p.m., Monday – Friday.**

09/20 Z MX181703

ALLEGHENY COUNTY
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Summary of PPOBlue Benefits

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Allegheny County Standard Plan **Groups #017934-00, 06, 70, 80**

Benefit	In Network	Out of Network
General Provisions		
Effective Date	January 1, 2022	
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) Individual Family	 $400 $800	 $4,500 $13,500
Plan Pays – payment based on the plan allowance	100% after deductible	50% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 $5,000 $15,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $7,150 $14,300	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after $30 copay	50% after deductible
Primary Care Provider Office Visits	100% after $30 copay	50% after deductible
Specialist Office Visits	100% after $30 copay	50% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	50% after deductible
Urgent Care Center Visits	100% after $30 copay	50% after deductible
Virtual Visits (PCP, Specialist, Retail Clinic)	100% after $15 copay	50% after deductible
Telemedicine Services (3)	100% after $15 copay	Not Applicable
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 50% after deductible
Adult Immunizations	100% (deductible does not apply)	not covered
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	50% after deductible
Mammograms, Annual Routine	100% (deductible does not apply)	50% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 not covered
Pediatric Immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible
Emergency Services		
Emergency Room Services	100% after $100 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency (5)	100% after deductible	100% after in-network deductible for emergencies; 50% after out-of-network deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	50% after deductible

Benefit	In Network	Out of Network
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	50% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $30 copay	50% after deductible
Respiratory Therapy	100% after deductible	50% after deductible
Speech Therapy	100% after $30 copay	50% after deductible
Occupational Therapy	100% after $30 copay	50% after deductible
Spinal Manipulations	100% after $30 copay limit: 20 visits/benefit period	50% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	50% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	50% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $30 copay	50% after deductible
Outpatient Substance Abuse Services	100% after $30 copay	50% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	50% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (6)	100% after deductible	50% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	100% after deductible	50% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	50% after deductible
Home Health Care	100% after deductible	50% after deductible benefit maximum of 100 visits/benefit period
Hospice	100% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (7)	100% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	50% after deductible
Skilled Nursing Facility Care	100% after deductible	50% after deductible
Transplant Services	100% after deductible	50% after deductible
Precertification Requirements (8)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	None None	
Prescription Drug Program (9) Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the National Select Formulary with an Incentive Benefit Design **Select Specialty Drugs are limited to 30-day Supply**	**(Prescriptions filled at non-network pharmacy are not covered)** **Retail Drugs (30-day Supply)** $10 generic copay $25 Formulary brand copay $50 Non-Formulary brand copay Mandatory Generic (8) 30-day supply **Maintenance Drugs through Mail Order (90-day Supply)** $20 generic copay $50 Formulary brand copay $100 Non-Formulary brand copay Mandatory Generic (8) 90-day supply	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits.
(6) Coverage for eligible members to age 21. After initial analysis, services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
(7) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(8) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.
(9) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed. Your plan requires that you use Alliance Rx Walgreens Prime or Giant Eagle specialty pharmacies for select specialty medications. To obtain medications for hemophilia, you must use a specific pharmacy, please contact member services for more details.

Preventive Schedule

What's preventive care?

When you're healthy, preventive care helps you stay that way. For most plans, if you see an in-network provider, essentials like scheduled shots, routine screenings, physicals, and breast exams are 100% covered.

2021 Preventive Schedule

Effective 7/1/2021

Plan your care: Know what you need and when to get it

Preventive or routine care helps us stay well or finds problems early, when they are easier to treat. The preventive guidelines on this schedule depend on your age, gender, health, and family history. As a part of your health plan, you may be eligible to receive some of these preventive benefits with little to no cost sharing when using in-network providers. Make sure you know what is covered by your health plan and any requirements before you receive any of these services.

Some services and their frequency may depend on your doctor's advice. That's why it's important to talk with your doctor about the services that are right for you. CHIP members may have additional preventive services and coverage. Please check the CHIP member booklet for further details of CHIP coverage of preventive services.

Questions?

- Call Member Service
- Ask your doctor
- Log in to your account

Adults: Ages 19+

Female Male

GENERAL HEALTH CARE	
Routine Checkup* (This exam is not the work- or school-related physical)	• Ages 19 to 49: Every 1 to 2 years • Ages 50 and older: Once a year
Depression Screening	Once a year
Illicit Drug Use Screening	Once a year
Pelvic, Breast Exam	Once a year
SCREENINGS/PROCEDURES	
Abdominal Aortic Aneurysm Screening	Ages 65 to 75 who have ever smoked: One-time screening
Ambulatory Blood Pressure Monitoring	To confirm new diagnosis of high blood pressure before starting treatment
Breast Cancer Genetic (BRCA) Screening (Requires prior authorization)	Those meeting specific high-risk criteria: One-time genetic assessment for breast and ovarian cancer risk
Cholesterol (Lipid) Screening	• Ages 20 and older: Once every 5 years • High-risk: More often
Colon Cancer Screening (Including Colonoscopy)	• Ages 50 and older: Every 1 to 10 years, depending on screening test • High-risk: Earlier or more frequently
Certain Colonoscopy Preps With Prescription	• Ages 50 and older: Once every 10 years • High-risk: Earlier or more frequently
Diabetes Screening	High-risk: Ages 40 and older, once every 3 years
Hepatitis B Screening	High-risk
Hepatitis C Screening	Ages 18-79
Latent Tuberculosis Screening	High-risk

* Routine checkup could include health history; physical; height, weight, and blood pressure measures; body mass index (BMI) assessment; counseling for obesity, fall prevention, skin cancer, and safety; depression screening; alcohol and drug abuse, and tobacco use assessment; age-appropriate guidance, and intimate partner violence screening and counseling for reproductive age women.

