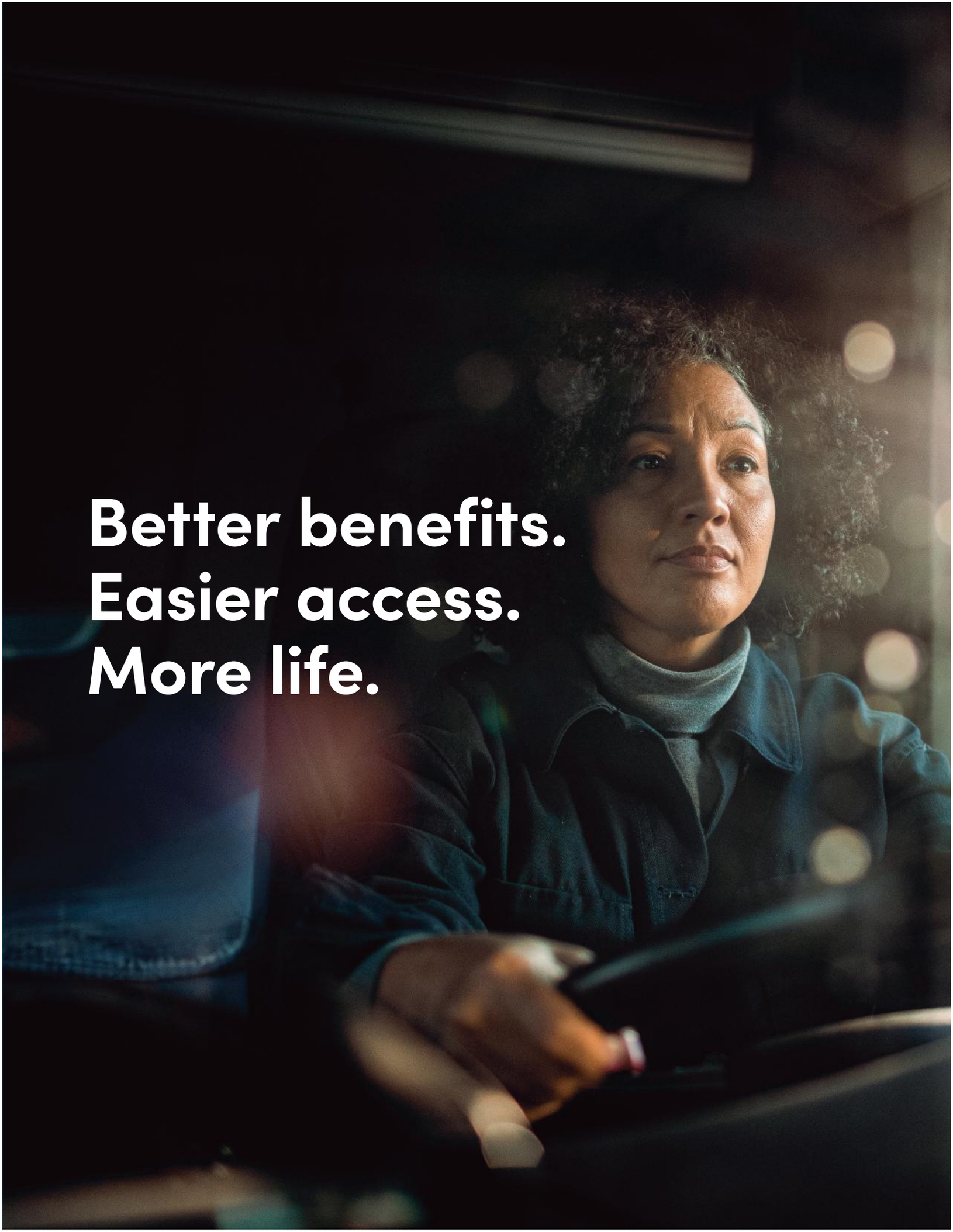

Better benefits.
Easier access.
More life.

Care that keeps up with your life.

Wherever you are, we've got you covered.

HIGHMARK

EPO Blue/PPO Blue

UFCW Health & Welfare Fund of
Northeastern Pennsylvania

Empire Kosher

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.

Thomas A. Doran
President, Highmark Health Plans

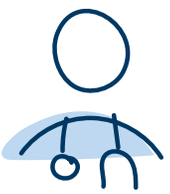
Contents

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 My Highmark app to get support from a registered nurse any time and put your worries to bed.



WELL360 VIRTUAL HEALTH

Personalized care when and where you want it.

Get care when and where you need it with Well360 Virtual Health. A board-certified doctor can see you right away. Register on **myhighmark.com** or log in if you are already using the Amwell® site.

DIABETES PREVENTION PROGRAM

Tips on how to avoid diabetes.

Lower your risk with simple, effective, practical strategies.

EMERGENCY CARE

When you need it most, you're covered.

Emergency care is always covered at the in-network level, wherever you get it. So don't hesitate. If you think it's an emergency, go straight to the nearest emergency room or dial 911. Your plan may also cover emergency care received outside the United States. Check your Summary of Benefits for more information.

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 within your plan for the type of care that fits your situation best.

CARE FOR SUBSTANCE USE DISORDERS

Guidance to keep you on track.

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

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. With Highmark, you can expect expert care from:

- OB-GYNs specializing in high-risk pregnancy, maternal fetal medicine, and fertility.
- Board-certified pediatricians and pediatric subspecialists.
- Childbirth and certified lactation experts.

