

All these benefits.
All for you.

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

That's why whoever you are and wherever you go,
Highmark makes it easy to find affordable, quality care.



PPO Blue

County of Allegheny

Welcome to your 2020 plan!

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, you get a plan that's simple to understand, easy to use, and easy to love.

Plus, you get access to personalized wellness programs, handy online tools, and 24/7 support for medical concerns you might have along the way.

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

A handwritten signature in black ink that reads "Deborah L. Rice-Johnson".

Deborah L. Rice-Johnson
President, Highmark Health Plans

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PPO Blue

Where the choice is yours

As a Highmark Member, you get to choose the health care provider you want while enjoying the comprehensive coverage and cost savings you and your family need.

- You and your dependents are covered for physician services, important preventive care, specialty care, hospital procedures, and more.
- You can choose from doctors, hospitals, and other health care providers you know and trust for convenient care close to home.

Local care and nationwide coverage

With *PPO Blue*, you can choose a health care provider from more than 50 community and specialty hospitals and more than 7,600 doctors in western Pennsylvania. You will find providers with experience in behavioral health, cancer care, cardiology, children's care, neuroscience, orthopedics and rehabilitation, transplant surgery, and women's care.

Should you need it, you can get first-class, specialty care using state-of-the-art technologies at Allegheny Health Network hospitals, including Allegheny General Hospital, Allegheny Valley Hospital, Forbes Hospital, Jefferson Hospital, West Penn Hospital, Saint Vincent Hospital, and Canonsburg Hospital.

You also have access to our nationwide Blue network that includes approximately 96 percent of all hospitals and 95 percent of all doctors in the United States — that's nearly 1.9 million unique providers across the country.



In-network vs. out-of-network

The health care providers that participate with *PPO Blue* are considered “in-network.” This means they deliver the top-quality, patient-centered care you expect, and they have agreed to accept the payment arrangement set by this plan. When you receive care from an in-network provider, you receive the maximum coverage from your plan along with prompt and accurate claims payments.

When you go to an out-of-network provider or one who doesn’t participate with this plan, you are still covered for most eligible services but at a lower level of benefits. You will also have to pay any difference between the provider’s actual charge and the plan’s allowed amount. That’s why it is important to check that a provider is in the network before you receive care.

Need help finding top-quality doctors and hospitals?

You can search for in-network doctors and hospitals at **highmarkbcbs.com**.

Click on **Find a Doctor or Rx**, then **Find a doctor, hospital, or other medical provider**, and search under the *PPO Blue* plan.

You can also call Member Service toll-free at the phone number on the back of your Member ID card.

Count on access to quality care—close to home

No referrals needed!

You don't need a referral to see a specialist. But, it's still a good idea to select a doctor to be your primary care provider, so he or she can get to know you and your health history, and better coordinate all your treatments and medications.

Select a Physician of Record

You can name a primary care provider as your Physician of Record. This could be any physician or practice you visit for primary care and routine health care services. It could be an internist, general practitioner, family practitioner, or pediatrician.

Your Physician of Record can help you achieve health goals, monitor chronic conditions, provide preventive services, and coordinate care with your other providers. However, you don't need to get approval from your Physician of Record to see a specialist or receive additional treatment from any network physician—making your life a bit easier.

There are three ways to choose your Physician of Record:

- Indicate your choice during open enrollment, if this option is provided.
- Go to **Highmarkbcbs.com** to update your Physician of Record selection online.
- Call the Member Service phone number on the back of your ID card.

Want to know how a physician measures up?

You can see how other patients rate their doctors and hospitals based on overall satisfaction, communication, availability, and other factors. Check out Patient Experience Reviews at Highmarkbcbs.com, and don't be shy to write a review of your own.



Your plan's network includes Allegheny Health Network

Allegheny Health Network (AHN) is a team of caregivers committed to improving health and promoting wellness in the community.

AHN is transforming patient care in support of Highmark's members.

AHN has more than 2,800 physicians with a virtually every community in western Pennsylvania. The AHN network includes eight hospitals with nearly 2,400 licensed beds:

- Allegheny General Hospital
- Allegheny Valley Hospital
- Canonsburg Hospital
- Forbes Hospital
- Jefferson Hospital
- Saint Vincent Hospital
- Westfield Memorial Hospital
- West Penn Hospital

Additional world-class collaborations

- Cleveland Clinic
- Johns Hopkins Sidney Kimmel Comprehensive Cancer Center
- Mayo Clinic
- Memorial Sloan-Kettering Cancer Center
- Pediatric Alliance
- Premier Medical Associates



West Penn Hospital

Regionally and nationally recognized for excellence in nursing, burn care, maternity, diabetes, cardiovascular, lupus, neurology, and cancer care. In addition, West Penn offers a Level III neonatal intensive care unit.



Allegheny General Hospital

AGH is renowned for neuroscience, orthopaedic, cardiovascular, rehabilitation, and cancer care. AGH physicians pioneer minimally invasive and robotic-assisted surgical techniques. Other medical innovations are realized through research and clinical trials.



Jefferson Hospital

Jefferson Hospital is regionally and nationally recognized for excellence in cardiovascular care. Jefferson also features a comprehensive cancer center, women's health center and women and infants center, including a Level II neonatal intensive care unit.



AHN Sports Complex at Cool Springs

The AHN Orthopaedic Institute offers sports medicine and performance training at the AHN Sports Complex at Cool Springs, Bethel Park. The premier Sports Performance training facility in the region has certified athletic trainers and strength and conditioning specialists on site.

Allegheny Health Network Health + Wellness Pavilions

AHN pavilions offer a one-stop health care experience where you can receive many health care services at the in-network benefit level. Check out the convenient locations and some of the available services.

Locations

- Bethel Park
- Peters Township
- Wexford
- Erie West Side
- Erie East Side

Classes and events

We offer a wide variety of classes and events, such as colon cancer screenings, prenatal yoga, and weight loss information sessions. Visit [AHN.org/EVENTS](https://www.ahn.org/EVENTS) to learn more.



Did you know?

AHN offers a variety of appointment options to easily fit into your schedule. From Extended Hours to Same-Day appointments, Express Care to Online Scheduling, we can help connect you to the care you need. Visit [AHN.org/CONNECT](https://www.ahn.org/CONNECT) to learn more.

* Features and services vary by location. Visit [AHN.org](https://www.ahn.org) for more details.

Features and services*

- Advanced imaging services (MRI, CT, mobile PET CT)
- Ambulatory surgery center
- Cardiac testing
- Full-service lab
- Physical and occupational therapies and cardiac rehabilitation
- Retail pharmacy
- Support care (palliative and hospice services)

Medical and surgical specialties

- Bariatrics
- Breast surgery
- Cardiology
- Cardiothoracic surgery
- Dermatology
- Ear, nose, and throat
- Esophageal and lung care
- Joint replacement
- Maternal/fetal medicine
- Medical oncology
- Neurosurgery
- Pediatrics
- Plastic surgery
- Primary care
- Radiation oncology
- Spine
- Sports medicine
- Surgical oncology
- Vascular surgery

Visit [ahn.org](https://www.ahn.org) for more information, or to schedule an appointment. You can also call **(412) DOCTORS (412-362-8677)**.

Maternity care

Pregnant, or plan to become pregnant?

We understand pregnancy can be both exciting and overwhelming for mothers-to-be. Highmark's Baby Blueprints program is here for you every step of the way.

This no-cost program offers you support throughout your pregnancy with many valuable online educational resources. In addition, you can enjoy more personalized attention with your own specially-trained health coach with guaranteed confidentiality. Call toll-free at **1-866-918-5267** to take advantage of all the program's offerings.

Access to high-quality care for your special delivery

You have access to exceptional maternity care at these locations in western Pennsylvania, including, but not limited, to:

- AHN Forbes Hospital in Monroeville
- AHN Jefferson Hospital in Jefferson Hills
- AHN West Penn Hospital in Bloomfield
- St. Clair Hospital in Mt. Lebanon
- Excela Health System
- Heritage Valley, Sewickley, and Beaver Hospitals
- Saint Vincent Hospital in Erie

For more information, visit highmarkbcbs.com.



Our network providers feature:

Birthing suites designed for comprehensive care, comfort, and family bonding

- Labor and delivery in the same spacious, light-filled room
- Mothers and babies bond with skin-to-skin contact immediately following birth
- Newborns and parents room together in quiet, family-centered comfort
- Highly personal care with a low patient-to-nurse ratio, with two nurses dedicated to every mother and baby

Expert physician care

- Obstetricians and gynecologists for traditional and high-risk pregnancy, maternal fetal medicine, and genetics
- Behavioral health specialists for emotional support
- Board-certified pediatricians and pediatric subspecialists
- Childbirth, child care, and certified lactation experts who give mothers, fathers, and babies the best possible start to family life

Distinguished neonatal care centers

- Neonatal transfer team that safely escorts hundreds of babies from community hospitals to West Penn's Level III NICU each year
- Level II NICUs at Forbes Hospital and Jefferson Hospital
- \$23 million investment in NICU patient care including a new wing with 20 private rooms designed to allow parents to fully bond with their babies day or night. Three rooms are specially designed for twins.
- Constant care and supervision using state-of-the-art technology to monitor and treat babies with more complex health issues.
- Secure web cameras that allow parents to watch their babies any time.
- Neonatal development follow-up program
- Collaboration with Children's Hospital of Pittsburgh for expertise in infant surgery

Count on us for all types of care

Your plan covers preventive and sick care, outpatient and inpatient hospital care, and more.

