



We've Got You Covered
Wherever You Live or Travel

No matter where you receive health care services, you can feel confident that you will receive affordable, quality care. You enjoy all the great advantages of reliable health care coverage from a respected health insurer with responsive support and service.

Your program offers you:

- A choice of health care providers, regionally and nationally, including primary care providers, specialists, hospitals, and other treatment facilities
- Control over your care — *you* decide who provides your care
- Coverage for an exceptional range of preventive care
- Coverage for emergency care wherever and whenever you need it
- Helpful, knowledgeable service by phone or online



PPO Blue|BlueCare®
Custom PPO
Kings College

Dear Employee,

Welcome to Highmark Blue Cross Blue Shield. We're pleased to offer you dependable, comprehensive health coverage to help you get the quality care you deserve.

Here are some of the advantages you will enjoy as a member.

- Great coverage with doctors close to home and across the country
- Best-in-class resources to help you get well, stay well or manage a health condition
- Online tools that help you find quality network doctors and hospitals, let you compare and estimate health care costs, and find ways to better manage those costs
- 24/7 Access to a Blues On CallSM health coach to answer your health questions
- My Care Navigator to help you find a network doctor, schedule an appointment, transfer medical records, and more
- Virtual medicine services to give you care for minor illnesses without leaving your home
- Discounts on fitness, health, and wellness products
- And more!

Take a few minutes to learn more about the exciting services and features you can look forward to and what your plan has to offer.

We thank you for choosing us. Our goal is to provide you with the highest-quality health care coverage and an exceptional member experience.

Sincerely,

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

Deborah L. Rice-Johnson
President
Highmark Health Plans

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PPO Blue

PPO Blue: A network where the choice is yours

With health coverage from Highmark Blue Cross Blue Shield, you enjoy the freedom to make your own health care decisions while gaining quality care, cost savings, and comprehensive coverage.

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

Local care and nationwide coverage

With *PPO Blue*, you can choose a health care provider from a large PPO network of community and specialty hospitals and physicians. This includes providers in our 13 counties in northeastern Pennsylvania and some located just outside this service area. You will find providers with experience in behavioral health, cancer care, cardiology, children's care, neuroscience, orthopedics and rehabilitation, transplant surgery, and women's care.

Nationwide, you can also use the Blue plans that include approximately 97 percent of all hospitals and 92 percent of all physicians in the United States — nearly 720,000 providers across the country.



BlueCare[®] Custom PPO

A select network where the choice is yours

With health coverage from Highmark Blue Cross Blue Shield, you enjoy the freedom to make your own health care decisions while gaining quality care, cost savings, and comprehensive coverage.

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

Local care and nationwide coverage

With *BlueCare Custom PPO*, you can choose a health care provider from the region's largest PPO network of community and specialty hospitals and physicians. This includes providers in our 13 counties in northeastern Pennsylvania and some located just outside this service area. You will find providers with experience in behavioral health, cancer care, cardiology, children's care, neuroscience, orthopedics and rehabilitation, transplant surgery, and women's care.

Nationwide, you can also use Blue plans that include approximately 97 percent of all hospitals and 92 percent of all physicians in the United States — nearly 720,000 providers across the country.

In-network

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

You will have the lowest out-of-pocket costs when you receive care from in-network providers.



Build a strong relationship with quality providers

No referrals needed!

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

Select a Physician of Record

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

Your Physician of Record can help you achieve health goals, monitor chronic conditions, provide preventive services, and coordinate care with other providers.

You don't need to get approval from your Physician of Record to see a specialist or receive additional treatment from any network physician.

There are three ways to choose your Physician of Record:

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

Want to know how a physician measures up?

Patient Experience Reviews are on **Highmarkbcbs.com**. You can see how other people rate the doctors and hospitals they've used for health care. They comment on overall satisfaction, communication, availability, and other factors. You can also write a review of your own.

Blue Distinction® — the sign of quality specialty care

In our provider directory, you can look for the Blue Distinction Center and Blue Distinction Center+ symbols of quality. Blue Distinction and Blue Distinction Center+ hospitals have earned this label for delivering superior results for high-risk, high-cost procedures. These might include cardiac care, complex and rare cancers, knee/hip replacements, maternity care; spine surgery, and transplants.

Your benefits are designed to save you money and reduce your out-of-pocket costs when you choose Blue Distinction Center and Blue Distinction Center+ facilities for certain types of care. Refer to your Summary of Benefits for complete details.

To find a Blue Distinction Center, go to **bcbs.com/bluedistinction/blue-distinction-finder**.