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

EPOBLUE

Here's how Highmark makes it simple for you:

Nationwide access to providers through the BlueCard® program.

You get 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 gives you easy access to hospitals and doctors right in your community. 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 **highmark.com/find-a-doctor**.
2. Choose a plan from the list.
3. Type a name or specialty into the search window.

With your **EPO**, unless it's for emergency services, remember that you won't have benefits if you go out of network. 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.

NEPA

*According to the Blue Cross Blue Shield Association.

PPOBLUE

Here's how Highmark makes it simple for you:

Nationwide access to providers through the BlueCard® program.

You get 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.

And you're covered close to home, too.

Our northeastern Pennsylvania network covers 13 counties with easy access to hospitals and doctors right in your community. 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.

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.

Need help finding top-quality doctors and hospitals?

To search for in-network providers:

1. Go to **highmark.com/find-a-doctor**.
2. Choose a plan from the list.
3. 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.

NEPA

*According to the Blue Cross Blue Shield Association.

Customized EPO Blue Sharing $200 $25/$50 w/Rx

On the chart below, you'll see what your plan pays for specific services. You are responsible for paying for non-emergency services received from an out-of-network provider. 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.

Benefit	Coverage
General Provisions	
Effective Date	04/01/2024
Benefit Period (1)	Contract Year
Deductible (per benefit period) Individual Family	 $200 $400
Plan Pays – payment based on the plan allowance	100% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copayments, 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
Office/Clinic/Urgent Care Visits	
Retail Clinic Visits & Virtual Visits	100% after $25 copayment
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $25 copayment
Specialist Office Visits & Virtual Visits	100% after $50 copayment
Virtual Visit Provider Originating Site Fee	100% after deductible
Urgent Care Center Visits	100% after $25 copayment - copayment does not apply to Urgent Care Center Visits prescribed for the treatment of Mental Health or Substance Abuse.
Telemedicine Services (3)	100% after $10 copayment
Preventive Care (4)	
Routine Adult Physical exams	 100% (deductible does not apply)
Adult immunizations	100% (deductible does not apply)
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)
Breast Cancer Screenings (annual routine and supplemental)	100% (deductible does not apply)
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)
Routine Pediatric Physical exams	 100% (deductible does not apply)
Pediatric immunizations	100% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)
Emergency Services	
Emergency Room Services (5)	100% after $200 copayment (waived if admitted)
Ambulance – Emergency	100% (deductible does not apply)
Ambulance – Non-Emergency (6)	100% after deductible
Hospital and Medical/Surgical Expenses (including Maternity) (5)	
Hospital Inpatient	100% after deductible
Outpatient Surgery	100% after deductible
Maternity (non-preventive professional services) including dependent daughter	100% after deductible
Medical Care (including inpatient visits and consultations)	100% after deductible
Therapy and Rehabilitation Services	
Physical Medicine	100% after $50 copayment **Benefit Limit:** 20 visits/benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse

Benefit	Coverage
Speech Therapy	100% after $50 copayment **Benefit Limit:** 12 visits/benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse
Occupational Therapy	100% after $50 copayment **Benefit Limit:** 12 visits/benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse
Respiratory Therapy	100% after deductible
Spinal Manipulations	100% after $50 copayment **Benefit Limit:** 12 visits/benefit period
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible
Mental Health/Substance Abuse	
Inpatient Mental Health Services	100% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	100% after $25 copayment
Outpatient Substance Abuse	100% after $25 copayment
Other Services	
Allergy Extracts and Injections	100% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	100% after deductible
Assisted Fertilization Procedures Limited to Artificial Insemination - 3 attempts per lifetime	100% after deductible
Dental Services Related to Accidental Injury	100% after deductible
Diagnostic Services	Copayments, if any, do not apply to Diagnostic Services prescribed for the treatment of Mental Health or Substance Abuse
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible
Mammograms (medically necessary)	100% (deductible does not apply)
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible
Home Health Care	100% after deductible **Benefit Limit:** Unlimited
Hospice	100% after deductible
Infertility Counseling, Testing and Treatment (8)	100% after deductible
Private Duty Nursing	Not Covered **Benefit Limit:** Not Applicable
Skilled Nursing Facility Care	100% after deductible **Benefit Limit:** 60 days/benefit period
Transplant Services	100% after deductible
Precertification/Authorization Requirements (9)	YES
Prescription Drugs	
Prescription Drug Deductible Individual Family	 None None
Prescription Drug Program (10) SensibleRx Choice *Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary with Incentive Benefit Design.* **Select Specialty Drugs are Limited to a 31-day Supply**	**Retail Drugs (34-day Supply)** Generic Drugs: $10 copayment Formulary Brand Drugs: $25 copayment Non-Formulary Brand Drugs: $50 copayment **Specialty Drugs (Limited to a 31-day Supply)** Specialty $150 copayment **Maintenance Drugs through Mail Order (90-day Supply)** Generic Drugs: $20 copayment Formulary Brand Drugs: $50 copayment Non-Formulary Brand Drugs: $100 copayment

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 benefit summary.