Preventive care

Preventive care helps you stay healthy. So why not take full advantage of Highmark's excellent preventive care benefits, including counseling, immunizations, screenings, routine gynecological exams and Pap tests. Be sure to read your Summary of Benefits for more information about your specific coverage.

Mental health care

You're also covered for a wide range of mental health services, including counseling and treatment. To assure responsive, appropriate care, Highmark offers you a choice of mental health providers, so you can get the level and type of care that best fits your situation.

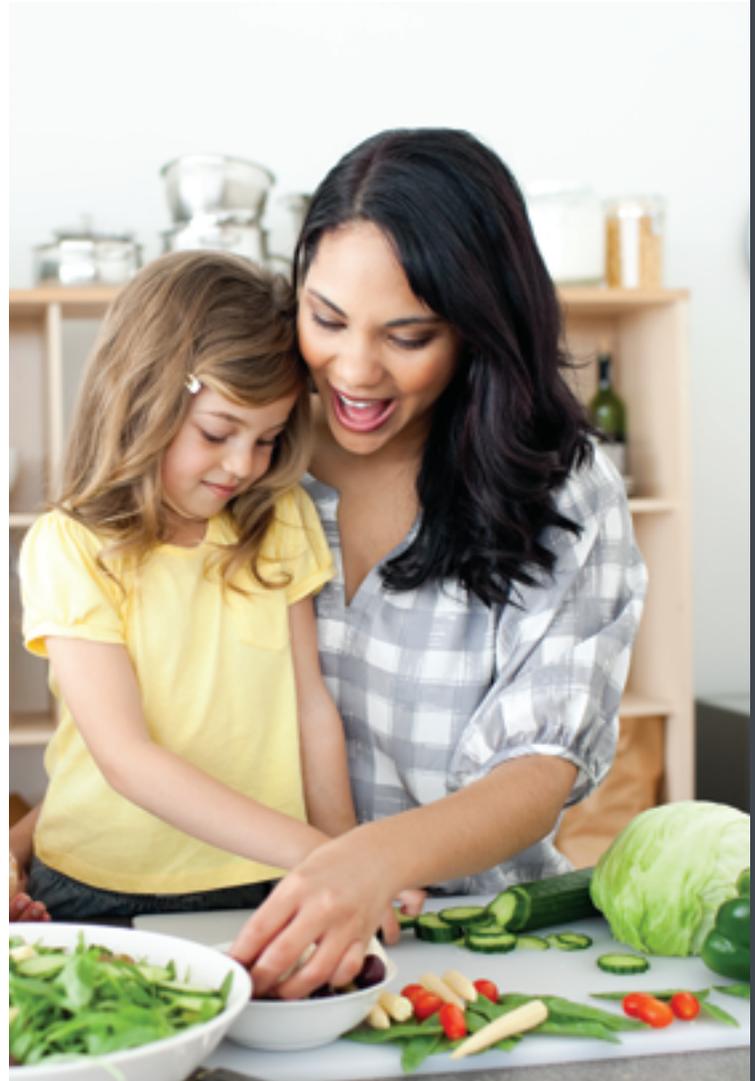
Substance abuse care

Your plan also provides coverage for a spectrum of substance abuse services. As a Highmark member, you are able to choose the substance abuse professional you feel will give you the necessary care.

Specialty care

We have you covered for all your specialty health care needs. You have access to state-of-the-art, patient-centered care from Allegheny Health Network physicians and other independent specialists in western Pennsylvania. You'll get access to excellent women's and children's care, as well as key specialties like cancer, heart, and orthopedic care, rehabilitation, and more.

We collaborate with some of the best minds, like Johns Hopkins Medicine, for cancer research and to provide guided access to clinical trials. Highmark members can also get care from cancer centers owned by UPMC or jointly operated by UPMC and other community hospitals. In addition, members have access to UPMC-employed physicians at a lower level of coverage.



Emergency care

More than anything, you want to know you're covered when you need care most. Emergency care is covered at the in-network level whether it is received from an in-network or out-of-network provider. The bottom line is you never have to worry when you need emergency care—go directly to the nearest hospital emergency room or call "911" or your area's emergency number.

You may not need emergency services for strains, sprains, fevers, and sore throats. In these cases, consider contacting a network doctor, or go to the nearest urgent care center or a retail clinic (typically found in pharmacies).

Worldwide care

No matter where you travel, count on Highmark for your critical and urgent care needs. The Global Core program gives you access to a worldwide network of care providers and medical assistance services. You can access these services by calling **1-800-810-BLUE**. Remember, the "Blue" name on your ID card is recognized around the world — and that's important protection!

Let us know if you'll be in the hospital

If you are receiving out-of-network services and you need overnight hospital care, you must call us to make sure it is covered. This is called "precertification." You can use the toll-free precertification phone number on your member ID card. Precertification is not necessary for maternity care or emergency care. For in-network services, your provider will take care of all precertification requirements.

Your specific plan may ask you for precertification before getting other services. Check your benefit booklet to learn the details about your plan. You will receive your benefit booklet once your enrollment is complete.

Virtual medicine services

Your plan covers virtual medicine services, which means you can talk to a doctor anytime, day or night, using your computer, tablet, or smartphone when you are experiencing a minor illness. Just another advantage of membership—convenient care, anytime and anywhere.

The virtual medicine service has a network of physicians who are board-certified in internal medicine, family practice, emergency medicine, and pediatrics. They can determine your problem, recommend treatment, and prescribe medication, when appropriate, for many medical issues. Adults and children may want to use this service when they have symptoms of a cold or flu, allergies, bronchitis, respiratory infections, ear infections or sinus problems.

Virtual medicine services provide a quick response and cost less than an urgent care or emergency room visit. This is a convenient alternative when you can't leave home, become ill in the middle of the night, or cannot reach your primary care physician. Virtual medicine services do not replace a primary care physician. To review your virtual medicine coverage, please see your Summary of Benefits.

You can find a virtual medicine provider in our online provider directory. Simply click on Find a Doctor at **highmarkbcbs.com**. You can also find a telemedicine service provider by calling Member Service at the number on your ID card, or My Care Navigator at **1-888-BLUE-428**.

What's not covered?

Some services are not covered under your health care plan. Those services include, but are not limited to, those listed below. Please keep in mind that you may have to pay the total payment to the provider for any health care services not covered by your plan. For additional information, please refer to your benefit booklet.

- Acupuncture
- Cosmetic surgery
- Hearing aids
- Long-term care
- Routine foot care
- Weight loss programs

Understanding health insurance

When you receive medical services, the doctor, hospital, or other facility will send us a claim. After we process the claim, Highmark will let you know if you have to pay a portion of the costs.

You often have a deductible. A deductible is the dollar amount you must pay for covered services before your insurance begins to pay. In addition, you may also have a copayment for doctors' office visits, therapy sessions, emergency care, or hospitalization.

After you have met your deductible for the benefit year, your insurance will pay a percentage of the cost. If it is less than 100 percent, you will owe the remaining percentage (your coinsurance).

Below is an explanation of some terms that you may see time to time—to help you better understand your plan.

Glossary of health care insurance terms

Allowed or Negotiated Amount: This is the amount of money that the doctor or hospital has agreed to accept for covered health care services.

Claim: A request for payment for the cost of covered services, sent from your health care provider to your insurance company. Your insurance plan processes the claim for payment according to the terms of the plan.

Covered Services: Health care procedures, tests, or treatments that are paid for (in whole or part) by your plan. You must pay all costs for non-covered services.

Coinsurance: The percentage of the allowed amount that the plan pays. You pay the remaining percentage.

Copay or Copayment: A fixed dollar amount you pay for certain services — typically for a doctor's office visit, prescriptions, or emergency care.

Deductible: The amount you must pay for covered services before your health plan begins to pay. Some services do not contribute to reaching your deductible. For instance, preventive care is covered at 100 percent, right from the start, so it is not applied to the deductible. After you reach your deductible, your plan will begin paying toward your claims.

Exclusive Provider Organization (EPO): This is a type of health insurance plan. It is based on an organization, or network of providers, who have agreed to the rules of the plan. An EPO typically does not offer coverage for out-of-network care, except for emergency services.

In-Network/Out-of-Network: Providers who are in-network have agreed on a cost for services. You will receive your best value when you use in-network providers. You will have to pay greater out-of-pocket costs for out-of-network care.

Precertify, Precertification: Telling your insurance company when you plan to get hospital care that requires an overnight stay. You must call to make sure that the insurance will pay for hospital care in your specific situation.

Preferred Provider Organization (PPO): This is a type of health insurance plan. It is based on an organization, or network of providers, who have agreed to the rules of the plan.

Provider: Any person or facility that provides health care services, such as a doctor, therapist, nurse practitioner, hospital, imaging center, lab or ambulatory care, or surgical center.

Retail Clinic: This is a small clinic, often in a pharmacy, which offers basic health care services and is open nights and weekends. It is often staffed by certified registered nurse practitioners who diagnose and treat common health problems, such as colds, the flu, or rashes.