Blue Distinction® is a registered service mark of the Blue Cross and Blue Shield Association. Blue Distinction® Centers met overall quality measures for patient safety and outcomes, developed with input from the medical community. Blue Distinction® Centers+ also met cost measures that address consumers' need for affordable healthcare. Individual outcomes may vary. National criteria are displayed on www.bcbs.com. A local Blue plan may require additional criteria for facilities located in its own service area. For details on local Blue plan criteria, contact your local Blue plan. Each hospital's cost index is calculated separately, based on data from its local Blue plan. Hospitals in portions of CA, ID, NY, PA, and WA may lie in two local Blue plans' areas, resulting in two cost index figures; and their own local Blue plans decide whether all hospitals in these areas must meet Blue Distinction Centers+ national criteria for one or both cost index figures. Neither Blue Cross and Blue Shield Association nor any Blue plans are responsible for damages, losses, or non-covered charges resulting from Blue Distinction or other provider finder information or care received from Blue Distinction or other providers.

Many types of care are covered

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

Preventive care

Preventive care can help you stay on top of your medical needs and have a healthy lifestyle. That's why we suggest you take advantage of Highmark's excellent preventive care benefits. Women are covered for routine gynecological exams, and Pap tests. Read your Summary of Benefits for details about your specific coverage.

Mental health care

Your plan also provides coverage for a range of mental health and substance abuse services, including counseling and treatment services. To assure members get responsive, appropriate care, the program offers a choice of mental health and substance abuse professional providers, so you can get the level and type of care appropriate to your situation.

Substance abuse care

Your plan also provides coverage for a range of substance abuse services, including counseling and treatment services. To assure members get responsive, appropriate care, the program offers a choice of substance abuse professional providers, so you can get the level of care appropriate to your situation.

Specialty care

Your plan has you covered for all your specialty health care needs. You have access to state-of-the-art, patient-centered women's and children's care, as well as key specialties like cancer, heart, and orthopedic care, rehabilitation, and more.



Emergency care

More than anything, you want the assurance of knowing that you're covered when you need care most. Emergency care is covered at the network level whether it is received from in-network or out-of-network providers.

So, you never have to worry when you need care immediately. If you believe that you are having an emergency and need immediate treatment, go directly to your nearest hospital emergency room or call "911" or your area's emergency number.

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

Worldwide care

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

Let us know if you'll be in the hospital

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

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

What's not covered?

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

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

Understanding health insurance

When you receive medical services, the doctor, hospital, or other facility will send a claim to your medical insurance. After your insurance processes the claim, they will let you know if you may have to pay a portion of the costs.

You often have a deductible. A deductible is the dollar amount you must pay for covered services before your insurance begins to pay. You may also have a dollar amount for a copayment that you pay for each doctor's office visit, therapy session, emergency care, or hospitalization.

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

Here are explanations of some of the terms that apply to your health insurance plan.

Glossary of health care insurance terms

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

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

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

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

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

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

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

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

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

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

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

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

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



Benefit Summary and Preventive Schedule

Kings College - \$150 Deductible

Client 116725; Groups 10213655, 10213656

Effective 7/1/2018

Renewal 7/1/2019

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		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period)		
Individual	\$150	\$1,000
Family	\$300	\$2,000
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	\$2,000	\$5,000
Family	\$4,000	\$10,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$6,600	not applicable
Family	\$13,200	not applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$50 copay	70% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after \$15 copay	70% after deductible
Specialist Office Visits & Virtual Visits	100% after \$25 copay	70% after deductible
Virtual Visit Originating Site Fee	100% (deductible does not apply)	70% after deductible
Urgent Care Center Visits	100% after \$50 copay	70% after deductible
Telemedicine Services (3)	not covered	not covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	70% after deductible
Adult Immunizations	100% (deductible does not apply)	70% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	70% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	70% (deductible does not apply)
Mammograms, Medically Necessary	100% (deductible does not apply)	70% (deductible does not apply)
Nutritional Therapy	100% (deductible does not apply)	70% after deductible
	limit: 6 visits/benefit period. Any diagnosis.	
Prostate Cancer Screening	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	70% after deductible
Pediatric Immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Emergency Services		
Emergency Room Services	100% after \$100 copay (waived if admitted)	
Ambulance (includes coverage for wheelchair van transport)	80% (deductible does not apply) – emergencies 80% after deductible – non-emergencies	80% (deductible does not apply) – emergencies 80% after deductible – non-emergencies
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	90% after deductible	70% after deductible
Inpatient Rehabilitation Therapy	90% after deductible	70% after deductible
	limit: 45 days/benefit period	
Hospital Outpatient	90% after deductible	70% after deductible
Maternity (non-preventive facility & professional services)	100% (deductible does not apply)	70% after deductible
Maternity for Dependent Daughters	100% (deductible does not apply)	70% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	90% after deductible	70% after deductible