1) Your group's benefit period is based on a Contract Year. Contact your employer to determine the effective date applicable to your program.
2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government, TMOOP must include deductible, coinsurance, copayments, prescription drug cost share and any qualified medical expense.
3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g., PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
7) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services - Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g., speech therapy, diagnostic services). Services for the treatment of Autism Spectrum Disorders do not reduce visit/day limits.
8) 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
9) If you receive services from an out-of-area 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.
10) 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 SensibleRx Choice, 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 a specific specialty pharmacy for hemophilia medications. Please contact member services for more details. Your plan offers the Free Market Health program for select specialty medications. You will be contacted by one of the specialty network pharmacies who will provide quality service, care, and coordination of your specialty prescription fill and delivery. No enrollment necessary.

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, First Priority Health, or First Priority Life.

Customized EPO Blue Sharing $400 $25/$50 w/Rx

On the chart below, you'll see what your plan pays for specific services. You are responsible for paying for non-emergency services received from an out-of-network provider. 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.

Benefit	Coverage
General Provisions	
Effective Date	04/01/2024
Benefit Period (1)	Contract Year
Deductible (per benefit period) Individual Family	 $400 $800
Plan Pays – payment based on the plan allowance	90% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 $1,000 $2,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copayments, 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
Office/Clinic/Urgent Care Visits	
Retail Clinic Visits & Virtual Visits	100% after $25 copayment
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $25 copayment
Specialist Office Visits & Virtual Visits	100% after $50 copayment
Virtual Visit Provider Originating Site Fee	90% after deductible
Urgent Care Center Visits	100% after $25 copayment - copayment does not apply to Urgent Care Center Visits prescribed for the treatment of Mental Health or Substance Abuse.
Telemedicine Services (3)	100% after $10 copayment
Preventive Care (4)	
Routine Adult Physical exams	 100% (deductible does not apply)
Adult immunizations	100% (deductible does not apply)
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)
Breast Cancer Screenings (annual routine and supplemental)	100% (deductible does not apply)
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)
Routine Pediatric Physical exams	 100% (deductible does not apply)
Pediatric immunizations	100% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)
Emergency Services	
Emergency Room Services (5)	100% after $200 copayment (waived if admitted)
Ambulance – Emergency	90% (deductible does not apply)
Ambulance – Non-Emergency (6)	90% after deductible
Hospital and Medical/Surgical Expenses (including Maternity) (5)	
Hospital Inpatient	90% after deductible
Outpatient Surgery	90% after deductible
Maternity (non-preventive professional services) including dependent daughter	90% after deductible
Medical Care (including inpatient visits and consultations)	90% after deductible
Therapy and Rehabilitation Services	
Physical Medicine	100% after $50 copayment **Benefit Limit:** 20 visits/benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse

Benefit	Coverage
Speech Therapy	100% after $50 copayment **Benefit Limit:** 12 visits/benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse
Occupational Therapy	100% after $50 copayment **Benefit Limit:** 12 visits/benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse
Respiratory Therapy	90% after deductible
Spinal Manipulations	100% after $50 copayment **Benefit Limit:** 12 visits/benefit period
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible
Mental Health/Substance Abuse	
Inpatient Mental Health Services	90% after deductible
Inpatient Detoxification/Rehabilitation	90% after deductible
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	100% after $25 copayment
Outpatient Substance Abuse	100% after $25 copayment
Other Services	
Allergy Extracts and Injections	90% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	90% after deductible
Assisted Fertilization Procedures Limited to Artificial Insemination - 3 attempts per lifetime	90% after deductible
Dental Services Related to Accidental Injury	90% after deductible
Diagnostic Services	Copayments, if any, do not apply to Diagnostic Services prescribed for the treatment of Mental Health or Substance Abuse
Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible
Mammograms (medically necessary)	90% (deductible does not apply)
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible
Home Health Care	90% after deductible **Benefit Limit:** Unlimited
Hospice	90% after deductible
Infertility Counseling, Testing and Treatment (8)	90% after deductible
Private Duty Nursing	Not Covered **Benefit Limit:** Not Applicable
Skilled Nursing Facility Care	90% after deductible **Benefit Limit:** 60 days/benefit period
Transplant Services	90% after deductible
Precertification/Authorization Requirements (9)	YES
Prescription Drugs	
Prescription Drug Deductible Individual Family	 None None
Prescription Drug Program (10) SensibleRx Choice *Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary with Incentive Benefit Design.* **Select Specialty Drugs are Limited to a 31-day Supply**	**Retail Drugs (34-day Supply)** Generic Drugs: $10 copayment Formulary Brand Drugs: $25 copayment Non-Formulary Brand Drugs: $50 copayment **Specialty Drugs (Limited to a 31-day Supply)** Specialty $150 copayment **Maintenance Drugs through Mail Order (90-day Supply)** Generic Drugs: $20 copayment Formulary Brand Drugs: $50 copayment Non-Formulary Brand Drugs: $100 copayment

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1) Your group's benefit period is based on a Contract Year. Contact your employer to determine the effective date applicable to your program.
2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government, TMOOP must include deductible, coinsurance, copayments, prescription drug cost share and any qualified medical expense.
3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g., PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
7) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services - Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g., speech therapy, diagnostic services). Services for the treatment of Autism Spectrum Disorders do not reduce visit/day limits.
8) 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
9) If you receive services from an out-of-area 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.
10) 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 SensibleRx Choice, 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 a specific specialty pharmacy for hemophilia medications. Please contact member services for more details. Your plan offers the Free Market Health program for select specialty medications. You will be contacted by one of the specialty network pharmacies who will provide quality service, care, and coordination of your specialty prescription fill and delivery. No enrollment necessary.

