
Better benefits.
Easier access.
More life.

Care that keeps up with your life.

Wherever you are, we've got you covered.

HIGHMARK

BlueCare® Custom PPO

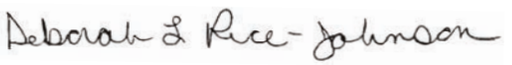
Allied Services

Hi there,

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

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

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



Deborah L. Rice-Johnson
President, Highmark Health Plans

Contents

Why Highmark

BLUE DISTINCTION® SPECIALTY CARE

See specialists who get better results.

When you or your family needs specialty care, you want to know which doctors deliver consistent high-quality care.

That's why Blue Cross and Blue Shield companies created a national recognition program — Blue Distinction® Specialty Care — to make it easier for you to find quality care that's right for you.

Blue Distinction Specialty Care designations:

- **Blue Distinction Centers:*** Health care providers demonstrate quality care and treatment expertise.

- **Blue Distinction Centers+:*** On top of treatment expertise, these providers deliver cost-efficient care in certain specialties.

Only doctors who consistently deliver safe, effective treatments make our Blue Distinction list. When you use our Find a Doctor tool, a special logo will appear by their name, so you can cherry-pick a top-performing specialist for any care you need.

**Blue Distinction Center specialists are available across 11 areas of specialty care.*

BLUES ON CALL℠

Answers from a health pro, 24/7.

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

MY CARE NAVIGATOR℠

Your appointments, booked for you.

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

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 **Well360VirtualHealth.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.

DISEASE MANAGEMENT PROGRAMS

Help managing chronic conditions.

Receive one-on-one nurse support for conditions like asthma, diabetes, heart disease, and other chronic conditions.

SPENDING ACCOUNTS

Save money, manage costs.

Spending accounts are a simple, smart way to pay for your health expenses with tax-free funds. And with online access, you can easily check balances and pay claims from your computer or mobile device. Find more details about spending accounts available to you in the Spending Accounts section.

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 it's an emergency, go straight to the nearest emergency room or dial 911. Also, your plan may cover emergency care received outside of 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

BLUECARE® CUSTOM PPO

Here's how Highmark makes it simple for you:

Nationwide access to providers through the BlueCard® program.

Access to the largest physician and hospital networks in the U.S. with over 1.7 million providers, including 95% of all hospitals.* And when you travel globally, you're covered in 190 countries through the Blue Cross Blue Shield Global® Core program.

Close-to-home coverage.

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. Emergency care is covered at in-network level of benefits even when provided by an out-of-network provider.

The BlueCare Custom PPO network includes:

- All First Priority Life® PPO network providers in our 13-county service area (hospitals and affiliated physicians).
- Blue Distinction Centers® for Transplants.
- Several hospitals and their participating doctors located just beyond our 13-county service area.

If you have BlueCard® PPO, your only in-network providers are those in the 13-county service area of northeastern Pennsylvania. If you go out of network, you will pay more out of pocket for BlueCard PPO providers. However, if you choose an out-of-network BlueCard PPO provider, you will still have a lower out-of-pocket cost than you would if you chose another out-of-network provider. That's because BlueCard PPO providers have agreed to charge Blue Plan members less.

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

You can still use out-of-network providers, but it may cost you more. So, check that a provider is in network before you get care. For over-the-phone help, call Member Service at the number on the back of your ID card.

*According to the Blue Cross Blue Shield Association.

Allied Services Custom PPO 01799540, 01799541

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	In Network	Out of Network
General Provisions		
Effective Date	July 1, 2023	
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 $3,000 $6,000	 $3,000 $6,000
Plan Pays – payment based on the plan allowance	80% after deductible	80% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 $3,000 $6,000	 None None
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $6,000 $12,000	 None None
Annual Maximum (per benefit period)	None	$500,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $20 copay	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $30 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after $50 copay	80% after deductible
Virtual Visit Originating Site Fee	80% after deductible	80% after deductible
Urgent Care Center Visits	100% after $40 copay	80% after deductible
Telemedicine Services(3)	100% after $10 copay	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	80% after deductible
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, Medically Necessary	100% (deductible does not apply)	80% (deductible does not apply)
Colorectal Cancer Screening	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric Physical Exams	 100% (deductible does not apply)	80% after deductible
Pediatric Immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services (5)	100% after $250 copay (waived if admitted)	
Ambulance – Emergency and Non-Emergency (6) (Includes coverage for wheelchair van transport)	100% (deductible does not apply) for emergencies; 80% after program deductible for non-emergencies	100% (deductible does not apply) for emergencies; 80% after program deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	80% after deductible	80% after deductible
Hospital Outpatient	80% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	80% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	80% after deductible	80% after deductible
Therapy and Rehabilitation Services		