Benefit	In Network	Out of Network
Therapy and Rehabilitation Services		
Physical Medicine	90% after deductible limit: 36 visits/benefit period aggregate with occupational therapy	70% after deductible
Respiratory Therapy	90% after deductible limit: unlimited visits/benefit period	70% after deductible
Pulmonary Therapy	90% after deductible limit: unlimited visits/benefit period	70% after deductible
Speech Therapy	90% after deductible limit: 36 visits/benefit period aggregate with occupational therapy and physical medicine	70% after deductible
Occupational Therapy	90% after deductible limit: 36 visits/benefit period aggregate with speech therapy and physical medicine	70% after deductible
Spinal Manipulations	90% after deductible limit: 18 visits/benefit period; ages 13 and up	70% after deductible
Cardiac Rehabilitation Therapy	90% after deductible limit: unlimited visits/benefit period	70% after deductible
Infusion Therapy	90% after deductible	70% after deductible
Chemotherapy	90% after deductible	70% after deductible
Radiation Therapy	90% after deductible	70% after deductible
Dialysis	90% after deductible	70% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	90% after deductible	70% after deductible
Inpatient Detoxification / Rehabilitation	90% after deductible	70% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	90% after deductible	70% after deductible
Outpatient Substance Abuse Services	90% after deductible	70% after deductible
Methadone Treatment	Not covered	Not covered
Other Services		
Allergy Extracts and Injections	90% after deductible	70% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	90% after deductible limited: \$40,000 per member/benefit period	70% after deductible
Assisted Fertilization Procedures (Limited to Artificial Insemination - 3 attempts per lifetime)	90% after deductible	70% after deductible
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible
Bony Impacted Wisdom Teeth Removal	90% after deductible limit: unlimited dollar maximum/benefit period	70% after deductible
Diagnostic Services	100% after \$75 copay – services done at Vision Imaging: NPI 1487609483 and 1487609715	70% after deductible
Advanced Imaging (MRI, CAT, PET scan, 3D mammograms, etc.)	100% after \$150 copay – services at all other imaging facilities	
Standard Imaging (x-rays, ultrasounds, ect)	100% after \$25 copay – services done at Vision Imaging: NPI 1487609483 and 1487609715	70% after deductible
	100% after \$50 copay – services at all other imaging facilities	
Basic Diagnostic Services (diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
Durable Medical Equipment and Supplies	90% after deductible	70% after deductible
Ostomy Supplies	90% after deductible limit: unlimited dollar maximum/benefit period	70% after deductible
Orthotics	90% after deductible	70% after deductible
Prosthetic Devices	90% after deductible	70% after deductible
Prescription Eye Glasses after Cataract Surgery	90% after deductible limit: unlimited dollar maximum/lifetime	90% after deductible
Home Health Care	90% after deductible	70% after deductible
Hospice	90% after deductible limit: 180 days/lifetime	70% after deductible
Infertility Counseling, Testing and Treatment (6)	90% after deductible Diagnostic services leading up the diagnosis of infertility only.	70% after deductible

Benefit	In Network	Out of Network
Private Duty Nursing	not covered	not covered
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	limit: 60 days/benefit period	
Transplant Services	90% after deductible	70% after deductible
Precertification Requirements (7)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	
Prescription Drug Program (8) 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	<p style="text-align: center;">Retail Drugs (30-day Supply) \$0 formulary low cost generic copay \$0 non-formulary low cost generic copay \$10 formulary generic copay \$10 non-formulary generic copay \$20 formulary brand copay \$35 non-formulary brand copay</p> <p style="text-align: center;">Maintenance Drugs through Mail Order (90-day Supply) \$0 formulary low cost generic copay \$0 non-formulary low cost generic copay \$20 formulary generic copay \$20 non-formulary generic copay \$40 formulary brand copay \$105 non-formulary brand copay</p>	

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

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.

(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health

(4) Services are limited to those listed on the Highmark Preventive Schedule with Enhancements (Women's Health Preventive Schedule may apply).

(5) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.

(6) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

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

(8) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the 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.