Adults: Ages 19+

SCREENINGS/PROCEDURES	
Lung Cancer Screening (Requires prior authorization and use of authorized facility)	Ages 55 to 80 with 30-pack per year history: Once a year for current smokers, or once a year if currently smoking or quit within past 15 years
Mammogram	Ages 40 and older: Once a year including 3D
Osteoporosis (Bone Mineral Density) Screening	Ages 65 and older: Once every 2 years, or younger if at risk as recommended by physician
Cervical Cancer Screening	• Ages 21 to 65 Pap: Every 3 years, or annually, per doctor's advice • Ages 30 to 65: Every 5 years if HPV only or combined Pap and HPV are negative • Ages 65 and older: Per doctor's advice
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)	• Sexually active males and females • HIV screening for adults to age 65 in the general population and those at risk, then screening over age 65 with risk factors
IMMUNIZATIONS**	
Chicken Pox (Varicella)	Adults with no history of chicken pox: One 2-dose series
Diphtheria, Tetanus (Td/Tdap)	One dose Tdap, then Td or Tdap booster every 10 years
Flu (Influenza)	Every year (Must get at your PCP's office or designated pharmacy vaccination provider; call Member Service to verify that your vaccination provider is in the Highmark network)
Haemophilus Influenzae Type B (Hib)	For adults with certain medical conditions to prevent meningitis, pneumonia, and other serious infections; this vaccine does not provide protection against the flu and does not replace the annual flu vaccine
Hepatitis A	At-risk or per doctor's advice: One 2- or 3-dose series
Hepatitis B	At-risk or per doctor's advice: One 2- or 3-dose series
Human Papillomavirus (HPV)	• To age 26: One 3-dose series • Ages 27-45, at-risk or per doctor's advice
Measles, Mumps, Rubella (MMR)	One or two doses
Meningitis*	At-risk or per doctor's advice
Pneumonia	High-risk or ages 65 and older: One or two doses, per lifetime
Shingles	Shingrix - Ages 50 and older: Two doses
PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Aspirin	• Ages 50 to 59, to reduce the risk of stroke and heart attack • Pregnant women at risk for preeclampsia
Folic Acid	Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid
Chemoprevention drugs such as raloxifene, tamoxifen, or aromatase* inhibitor**	At risk for breast cancer, without a cancer diagnosis, ages 35 and older

* Meningococcal B vaccine per doctor's advice.
** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.
*** Aromatase inhibitors when the other drugs can't be used such as when there is a contraindication or they are not tolerated.

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Tobacco Cessation (Counseling and medication)	Adults who use tobacco products
Low to Moderate Dose Select Generic Statin Drugs for Prevention of Cardiovascular Disease (CVD)	Ages 40 to 75 years with 1 or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and have calculated 10-year risk of a cardiovascular event of 10% or greater
Select PrEP Drugs for Prevention of HIV Infection	Adults at risk for HIV infection, without an HIV diagnosis
PREVENTIVE CARE FOR PREGNANT WOMEN	
Screenings and Procedures	• Gestational diabetes screening • Hepatitis B screening and immunization, if needed • HIV screening • Syphilis screening • Smoking cessation counseling • Depression screening during pregnancy and postpartum • Depression prevention counseling during pregnancy and postpartum • Rh typing at first visit • Rh antibody testing for Rh-negative women • Tdap with every pregnancy • Urine culture and sensitivity at first visit • Alcohol misuse screening and counseling
PREVENTION OF OBESITY, HEART DISEASE, DIABETES, AND STROKE	
Adults with BMI 25 to 29.9 (overweight) and 30 to 39.9 (obese) are eligible for:	• Additional annual preventive office visits specifically for obesity and blood pressure measurement • Additional nutritional counseling visits specifically for obesity • Recommended lab tests: – ALT – AST – Hemoglobin A1c or fasting glucose – Cholesterol screening
Adults with a diagnosis of Hypertension, High Blood Pressure, Dyslipidemia, or Metabolic Syndrome **Adults with BMI 40 and over**	Nutritional counseling
ADULT DIABETES PREVENTION PROGRAM (DPP)	
Applies to Adults • Without a diagnosis of diabetes (does not include a history of gestational diabetes) • Overweight or obese (determined by BMI) • Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7% to 6.4% or Impaired Glucose Tolerance Test of 140-199mg/dl	Enrollment in certain select CDC-recognized lifestyle change DPP programs for weight loss

2021 Preventive Schedule

Plan your child's care: Know what your child needs and when to get it

Preventive or routine care helps your child stay well or finds problems early, when they are easier to treat. Most of these services may not have cost sharing if you use the plan's in-network providers. Make sure you know what is covered by your health plan and any requirements before you schedule any services for your child.

It's important to talk with your child's doctor. The frequency of services, and schedule of screenings and immunizations, depends on what the doctor thinks is right for your child.

Questions?