Benefit	In Network	Out of Network
Physical Medicine	80% after deductible	80% after deductible
	limit: 20 visits/benefit period	
Respiratory Therapy	80% after deductible	80% after deductible
Speech Therapy	80% after deductible	80% after deductible
	limit: 12 visits/benefit period	
Occupational Therapy	80% after deductible	80% after deductible
	limit: 12 visits/benefit period	
Spinal Manipulations	80% after deductible	80% after deductible
	limit: 18 visits/benefit period. No age limit	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	80% after deductible	80% after deductible
Inpatient Detoxification / Rehabilitation	80% after deductible	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	80% after deductible	80% after deductible
Outpatient Substance Abuse Services	80% after deductible	80% after deductible
Other Services		
Allergy Extracts and Injections	80% after deductible	80% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (7)	80% after deductible	80% after deductible
Assisted Fertilization Procedures (Limited to Artificial Insemination - 3 attempts per lifetime)	80% after deductible	80% after deductible
Dental Services Related to Accidental Injury	80% after deductible	80% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	80% after deductible
Durable Medical Equipment, Orthotics, and Prosthetics	80% after deductible	80% after deductible
Home Health Care	80% after deductible	80% after deductible
Hospice	80% after deductible	80% after deductible
	limit: 180 days/ lifetime maximum of 30 days can be used for continuous or inpatient care 10 days/ lifetime can be used for respite care	
Infertility Counseling, Testing and Treatment(8)	80% after deductible to determine diagnosis only	80% after deductible to determine diagnosis only
Private Duty Nursing	not covered	not covered
Skilled Nursing Facility Care	80% after deductible	80% after deductible
	limit: 60 days/benefit period	
Transplant Services	80% after deductible	80% after deductible
Precertification Requirements (9)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	
Prescription Drug Program (10) Hard 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 Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (31/60/90-day Supply)** $3 / $6 / $9 formulary low cost generic copay $3 / $6 / $9 non-formulary low cost generic copay $20 / $40 / $60 formulary generic copay $20 / $40 / $60 non-formulary generic copay $40 / $80 / $120 formulary brand copay $60 / $120 / $180 non-formulary brand copay **Active Choice** **Maintenance Drugs through Mail Order (90-day Supply)** $6 formulary low cost generic copay $6 non-formulary low cost generic copay $40 formulary generic copay $40 non-formulary generic copay $80 formulary brand copay $120 non-formulary brand copay Specialty Drugs: $100 copay per prescription	

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 Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. 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.
(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. Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
(4) Services are limited to those listed on the Highmark Preventive Schedule with enhancements (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) After initial evaluation, Applied Behavioral Analysis 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). Treatment for Autism Spectrum Disorders does 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) 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 hard 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. With the Active Choice program, you must choose how you want to fill your maintenance prescription drugs. You may choose a retail pharmacy or your mail order program. If after two fills at a retail pharmacy you have not made your selection, you will need to pay full cost of the drug allowed by your plan for any future refills. You can change your selection at any time. Your plan requires that you use Accredo specialty pharmacy for select specialty medications. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment.

Discrimination is Against the Law

The claims administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- 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 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.

Please note that your employer – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/ program; including, any exclusion or limitation described in the benefit Booklet.

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).

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).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

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

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).

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).

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.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

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

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់លោកអ្នក (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).

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).

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.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడితే, లాగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दनिुहोस्: यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। तपाईको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).

U65_ASO_G_M_2Col_8pt_blk_NL

Allied Services BlueCare Custom PPO QHD $2000 01799542, 01799543

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	In Network	Out of Network
General Provisions		
Effective Date	July 1, 2023	
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 $2,000 $4,000	 $2,000 $4,000
Plan Pays – payment based on the plan allowance	80% after deductible	80% after deductible
Out-of-Pocket Limit (Includes prescription drug expenses, coinsurance and copays. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 $2,000 $4,000	 None None
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $4,000 $8,000	 None None
Annual Maximum (per benefit period)	None	$500,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	80% after deductible	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	80% after deductible	80% after deductible
Specialist Office Visits & Virtual Visits	80% after deductible	80% after deductible
Virtual Visit Originating Site Fee	80% after deductible	80% after deductible
Urgent Care Center Visits	80% after deductible	80% after deductible
Telemedicine Services(3)	80% after deductible	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	80% after deductible
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	80% after deductible
Mammograms, Annual Routine	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, Medically Necessary	100% (deductible does not apply)	80% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	80% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 80% after deductible
Pediatric Immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services (5)	80% after deductible	80% after deductible in-network deductible applies
Ambulance – Emergency and Non-Emergency (6) (Includes coverage for wheelchair van transport)	80% after deductible	80% after in-network deductible for emergencies; 80% after out-of-network deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	80% after deductible	80% after deductible
Hospital Outpatient	80% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	80% after deductible	80% after deductible