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, First Priority Health, or First Priority Life.

Customized PPO Blue Healthy Savings $3,500Q 70/50 w/Rx

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). 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.

Benefit	Network	Out-of-Network
General Provisions		
Effective Date	04/01/2024	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual Family	 $3,500 $7,000	 $6,350 $12,700
Plan Pays – payment based on the plan allowance	70% after deductible	50% after deductible
Out-of-Pocket Limit (Includes prescription drug expenses, coinsurance, and copayments). Once met, the plan pays 100% coinsurance for the rest of the benefit period. Individual Family	 None None	 $10,000 $20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copayments, 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	 $6,550 $13,100	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	70% after deductible	50% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	70% after deductible	50% after deductible
Specialist Office Visits & Virtual Visits	70% after deductible	50% after deductible
Virtual Visit Provider Originating Site Fee	70% after deductible	50% after deductible
Urgent Care Center Visits	70% after deductible	70% after deductible
Telemedicine Services (3)	70% after deductible	Not Covered
Preventive Care (4)		
Routine Adult Physical exams	 100% (deductible does not apply)	 50% after deductible
Adult immunizations	100% (deductible does not apply)	50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	50% (deductible does not apply)
Breast Cancer Screenings (annual routine and supplemental)	100% (deductible does not apply)	50% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	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)	 50% after deductible
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 (5)	70% after network deductible (waived if admitted to hospital)	
Ambulance – Emergency (6)	100% after network deductible	
Ambulance – Non-Emergency (6)	70% after network deductible	50% after deductible
Hospital and Medical/Surgical Expenses (including maternity) (5)		
Hospital Inpatient	70% after deductible	50% after deductible
Outpatient Surgery	70% after deductible	50% after deductible
Maternity (non-preventive professional services) including dependent daughter	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)	70% after deductible	50% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	70% after deductible **Benefit Limit:** 20 visits/benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	50% after deductible
Speech Therapy	70% after deductible	50% after deductible

Benefit	Network	Out-of-Network
	Benefit Limit: 12 visits/benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Occupational Therapy	70% after deductible	50% after deductible
	Benefit Limit: 12 visits/benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Respiratory Therapy	70% after deductible	50% after deductible
Spinal Manipulations	70% after deductible	50% after deductible
	Benefit Limit: 12 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	70% after deductible	50% after deductible
Mental Health/Substance Abuse		
Inpatient Mental Health Services	70% after deductible	50% after deductible
Inpatient Detoxification/Rehabilitation	70% after deductible	50% after deductible
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	70% after deductible	50% after deductible
Outpatient Substance Abuse	70% after deductible	50% after deductible
Other Services		
Allergy Extracts and Injections	70% after deductible	50% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	70% after deductible	50% after deductible
Assisted Fertilization Procedures Limited to Artificial Insemination - 3 attempts per lifetime	70% after deductible	50% after deductible
Dental Services Related to Accidental Injury	70% after deductible	50% after deductible
Diagnostic Services	Copayments, if any, do not apply to Diagnostic Services prescribed for the treatment of Mental Health or Substance Abuse	
Advanced Imaging (MRI, CAT, PET scan, etc.)	70% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	70% after deductible	50% after deductible
Mammograms (medically necessary)	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	70% after deductible	50% after deductible
Home Health Care	70% after deductible	50% after deductible
	Benefit Limit: Unlimited	
Hospice	70% after deductible	50% after deductible
	Benefit Limit: Unlimited	
Impacted Wisdom Teeth Extraction	70% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (8)	70% after deductible	50% after deductible
Private Duty Nursing	Not Covered	Not Covered
	Benefit Limit: Not Applicable	
Skilled Nursing Facility Care	70% after deductible	50% after deductible
	Benefit Limit: 60 days/benefit period	
Transplant Services	70% after deductible	50% after deductible
Precertification/Authorization Requirements (9)	YES	
Prescription Drugs		
Prescription Drug Deductible Individual Family	 Integrated with medical deductible Integrated with medical deductible	
Prescription Drug Program (10) SensibleRx Choice *Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary with Incentive Benefit Design.* **Select Specialty Drugs are Limited to a 31-day Supply**	**Retail Drugs (34-day Supply)** Generic Drugs: $10 copayment after deductible Formulary Brand Drugs: $25 copayment after deductible Non-Formulary Brand Drugs: $50 copayment after deductible **Specialty Drugs (Limited to a 31-day Supply)** Specialty $150 copayment after deductible **Maintenance Drugs through Mail Order (90-day Supply)** Generic Drugs: $20 copayment after deductible Formulary Brand Drugs: $50 copayment after deductible Non-Formulary Brand Drugs: $100 copayment after deductible	

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 benefit summary.