- Call Member Service
- Ask your doctor
- Log in to your account

Children: Birth to 30 Months[1]

GENERAL HEALTH CARE	BIRTH	1M	2M	4M	6M	9M	12M	15M	18M	24M	30M
Routine Checkup* (This exam is not the preschool- or day care-related physical.)	●	●	●	●	●	●	●	●	●	●	●
Hearing Screening	●										
SCREENINGS											
Autism Screening									●	●	
Critical Congenital Heart Disease (CCHD) Screening With Pulse Oximetry	●										
Developmental Screening						●			●		●
Hematocrit or Hemoglobin Screening							●				
Lead Screening						●	●			●	
Newborn Blood Screening and Bilirubin	●										
IMMUNIZATIONS											
Chicken Pox							Dose 1				
Diphtheria, Tetanus, Pertussis (DTaP)			Dose 1	Dose 2	Dose 3			Dose 4			
Flu (Influenza)**					Ages 6 months to 30 months: 1 or 2 doses annually						
Haemophilus Influenzae Type B (Hib)			Dose 1	Dose 2	Dose 3		Dose 4				
Hepatitis A							Dose 1		Dose 2		
Hepatitis B	Dose 1	Dose 2			Dose 3						
Measles, Mumps, Rubella (MMR)							Dose 1				
Pneumonia			Dose 1	Dose 2	Dose 3		Dose 4				
Polio (IPV)			Dose 1	Dose 2	Ages 6 months to 18 months: Dose 3						
Rotavirus			Dose 1	Dose 2	Dose 3						

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance. Additional: Instrument vision screening to assess risk for ages 1 and 2 years.

** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.

Children: 3 Years to 18 Years[1]

GENERAL HEALTH CARE	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	15Y	18Y
Routine Checkup* (This exam is not the preschool- or day care-related physical)	●	●	●	●	●	●	●	●	Once a year from ages 11 to 18			
Ambulatory Blood Pressure Monitoring**												●
Depression Screening									Once a year from ages 11 to 18			
Illicit Drug Use Screening												●
Hearing Screening***		●	●	●		●		●		●	●	●
Visual Screening***	●	●	●	●		●		●		●	●	●
SCREENINGS												
Hematocrit or Hemoglobin Screening			Annually for females during adolescence and when indicated									
Lead Screening	When indicated (Please also refer to your state-specific recommendations)											
Cholesterol (Lipid) Screening							Once between ages 9-11 and ages 17-21					
IMMUNIZATIONS												
Chicken Pox		Dose 2								If not previously vaccinated: Dose 1 and 2 (4 weeks apart)		
Diphtheria, Tetanus, Pertussis (DTaP)		Dose 5							One dose Tdap			
Flu (Influenza)******	Ages 3 to 18: 1 or 2 doses annually											
Human Papillomavirus (HPV)							Provides long-term protection against cervical and other cancers. 2 doses when started ages 9-14. 3 doses, all other ages.					
Measles, Mumps, Rubella (MMR)		Dose 2										
Meningitis*******									Dose 1		Age 16: One-time booster	
Pneumonia	Per doctor's advice											
Polio (IPV)		Dose 4										
CARE FOR PATIENTS WITH RISK FACTORS												
BRCA Mutation Screening (Requires prior authorization)					Per doctor's advice							
Cholesterol Screening	Screening will be done based on the child's family history and risk factors											
Fluoride Varnish (Must use primary care doctor)	Ages 5 and younger											
Hepatitis B Screening									Per doctor's advice			
Hepatitis C Screening											High-risk	
Latent Tuberculosis Screening												High-risk
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)									For all sexually active individuals HIV routine check once between ages 15-18			
Tuberculin Test	Per doctor's advice											

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance; alcohol and drug abuse, and tobacco use assessment. ** To confirm new diagnosis of high blood pressure before starting treatment. *** Hearing screening once between ages 11-14, 15-17, and 18-21. Vision screening covered when performed in doctor's office by having the child read letters of various sizes on a Snellen chart. Includes instrument vision screening for ages 3, 4, and 5 years. A comprehensive vision exam is performed by an ophthalmologist or optometrist and requires a vision benefit. **** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network. ***** Meningococcal B vaccine per doctor's advice.

Children: 6 Months to 18 Years[1]

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Oral Fluoride	For ages 6 months to 16 years whose primary water source is deficient in fluoride

PREVENTION OF OBESITY, HEART DISEASE, DIABETES, AND STROKE	
Children with a BMI in the 85th to 94th percentile (overweight) and the 95th to 98th percentile (obese) are eligible for:	• Additional annual preventive office visits specifically for obesity • Additional nutritional counseling visits specifically for obesity • Recommended lab tests: – Alanine aminotransferase (ALT) – Aspartate aminotransferase (AST) – Hemoglobin A1c or fasting glucose (FBS) – Cholesterol screening
Age 18 with a diagnosis of Hypertension, High Blood Pressure, Dyslipidemia, or Metabolic Syndrome	Nutritional counseling

ADULT DIABETES PREVENTION PROGRAM (DPP) AGE 18	
Applies to Adults • Without a diagnosis of diabetes (does not include a history of gestational diabetes) • Overweight or obese (determined by BMI) • Fasting Blood Glucose of 100–125 mg/dl or HGBA1c of 5.7% to 6.4% or Impaired Glucose Tolerance Test of 140–199mg/dl	Enrollment in certain select CDC-recognized lifestyle change DPP programs for weight loss

Women's Health Preventive Schedule

SERVICES	
Well-Woman Visits (Includes: preconception and first prenatal visit, urinary incontinence screening)	Up to 4 visits each year for developmentally and age-appropriate preventive services
Contraception (Birth Control) Methods and Discussion*	All women planning or capable of pregnancy

SCREENINGS/PROCEDURES	
Diabetes Screening	• High-risk: At the first prenatal visit • All women between 24 and 28 weeks pregnant • Postpartum women without diabetes but with a history of gestational diabetes
HIV Screening and Discussion	All sexually active women: Once a year
Human Papillomavirus (HPV) Screening Testing	Beginning at age 30: Every 3 years
Domestic and Intimate Partner Violence Screening and Counseling	Once a year
Breast-feeding (Lactation) Support and Counseling, and Costs for Equipment	During pregnancy and/or after delivery (postpartum)
Sexually Transmitted Infections (STI) Discussion	All sexually active women: Once a year
Screening for Anxiety	The Women's Preventive Services Initiative recommends screening for anxiety in adolescent girls and adult women, including those who are pregnant or postpartum.