Urgent Care Center: A freestanding, full-service, walk-in health care clinic that is open long hours during the week and often on weekends. Usually, no appointment is required. It is staffed by physicians and can treat minor illnesses and injuries and give physicals and immunizations, as well as blood tests, drug tests, and X-rays.



Benefit Summary and Preventive Schedule

Summary of PPO Blue Benefits

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

Allegheny County Standard Plan

Groups #017934-00, 06, 70, 80

Benefit	In Network	Out of Network
General Provisions		
Effective Date	January 1, 2020	
Benefit Period (1)	Calendar Year	
Deductible (per benefit period)		
Individual	\$400	\$4,500
Family	\$800	\$13,500
Plan Pays – payment based on the plan allowance	100% after deductible	50% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	None	\$5,000
Family	None	\$15,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$7,150	Not Applicable
Family	\$14,300	Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$30 copay	50% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after \$30 copay	50% after deductible
Specialist Office Visits & Virtual Visits	100% after \$30 copay	50% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	50% after deductible
Urgent Care Center Visits	100% after \$30 copay	50% after deductible
Telemedicine Services (3)	100% after \$30 copay	Not Applicable
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	50% after deductible
Adult Immunizations	100% (deductible does not apply)	not covered
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	50% after deductible
Mammograms, Annual Routine	100% (deductible does not apply)	50% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	not covered
Pediatric Immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible
Emergency Services		
Emergency Room Services	100% after \$100 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency	100% after deductible	100% after in-network deductible for emergencies; 50% after out-of-network deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	50% after deductible

Benefit	In Network	Out of Network
Therapy and Rehabilitation Services		
Physical Medicine	100% after \$30 copay	50% after deductible
Respiratory Therapy	100% after deductible	50% after deductible
Speech Therapy	100% after \$30 copay	50% after deductible
Occupational Therapy	100% after \$30 copay	50% after deductible
Spinal Manipulations	100% after \$30 copay limit: 20 visits/benefit	50% after deductible period
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	50% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	50% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after \$30 copay	50% after deductible
Outpatient Substance Abuse Services	100% after \$30 copay	50% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	50% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (5)	100% after deductible	50% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	100% after deductible	50% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	50% after deductible
Home Health Care	100% after deductible	50% after deductible benefit maximum of 100 visits/benefit period
Hospice	100% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (6)	100% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	50% after deductible
Skilled Nursing Facility Care	100% after deductible	50% after deductible
Transplant Services	100% after deductible	50% after deductible
Precertification Requirements (7)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	None None	
Prescription Drug Program (8) Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the National Select Formulary with an Incentive Benefit Design	(Prescriptions filled at non-network pharmacy are not covered) Retail Drugs (30-day Supply) \$10 generic copay \$25 Formulary brand copay \$50 Non-Formulary brand copay Mandatory Generic (8) 30-day supply Maintenance Drugs through Mail Order (90-day Supply) \$20 generic copay \$50 Formulary brand copay \$100 Non-Formulary brand copay Mandatory Generic (8) 90-day supply	

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

- (1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
- (2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
- (3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.
- (4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
- (5) Coverage for eligible members to age 21. After initial analysis, services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
- (6) 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.

Group #s 017934-00,06,70,80 PPO Blue Standard Plan Eff Jan 2020

(7) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

(8) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed.

Preventive Care

Take advantage of your generous coverage for preventive care services. Preventive care is critical to maintaining good health and identifying health issues before they become more serious.

Preventive care matters for everyone, at every stage of life

- Children need regular physical examinations and immunizations
- Women need mammograms and Pap tests
- Pregnant women need maternity care
- Adults need physical examinations, cholesterol screenings, and flu shots

Preventive vs. diagnostic care

Preventive care is the type of care you get when you are well that helps you stay healthy. You usually get preventive care when you aren't having any current symptoms or other problems.

Some examples of preventive care are:

- Routine wellness exams
- Immunizations
- Screenings such as blood tests for cholesterol and blood sugar, mammograms, and colonoscopies

This type of care follows guidelines such as those shown in the Preventive Schedule. It is usually covered by your plan at 100 percent.

Diagnostic care is the type of care you get when you are having symptoms of an illness or managing a health condition to identify, diagnose or monitor a problem.

Some examples of diagnostic care are:

- An MRI for back pain
- A blood test to measure your blood sugar when you have diabetes
- A doctor's visit for a cough, fever, and runny nose

Things to know

Review the preventive schedule on the following pages to find out about recommended examinations, screenings, and tests. You can also access this schedule on your member website.

When you call to make appointments or schedule tests, be sure to tell the office staff that your appointment is for preventive care, such as a routine physical.

If your doctor recommends tests and screenings, be sure to ask if they are considered preventive or diagnostic. This way you will know ahead of time if cost sharing is required. You can also call Member Service at the number on your ID card to find out.

2019 Preventive Schedule

Effective 7/1/2019

PLAN YOUR CARE: KNOW WHAT YOU NEED AND WHEN TO GET IT

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

Some services and their frequency may depend on your doctor's advice. That's why it's important to talk with your doctor about the services that are right for you.

QUESTIONS?

 Call Member Service

 Ask your doctor

 Log in to your account

Adults: Ages 19+



Male



Female

General Health Care

 Routine Checkup* (This exam is not the work- or school-related physical)	<ul style="list-style-type: none"> Ages 19 to 49: Every 1 to 2 years Ages 50 and older: Once a year
 Depression 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	<ul style="list-style-type: none"> Ages 20 and older: Once every 5 years High-risk: More often
 Colon Cancer Screening (Including Colonoscopy)	<ul style="list-style-type: none"> Ages 50 and older: Every 1 to 10 years, depending on screening test High-risk: Earlier or more frequently
 Certain Colonoscopy Preps With Prescription	<ul style="list-style-type: none"> Ages 50 and older: Once every 10 years High-risk: Earlier or more frequently
 Diabetes Screening	High-risk: Ages 40 and older, once every 3 years
 Hepatitis B Screening	High-risk
 Hepatitis C Screening	High-risk
 Latent Tuberculosis Screening	High-risk
 Lung Cancer Screening (Requires prior authorization and use of authorized facility)	Ages 55 to 80 with 30-pack per year history: Once a year for current smokers, or once a year if currently smoking or quit within past 15 years
 Mammogram	Ages 40 and older: Once a year including 3-D

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

Adults: Ages 19+

Screenings/Procedures

 Osteoporosis (Bone Mineral Density) Screening	Age 65 and older: once every 2 years. Younger if at risk as recommended by physician
 Pap Test	<ul style="list-style-type: none"> • Ages 21 to 65: Every 3 years, or annually, per doctor's advice • Ages 30 to 65: Every 5 years if HPV 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

Immunizations

 Chicken Pox (Varicella)	Adults with no history of chicken pox: One 2-dose series
 Diphtheria, Tetanus (Td/Tdap)	<ul style="list-style-type: none"> • One-time Tdap • Td booster every 10 years
 Flu (Influenza)	Every year (Must get at your PCP's office or designated pharmacy vaccination provider; call Member Service to verify that your vaccination provider is in the Highmark network)
 Haemophilus Influenzae Type B (Hib)	For adults with certain medical conditions to prevent meningitis, pneumonia and other serious infections; this vaccine does not provide protection against the flu and does not replace the annual flu vaccine
 Hepatitis A	At-risk or per doctor's advice: One 2 or 3 dose series
 Hepatitis B	At-risk or per doctor's advice: One 2 or 3 dose series
 Human Papillomavirus (HPV)	To age 26: One 3-dose series
 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	<ul style="list-style-type: none"> • Zostavax - Ages 60 and older: One dose • Shingrix - Ages 50 and older: Two doses

Preventive Drug Measures That Require a Doctor's Prescription

 Aspirin	<ul style="list-style-type: none"> • Ages 50 to 59 to reduce the risk of stroke and heart attack • Pregnant women at risk for preeclampsia
 Folic Acid	Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid
 Raloxifene Tamoxifen	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 1 or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and have calculated 10-year risk of a cardiovascular event of 10% or greater.

* Meningococcal B vaccine per doctor's advice.

Preventive Care for Pregnant Women



Screenings and Procedures

- Gestational diabetes screening
- Hepatitis B screening and immunization, if needed
- HIV screening
- Syphilis screening
- Smoking cessation counseling
- Depression screening during pregnancy and postpartum
- Rh typing at first visit
- Rh antibody testing for Rh-negative women
- Tdap with every pregnancy
- Urine culture and sensitivity at first visit
- Alcohol misuse screening and counseling

Prevention of Obesity, Heart Disease and Diabetes



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

Adult Diabetes Prevention Program (DPP)



Applies to Adults

- Without a diagnosis of Diabetes (does not include a history of Gestational Diabetes) and
- Overweight or obese (determined by BMI) and
- Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7 to 6.4 percent or Impaired Glucose Tolerance Test of 140-199mg/dl.

Enrollment in certain select CDC recognized lifestyle change DPP programs for weight loss.

2019 Preventive Schedule

PLAN YOUR CHILD'S CARE: KNOW WHAT YOUR CHILD NEEDS AND WHEN TO GET IT

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

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

QUESTIONS?