Kings College - \$500 Deductible

Client 116725; Group 10213657, 10213658

Effective 7/1/2018

Renewal 7/1/2019

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		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period)		
Individual	\$500	\$2,000
Family	\$1,000	\$4,000
Plan Pays – payment based on the plan allowance	80% after deductible	70% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	\$3,000	\$8,000
Family	\$6,000	\$16,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$6,600	not applicable
Family	\$13,200	not applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$50 copay	70% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after \$15 copay	70% after deductible
Specialist Office Visits & Virtual Visits	100% after \$25 copay	70% after deductible
Virtual Visit Originating Site Fee	100% (deductible does not apply)	70% after deductible
Urgent Care Center Visits	100% after \$50 copay	70% after deductible
Telemedicine Services (3)	not covered	not covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	70% after deductible
Adult Immunizations	100% (deductible does not apply)	70% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	70% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	70% (deductible does not apply)
Mammograms, Medically Necessary	100% (deductible does not apply)	70% (deductible does not apply)
Nutritional Therapy	100% (deductible does not apply)	70% after deductible
	limit: 6 visits/benefit period. Any diagnosis.	
Prostate Cancer Screening	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	70% after deductible
Pediatric Immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Emergency Services		
Emergency Room Services	100% after \$100 copay (waived if admitted)	
Ambulance (includes coverage for wheelchair van transport)	80% (deductible does not apply) – emergencies 80% after deductible – non- emergencies	80% (deductible does not apply) – emergencies 80% after deductible – non- emergencies
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	80% after deductible	70% after deductible
Inpatient Rehabilitation Therapy	80% after deductible	70% after deductible
	limit: 45 days/benefit period	
Hospital Outpatient	80% after deductible	70% after deductible
Maternity (non-preventive facility & professional services)	80% (deductible does not apply)	70% after deductible
Maternity for Dependent Daughters	80% (deductible does not apply)	70% after deductible

Benefit	In Network	Out of Network
Medical Care (including inpatient visits and consultations)/Surgical Expenses	80% after deductible	70% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	80% after deductible limit: 36 visits/benefit period aggregate with speech therapy and occupational therapy	70% after deductible
Respiratory Therapy	80% after deductible limit: unlimited visits/benefit period	70% after deductible
Pulmonary Therapy	80% after deductible limit: unlimited visits/benefit period	70% after deductible
Speech Therapy	80% after deductible limit: 36 visits/benefit period aggregate with occupational therapy and physical medicine	70% after deductible
Occupational Therapy	80% after deductible limit: 36 visits/benefit period aggregate with speech therapy and physical medicine	70% after deductible
Spinal Manipulations	80% after deductible limit: 12 visits/benefit period; ages 13 and up	70% after deductible
Cardiac Rehabilitation Therapy	80% after deductible limit: unlimited visits/benefit period	70% after deductible
Infusion Therapy	80% after deductible	70% after deductible
Chemotherapy	80% after deductible	70% after deductible
Radiation Therapy	80% after deductible	70% after deductible
Dialysis	80% after deductible	70% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	80% after deductible	70% after deductible
Inpatient Detoxification / Rehabilitation	80% after deductible	70% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	80% after deductible	70% after deductible
Outpatient Substance Abuse Services	80% after deductible	70% after deductible
Methadone Treatment	Not covered	Not covered
Other Services		
Allergy Extracts and Injections	80% after deductible	70% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	80% after deductible limited: \$40,000 per member/benefit period	70% after deductible
Assisted Fertilization Procedures (Limited to Artificial Insemination - 3 attempts per lifetime)	80% after deductible	70% after deductible
Dental Services Related to Accidental Injury	80% after deductible	70% after deductible
Bony Impacted Wisdom Teeth Removal	80% after deductible limit: unlimited dollar maximum/benefit period	70% after deductible
Diagnostic Services	100% after \$75 copay – services done at Vision Imaging: NPI 1487609483 and 1487609715	70% after deductible
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after \$150 copay – services at all other imaging facilities	
Standard Imaging (x-rays, ultrasounds, ect)	100% after \$25 copay – services done at Vision Imaging: NPI 1487609483 and 1487609715	70% after deductible
	100% after \$50 copay – services at all other imaging facilities	
Basic Diagnostic Services (diagnostic medical, lab/pathology, allergy testing)	80% after deductible	70% after deductible
Durable Medical Equipment and Supplies	80% after deductible	70% after deductible
Ostomy Supplies	80% after deductible limit: unlimited dollar maximum/benefit period	70% after deductible
Orthotics	80% after deductible	70% after deductible
Prosthetic Devices	80% after deductible	70% after deductible
Prescription Eye Glasses after Cataract Surgery	80% after deductible limit: unlimited dollar maximum/lifetime	70% after deductible
Home Health Care	80% after deductible	70% after deductible
Hospice	80% after deductible limit: 180 days/ lifetime	70% after deductible