* FDA-approved contraceptive methods may include sterilization and procedures as prescribed. One form of contraception in each of the 18 FDA-approved methods is covered without cost sharing. If the doctor recommends a clinical service or FDA-approved item based on medical necessity, there will be no cost sharing.

Information About the Affordable Care Act (ACA)

This schedule is a reference tool for planning your family's preventive care, and lists items and services required under the Affordable Care Act (ACA), as amended. It is reviewed and updated periodically based on the advice of the U.S. Preventive Services Task Force, laws and regulations, and updates to clinical guidelines established by national medical organizations. Accordingly, the content of this schedule is subject to change. Your specific needs for preventive services may vary according to your personal risk factors. Your doctor is always your best resource for determining if you're at increased risk for a condition. Some services may require prior authorization. If you have questions about this schedule, prior authorizations, or your benefit coverage, please call the Member Service number on the back of your member ID card.

[1]Information About Children's Health Insurance Program (CHIP)

Because the Children's Health Insurance Program (CHIP) is a government-sponsored program and not subject to ACA, certain preventive benefits may not apply to CHIP members and/or may be subject to copayments.

The ACA authorizes coverage for certain additional preventive care services. These services do not apply to "grandfathered" plans. These plans were established before March 23, 2010, and have not changed their benefit structure. If your health coverage is a grandfathered plan, you would have received notice of this in your benefit materials.

Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.

Discrimination is Against the Law

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

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

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

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

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

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

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

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

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

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

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

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

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

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

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

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

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

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

U65_BCBS_G_M_2Col_8pt_blk_NL

Prescription Drug Coverage

PRESCRIPTION DRUG BENEFITS

Here's how your drug coverage works.

First off, you'll use the same ID card for your medications as you do for your medical coverage. When you go to an in-network pharmacy, depending on your plan and the prescription, you might have a copy or need to pay a percentage of the drug's cost.

Knowing that, here are two important things to remember:

1. You'll usually save money by choosing a generic drug over a brand-name drug.
2. You can save even more by using mail order for maintenance prescription drugs.

And when it comes to staying on top of your coverage, your member website has details on your drug coverage and easy-to-use tools to manage your benefits and prescriptions.

- **Find in-network pharmacies**
- **View covered drugs**
- **See drug prices and lower-cost options**
- **Enroll in mail-order refills**
- **Refill or renew a prescription**
- **Get drug interaction warnings**
- **Compare cost savings with mail order**
- **Access forms needed for your coverage**

Once you're a member, you can log in to **highmarkbcbs.com** or call the number on the back of your Member ID card to learn more.

Programs to keep you safe and drug costs down.

When it comes to your medications, Highmark uses programs to help you make safer, more cost-effective drug choices. In the course of getting you the right drug, at the right time, in the right amount, at the right price, you might run into one of the following programs:

Prior Authorization:

When enrolled and you go to fill a prescription, we'll automatically check to be sure it's the best way to treat your diagnosed condition (or that you've tried other treatments before and they didn't work for you). If it's not or you haven't, you'll need to get a Prior Authorization from your doctor. It's our way of double-checking that you're getting safe, effective, medically necessary drugs.

Quantity Limits:

Some drugs are regulated to make sure you get the right dosage. Limits can be based on gender, age, or other factors that restrict how often or how much of a refill you can get. They're in place to keep you safe.

Step Therapy:

For certain medications, our drug programs use a "step" approach. That means you'll need to try preferred medications first before less-preferred medications are covered. Preferred medications tend to be the lower-cost generic drugs that have already been clinically proven to be safe and just as effective as their more expensive counterparts. Step therapy is designed to help lower costs while still providing access to non-preferred medications.

If your prescription drug requires Prior Authorization, tell your doctor. They can get it for you three ways:

1. Call the Pharmacy Hotline at **800-600-2227.**
2. Send a request online by using the **NaviNet® program.**
3. Fax a request form to the Hotline staff at **866-240-8123.**
   (Get a form at **highmarkbcbs.com** by clicking Helpful Links, Forms Library, then Pharmacy Forms)

Save even more with the mail order pharmacy.

If you take medications regularly, the mail order pharmacy can make life simpler and help you save with:

- 90-day drug refills with just a single copay
- 24/7 ordering online, by mail, or by phone
- Typical delivery in 3 to 5 days
- Free Standard Shipping
- Helpful pharmacists available to you 24/7
- Simple payments via e-check, credit card, or a health spending account

How to start using the mail order pharmacy

Get a new prescription for up to a 90-day supply, plus refills for up to one year from your doctor. Then:

- Have your doctor fax in your new prescription or submit it as an e-prescription.

  Or

- Use it to file your Pharmacy Mail Order Form and Health, Allergy and Medication Questionnaire.

You'll find those forms at the end of this Pharmacy Benefits section. They're also available at highmarkbcbs.com by clicking Helpful Hints, then Forms Library under the Pharmacy Forms section.