 Call Member Service

 Ask your doctor

 Log in to your account

Children: Birth to 30 Months¹

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

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance. Additional: Instrument vision screening to assess risk for ages 1 and 2 years. ** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.

Children: 3 Years to 18 Years¹

General Health Care	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	15Y	18Y	
Routine Checkup* (This exam is not the preschool- or day care-related physical)	●	●	●	●	●	●	●	●	Once a year from ages 11 to 18				
Ambulatory Blood Pressure Monitoring**												●	
Depression Screening									Once a year from ages 11 to 18				
Hearing Screening***		●	●	●		●		●		●	●	●	
Visual Screening***	●	●	●	●		●		●		●	●	●	
Screenings													
Hematocrit or Hemoglobin Screening			Annually for females during adolescence and when indicated										
Lead Screening	When indicated (Please also refer to your state-specific recommendations)												
Cholesterol (Lipid) Screening									Once between ages 9-11 and ages 17-21				
Immunizations													
Chicken Pox		Dose 2								If not previously vaccinated: Dose 1 and 2 (4 weeks apart)			
Diphtheria, Tetanus, Pertussis (DTaP)		Dose 5							One dose Tdap				
Flu (Influenza)****	Ages 3 to 18: 1 or 2 doses annually												
Human Papillomavirus (HPV)								Provides long-term protection against cervical and other cancers. 2 doses when started ages 9-14. 3 doses all other ages.					
Measles, Mumps, Rubella (MMR)		Dose 2											
Meningitis*****									Dose 1		Age 16: One-time booster		
Pneumonia	Per doctor's advice												
Polio (IPV)		Dose 4											
Care for Patients With Risk Factors													
BRCA Mutation Screening (Requires prior authorization)					Per doctor's advice								
Cholesterol Screening	Screening will be done based on the child's family history and risk factors												
Fluoride Varnish (Must use primary care doctor)	Ages 5 and younger												
Hepatitis B Screening									Per doctor's advice				
Hepatitis C Screening											High-risk		
Latent Tuberculosis Screening												High-risk	
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV and Syphilis)									<ul style="list-style-type: none"> For all sexually active individuals HIV routine check once between ages 15-18 				
Tuberculin Test	Per doctor's advice												

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

Children: 6 Months to 18 Years¹

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
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Prevention of Obesity and Heart Disease

Children With a BMI in the 85th to 94th Percentile (Overweight) and the 95th to 98th Percentile (Obese) Are Eligible For:	<ul style="list-style-type: none"> • Additional annual preventive office visits specifically for obesity • Additional nutritional counseling visits specifically for obesity • Recommended lab tests: <ul style="list-style-type: none"> – Alanine aminotransferase (ALT) – Aspartate aminotransferase (AST) – Hemoglobin A1c or fasting glucose (FBS) – Cholesterol screening
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Adult Diabetes Prevention Program (DPP) Age 18

 Applies to Adults <ul style="list-style-type: none"> • Without a diagnosis of Diabetes (does not include a history of Gestational Diabetes) and • Overweight or obese (determined by BMI) and • Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7 to 6.4 percent or Impaired Glucose Tolerance Test of 140-199mg/dl. 	Enrollment in certain select CDC recognized lifestyle change DPP programs for weight loss.
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Women's Health Preventive Schedule

Services

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

Screenings/Procedures

Diabetes Screening	<ul style="list-style-type: none"> • High-risk: At the first prenatal visit • All women between 24 and 28 weeks pregnant • Postpartum women without Diabetes but with a history of gestational diabetes
HIV Screening and Discussion	All sexually active women: Once a year
Human Papillomavirus (HPV) Screening Testing	Beginning at age 30: Every 3 years
Domestic and Intimate Partner Violence Screening and Counseling	Once a year
Breast-feeding (Lactation) Support and Counseling, and Costs for Equipment	During pregnancy and/or after delivery (postpartum)
Sexually Transmitted Infections (STI) Discussion	All sexually active women: Once a year

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



Prescription Drug Coverage

Your prescription drug program

Your retail pharmacy benefits

Your prescriptions are covered when you use our large network of pharmacies. There are many locations from major chains to independent pharmacies.

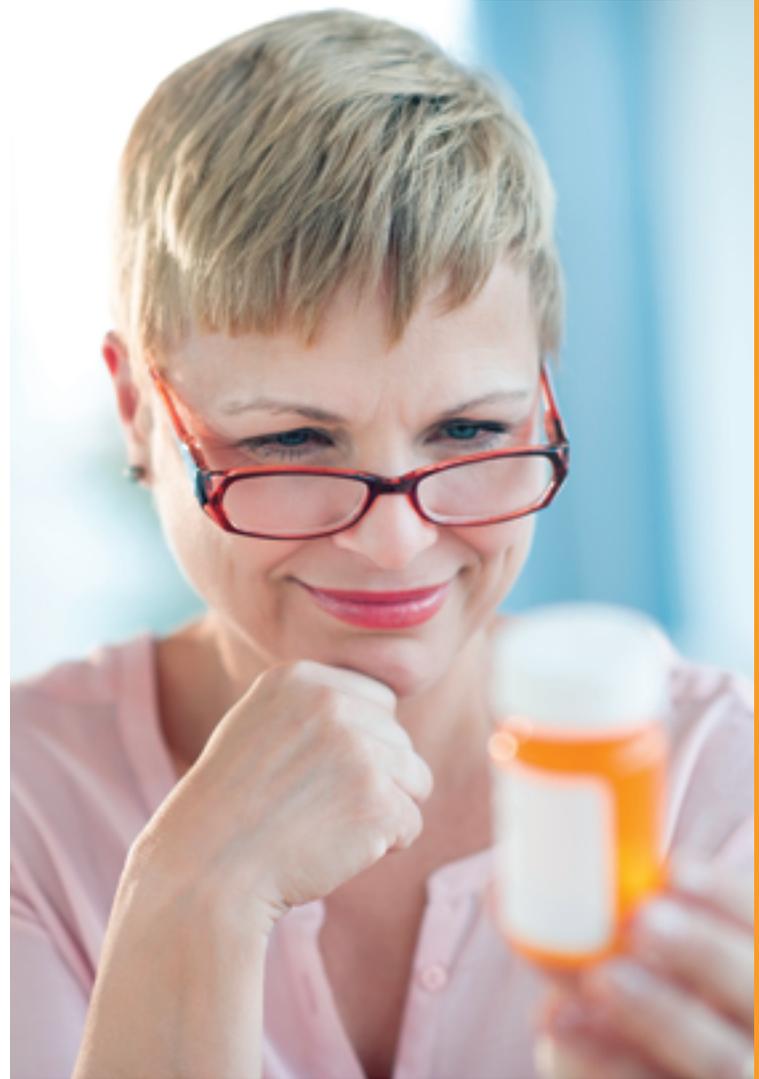
When you take your prescription to a network pharmacy, they will apply your coverage. Depending on your plan, you may have to pay a copayment or a percentage of the cost.

To find a pharmacy near you, check the list of national chain pharmacies that follows this page. To find independent pharmacies, log in to [Highmarkbcbs.com](https://www.highmarkbcbs.com) and click on the **Find a Doctor or Rx** tab near the top of the page, or call Member Service, toll-free, at the phone number on the back of your ID card.

Our quality control services ensure that your use of prescription drugs is safe and effective. Refer to your *Summary of Benefits* documents for details about your coverage.

- In most cases, you'll save money by choosing a generic drug instead of a brand-name drug
- You can also save by using a mail order pharmacy program

If you have a closed formulary, we must approve payment for drugs that are not on the formulary. If your doctor thinks you need to take a drug that is not on the formulary, your doctor will send us a request for approval. You or someone you designate can also request a non-formulary drug exception.



Affordable prescription drug coverage

Highmark prescription drug plans help you get the medications you need at a cost you can afford.

We make sure you get the right drug, at the right time, in the right amount, and at the right price, by implementing the following plan management features:

- **Prior Authorization:** In some cases, your doctor must provide information before your drug is covered at the pharmacy. You and your doctor can find out if your drug requires prior authorization by visiting our formulary website.
- **Quantity Limits:** Some drugs have limits on how many can be dispensed at one time—to be sure that they are used safely, and to prevent waste. You and your doctor can find out if your drug has a quantity limit by visiting our formulary website.

These prescription drug management features are activated at the time of your pharmacy visit. If your drug requires prior authorization, or the amount of drug is greater than policies allow, the prescription will be rejected for payment, and the pharmacist will receive a message about why it was rejected.

What to do if your prescription drug requires preauthorization

Simply inform your doctor that prior authorization is required. Your doctor has three ways to send the necessary information:

- Call the Pharmacy Affairs Hotline at **800-600-2227** and speak directly to a staff member
- Send a request online by using the NaviNet program
- Fill out and fax a medication request form (available on our website) to **866-240-8123**, which goes to the Hotline staff



National Network Retail Pharmacy Chains

Below is a listing of retail pharmacy chains currently in the National Network.

Locate all pharmacies in the network by zip code when logging into your member website and selecting Find a Doctor or Rx.