1) Your group's benefit period is based on a Contract Year. Contact your employer to determine the effective date applicable to your program.
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. If you are enrolled in a "Family" plan, with your embedded deductible, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. In addition, with your embedded out-of-pocket limit, once an individual family member's out-of-pocket limit is satisfied, additional claims reimbursement begins for that person. Finally, with your embedded TMOOP, once any eligible family member satisfies his/her individual TMOOP, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family TMOOP amount is met.
3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g., PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
7) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist, or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant, or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services-Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g., speech therapy, diagnostic services). Services for the treatment of Autism Spectrum Disorders do not reduce visit/day limits.
8) 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.
9) 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.
10) At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you pay for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled. 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 SensibleRx Choice, 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 a specific specialty pharmacy for hemophilia medications. Please contact member services for more details. Your plan offers the Free Market Health program for select specialty medications. You will be contacted by one of the specialty network pharmacies who will provide quality service, care, and coordination of your specialty prescription fill and delivery. No enrollment necessary.

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 flu shots, routine screenings, checkups, and breast exams are 100% covered.

2024 Preventive Schedule

Effective 1/1/2024

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. 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. Recommended annual services are based on a calendar year resetting January 1 of every year.

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 your age, gender and family history. 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 one to two years • Ages 50 and older: Once a year
Depression Screening and Anxiety 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 five years • High-risk: More often
Colon Cancer Screening (Including Colonoscopy)	• Ages 45 and older: Every one to 10 years, depending on screening test • High-risk: Earlier or more frequently
Colon Cancer Screening	Ages 45 and older: Colonoscopy following a positive result obtained within one year by other mandated screening method
Certain Colonoscopy Preps With Prescription	• Ages 45 and older: Once every 10 years • High-risk: Earlier or more frequently
Diabetes Screening	High-risk: Ages 40 and older, once every three years
Hepatitis B Screening	• Once per lifetime for adults • High-risk: More often

* 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.

* USPSTF mandated Routine Labs

Adults: Ages 19+

SCREENINGS/PROCEDURES	
Hepatitis C Screening	Ages 18 to 79
Latent Tuberculosis Screening	High-risk
Lung Cancer Screening (Requires prior authorization and use of authorized facility)	Ages 50 to 80 with 20-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. Screening follow up MRI or Ultrasound per doctor's recommendation
Osteoporosis (Bone Mineral Density) Screening	Ages 65 and older: Once every two years, or younger if at risk as recommended by physician
Cervical Cancer Screening	• Ages 21 to 65 Pap: Every three years, or annually, per doctor's advice • Ages 30 to 65: Every five 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 two-dose series
COVID-19 Vaccine	Per doctor's advice following CDC and Emergency Use Authorization Guidelines
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 two-, three-, or four-dose series
Hepatitis B	• Ages 19–59: Two to four doses per doctor's advice • Ages 60 and older: High-risk per doctor's advice
Human Papillomavirus (HPV)	• To age 26: One three-dose series • Ages 27 to 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 • Ages 19 to 49: Immunocompromised per doctor's advice

* 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

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Aspirin	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
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 one 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 and Certain Related Services 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 and anxiety 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 • Nutritional counseling for pregnant women to promote healthy weight during the pregnancy

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	Nutritional counseling	
Adults with BMI 40 and over	Nutritional counseling and fasting glucose screening	

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

*** Aromatase inhibitors when the other drugs can't be used such as when there is a contraindication or they are not tolerated.

2024 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.

Services include Bright Futures recommendations. CHIP members may have additional preventive services and coverage. Please check the CHIP member booklet for further details of CHIP coverage of preventive services.

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 Anemia Screening							●				
Lead Screening**							●			●	
Newborn Blood Screening and Bilirubin	●										
IMMUNIZATIONS											
Chicken Pox							Dose 1				
COVID-19 Vaccine	Per doctor's advice following CDC and Emergency Use Authorization Guidelines										
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 3 or 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.

** Per Bright Futures, and refer to state-specific recommendations as needed.

*** 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**												●
Anxiety Screening						Once a year from ages 8 to 18						
Depression Screening										Once a year from ages 12 to 18		
Illicit Drug Use Screening												●
Hearing Screening***		●	●	●		●		●		●	●	●
Visual Screening***	●	●	●	●		●		●		●	●	
SCREENINGS												
Hematocrit or Hemoglobin Anemia 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 to 11 and ages 17 to 21					
IMMUNIZATIONS												
Chicken Pox		Dose 2								If not previously vaccinated: Dose 1 and 2 (4 weeks apart)		
COVID-19 Vaccine	Per doctor's advice following CDC and Emergency Use Authorization Guidelines											
Dengue Vaccine							9–16 years living in dengue endemic areas in U.S. Territories AND have laboratory confirmation of previous dengue infection					
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 to 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										

* 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.

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	●	
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 to 21	
Tuberculin Test	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 four 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	Screen for diabetes in pregnancy at first prenatal visit or at weeks 24–28 and after pregnancy in women with a history of gestational diabetes and no diagnosis of diabetes.
HIV Screening and Discussion	• All sexually active women: Once a year • Ages 15 and older, receive a screening test for HIV at least once during their lifetime • Risk assessment and prevention education for HIV infection beginning at age 13 • Screen for HIV in all pregnant women upon initiation of prenatal care with rescreening during pregnancy based on risk factors
Human Papillomavirus (HPV) Screening Testing	Beginning at age 30: Every three 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.
Nutritional Counseling	Ages 40–60 with normal BMI and overweight BMI