Mail your completed forms to:
Express Scripts
Home Delivery Service
P.O. Box 74700 Cincinnati, OH 45273

For help with your order, call pharmacy services at 1-800-903-6228. (TTY call 1-800-759-1089)

NATIONAL NETWORK

Over 60,000 pharmacies are in the National with CVS network, including:

Accredo
Acme
Ahold
Albertsons
Aurora Pharmacy
Bartell Drug
Big Y Foods
Bi-Lo Holdings
Bi-Mart
Brookshire Brothers
Brookshire Grocery
Coborns
Costco
CVS
Dept Of Veterans Affairs
Discount Drug Mart
Familycare
Food City Pharmacy
Freds
Fruth Pharmacy
Giant Eagle
Hannaford Brothers
Harps Phcy-Price Cutter Phcy
Heb Grocery
Henry Ford Health System
Hip Pharmacy Services
Homeland Pharmacy
Horton & Converse Pharmacies
Hy-Vee
IHC Pharmacy Services
Ingles Markets
Instymeds
Kelsey-Seybold Pharmacy Div
Kinney Drugs
Kmart
Knight Drugs
Kroger
Lewis Drugs Inc
M K Stores
Marc Glassman
Martins Super Markets
Maxor Pharmacy
Med-Fast Pharmacy
The Medicine Shoppe
Meijer
Metrocare
Neighborcare
Northeast Ohio Neighborhood
Omnicare
Osborn Drugs Inc
Patient First
Pharmaca Integrative Pharmacy
Pharmerica
Planned Parenthood
Prescribeit Rx
Price Chopper Pharmacy
Publix
Quick Check Food Stores
Raleys
Reasors
Recept Pharmacy
Red Cross Pharmacy
Redners Markets
Rite Aid
Ritzman Pharmacies
Roundys Supermarkets
Safeway
Sam's Club
Sav-On
Save Mart Supermarkets
Schnucks
Seip Drug
Shopko
Spartan
Supervalu
Target (CVS Pharmacy)
Thrifty White Stores
Tops Markets
United Supermarkets
Unity Pharmacies
Value Drugs
Wakefern
Walmart
Wegmans
Weis Market

HOME DELIVERY ORDER FORM

EXPRESS SCRIPTS®

Home Delivery Order Options

Ask your doctor to write your prescription for up to a 90-day supply or the maximum days allowed by your plan with refills up to one year, if appropriate.

ePrescribe: For fastest service ask your doctor to submit prescriptions electronically to the Express Scripts Pharmacy[SM].

Online/Mobile App: Log in to **express-scripts.com** or the Express Scripts Mobile App, choose the medicine you want delivered, add it to your cart, then check out.

Fax: Have your doctor call 888.327.9791 for faxing instructions. (Faxes can only be accepted from a doctor's office.)

Phone: Call Express Scripts at the toll-free number on the back of your ID card for assistance in switching to home delivery.

Mail: Complete the order form and send to Express Scripts along with prescriptions and payment.

Please use ALL CAPITAL LETTERS with black or blue ink. Fill in the ovals as shown. (●)

1 Member Information

Member ID Number	Group #
Member Last Name	Member First Name
☐ Please send email notices regarding this order's status	Email address

To GO GREEN go to express-scripts.com to update your Communication Preferences under Account

2 Shipping Address

○ Permanent ○ Temporary — If temporary address, please provide effective dates From____/____/____ To ____/___/_____

Shipping Address Line 1 (Street address is preferred over PO Box)		Apt#
Shipping Address Line 2		
City	State	Zip

Primary Phone Number	Choose One M○ H○ W○	Secondary Phone Number	Choose One M○ H○ W○

Shipping Method (Expedited shipping will **not** rush prescription processing)

○ Standard	Free	Arrives within 5-10 days after order is shipped
○ Two Day	$12.00	Arrives 2 business days after order is shipped
○ One Day	$21.00	Arrives 1 business day after order is shipped

3 Patient Information

Please only include prescriptions for patients covered under the above Member ID

Patient #1	
Patient Last Name	Patient First Name
Patient DOB	Gender ○ Male ○ Female
Physician Name	Physician Phone
Patient #2	
Patient Last Name	Patient First Name
Patient DOB	Gender ○ Male ○ Female
Physician Name	Physician Phone

 EME47693 CRP1808_0413 STLF14WB

4 Payment Method — Do not send cash

You authorize us to retain on file your payment card details that you used to make this purchase and to charge your payment card account to pay for any prescription orders requested by you. Should you also choose to enroll in the auto-pay program, you further consent that we may charge your enrolled payment method for prescription orders made by covered household members, including previously ordered prescriptions which are unpaid.

- We will notify you of any changes to this authorization by email or mail as applicable. This Card on File Authorization, and if applicable auto-pay enrollment, will remain in effect until you cancel the authorization by logging into your account or calling the 1-800 number on the back of your prescription card. The transaction amount is determined by your plan's benefit structure at the time the prescription is shipped.
- State law prohibits the return of prescription medications for resale or reuse. We cannot accept the return of properly dispensed prescription medications for credit or refund.
- See our privacy policy for information regarding our use and disclosure of personally identifiable information.

Signature X _____

Credit Card: We accept VISA, MC, Discover, AMEX, Diners	**Check or Checking Account**
◯ **Automatic, ongoing payment through credit card** Authorize to pay for this order and all future orders with the credit card below.	◯ **Automatic, ongoing payment through checking account** I authorize to pay for this order and all future orders with the checking account information below or include a voided check.
◯ **For this order only.** Simply fill in your credit card information below.	◯ **For this order only.** Enclose a check payable to Express Scripts. Write invoice number on the check.
Credit Card Number _____ Exp Date _____	Name of checking account holder _____ Checking Account Number _____ Routing Number (first 9 digits lower-left corner of personal check) _____

Review your account balance and pay outstanding balances anytime at express-scripts.com. To change the limit of the amount we can charge your card without a call to you:

- Go to express-scripts.com
- Select Payment Methods under Account then Edit Information.
- Change the payment authorization limit

You can manage all account preferences at **express-scripts.com** or call Member Services at the toll-free number on your ID card.