A

- A&P
- AADP
- Acme
- Affiliated Health Services
- Ahold
- Albertson's
- Aurora Pharmacy

B

- Bartell Drugs
- Big Y Pharmacy
- Bi-Lo Pharmacy
- Bi-Mart
- Brookshire Brothers
- Brookshire Pharmacy

C

- Coborns
- CostCo
- CVS

D

- Discount Drug Mart

F

- Fairview Health Services
- Food City Pharmacy
- Freds
- Fruth Pharmacy

G

- Giant Eagle

H

- Hannaford Food And Drug
- Harps Pharmacy
- Harris Teeter
- H-E-B Pharmacy
- Homeland Pharmacy
- Hy-Vee

I

- Infusion Partners
- Ingles Markets
- Instymeds

K

- Kinney Drugs
- Kmart Pharmacy
- Kroger

M

- Marc's Pharmacy
- Marsh Drug Store
- Medicine Shoppe
- Meijer Pharmacy Receivables

O

- Omnicare

P

- Patient First
- Pharmerica
- Price Chopper Pharmacy
- Publix

R

- Raley's Drug Center
- Rite Aid
- Ritzman Pharmacy
- Roundy's Supermarkets

S

- Safeway
- Sam's Club
- Save Mart Pharmacy
- Sav-Mor Drug Stores
- Schnucks Pharmacy
- Shop 'N Save
- Shopko Pharmacy
- Spartan Pharmacy
- Supervalu Pharmacies

T

- Texas Oncology Pharmacy
- Thrifty White Drug
- Tops Pharmacy

U

- United Pharmacy

V

- Value Drugs

W

- Wakefern
- Wal-Mart
- Wegmans Pharmacy
- Weis

Save by using a mail order pharmacy

If you take medications on an ongoing basis, you can save money and enjoy the great convenience of having your prescriptions mailed directly to you.

- Get up to a 90-day supply for just one mail order copay
- Registered pharmacists are available 24 hours a day, 7 days a week
- Order refills online, by mail or by phone — anytime day or night
- Refills are usually delivered within 3 to 5 days
- Standard shipping is free

Choose a convenient payment option

You can pay online by e-check, credit card, or through your health spending account.

You can call pharmacy services, toll-free, at **1-800-903-6228** (TTY users call **1-800-759-1089**) for help with your order.

How to start using the mail order pharmacy

Ask your doctor to write a new prescription for up to a 90-day supply, plus refills for up to one year, if appropriate. He or she can fax or send it as an e-prescription.

Or, you can complete the Pharmacy Mail Order Form in this booklet. You can also find this form at **Highmarkbcbs.com**. Click on Important Forms under the Helpful Hints link at the bottom of the page. You can then find the form needed under the Prescription Drug Forms section.

Be sure you have enough medications on hand (at least a 14-day supply) to cover your needs until your order is confirmed, processed, and mailed.

You can mail your completed form to:

Express Scripts
Home Delivery Service
P.O. Box 74700
Cincinnati, OH 45273

Learn more online

Highmark's member website, **Highmarkbcbs.com**, has helpful information about your prescription drug program, along with easy-to-use tools to manage your benefits and prescriptions. You can log in to:

- Find pharmacies in your plan's network
- Check to see if prescription drugs are on your formulary and covered by your plan
- Submit mail order refills and check on order status
- Learn about low-cost generic options
- Compare cost savings from using mail order
- Get forms to manage your coverage
- Find answers to common questions about your benefits and prescriptions

Protecting your safety and privacy

We are committed to protecting your safety and privacy—so, we check for potential interactions and drug allergies to minimize risk when you take your medication. We will also consult with your doctor to find appropriate drugs that will save you money on your plan.

Your plan may have coverage limits

If you submit a prescription for a drug that has coverage limits, we will tell you, in writing, that you need approval before the prescription can be filled.

Patient/doctor information continued

First name

Last name

Birth date (MM/DD/YYYY)

Sex

 M F

Patient's relationship to member

 Self Spouse Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex

 M F

Patient's relationship to member

 Self Spouse Dependent

Doctor's last name

1st initial

Doctor's phone number

Important reminders and other information

Check that your doctor has prescribed the maximum days' supply allowed by your plan (not a 30-day supply), plus refills for up to 1 year, if appropriate. Also, ask your doctor or pharmacist about safe, effective, and less expensive generic drugs.

Complete the Health, Allergy & Medication Questionnaire.

There may be a limit to the balance that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

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 phone number found on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1.800.633.4227.

Express Scripts will make all possible efforts, as appropriate by law, to substitute generic formulations of medication, unless you or your doctor specifically directs otherwise.

Pennsylvania and Texas laws permit pharmacists to substitute a less expensive generic equivalent for a brand-name drug unless you or your doctor directs otherwise.

Check the box if you do not wish a less expensive brand or generic drug.

Please note that this applies only to new prescriptions and to any refills of that prescription.

For additional information or help, visit us at Express-Scripts.com or call Member Services at the phone number found on your ID card. TTY/TDD users should call 1.800.759.1089.

Federal law prohibits the return of dispensed controlled substances.

FOLD HERE

FOLD HERE

Please mail your prescription(s), this form, and your payment to the address indicated. Do not use staples or paper clips.

EXPRESS SCRIPTS
PO BOX 747000
CINCINNATI, OH 45274-7000





Wellness

Wellness

Improving your health from every angle

It's no secret. When you live in a healthy way, you feel better. When you take care of yourself and adopt healthy habits, you have more energy, a better attitude, increased focus and get more enjoyment from life.

At Highmark we want to help you take control of your health by providing you with the tools you need to help live a healthier lifestyle. Take advantage of the many resources available to you as a Highmark member.

Blues On CallSM

You have access to a 24-hour nurse line. This member service puts you in touch with a nurse who can discuss in confidence any health topic that concerns you. Connect with Blues On Call anytime of the day or night by calling 1-888-BLUE-428 (1-888-258-3428).

Wellness Coaching

Reach out to a health coach for help in managing a healthy lifestyle with access to programs such as smoking cessation and weight management. Call 1-888-258-3428 to talk to a coach or enroll in a program.

Disease Management Programs

Get expert help from a nurse when you are faced with the day-to-day challenges of managing chronic conditions such as asthma and diabetes. Call 1-888-258-3428 for more information and to talk to a nurse.

Baby Blueprints[®]

If you are pregnant, join the no-cost Baby Blueprints maternity education and support program. You'll be able to connect with support from online resources and a health coach on all aspects of pregnancy and childbirth. Call toll-free 1-866-918-5267 to enroll.



Meet Sharecare®

Sharecare is your digital health solution to help manage your health in one place. With Sharecare, you'll receive a wealth of personalized guidance to help you live a healthier lifestyle by eating right, exercising, getting the right amount of sleep, reducing stress, and more.

RealAge® Test

The RealAge Test is the first step toward optimizing your health. It arms you with information on how your lifestyle choices help you stay younger or make you age faster than your calendar age. Simply answer a few questions to learn what your RealAge is!

Personalized Content

Receive personalized news, articles, videos and more based on your RealAge results, where you are on your health journey and the topics or conditions you care about.

Green Day Health Tracker

Track the core health factors that influence your health the most. Each green day you earn may contribute to a reduction in your RealAge.

AskMD®

This comprehensive symptom checker matches your answers against the latest clinical research. It tells you what you should know and what you can do to be better informed before you visit the doctor.

Once you've received your new member ID card in the mail, register and get started at mycare.sharecare.com.

Already have an existing Sharecare account?
Sign in with your existing Sharecare username and password.

New to Sharecare? Follow the prompts to set up a new account.

Verify your eligibility. Enter your information exactly as it appears on your Highmark member ID card.

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

Baby BluePrints is a registered mark of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Sharecare, RealAge Test and AskMD are registered trademarks of Sharecare, LLC., an independent and separate company that provides a consumer care engagement platform for Highmark members. Sharecare is solely responsible for its programs and services, which are not a substitute for professional medical advice, diagnosis or treatment. Sharecare does not endorse any specific product service or treatment. Health care plans and the benefits thereunder are subject to the terms of the applicable benefit agreement.



Health Tools & Resources

Take advantage of the many tools and resources available to you

Start by visiting your member website, **Highmarkbcbs.com**. Take a few minutes to register online. Then you can log in from any computer, smart phone, tablet or other mobile device.

After you've registered, log in and click the **Other Member Information** link on your member website's homepage. In the Account Settings page, click the **Contact Information** link to make sure your contact information is correct.

After you verify your contact information or make any changes, click the **Contact Preferences** link in the Account Settings page to tell us the best ways to communicate with you.

This way, we'll be able to share important information about your health coverage and ways to stay healthy.