* FDA-approved contraceptive methods may include sterilization and procedures as prescribed. One or more forms of contraception in each of the 18 FDA-approved methods, as well as any particular service or FDA approved, cleared or granted contraceptive product that an individual's provider determines is medically appropriate, are covered without cost sharing. Exception Process: Your provider may request an exception for use of a prescribed nonformulary contraception drug due to medical necessity by completing the online request form. When approved, the prescribed drug will then be made available to you with zero-dollar cost share. Note: On page 2 of the form under the title Prior Authorization reads "Contraceptives require a statement of medical necessity only". The following link works for all states. [https://content.highmarkprc.com/Files/Region/PA/Forms/MM-056.pdf] Only FDA approved contraception apps, which are not part of the 18 method categories, and are available for download to a cell phone are reimbursable through the paper claim process with a prescription. Members need to submit three documents to obtain reimbursement; 1) completed the paper Claim Form: [https://www.highmarkbcbs.com/redesign/pdfs/mhs/Medical_Claim_Form.pdf] Under section DIAGNOSIS OR NATURE OF ILLNESS OR INJURY – write "contraception app purchase" 2) receipt of payment for the FDA approved contraception app, 3) provider prescription for the FDA approved contraception app.

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 Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

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.

Prescription Drug Coverage

PRESCRIPTION DRUG BENEFITS

A pharmacy plan that fits your life.

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. Our mail order service for maintenance prescription drugs is a convenient option that saves you trips to the pharmacy.

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. Use the website to:

- **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 the **My Highmark app**, or the member website at **MyHighmark.com**, or call the number on the back of your member ID card to learn more.

Programs to keep you safe while keeping 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 you're enrolled and it's time 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 that didn't work for you). If the prescription isn't right for you, 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.

For fully insured business, members may qualify for an exception from this protocol in certain circumstances.

If your prescription drug requires prior authorization, tell your doctor. There are three options for obtaining prior authorization:

1. **Send a request online by using CoverMyMeds® (covermymeds.com).**
2. **Call the Pharmacy Hotline at 800-600-2227.**
3. **Fax a request form to the hotline staff at 866-240-8123.**
   (Get a form at myhighmark.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 three to five 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 are also available in the **My Highmark app**, or the member website at **MyHighmark.com**. Simply log in and click on the Support tab. Next, select Forms Library under the Health Plan Documents section.

Mail your completed forms to:
Express Scripts Pharmacy
PO Box 66577
St Louis, MO 63166-6577

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

PARTICIPATING CVS NATIONAL NETWORK PHARMACIES

Over 55,000 pharmacies are in the CVS National Network, including:

Accredo
Ahold
Albertsons
Aurora Pharmacy
Bi-Lo Holdings
Brookshire Grocery
Coborn's
Coram Healthcare
Costco
Dept. of Veterans Affairs
Discount Drug Mart
Food City Pharmacy
Giant Eagle
Hannaford Brothers
H-E-B Grocery
Hy-Vee
Ingles Markets
Kinney Drugs
Kmart
Lewis Drugs Inc.
MK Stores
Marc Glassman
Maxor Pharmacy
The Medicine Shoppe
Meijer
Planned Parenthood
Price Chopper Pharmacy
Publix
Raley's
Rite Aid
Roundy's Supermarkets
Safeway
Sam's Club
Sav-On
Save Mart Supermarkets
Schnucks
SuperValu
Thrifty White Stores
Value Drugs
Wakefern
Walmart
Wegmans
Weis Markets

HOME DELIVERY ORDER FORM

Express Scripts® Pharmacy

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 Express Scripts Home Delivery.
Online/mobile app: Log in to **express-scripts.com/rx** 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 **1.888.327.9791** 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® Pharmacy along with prescriptions and payment.

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

1	**Member Information**
Member ID Number	Group #
Member Last Name	Member First Name
Want updates on your order? Register on our website. **https://www.express-scripts.com**	Email address
To GO GREEN go to https://www.express-scripts.com/green 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

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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 toll-free number on the back of your ID 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® Pharmacy. Write invoice number on the check.
Credit Card Number _____	**Name of checking account holder** _____
Exp Date _____	**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/rx. To change the limit of the amount we can charge your card without a call to you:

- Go to express-scripts.com/rx
- Log in to your account
- Under Account, select Payment Methods; under the method, select Edit
- Change the payment authorization limit and Save

You can manage all account preferences at express-scripts.com/rx 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 **https://www.express-scripts.com/frontend/consumer/#/health-profile** or call **1.877.438.4417**. 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/rx** 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 sticky notes to form.

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

Wellness

WELLNESS COACHES

Personalized support for health goals.

Looking to lose weight? Quit smoking? Be more active? Balance stress? A wellness coach can create a personalized plan for you, right over the phone, on your schedule. Sessions are free and confidential. Call the number on the back of your ID card and choose the prompt to speak with a wellness coach, or visit **HighmarkHealthCoachBCBS.com**.

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.

Health Tools and Resources

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 **myhighmark.com**.

CARE COST ESTIMATOR

Know what you'll owe for care.

Before making an appointment for a test, scan, or procedure, Care Cost Estimator helps you estimate your bill in advance. Available on your member website, **myhighmark.com**.

BLUE365®

Discounts to help you stay healthy and active.

From workout gear to personal wellness 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**.

MY HIGHMARK APP

Your health plan in your pocket.

Get instant access to your digital member ID card, care-finding tools, claims updates, and easy online premium payments right on your mobile device. To start, just download the My Highmark 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.)

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

COINSURANCE
The percentage you may owe for certain covered services after reaching your deductible. For example, if your plan pays 80%, you pay 20%.

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

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.