Benefit	In Network	Out of Network
Medical Care (including inpatient visits and consultations)/Surgical Expenses	80% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	80% after deductible	80% after deductible
	limit: 20 visits/benefit period	
Respiratory Therapy	80% after deductible	80% after deductible
Speech Therapy	80% after deductible	80% after deductible
	limit: 12 visits/benefit period	
Occupational Therapy	80% after deductible	80% after deductible
	limit: 12 visits/benefit period	
Spinal Manipulations	80% after deductible	80% after deductible
	limit: 12 visits/benefit period. No age limit	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	80% after deductible	80% after deductible
Inpatient Detoxification / Rehabilitation	80% after deductible	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	80% after deductible	80% after deductible
Outpatient Substance Abuse Services	80% after deductible	80% after deductible
Other Services		
Allergy Extracts and Injections	80% after deductible	80% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (7)	80% after deductible	80% after deductible
Assisted Fertilization Procedures (Limited to Artificial Insemination - 3 attempts per lifetime)	80% after deductible	80% after deductible
Dental Services Related to Accidental Injury	80% after deductible	80% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	80% after deductible
Durable Medical Equipment, Orthotics, and Prosthetics	80% after deductible	80% after deductible
Home Health Care	80% after deductible	80% after deductible
Hospice	80% after deductible	80% after deductible
	limit: 180 days/ lifetime maximum of 30 days can be used for continuous or inpatient care 10 days/ lifetime can be used for respite care	
Infertility Counseling, Testing and Treatment(8)	80% after deductible to determine diagnosis only	80% after deductible to determine diagnosis only
Private Duty Nursing	not covered	not covered
Skilled Nursing Facility Care	80% after deductible	80% after deductible
	limit: 60 days/benefit period	
Transplant Services	80% after deductible	80% after deductible
Precertification Requirements (9)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	Integrated with medical deductible Integrated with medical deductible	

Benefit	In Network	Out of Network
Prescription Drug Program (10) Hard 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 Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (31/60/90-day Supply)** $3 / $6 / $9 formulary low cost generic copay $3 / $6 / $9 non-formulary low cost generic copay $20 / $40 / $60 formulary generic copay $20 / $40 / $60 non-formulary generic copay $40 / $80 / $120 formulary brand copay $60 / $120 / $180 non-formulary brand copay **Active Choice** **Maintenance Drugs through Mail Order (90-day Supply)** $6 low cost generic copay $6 non-formulary low cost generic copay $40 formulary generic copay $40 non-formulary generic copay $80 formulary brand copay $120 non-formulary brand copay Specialty Drugs: $100 copay per prescription 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 benefits summary.
(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. 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 non-embedded deductible, the entire family deductible must be satisfied before claims reimbursement begins. In addition, with your non-embedded out-of-pocket limit, the entire family out-of-pocket limit must be satisfied before additional claims reimbursement begins. Finally, with your non-embedded TMOOP, once the entire family TMOOP is satisfied, claims will pay at 100% of the plan allowance for covered expenses for the family, for the rest of the plan year.
(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. Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
(4) Services are limited to those listed on the Highmark Preventive Schedule with enhancements (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) After initial evaluation, Applied Behavioral Analysis 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). Treatment for Autism Spectrum Disorders does 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) 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 hard 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. With the Active Choice program, you must choose how you want to fill your maintenance prescription drugs. You may choose a retail pharmacy or your mail order program. If after two fills at a retail pharmacy you have not made your selection, you will need to pay full cost of the drug allowed by your plan for any future refills. You can change your selection at any time. To obtain medications for hemophilia, you must use a specific pharmacy, please contact member services for more details.

Discrimination is Against the Law

The claims administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- 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 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.

Please note that your employer – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/ program; including, any exclusion or limitation described in the benefit Booklet.

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).

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).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

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

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).

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).

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.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

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

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់លោកអ្នក (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).

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).

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.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడితే, లాగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दनिुहोस्: यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। तपाईको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).

U65_ASO_G_M_2Col_8pt_blk_NL

Allied Services BlueCare Custom PPO QHD $3000 01799544, 01799545

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	In Network	Out of Network
General Provisions		
Effective Date	July 1, 2023	
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 $3,000 $6,000	 $3,000 $6,000
Plan Pays – payment based on the plan allowance	80% after deductible	80% after deductible
Out-of-Pocket Limit (Includes prescription drug expenses, coinsurance and copays. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 $3,000 $6,000	 None None
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $6,000 $12,000	 None None
Annual Maximum (per benefit period)	None	$500,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	80% after deductible	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	80% after deductible	80% after deductible
Specialist Office Visits & Virtual Visits	80% after deductible	80% after deductible
Virtual Visit Originating Site Fee	80% after deductible	80% after deductible
Urgent Care Center Visits	80% after deductible	80% after deductible
Telemedicine Services(3)	80% after deductible	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 80% after deductible
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	80% after deductible
Mammograms, Annual Routine	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, Medically Necessary	100% (deductible does not apply)	80% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	80% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 80% after deductible
Pediatric Immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services (5)	80% after deductible	80% after in-network deductible
Ambulance – Emergency and Non-Emergency (6) (Includes coverage for wheelchair van transport)	80% after deductible	80% after in-network deductible for emergencies; 80% after out-of-network deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	80% after deductible	80% after deductible
Hospital Outpatient	80% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	80% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	80% after deductible	80% after deductible