5 Health History

To update your allergies or health conditions: Visit us at **express-scripts.com/healthform** or call **877.438.4417**. This information helps us protect you against potentially harmful drug interactions and allergies.

6 Important reminders and other information

If you are a Medicare Part B beneficiary AND have private health insurance, check your prescription drug benefit materials to determine the best way to get Medicare Part B drugs and supplies. Or, call Member Services at the toll-free number found on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1.800.633.4227.

For additional information or help, visit us at **express-scripts.com** or call Member Services at the toll-free number found on your ID card. TTY/TDD users should call 1.800.759.1089.

Your order may be filled at any one of our Express Scripts Pharmacies located nationwide.

7 Generic Substitution

State law permits a pharmacist to substitute a less expensive generic equivalent drug for a brand-name drug unless you or your physician directs otherwise. Please note that this applies to new prescriptions and to any future refills of that prescription. Also be aware that you may pay more for a brand-name drug.

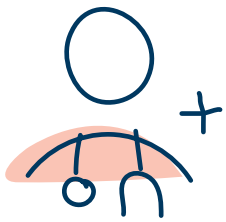
☐ I do not wish to receive a less expensive brand or generic medication.

If the prescription is being submitted electronically, discuss with your doctor.

Place your prescription(s), order form(s) and your payment in an envelope.
Do not use staples or paper clips.
Do not affix post it notes to form.

EXPRESS SCRIPTS
PO BOX 66577
ST LOUIS, MO 63166-6577

Wellness



BEST DOCTORS®

Expert second opinions from top doctors.

Talk to a case manager who can help confirm a diagnosis when you're facing a difficult health condition.

HEALTH COACHES

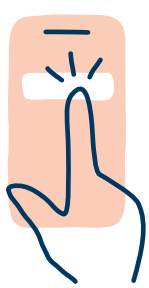
Personalized support for health goals.

Looking to lose weight? Quit smoking? Be more active? A wellness coach can create a personalized plan for you, right over the phone, on your schedule. Sessions are free and confidential.

BABY BLUEPRINTS®

Pregnancy advice, answers, and support.

Our maternity education program for mom-to-be questions and over-the-phone support from a nurse health coach that's available at no additional cost. Call 1-866-918-5267 to enroll.



SHARECARE®

Say hello to your online health and wellness hub.

Find out your RealAge®, track your health habits, and monitor sleep, stress, and fitness — in real time.

Health Tools & Resources

HIGHMARK CONCIERGE

Get the VIP treatment.

Your specialized team of coverage experts dedicated to answering all of your questions. Help finding cost-effective care, setting appointments, navigating wellness programs are just the beginning. Call the phone number on the back of your ID card or from the Highmark app.

ONLINE TOOLS & MEMBER WEBSITE

Your entire plan at your fingertips.

No more searching for old files or waiting on snail mail. Your digital ID card, Find a Doctor tool, deductible progress, and claims status are all available online at **highmarkbcbs.com**.

CARE COST ESTIMATOR

See what care might cost you.

Before making an appointment for a test, scan, or procedure, Care Cost Estimator helps you estimate what that care may cost. Available on your member website, **highmarkbcbs.com**.

MY CARE NAVIGATOR

Your appointments, booked for you.

It's as simple as calling the phone number on the back of your member ID card or from the Highmark app. We'll help you find the in-network doctor you need and reserve some space on their calendar for a checkup. Which means less on-hold music for you.

BLUE365®

Discounts to help you stay healthy and active.

From workout gear to gym memberships to healthy meal services, we'll take a little off the top while you're taking a little off your middle. Member-only deals are at **blue365deals.com**.

HIGHMARK PLAN APP

Your health plan in your pocket.

Get instant access to your digital member ID card, care-finding tools, and claims updates right on your mobile device. To start, just download the Highmark Plan App from the App Store or Google Play and set up your profile.

Additional Important Information

Health care lingo, translated.

When you're reviewing plans, you're bound to see certain terms over and over. Here's a cheat sheet for a few of the most important ones. (If you want the complete glossary, check your benefit booklet.)

PREMIUM
The monthly amount you or your employer pay so you have health coverage.

DEDUCTIBLE
The set amount you pay for a health service before your plan starts paying.

COPAY
The set amount you pay for a covered service, for example: $20 for a doctor visit or $30 for a specialist visit.

COINSURANCE
The percentage you owe, after your deductible. For example, if your plan pays 80%, you pay 20%.

PLAN ALLOWANCE
The set amount you and your plan will pay for a health service. In-network providers aren't allowed to bill you more than this amount.

IN-NETWORK PROVIDER
A doctor or hospital that has an agreement with your plan to accept your plan allowance and cost-sharing as full payment. They won't bill you extra for covered services, but you could still have to pay your deductible, coinsurance or copays.

MAXIMUM OUT-OF-POCKET
The most you'd pay for covered care. If you hit this amount, your plan pays after that.

CLAIM
The request for payment that's sent to your health insurance company after you receive covered care.

COVERED SERVICES
All the care, drugs, supplies, and equipment that are paid for, at least in some part, by your health plan after you've met your deductible.

EXCLUSIVE PROVIDER ORGANIZATION (EPO)
A type of plan where services are usually only covered if you use in-network doctors or hospitals, except for emergencies or urgent care. If you travel, you'll have coverage for emergency or urgent care, but usually not for routine care.