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

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

EXPLANATION OF BENEFITS (EOB)
A statement from your insurance company that shows services you received, including the amount your insurance covers and what you'll owe.

HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)
A plan that usually comes with a lower premium because you pay more for health care services upfront before the insurance company starts to pay. These plans are often combined with a health savings account.

IN-NETWORK PROVIDER
A doctor, hospital, or other facility 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.

NETWORK TYPES
Broad: The network that provides access to many doctors and facilities in your area.

Tiered: A network that offers access to most doctors and facilities in your area based on a tiered system — Enhanced and Standard. You generally pay less for the Enhanced level of benefits than the Standard level.

Narrow: Local networks specific to certain markets. They tend to be close to where you live. You have access to the doctors and facilities in that network.

OUT-OF-NETWORK PROVIDER
A doctor or hospital that generally charges more than your plan allowance for the same services.

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.

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 providers, usually with the added security of coverage for care you might need when you're away from home.

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

PROVIDER
Whether it's your primary doctor, a lab technician, or a physical therapist, the person or facility providing your 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.

How we approve what's covered:

Determining care for coverage

We have a group of experts called Clinical Services. Their job is to make sure you're receiving 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 receive care and have it covered without needing to do anything else.

You are required to confirm that your provider obtained a prior authorization for any out-of-area services requiring authorization in advance of receiving the service. This also includes advanced radiology and cardiac imaging. Call the Member Service number on the back of your member ID card or in the My Highmark app to review your coverage and confirm if you need your provider to get a prior authorization.*

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

*A prior authorization is not a guarantee of coverage, payment, or payment amount. All services are subject to contract exclusions and eligibility at the time the service is rendered.

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 securing protected health information (PHI).

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

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 differ 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.
- Ensures that 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:

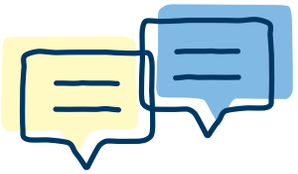
- Assess the medical need to continue treatment.
- Evaluate the right level of care for treatment.
- Foresee any possible quality of care concerns.
- Identify situations that require a physician consultation.
- Determine potential case or condition management benefits.
- Update and/or revise the discharge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

Discharge Planning occurs throughout the course of treatment to:

- Promote alternative levels of care, when appropriate.
- Ensure that 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 include:

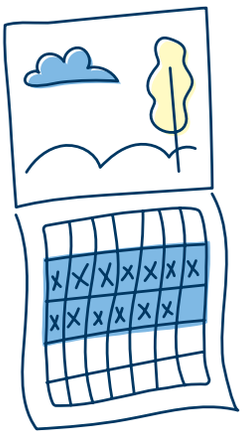
- Identifying and resolving gaps in care.
- Assuring the right care at the right time through appropriate facilities and providers.
- Increasing members' understanding of their condition or situation.
- Reducing medication inconsistencies and ensuring correct use of prescribed medications.
- Addressing any caregiver issues that may affect members' conditions.
- Improving members' ability to self-manage their conditions and wellness focus.
- Reducing potentially avoidable emergency room visits and hospital readmissions.
- Assessing medication needs and consulting 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 by:

- 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.



Prior authorization for out-of-area services

You are required to confirm that your provider obtained a prior authorization for any out-of-area services requiring authorization *in advance of receiving the service*. This includes radiology and cardiac imaging. A prior authorization just means that we work with your provider before you receive the proposed service to make sure that the procedure is medically necessary. Your out-of-area provider will be expected to reach out to us about that, but it is important that you stay in contact with them.

The provider may also call Provider Services to determine if a prior authorization for proposed service is required.

If no prior authorization is received, you could be responsible for 100% of your bill.*

Call Member Service, the number on the back of your identification card, to review your coverage and confirm if you need your provider to get a prior authorization.*

*A prior authorization is not a guarantee of coverage, payment, or payment amount.
All services are subject to contract exclusions and eligibility at the time the service is rendered.

Let's break this down a little more.

1. You and your provider agree on a service that you need.
2. Your provider lets Highmark know all of the details about the procedure. **You should stay in contact with your provider.**
3. Highmark will review your requested service.
4. We'll send you and your provider a prior authorization if the request is determined to be medically necessary.

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

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration.

Onduo is a separate company that provides a virtual care program for your health plan.

Sword Health Inc. is an independent company that provides wellness services for your health plan.

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 manages the virtual second medical consultation 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.

American Well is an independent company that provides virtual health services. American Well does not provide Blue Cross and/or Blue Shield products or services and it is solely responsible for its telemedicine services.

Baby Blueprints is a registered mark of the Blue Cross Blue Shield Association.

Blue365 is a registered mark of the Blue Cross Blue Shield Association.

Davis Vision is an independent company that provides the network and administers vision benefits for Highmark members.