Benefit	In Network	Out of Network
Infertility Counseling, Testing and Treatment (6)	80% after deductible	70% after deductible
	Diagnostic services leading up the diagnosis of infertility only.	
Private Duty Nursing	not covered	not covered
Skilled Nursing Facility Care	80% after deductible	70% after deductible
	limit: 60 days/benefit period	
Transplant Services	80% after deductible	70% after deductible
Precertification Requirements (7)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	
Prescription Drug Program (8) 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	<p style="text-align: center;">Retail Drugs (30-day Supply)</p> <p style="text-align: center;">\$0 formulary low cost generic copay \$0 non-formulary low cost generic copay \$10 formulary generic copay \$10 non-formulary generic copay \$20 formulary brand copay \$35 non-formulary brand copay</p> <p style="text-align: center;">Maintenance Drugs through Mail Order (90-day Supply)</p> <p style="text-align: center;">\$0 formulary low cost generic copay \$0 non-formulary low cost generic copay \$20 formulary generic copay \$20 non-formulary generic copay \$40 formulary brand copay \$105 non-formulary brand copay</p>	

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(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health

(4) Services are limited to those listed on the Highmark Preventive Schedule with Enhancements (Women's Health Preventive Schedule may apply).

(5) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.

(6) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

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

(8) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the 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.

Kings College - Custom PPO

Client 116725; Groups 10213659, 10213660

Effective 7/1/2018

Renewal 7/1/2019

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 – BlueCare Custom PPO Network	Out of Network – BlueCard PPO Network
General Provisions		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period)		
Individual	\$300	\$1,200
Family	\$600	\$2,400
Plan Pays – payment based on the plan allowance	80% after deductible	60% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	\$3,000	\$8,000
Family	\$6,000	\$16,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$6,600	not applicable
Family	\$13,200	not applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$50 copay	60% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after \$25 copay	60% after deductible
Specialist Office Visits & Virtual Visits	100% after \$35 copay	60% after deductible
Virtual Visit Originating Site Fee	100% (deductible does not apply)	60% after deductible
Urgent Care Center Visits	100% after \$50 copay	60% after deductible
Telemedicine Services (3)	not covered	not covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	60% after deductible
Adult Immunizations	100% (deductible does not apply)	60% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	60% after deductible
Mammograms, Annual Routine	100% (deductible does not apply)	60% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	60% after deductible
Nutritional Therapy	100% (deductible does not apply)	60% after deductible
	limit: 6 visits/benefit period. Any diagnosis.	
Prostate Cancer Screening	100% (deductible does not apply)	60% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	60% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	60% after deductible
Pediatric Immunizations	100% (deductible does not apply)	60% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	60% after deductible
Emergency Services		
Emergency Room Services	100% after \$100 copay (waived if admitted)	
Ambulance (includes coverage for wheelchair van transport)	80% (deductible does not apply) – emergencies 80% after deductible – non-emergencies	80% (deductible does not apply) – emergencies 80% after deductible – non-emergencies
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	80% after deductible	60% after deductible
Inpatient Rehabilitation Therapy	80% after deductible	60% after deductible
	limit: 45 days/benefit period	
Hospital Outpatient	80% after deductible	60% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	80% after deductible	60% after deductible