Benefit	In Network	Out of Network
Therapy and Rehabilitation Services		
Physical Medicine	80% after deductible	80% after deductible
	limit: 20 visits/benefit period	
Respiratory Therapy	80% after deductible	80% after deductible
Speech Therapy	80% after deductible	80% after deductible
	limit: 12 visits/benefit period	
Occupational Therapy	80% after deductible	80% after deductible
	limit: 12 visits/benefit period	
Spinal Manipulations	80% after deductible	80% after deductible
	limit: 12 visits/benefit period. No age limit	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	80% after deductible	80% after deductible
Inpatient Detoxification / Rehabilitation	80% after deductible	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	80% after deductible	80% after deductible
Outpatient Substance Abuse Services	80% after deductible	80% after deductible
Other Services		
Allergy Extracts and Injections	80% after deductible	80% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (7)	80% after deductible	80% after deductible
Assisted Fertilization Procedures (Limited to Artificial Insemination - 3 attempts per lifetime)	80% after deductible	80% after deductible
Dental Services Related to Accidental Injury	80% after deductible	80% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	80% after deductible
Durable Medical Equipment, Orthotics, and Prosthetics	80% after deductible	80% after deductible
Home Health Care	80% after deductible	80% after deductible
Hospice	80% after deductible	80% after deductible
	limit: 180 days/ lifetime maximum of 30 days can be used for continuous or inpatient care 10 days/ lifetime can be used for respite care	
Infertility Counseling, Testing and Treatment(8)	80% after deductible to determine diagnosis only	80% after deductible to determine diagnosis only
Private Duty Nursing	not covered	not covered
Skilled Nursing Facility Care	80% after deductible	80% after deductible
	limit: 60 days/benefit period	
Transplant Services	80% after deductible	80% after deductible
Precertification Requirements (9)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	Integrated with medical deductible Integrated with medical deductible	

Benefit	In Network	Out of Network
Prescription Drug Program (10) Hard 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 Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (31/60/90-day Supply)** $3 / $6 / $9 formulary low cost generic copay $3 / $6 / $9 non-formulary low cost generic copay $20 / $40 / $60 formulary generic copay $20 / $40 / $60 non-formulary generic copay $40 / $80 / $120 formulary brand copay $60 / $120 / $180 non-formulary brand copay **Active Choice** **Maintenance Drugs through Mail Order (90-day Supply)** $6 low cost generic copay $6 non-formulary low cost generic copay $40 formulary generic copay $40 non-formulary generic copay $80 formulary brand copay $120 non-formulary brand copay Specialty Drugs: $100 copay per prescription 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 benefits summary.
(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. 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. Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
(4) Services are limited to those listed on the Highmark Preventive Schedule with enhancements (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) After initial evaluation, Applied Behavioral Analysis 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). Treatment for Autism Spectrum Disorders does 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) 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 hard 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. With the Active Choice program, you must choose how you want to fill your maintenance prescription drugs. You may choose a retail pharmacy or your mail order program. If after two fills at a retail pharmacy you have not made your selection, you will need to pay full cost of the drug allowed by your plan for any future refills. You can change your selection at any time. To obtain medications for hemophilia, you must use a specific pharmacy, please contact member services for more details.

Discrimination is Against the Law

The claims administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- 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 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.

Please note that your employer – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/ program; including, any exclusion or limitation described in the benefit Booklet.

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).

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).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

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

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).

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).

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.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

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

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់លោកអ្នក (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).

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).

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.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడితే, లాగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दनिुहोस्: यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। तपाईको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).

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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.

2023 Preventive Schedule

Effective 1/1/2023

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

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

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

Questions?

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

Adults: Ages 19+

Female Male

GENERAL HEALTH CARE	
Routine Checkup* (This exam is not the work- or school-related physical)	• Ages 19 to 49: Every 1 to 2 years • Ages 50 and older: Once a year
Depression Screening	Once a year
Illicit Drug Use Screening	Once a year
Pelvic, Breast Exam	Once a year
SCREENINGS/PROCEDURES	
Abdominal Aortic Aneurysm Screening	Ages 65 to 75 who have ever smoked: One-time screening
Ambulatory Blood Pressure Monitoring	To confirm new diagnosis of high blood pressure before starting treatment
Breast Cancer Genetic (BRCA) Screening (Requires prior authorization)	Those meeting specific high-risk criteria: One-time genetic assessment for breast and ovarian cancer risk
Cholesterol (Lipid) Screening	• Ages 20 and older: Once every 5 years • High-risk: More often
Colon Cancer Screening (Including Colonoscopy)	• Ages 45 and older: Every 1 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 1 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 3 years
Hepatitis B Screening	High-risk