Blue Distinction® Specialty Care is a registered mark of the Blue Cross Blue Shield Association. Blue Distinction Centers (BDC) met overall quality measures, developed with input from the medical community. A Local Blue Plan may require additional criteria for providers located in its own service area; for details, contact your Local Blue Plan. Blue Distinction Centers+ (BDC+) also met cost measures that address consumers' need for affordable healthcare. Each provider's cost of care is evaluated using data from its Local Blue Plan. Providers in CA, ID, NY, PA, and WA may lie in two Local Blue Plans' areas, resulting in two evaluations for cost of care; and their own Local Blue Plans decide whether one or both cost of care evaluation(s) must meet BDC+ national criteria. Total Care ("Total Care") providers have met national criteria based on provider commitment to deliver value-based care to a population of Blue members. Total Care+ providers also met a goal of delivering quality care at a lower total cost relative to other providers in their area. Program details are displayed on www.bcbs.com. Individual outcomes may vary. For details on a provider's in-network status or your own policy's coverage, contact your Local Blue Plan and ask your provider before making an appointment. Neither Blue Cross and Blue Shield Association nor any Blue Plans are responsible for non-covered charges or other losses or damages resulting from Blue Distinction, Total Care, or other provider finder information or care received from Blue Distinction, Total Care, or other providers.

Blues On Call is a service mark of the Blue Cross Blue Shield Association.

Blue Cross Blue Shield Global® Core is a registered mark of the Blue Cross Blue Shield Association.

BlueCard is a registered mark of the Blue Cross Blue Shield Association. Statics regarding coverage are according to the Blue Cross Blue Shield Association.

Blue High Performance Network is an in-network only, Exclusive Provider Organization (EPO), single-tier network in most markets. However, there are exceptions in these two markets: New Jersey and Philadelphia. Please contact your client manager for additional information on the two-tier in-network model in these markets. Blue High Performance Network is a service mark of the Blue Cross Blue Shield Association.

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.

07/23 MX2437301

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.

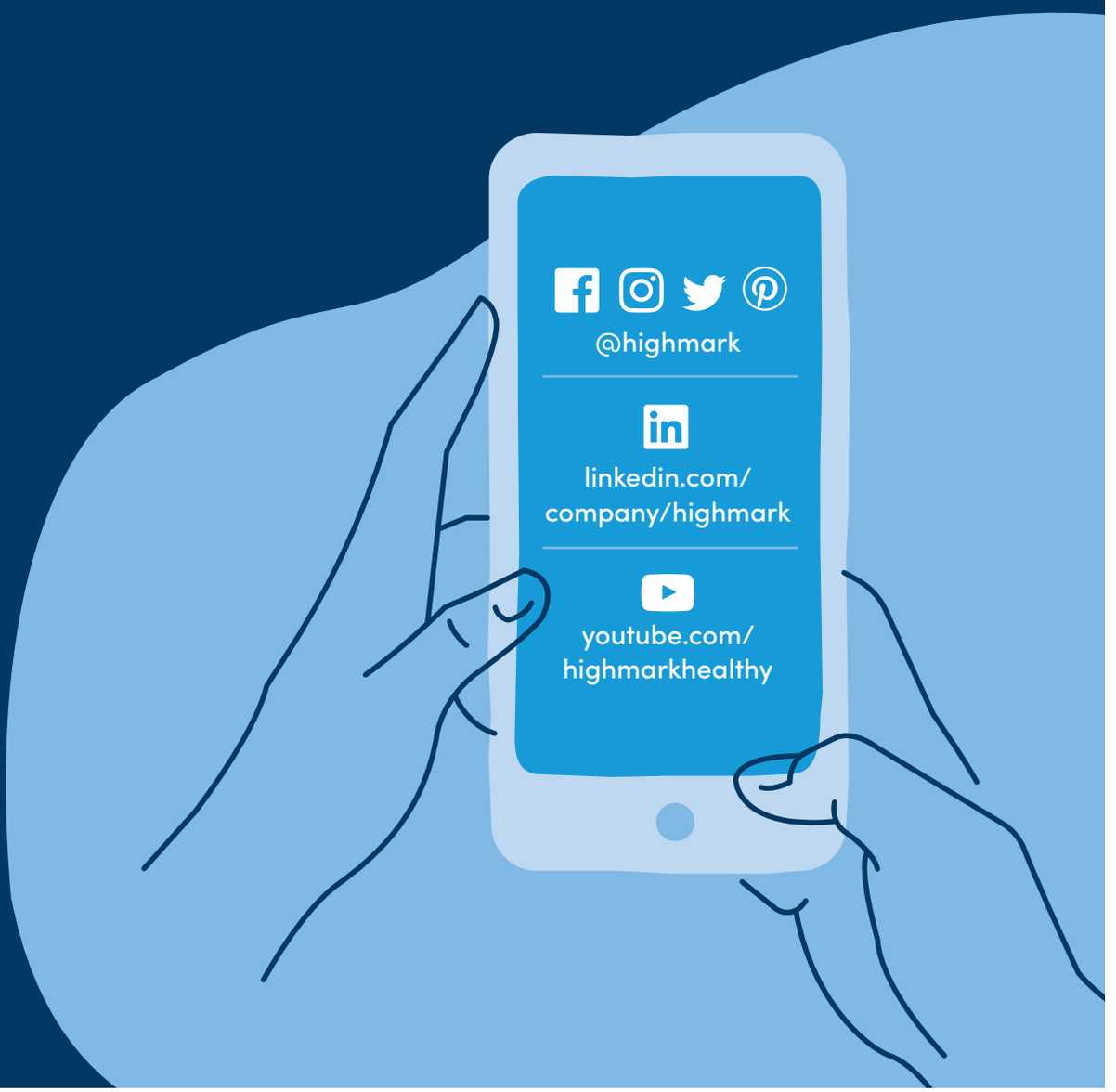
Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.

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.