OUT-OF-NETWORK PROVIDER
A doctor or hospital that can charge more than your plan allowance for their services. If they do, you'll most likely be on the hook for additional costs.

PRECERTIFICATION
A decision made ahead of time by your health plan that a service, treatment, or drug is medically necessary for you. It can be called prior authorization or prior approval, but it's not a promise that anything will be fully covered.

PREFERRED PROVIDER ORGANIZATION (PPO)
A type of plan that offers more flexibility in choosing doctors and hospitals, usually with the added security of coverage for care you might need when you're away from home.

PROVIDER
Whether it's your primary doctor, a lab technician, or a physical therapist, the person or facility where you get care is referred to as a health care provider.

RETAIL CLINIC
Walk-in centers for less complex health needs, generally open in the evenings and on weekends.

URGENT CARE CENTER
A walk-in center for when you have a condition that's serious enough to need care right away, but not serious enough for a trip to the emergency room.

Determining Care for Coverage.

How we approve what's covered.

We have a group of experts called Medical Management & Quality. Their job is to make sure you're covered for care that is medically necessary and appropriate. What that means, generally, is that care is:

- **a standard medical practice.**
- **proven to be effective.**
- **not just done out of convenience for you or your doctor.**
- **not more expensive than something else that would be just as effective.**

Most of the care covered by your plan meets these guidelines, so you can have it done and covered without needing to do anything else.

If you're denied coverage because we determine care doesn't meet those qualifications, you always have the right to appeal that decision.

How we keep your information safe.

You've trusted us with your personal information and we take protecting it very seriously. We follow very strict policies for handling and protecting Protected Health Information (PHI).

In the course of using your coverage, we sometimes share PHI for routine things like ensuring you're getting safe and effective treatments or doctors are receiving payment for the care you get.

If you're interested, you always have the right to see all the information in your medical records. The fastest way to access it is to ask your primary doctor.

That's the gist of how we make sure you're protected and getting appropriate, medically necessary care.

If you want to read the full, legal descriptions of the policies we've summed up here, go to **discoverhighmark.com**. Scroll to the bottom of the page, click on **Quality Assurance,** and enter your ZIP code.

Care and Case Management

Programs for care support and complex condition management.

CARE MANAGEMENT PROGRAM

From person to person, care needs can be different and change over time. Our Care Management program focuses on connected care so we can help you get safe, effective, appropriate care right when you need it.

Services under the Care Management Program:

Precertification Review, starts before you get care and:

- Confirms you're eligible and have benefits for care
- Determines if care is medically necessary and appropriate
- Makes sure care happens at the right facility by the right provider
- Provides alternatives for care, if available
- Identifies if case or condition management could help the member

Concurrent Review, happens during the course of treatment to:

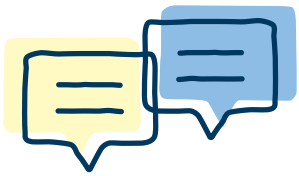
- Assess the medical need to continue treatment
- Evaluate the right level of care for treatment
- Foresee any possible quality of care concerns
- Identify situations that require a physician consultation
- Determine potential case or condition management benefits
- Update and/or revise the discharge plan

Discharge Planning, occurs throughout the course of treatment to:

- Promote alternative levels of care, when appropriate
- Make sure care is delivered in the appropriate setting
- Identify case or condition management program prospects early on
- Make timely referrals for intervention
- Develop and carry out appropriate discharge plans

Retrospective Review, happens after services have been provided and:

- Evaluates the appropriateness of medical services
- Solely on information available at the time the medical care was provided



CASE MANAGEMENT PROGRAM

Based on the Case Management Society of America (CMSA) standards, the Case Management Program supports members with serious and complex medical conditions by helping them navigate the health care system and make informed care decisions. Regardless of the condition, the overall goal is to get members back to the highest possible level of functioning in their work, family, and social lives.

Individual Goals of Case Management

- Identify and resolve gaps in care
- Assure the right care at the right time through appropriate facilities and providers
- Increase members' understanding of their condition or situation
- Reduce medication inconsistencies and ensure correct use of prescribed medications
- Address any caregiver issues that may affect members' conditions
- Improve members' ability to self-manage their conditions and wellness focus
- Reduce potentially avoidable emergency room visits and hospital readmissions
- The case manager assesses medication needs and consults with the Highmark pharmacy team as deemed necessary.

How the Case Management Program Works:

A Registered Nurse Case Manager collaborates with a multidisciplinary team, consisting of medical directors, pharmacists, behavioral health specialists, social workers, wellness specialists, and dietitians, to evaluate an individual's health needs in the following ways:

- Planning, coordinating, and monitoring care and progress toward health
- Evaluating all of a member's options, resources and services
- Identifying gaps and/or barriers to optimal care before inpatient admission and/or discharge
- Helping members and caregivers to understand conditions and plans of care so they can manage their health
- Educating on care coordination, support systems, medication, health, and wellness
- Collaborating with a variety of providers, care facilities, and home health agencies to ensure appropriate care

Case Management is voluntary. Members can end their involvement with the program any time.

Our friends in the legal department asked us to include this. Enjoy all the nitty gritty details.

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Livongo is an independent company that provides a diabetes management program on behalf of Highmark.

Lark is an independent company that manages digital health and wellness coaching programs on behalf of your health plan.

Best Doctors is an independent company that manage the virtual second medical opinion program on behalf of Highmark.