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

* 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
Osteoporosis (Bone Mineral Density) Screening	Ages 65 and older: Once every 2 years, or younger if at risk as recommended by physician
Cervical Cancer Screening	• Ages 21 to 65 Pap: Every 3 years, or annually, per doctor's advice • Ages 30 to 65: Every 5 years if HPV only or combined Pap and HPV are negative • Ages 65 and older: Per doctor's advice
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)	• Sexually active males and females • HIV screening for adults to age 65 in the general population and those at risk, then screening over age 65 with risk factors
IMMUNIZATIONS**	
Chicken Pox (Varicella)	Adults with no history of chicken pox: One 2-dose series
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 2- or 3-dose series
Hepatitis B	• Ages 19–59: 2 to 4 doses per doctor's advice • Ages 60 and older: High-risk per doctor's advice
Human Papillomavirus (HPV)	• To age 26: One 3-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 1 or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and have calculated 10-year risk of a cardiovascular event of 10% or greater
Select PrEP Drugs 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 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.

2023 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 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**												●
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 18	
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 4 visits each year for developmentally and age-appropriate preventive services
Contraception (Birth Control) Methods and Discussion*	All women planning or capable of pregnancy
SCREENINGS/PROCEDURES	
Diabetes Screening	• High-risk: At the first prenatal visit
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 3 years
Domestic and Intimate Partner Violence Screening and Counseling	Once a year
Breast-feeding (Lactation) Support and Counseling, and Costs for Equipment	During pregnancy and/or after delivery (postpartum)
Sexually Transmitted Infections (STI) Discussion	All sexually active women: Once a year
Screening for Anxiety	The Women's Preventive Services Initiative recommends screening for anxiety in adolescent girls and adult women, including those who are pregnant or postpartum.
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. [https://hbs.highmarkprc.com/Forms/Pharmacy-Prior-Authorization-Forms] 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.highmarkbs.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 Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.

Discrimination is Against the Law

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

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

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

Programs to keep you safe 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:

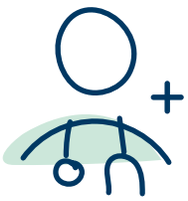
Some drugs are regulated to make sure you get the right dosage. Limits can be based on gender, age, or other factors that restrict how often or how much of a refill you can get. They're in place to keep you safe.

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 highmarkbcbs.com by clicking Helpful Links, Forms Library, then Pharmacy Forms.)

One last special case:

Some drugs may have restrictions on how much of their cost is covered by your plan. These are called coverage limits. If you submit a prescription for a drug that has coverage limits, we'll tell you, in writing, that you need to get approval before the prescription can be filled.



Talk to your employer or your HR manager to find out what additional benefits are available to you.

Formulary Drugs

A formulary is a list of FDA-approved medications selected by the Plan, divided up by the condition they are used to treat. Understanding your formulary can help you better manage your drug costs and get the care you need. To see your full formulary list, log on to **Highmarkbcbs.com** and click **Prescriptions**.

Specialty Drugs

Highmark helps ensure that specialty medications are dispensed appropriately and are cost-effective for members. Through the expertise of specialty teams, we work with prescribers, patients, and caregivers to help control costs without sacrificing patient care.

$3 Generic Drug Program

By offering you certain drugs at reduced costs, this program helps you stick to your medication routines and improve your health outcomes.

Vaccines at Retail Pharmacies

Your pharmacy benefit covers certain vaccines at participating retail pharmacies. No appointment needed. These vaccines may include:

- Chickenpox (Varicella)
- Diphtheria, tetanus (Td/Tdap)
- Diphtheria, tetanus, pertussis (DTaP)
- Flu
- Haemophilus influenzae Type B (Hib)
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Measles, mumps, rubella (MMR)
- Meningitis
- Pneumonia
- Polio (IPV)
- Rotavirus
- Shingles

High Deductible Health Plan (HDHP) Preventive Lists

If you are enrolled in an HDHP, then there are two Preventive Medication Coverage lists that may be applied to your plan — HDHP Value and HDHP Premier. They include some of the most commonly used preventive care drugs. If you need them to stay healthy, you can get them at a lower cost.

For additional information, please call the number on the back of your member ID card or on the Highmark app.

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're also available at **highmarkbcbs.com** by clicking **Helpful Hints** and then **Forms Library** under the **Pharmacy Forms** section.

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

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

Active Choice

Program for Maintenance Medications

Your prescription drug plan includes the **Active Choice Home Delivery Program**. We worked with Express Scripts® to implement this program, which is designed to help you better manage your prescription costs and your health.

Active Choice gives you an opportunity to learn about the advantages of mail order for your maintenance drug prescriptions. Maintenance drugs are those taken on an ongoing basis and are appropriate for a 90-day supply.

How it works

You (and your enrolled dependents) must let Express Scripts know how you will fill your maintenance prescription drugs. You can choose:

Mail order through Express Scripts Pharmacy

Or

Retail pharmacy

You have up to two fills at a retail pharmacy before you are required to make your choice. By the third fill, you will need to make a decision on how you will be refilling your maintenance drug going forward, or pay 100% of the drug cost. You will continue to pay 100% of the cost until you make your choice.