Member Service: Where to turn for help

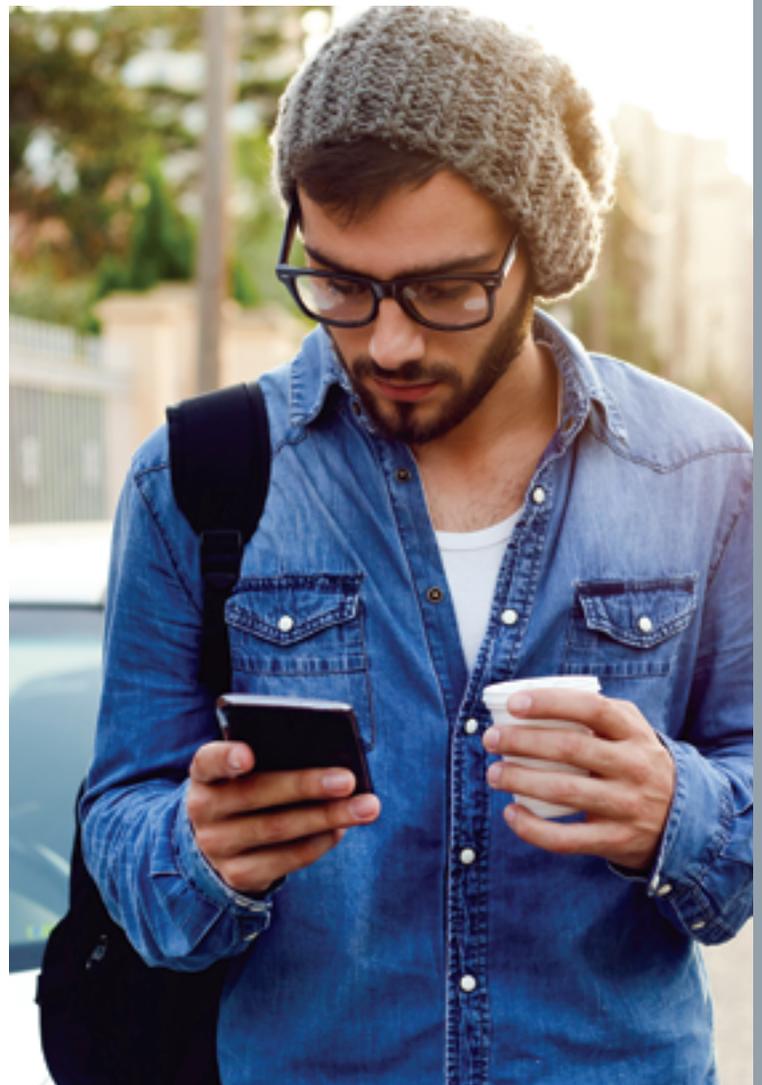
If you aren't sure who can answer your questions, start with Member Service. Their toll-free number is on the back of your ID card.

If your question is about medical claims or coverage, please collect all relevant data before you call. This includes your member ID number, claim number, date of service, bills and Explanation of Benefits forms. We can also determine if a treatment is covered by your plan and what your out-of-pocket costs will be. Remember to get the name of the procedure and diagnosis code from your doctor before you call.

If English is not your native language

If English is not your native language or you belong to a racial, ethnic, or cultural group that has not always received the appropriate quality of care, let us know.

Providing this information is voluntary. Your responses will not affect your benefits in any way. We are committed to protecting all your personal information with respect and integrity.



Online health tools put health care in your hands

With reliable cost and quality information, these health tools are easy to use:

- **Care Cost Estimator** — Compare prices and quality for different health care providers. You can do side-by-side comparisons for quality ratings, convenience, and cost for doctors and hospitals for hundreds of medical services. The cost estimates include all services related to a procedure — like physician fees, supplies, and medications. It uses your own specific coverage to calculate what your out-of-pocket costs might be.
- **Find a doctor or Rx** — Select health care professionals based on their quality, experience, location and more. It all starts with a simple search. You can also see how others rate their experiences with doctors and medical facilities or share your own experience.
- **Compare prescription costs** — Learn how much medications cost and how to save money by using generics.

Navigating health care is easy with My Care NavigatorSM

Navigating the health care system shouldn't be like walking through a maze, getting caught in endless twists, turns, and dead ends. It shouldn't take multiple phone calls and tons of paperwork for you to get the care services you need. It should be a lot quicker and easier.

Now it is! You and your family members have a built-in guide who can navigate the ins and outs of the health system for you. Getting your care questions answered and problems solved is as easy as dialing 1-888-BLUE-428 (1-888-258-3428) and waiting for the My Care Navigator prompt.

My Care Navigator can help you:

- Locate a convenient health care provider
- Schedule a prompt appointment
- Transfer your medical records
- Learn about wellness services, such as elder care or special needs care
- Understand your prescription drug coverage
- Learn how to better manage your care costs

My Care Navigator is a service mark of Highmark Health.

Member discounts with Blue365®

Your health care coverage includes access to a wide range of discounts on health and wellness-related products and services from national, well-known brands.

- Get discounts on fitness centers, personal trainers, and running shoes.
- Save on nutrition counseling, diet programs, and vitamin supplements.
- Try yoga, tai chi or massage at discounted rates.
- Experience the benefits of acupuncture, mind/body therapies or holistic medicine.
- Buy hearing aids at discounted prices or explore eye surgery options.

Get started

To search the member discounts available to you or to find participants in this discount program:

- Log in or register at Highmarkbcbs.com
- Select the **Member Discounts** link
- Select the **Blue365 discounts** link

When you visit a participant, just show your ID card to get your discount. You are responsible for paying the practitioner directly at the time the product is purchased or the service is received.

The member discount program is separate and distinct from your health benefits plan.

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

View your ID card on your mobile device

Your ID card information is available as soon as your coverage is effective. You can:

- View ID cards for everyone on your policy
- Fax your ID card information to doctors and hospitals
- Order replacement ID cards

Once you register and log in, follow these steps to view your ID card:

1. Click the **View ID Card** button
2. Click on the **name of the person** whose ID card you want to view

You can also fax your ID card to your doctor's office or other providers by clicking on the fax button and following the instructions.

Find a Doctor

Find a Doctor is an online search tool that makes it easy to find the right providers for you. You can search for:

- Primary care providers
- Specialists
- Hospitals
- Imaging centers
- Urgent care centers and retail clinics
- Pharmacies
- ...And more!

It all starts with a simple search.

Find a Doctor can help you...

- Know if your current providers are in your plan's network
- Find new providers or specialists
- Compare quality measures on providers
- See how patients like you rate their experiences with doctors — and rate your own experience

Go to your member website at Highmarkbcbs.com and click the **Find a Doctor or Rx** tab to start your search.

Healthy behaviors to save you time and money

Choose in-network providers

Network providers are doctors, hospitals, and other health care professionals that have an agreement with your health plan to accept the amount the plan will pay for covered services. You have the highest level of coverage and pay the least when you go to an in-network provider.

Out-of-network providers do not have an agreement with your health plan. If you are treated by an out-of-network provider, you are responsible for a larger share of the costs. You may also need to pay any difference between the amount your health plan pays and the provider's charge for the service, and you may have to file your own claims.

When you make an appointment, ask if the doctor participates in your plan's network.

Tell your doctor your reason for visiting

When you call to make an appointment for your routine physical, be sure to tell the office staff and doctor that your appointment is for a routine physical and most preventive care is covered at 100 percent.

Choose generic drugs

Approved by the Food and Drug Administration (FDA), generic drugs are comparable to brand names in dosage form, strength, quality, performance, and intended use. They must contain the same active ingredients as their brand-name equivalents. But they can cost you much less — as much as 80 percent less than brand names! Talk with your doctor to see if your medicine is available as a generic.

Go to urgent care centers for non-emergency care

If you have an urgent medical problem that's not an emergency, such as a sprain, nausea, a rash, or a cough, going to your primary care doctor or an urgent care center instead of the emergency room (ER) saves you time and money. If you go to the ER for non-emergency care, you can wait hours for care and end up paying more for care once you get it.

If you believe that you are having a medical emergency and you need immediate treatment, go directly to a hospital emergency room or call 911.

Use virtual medicine services

When your doctor isn't available or you can't leave work or home, take advantage of convenient virtual medicine services for minor illnesses. This service is covered like your primary office visit, quite a savings compared to the cost of visiting the ER in non-emergency situations. Refer to your Summary of Benefits for details.

Get blood tests at an independent lab

You enjoy the same kind of savings by going to independent labs rather than hospitals. And since labs are dedicated to providing tests that measure blood cell count, glucose and cholesterol levels, and thyroid functions, you get more efficient service.

Get X-rays at an imaging center

The next time your doctor orders X-rays, CT scans, or an MRI, consider going to your local X-ray/imaging center instead of the hospital, where imaging tests can be approximately 30 percent more expensive.

Ask to transfer your medical test results to all your care providers

Other factors contributing to the high costs of care are unnecessary duplicate tests and procedures. To ensure you don't pay for care you don't need and to keep your health care providers all on the same page, make sure your medical test results are shared with all appropriate care providers.