Sapphire Digital is an independent company that administers the SmartShopper program for your health plan. Pricing may not be available on all medical procedures, tests or healthcare providers.

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Doctor on Demand is an independent company that provides telemedicine services. Doctor on Demand does not provide Blue Cross and/or Blue Shield products or services and it is solely responsible for its telemedicine services.

The programs discussed herein are not intended to be a substitute for professional medical advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health provider with any questions or concerns regarding a medical condition. Health plan coverage is subject to the terms of your health plan benefit agreement.

*This is not a contract.

HIGHMARK

An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

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

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

Insurance or benefit/claims administration may be provided by Highmark, Highmark Choice Company, Highmark Coverage Advantage, Highmark Health Insurance Company, First Priority Life Insurance Company, First Priority Health, Highmark Benefits Group, Highmark Select Resources, Highmark Senior Solutions Company or Highmark Senior Health Company, all of which are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

If you speak English, language assistance services, free of charge, are available to you. Call 1-800-876-7639.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-800-876-7639.

如果您说中文，可向您提供免费语言协助服务。 請致電 1-800-876-7639.

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-800-876-7639.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-800-876-7639 로 전화.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-800-876-7639.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-800-876-7639.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-800-876-7639.

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-800-876-7639.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-800-876-7639.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-800-876-7639.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-800-876-7639.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-800-876-7639.

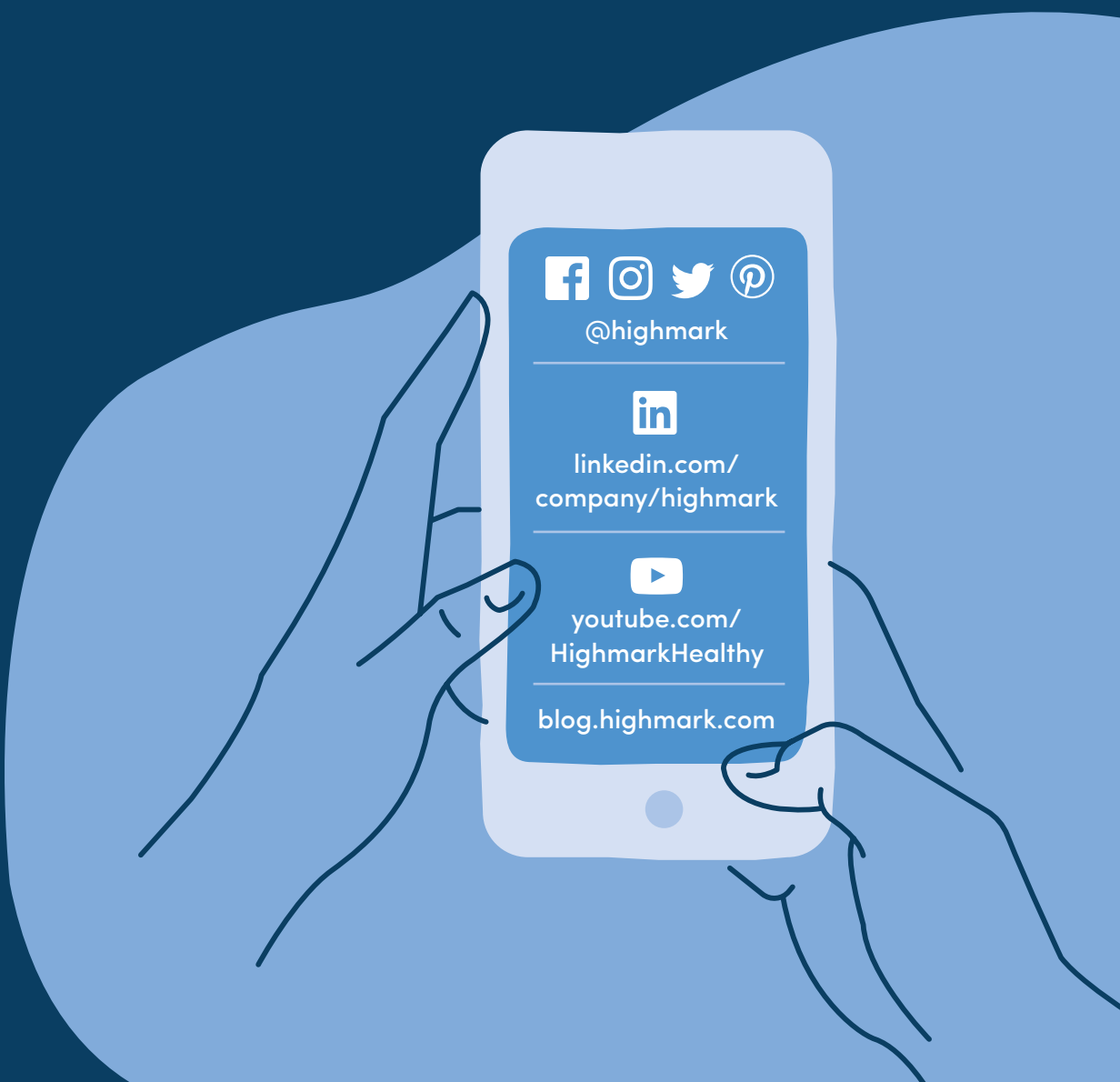
Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.

日本語が母国語の方は言語アシスタンス・ サービスを無料でご利用いただけます。 1-800-876-7639 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-800-876-7639 .

Connect with us.

We're on most of your favorite social media sites, so contact us there if it's easier for you. You can say hi, ask questions, or give feedback. Find us here:



We’ve got your back.

For coverage questions, call the number on the back of your member ID card or talk with your plan administrator.