No penalty for choosing retail

There is no penalty if you choose to continue to refill your maintenance prescription drugs through a retail pharmacy, and you can change your preference at any time by contacting Express Scripts.

Choose and save

Make your choice by:

1. Calling the Member Choice Center toll-free at **1-855-686-9786,** available 24/7.
2. Going online to the member website at **highmarkbcbs.com**. You simply:
   - Choose **Prescriptions** and review the prescriptions you have.
   - Select **Refills & Order Status**.
   - You can **Switch all to delivery** or make choices for each prescription.

NATIONAL NETWORK

Over 57,000 pharmacies are in the National with CVS network, including:

Accredo
Acme
Ahold
Albertsons
Aurora Pharmacy
Bartell Drugs
Big Y Foods
Bi-Lo Holdings
Bi-Mart
Brookshire Brothers
Brookshire Grocery
Coborn's
Costco
CVS
Dept. of Veterans Affairs
Discount Drug Mart
Family Care
Food City Pharmacy
Fruth Pharmacy
Giant Eagle
Hannaford Brothers
Harps & Price Cutter
H-E-B Grocery
Henry Ford Health System
HIP Pharmacy Services
Homeland Pharmacy
Hy-Vee
IHC Pharmacy Services
Ingles Markets
InstyMeds
Kelsey-Seybold Pharmacy Div
Kinney Drugs
Kmart
Knight Drugs
Lewis Drugs Inc.
MK Stores
Marc Glassman
Maxor Pharmacy
Med-Fast Pharmacy
The Medicine Shoppe
Meijer
Metrocare
NeighborCare
Northeast Ohio Neighborhood
Omnicare
Osborn Drugs Inc.
Patient First
Pharmaca Integrative Pharmacy
PharMerica
Planned Parenthood
PrescribeIT Rx
Price Chopper Pharmacy
Publix
Raley's
Reasor's
ReCept Pharmacy
Red Cross Pharmacy
Rite Aid
Roundy's Supermarkets
Safeway
Sam's Club
Sav-On
Save Mart Supermarkets
Schnucks
Seip Drug
Spartan
SuperValu
Target (CVS Pharmacy)
Thrifty White Stores
Tops Markets
United Supermarkets
Unity Pharmacies
Value Drugs
Wakefern
Walmart
Wegmans
Weis Markets

HOME DELIVERY ORDER FORM

EXPRESS SCRIPTS®

Home Delivery Order Options

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

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

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

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

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

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

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

1 Member Information

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

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

2 Shipping Address

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

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

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

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

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

3 Patient Information

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

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

 EME47693 CRP1808_0413 STLF14WB

4 Payment Method — Do not send cash

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

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

Signature X _____

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

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

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

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

5 Health History

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

6 Important reminders and other information

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

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

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

7 Generic Substitution

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

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

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

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

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

Spending Accounts

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

A simple way to save for everyday medical expenses.

How does an FSA work?

When you have an FSA, you can use it to pay for medical, dental, vision, prescription, and other qualified medical expenses. It can reduce your taxable income by using pre-tax dollars to pay for your care.

What's the advantage of an FSA?

A big perk to your FSA is that you'll have access to your entire elect amount at the beginning of your plan year. That means you can immediately start using your FSA money for qualified medical expenses. Another advantage is that the plan may also allow money to carry over or give you extra time to submit expenses.

How do you set up an FSA?

First, you decide how much money to contribute for the year. This amount is called your "annual election." Your annual election gets deducted evenly from each paycheck before taxes and put into your FSA. The IRS sets maximum amounts for yearly contributions to FSAs, which are subject to adjustment by the IRS on the basis of inflation. In 2023, the maximum FSA contribution limit is $3,050 with an FSA carryover limit of $570 where applicable.

What's considered a qualified medical expense?

- Deductibles, copays, and coinsurance
- Medication
- Dental care
- Orthodontia
- Eye exams
- Laser eye surgery
- Glasses and contact lenses
- Hearing aids
- Diabetes supplies

You can view an extensive list of qualified medical expenses at **highmarkspendingaccounts.com**.

Check with your employer for more details regarding your FSA.

DEPENDENT CARE FSA

A dependent care FSA is a flexible spending account that can be used to pay for dependent care you or your spouse need in order to work, look for work, or go to school. Like other FSAs, it saves you money by reducing your taxable income by spending pre-tax dollars on dependent care.

How does a dependent care FSA work?

You first decide how much money to contribute throughout the year. That amount gets deducted evenly from each paycheck before taxes and put into your FSA. The current maximum annual contribution amounts are $5,000 if you're single or married filing jointly and $2,500 if you're married filing separately.

With dependent care FSAs, you can only spend up to the amount that's already been deducted from your paycheck. Your plan might also give you extra time to submit expenses.

Who qualifies as an eligible dependent?

- A qualifying child under age 13 who lives with you
- Any spouse, child, or relative of any age who lives with you and is physically or mentally unable to care for themselves

What's considered a qualified expense for dependent care?