Use mail order for maintenance medications

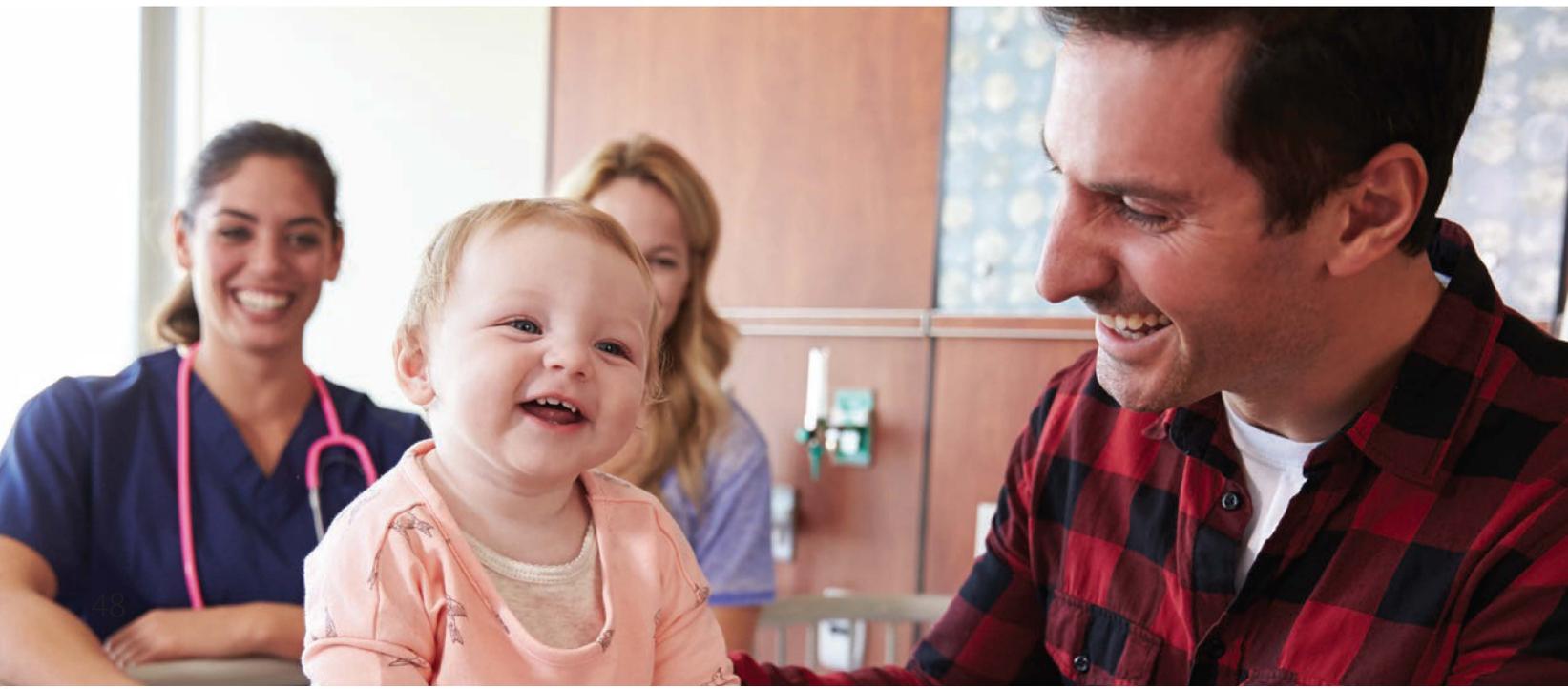
If you take a maintenance medication for a condition like high blood pressure, high cholesterol, or diabetes, getting your prescription by mail order can help you save not only the money but also the time spent going to your local pharmacy and waiting for refills.

Shop around for value

Because costs can vary a lot for even the same service, it's important to know what different providers may cost. Using the Care Cost Estimator lets you shop for the providers who offer the best value.

To find a primary care doctor, urgent care centers, labs, or imaging centers:

- Go to [Highmarkbcbs.com](https://www.highmarkbcbs.com) and click the **Find a Doctor or Rx** tab.
- Call My Care Navigator at **1-888-BLUE-428**.





Additional Important Information

Determining your coverage for care

For benefits to be paid under your program, services and supplies must be considered “medically necessary and appropriate.”

Medical Management & Quality (MM& Quality) is responsible for determining that care is medically necessary and provided in the appropriate setting. This means it is:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient’s illness, injury, or disease
- Not primarily for the convenience of the patient, physician, or other health care provider
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease

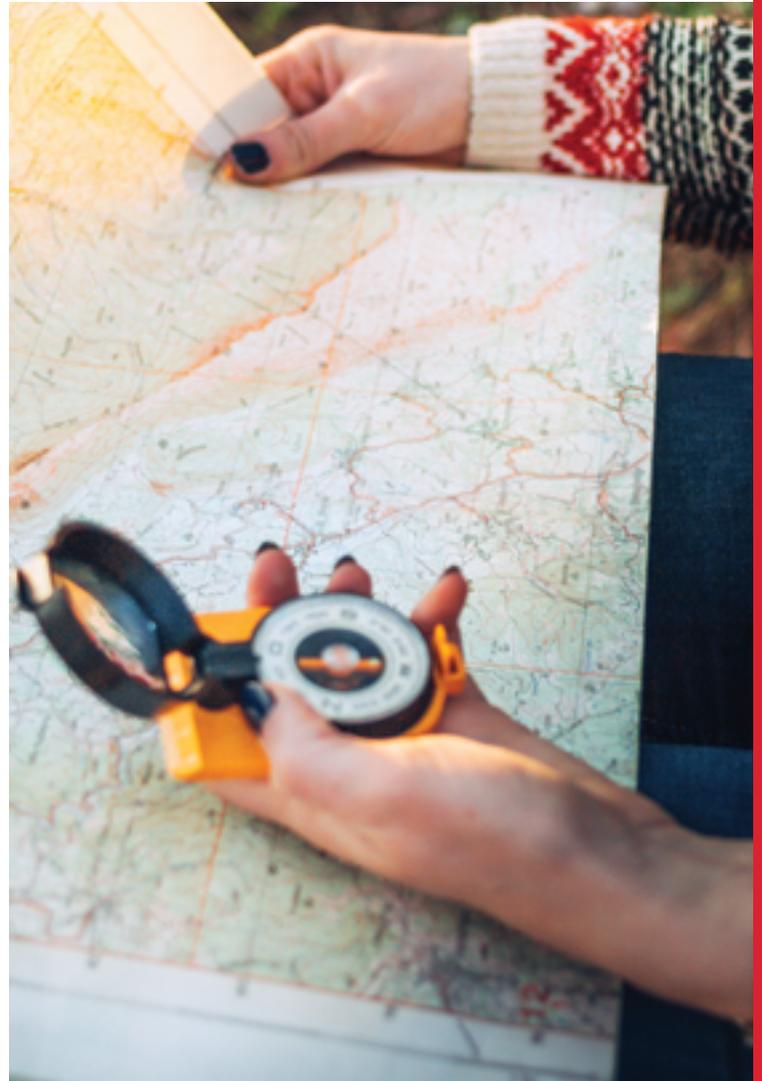
We must approve some services before you can get them. This is called prior authorization, or preservice review.

If you need a service that we must first approve, your in-network doctor will call us to get the authorization. The number to call for prior authorization is included on the ID card you will receive after you enroll.

If you are admitted to the hospital and your doctor feels that you may need more days of care, a “concurrent review” may happen. A concurrent review is a detailed review while you are still in the hospital. We do this to determine if the additional in-hospital services are medically necessary and appropriate.

If we denied payment for a service that you already had, your doctor may ask for a “retrospective review.” For this review, we will take a detailed look at your records and information to determine if the services were medically necessary and appropriate.

If we deny coverage of a service or claim, you have the right to appeal the denial decision. More information about the appeal process is included in the benefit booklet that you will receive after you enroll.



How We Protect Your Rights to Confidentiality

We have established policies and procedures to protect the privacy of our members' protected health information (PHI) from unauthorized or improper use. We maintain physical, electronic and procedural safeguards that comply with state and federal regulations to safeguard against unauthorized access, use and disclosures. PHI may be oral, written, or electronic.

As permitted by law, we may use or disclose PHI for treatment, payment and health care operations, such as: claims management, routine audits, coordination of care, quality assessment and measurement, case management, utilization review, performance measurement, customer service, credentialing, medical review, and underwriting. With the use of measurement data, we are able to manage members' health care needs, even targeting certain individuals for quality improvement programs, such as health, wellness, and disease management programs.

If we ever use your PHI for non-routine uses, we will ask you to give us your permission by signing a special authorization form, except with regard to court orders and subpoenas.

You have the right to access the information your doctor has been keeping in your medical records and any such request should be directed first to your network physician.

You benefit from the many safeguards we have in place to protect the use of data and PHI, including oral PHI, which we maintain from unauthorized or improper use. This includes not discussing PHI outside of our offices, confirming who you are before we discuss PHI on the phone, requiring employees to sign statements in which they agree to protect your confidentiality, not discussing PHI outside of our offices (i.e., in hallways or elevators), verifying your identity before we discuss PHI with you over the phone, using computer passwords to limit access to your PHI, and including confidential language in our contracts with doctors, hospitals, vendors, and other health care providers.

We provide aggregate information to employer groups whenever possible. In those instances where protected health information is required, the employer group will be required to sign an agreement before the information is released.

Our Privacy Department reviews and approves policies regarding the handling of confidential information.

Recognizing that you have a right to privacy in all settings, we even inspect the privacy of examination rooms when we conduct on-site visits to doctors' offices. It's all part of assuring that your PHI is kept confidential.