- Licensed day care providers
- Before- and after-school care for children under 13
- Summer day camps for children under 13
- Care provided in your home
- Non-medical home or day care for eligible disabled dependents
- Registration fees
- Educational expenses for preschool

Common expenses that don't qualify:

- Educational expenses for kindergarten and higher grades
- Overnight camps
- Food or clothing
- Transportation

For more details on Dependent Care FSAs, check with your employer.

Wellness

HEALTH COACHES

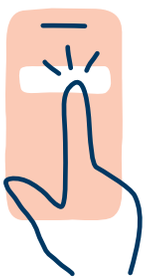
Personalized support for health goals.

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

BABY BLUEPRINTS®

Pregnancy advice, answers, and support.

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



SHARECARE®

Say hello to your online health and wellness hub.

Find out your RealAge®, track your health habits, and monitor sleep, stress, and fitness — in real time. Visit **mycare.sharecare.com**.

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 **highmarkbcbs.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, **highmarkbcbs.com**.

MY CARE NAVIGATOR℠

Your appointments, booked for you.

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

BLUE365®

Discounts to help you stay healthy and active.

From workout gear to 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**.

HIGHMARK PLAN 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 Highmark Plan app from the App Store or Google Play and set up your profile.

Additional Important Information

Health care lingo, translated.

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

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.

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 where you get care is referred to as a health care provider.

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

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

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 have it done and 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. Beginning Aug. 8, 2021, this will also include advanced radiology and cardiac imaging. Call the Member Service number on the back of your member ID card or in the 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 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 protecting Protected Health Information (PHI).

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

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

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

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

Care and case management

Programs for care support and complex condition management.

CARE MANAGEMENT PROGRAM

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

Services under the Care Management Program:

Precertification Review starts before you get care and:

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

Concurrent Review happens during the course of treatment to:

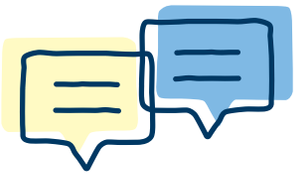
- Assess the medical need to continue treatment.
- Evaluate the right level of care for treatment.
- Foresee any possible quality of care concerns.
- Identify situations that require a physician consultation.
- Determine potential case or condition management benefits.
- Update and/or revise the discharge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

Discharge Planning occurs throughout the course of treatment to:

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

Retrospective Review happens after services have been provided and:

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



CASE MANAGEMENT PROGRAM

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

Individual goals of Case Management:

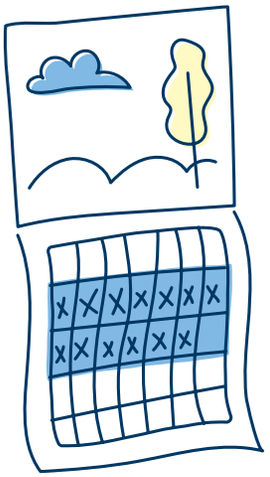
- Identify and resolve gaps in care
- Assure the right care at the right time through appropriate facilities and providers
- Increase members' understanding of their condition or situation
- Reduce medication inconsistencies and ensure correct use of prescribed medications
- Address any caregiver issues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

How the Case Management Program works:

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

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

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



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.

Enrollment Application

HIGHMARK

ENROLLMENT/WAIVE FORM

I. EMPLOYEE INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer Name	Group Number	Payroll Location

Last Name	First Name	MI	Social Security No.

Address

City	State	Zip	Home Phone

Product Selection:
- ❑ Medical Product Name: _____
- ❑ Vision Product Name: _____
- ❑ Dental Product Name: _____

Employment Status	Date of Full-Time Hire (Mo / Day / Yr)	Hours Worked Per Week	❑ COBRA
❑ Active ❑ COBRA ❑ Disabled			Start Date _____ End Date _____

COBRA REASON:
❑ Deceased ❑ Involuntary Lay-Off Date of Event _____
❑ Left Employment ❑ Other _____

II ENROLLMENT INFORMATION AND COVERAGE SELECTION

List ALL Dependents, Relationship to Employee and Coverage Selection	First Name & Middle Initial (show Last Name if different from Subscriber)	Social Security #	Birthdate	Gender	Dependent Status If Over Age 26	Product Selection Med**	Vis	Den
Employee			/ /	❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
❑ Spouse ❑ Dom. Part.* ☐☐			/ /	❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
❑ Child ❑ Other* ☐☐			/ /	❑ M ❑ F	❑ Disabled	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
❑ Child ❑ Other* ☐☐			/ /	❑ M ❑ F	❑ Disabled	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
❑ Child ❑ Other* ☐☐			/ /	❑ M ❑ F	❑ Disabled	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

*If "domestic partner" or "other" applies, complete using one of the following codes: (02) Adopted Child, (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter and (29) Domestic Partner. Legal Documentation (Court Decree, Guardianship Papers, Domestic Partner Affidavit, etc.) must be provided prior to enrollment. ❑ Other: _____

If you answered No to Med** under Product Selection, please list reason: _____

I hereby certify that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/or any of my Eligible Dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a qualifying event occurs before coverage will be offered.