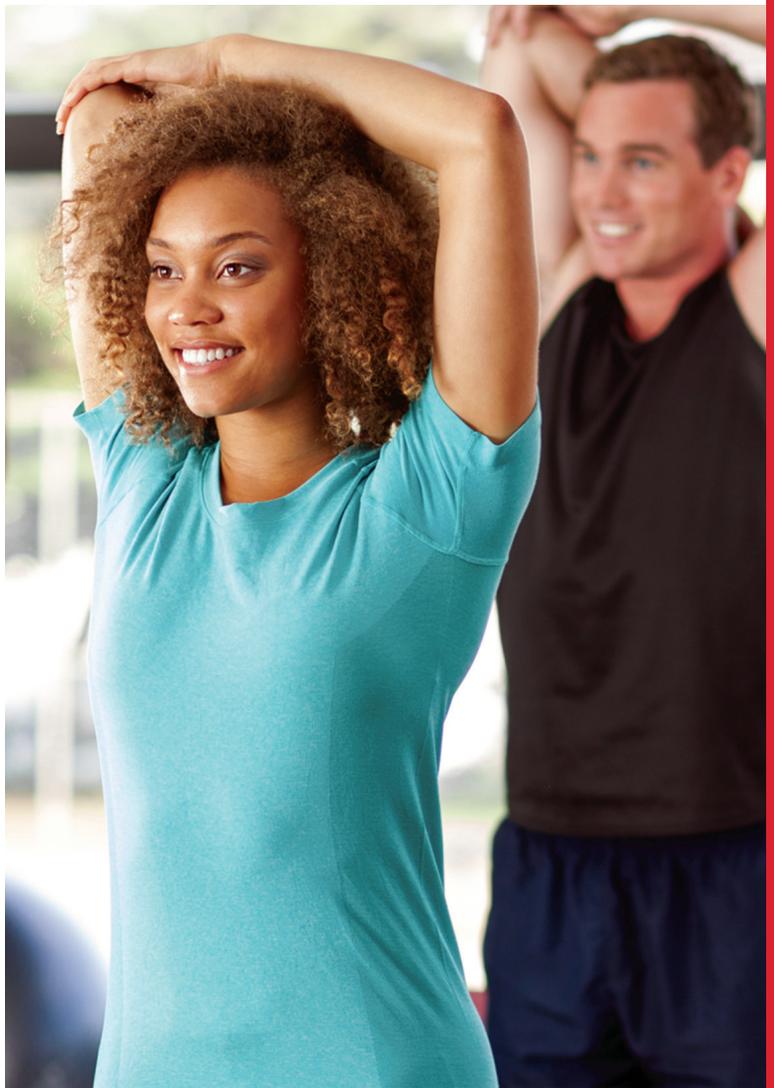
Care & Case Management

Care Management Program

Everyone has different needs at different times. Our Care Management program uses an integrated, comprehensive approach to provide care support and ensure the care you receive is responsive and appropriate.

These services are part of the Care Management Program:

- **Precertification Review**, which begins once treatment information is received, is designed to:
 - Verify your eligibility for services and benefits
 - Determine if care is medically necessary and appropriate
 - Establish that care is being rendered at an appropriate site by an appropriate provider
 - Initiate alternative levels of care when feasible
 - Identify members who will benefit from case management or condition management
- **Concurrent Review**, which may occur during the course of ongoing treatment, is designed to:
 - Evaluate members' current medical status to determine need for service continuation
 - Evaluate appropriate level of care for treatment
 - Identify any potential quality of care concerns
 - Identify situations that require a physician consultation
 - identify cases that may benefit from case management or condition management
 - Update and/or revise the discharge plan
- **Discharge Planning**, an integral part of the inpatient review process, often begins before a scheduled admission and continues throughout the course of treatment to:
 - Promote , when appropriate, the use of alternative levels of care
 - Arrange for the provision of care in an appropriate setting
 - Provide early identification of members who may benefit from case management or condition management programs and make timely referrals for intervention
 - Develop and implement appropriate discharge plans
- **Retrospective Review**, the process of assessing the appropriateness of medical services after the services have been provided, is based solely on the medical information available to the attending physician or ordering provider at the time the medical care was provided.



Case Management Program

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.

These conditions may include, for example, an inpatient hospitalization resulting from a chronic condition or a serious injury or illness which may require a high level of care.

Goals of the Case Management Program

Our Case Management program is based on the Case Management Society of America (CMSA) standards and includes the primary overall goals of:

- Identifying and resolving gaps in care
- Assuring the use of appropriate facilities and providers to get “the right care at the right time.”
- Increasing members' understanding of their condition or situation.
- Reducing medication discrepancies and assuring appropriate use of prescribed medications.
- Addressing any caregiver issues that may affect the members' condition.
- Improving members' ability to self-manage their conditions and turn attention to wellness.
- Reducing potentially avoidable emergency room visits and hospital readmissions.

The overall goal is to restore members to the highest possible level of functioning in their work, family, and social lives.

How the Case Management Program Works

A Registered Nurse Case Manager leads a team of multidisciplinary clinical staff comprised of social workers, pharmacists, and dieticians to evaluate the preferences and services necessary to meet the member's health needs. This team:

- Collaborates with members, their families, significant others, and providers to assess, plan, implement, coordinate, monitor and evaluate the options and services required to meet an individual's health needs.
- Addresses gaps and/or barriers to care before inpatient admission and/or discharge.
- Helps members understand and manage their conditions.
- Educates members on care coordination, support systems, medication knowledge, health, and wellness.
- Connects members to helpful resources.

This program is voluntary and members may decline participation or discontinue the program at any time.

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

Discrimination is Against the Law

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

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

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

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

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

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

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

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

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

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

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

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

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

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

إذا كنت تتحدث اللغة العربية، فهناك خدمات المساعدة 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.

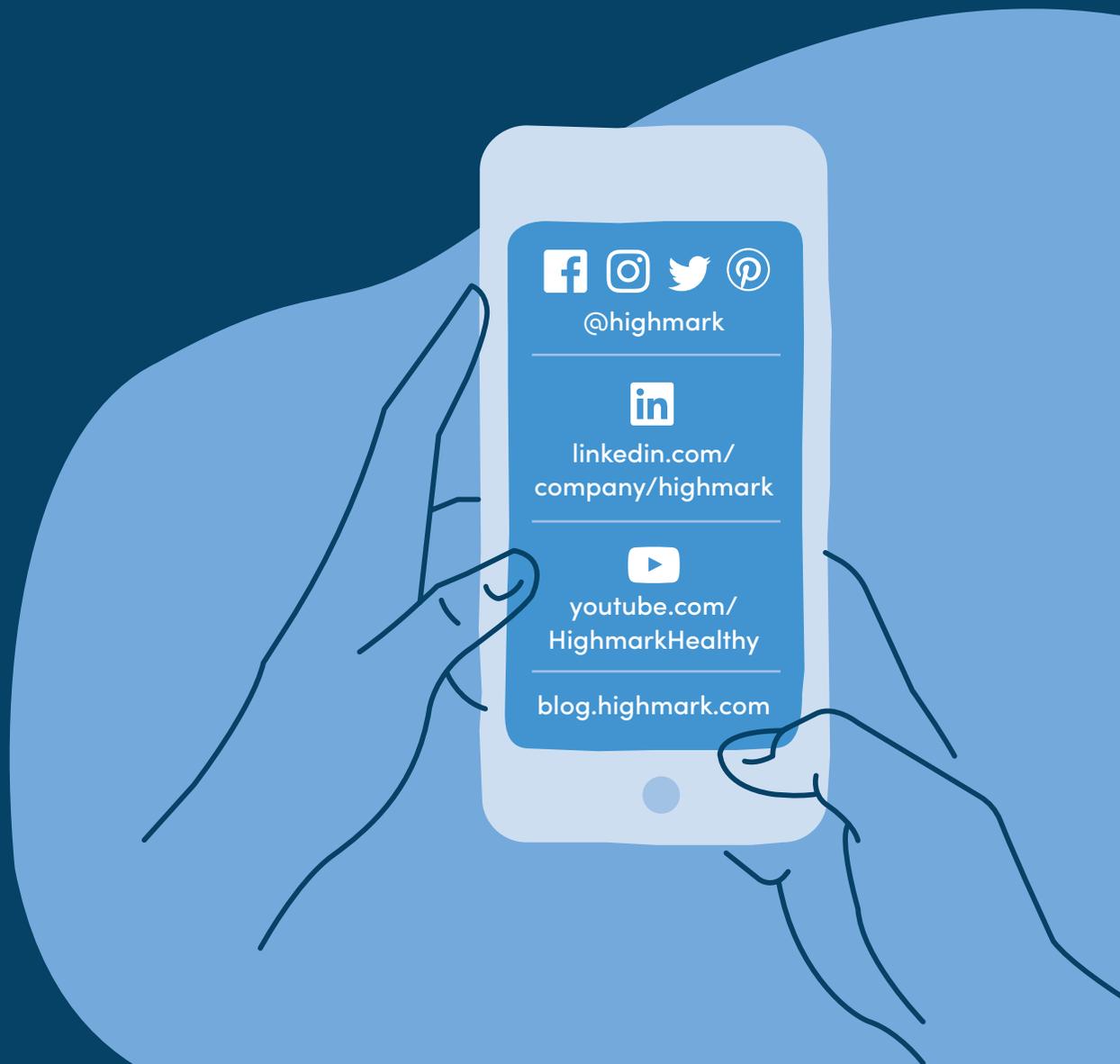
Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.

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.