By entering your name on the signature line below, you understand that you are creating an electronic signature which has the same effect as a written signature, and you are representing that you have reviewed and submitted this form accordingly.

_____ _____

Employee Signature ONLY SIGN IF YOU ARE WAIVING COVERAGE Date

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, as long as you are covered by the group's health insurance plan provided by your employer, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

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

Sharecare is a registered trademark of Sharecare, Inc., an independent and separate company that provides a consumer care engagement platform for your health plan. 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.

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

Best Doctors is an independent company that manage the virtual second medical 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.

NaviNet is a registered trademark of NaviNet, Inc., which is an independent company that provides a secure, web-based portal between providers and health care insurance companies.

Express Scripts is an independent company that administers your prescription drug benefit for your health plan.

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

The Highmark Wellness Card is exclusive to the Highmark Western NY and Northeastern NY service areas and cannot be used in other Highmark service areas.

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.

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HIGHMARK

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.

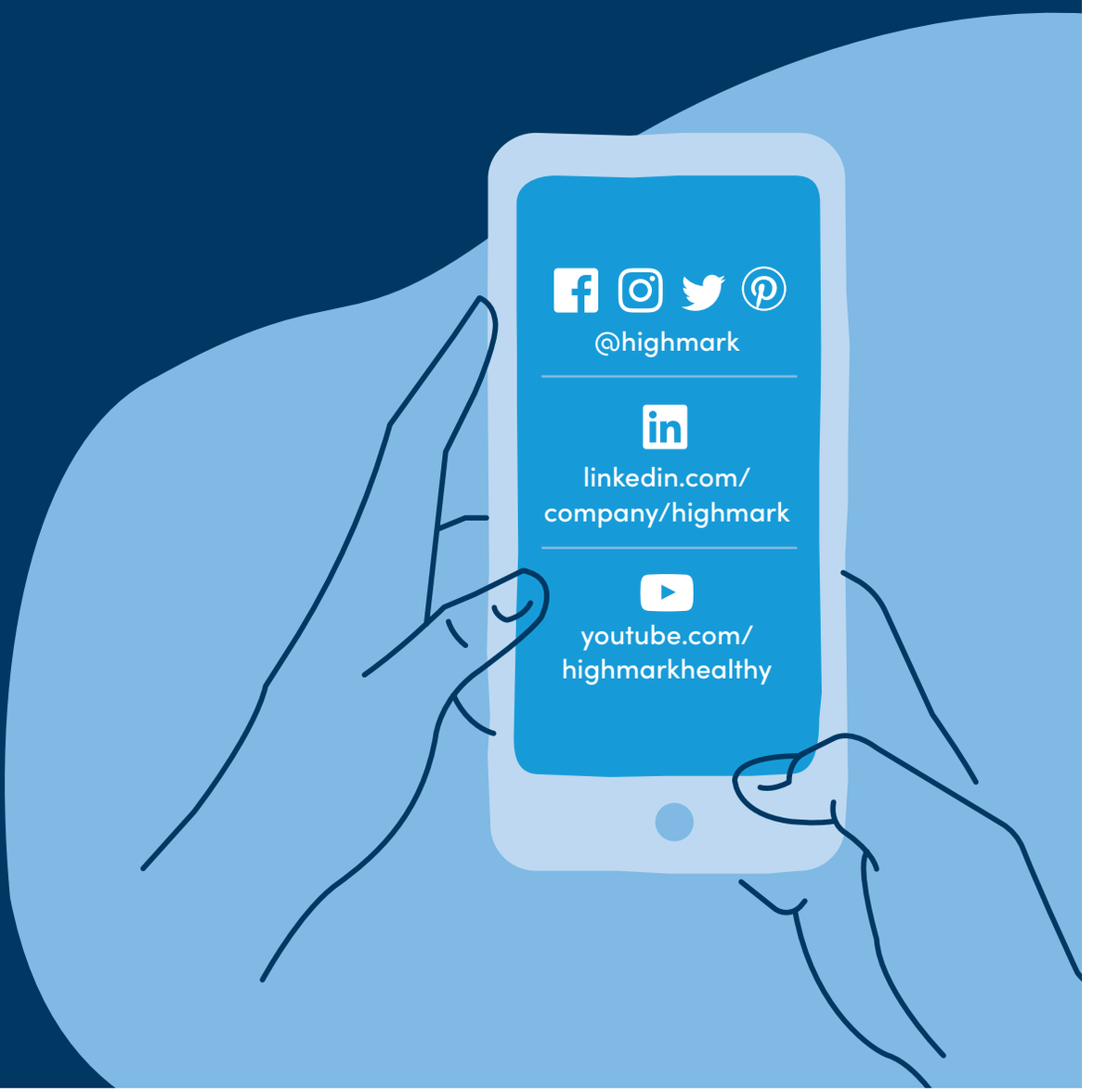
Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.

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.