Benefit	In Network – BlueCare Custom PPO Network	Out of Network – BlueCard PPO Network
Medical Care (including inpatient visits and consultations)/Surgical Expenses	80% after deductible	60% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	80% after deductible limit: 36 visits/benefit period aggregate with occupational therapy	60% after deductible speech therapy and occupational therapy
Respiratory Therapy	80% after deductible limit: unlimited visits/benefit period	60% after deductible
Pulmonary Therapy	80% after deductible limit: unlimited visits/benefit period	60% after deductible
Speech Therapy	80% after deductible limit: 36 visits/benefit period aggregate with occupational therapy and physical medicine	60% after deductible
Occupational Therapy	80% after deductible limit: 36 visits/benefit period aggregate with speech therapy and physical medicine	60% after deductible
Spinal Manipulations	80% after deductible limit: 12 visits/benefit period	60% after deductible
Cardiac Rehabilitation Therapy	80% after deductible limit: unlimited visits/benefit period	60% after deductible
Infusion Therapy	80% after deductible	60% after deductible
Chemotherapy	80% after deductible	60% after deductible
Radiation Therapy	80% after deductible	60% after deductible
Dialysis	80% after deductible	60% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	80% after deductible	60% after deductible
Inpatient Detoxification / Rehabilitation	80% after deductible	60% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	80% after deductible	60% after deductible
Outpatient Substance Abuse Services	80% after deductible	60% after deductible
Methadone Treatment	Not covered	Not covered
Other Services		
Allergy Extracts and Injections	80% after deductible	60% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	80% after deductible limited: \$40,000 per member/benefit period	60% after deductible
Assisted Fertilization Procedures (Limited to Artificial Insemination - 3 attempts per lifetime)	80% after deductible	60% after deductible
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after \$75 copay – services done at Vision Imaging: NPI 1487609483 and 1487609715 100% after \$150 copay – services at all other imaging facilities	60% after deductible
Standard Imaging (x-rays, ultrasounds, ect)	100% after \$25 copay – services done at Vision Imaging: NPI 1487609483 and 1487609715 100% after \$50 copay – services at all other imaging facilities	60% after deductible
Basic Diagnostic Services (diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
Durable Medical Equipment and Supplies	80% after deductible	60% after deductible
Ostomy Supplies	80% after deductible limit: unlimited dollar maximum/benefit period	60% after deductible
Orthotics	80% after deductible	60% after deductible
Prosthetic Devices	80% after deductible	60% after deductible
Prescription Eye Glasses after Cataract Surgery	80% after deductible limit: unlimited dollar maximum/lifetime	60% after deductible
Home Health Care	80% after deductible	60% after deductible
Hospice	80% after deductible limit: 180 days/ lifetime	60% after deductible
Infertility Counseling, Testing and Treatment (6)	80% after deductible	60% after deductible

Benefit	In Network – BlueCare Custom PPO Network	Out of Network – BlueCard PPO Network
	Diagnostic services leading up to the diagnosis of infertility only.	
Private Duty Nursing	not covered	not covered
Skilled Nursing Facility Care	80% after deductible	60% after deductible
	limit: 60 days/benefit period	
Transplant Services	80% after deductible	60% after deductible
Precertification Requirements (7)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	
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2018 Preventive Schedule

Effective 1/1/2018

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

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

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

QUESTIONS?

 Call Member Service

 Ask your doctor

 Log in to your account

Adults: Ages 19+





Male



Female

General Health Care

 Routine Checkup* (This exam is not the work- or school-related physical)	<ul style="list-style-type: none"> Ages 19 to 49: Every 1 to 2 years Ages 50 and older: Once a year
 Pelvic, Breast Exam	Once a year



Screenings/Procedures

 Abdominal Aortic Aneurysm Screening	Ages 65 to 75 who have ever smoked: One-time screening
 Ambulatory Blood Pressure Monitoring	To confirm new diagnosis of high blood pressure before starting treatment
 Breast Cancer Genetic (BRCA) Screening (Requires prior authorization)	Those meeting specific high-risk criteria: One-time genetic assessment for breast and ovarian cancer risk
 Cholesterol (Lipid) Screening	<ul style="list-style-type: none"> Ages 20 and older: Once every 5 years High-risk: More often
 Colon Cancer Screening (Including Colonoscopy)	<ul style="list-style-type: none"> Ages 50 and older: Every 1 to 10 years, depending on screening test High-risk: Earlier or more frequently
 Certain Colonoscopy Preps With Prescription	<ul style="list-style-type: none"> Ages 50 and older: Once every 10 years High-risk: Earlier or more frequently
 Diabetes Screening	High-risk: Ages 40 and older, once every 3 years
 Hepatitis B Screening	High-risk
 Hepatitis C Screening	High-risk
 Latent Tuberculosis Screening	High-risk
 Lung Cancer Screening (Requires use of authorized facility)	Ages 55 to 80 with 30-pack per year history: Once a year for current smokers, or once a year if currently smoking or quit within past 15 years
 Mammogram	Ages 40 and older: Once a year including 3-D
 Osteoporosis (Bone Mineral Density) Screening	Ages 60 and older: Once every 2 years












* 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; and age-appropriate guidance.

Adults: Ages 19+







Screenings/Procedures

 Pap Test	<ul style="list-style-type: none"> • Ages 21 to 65: Every 3 years, or annually, per doctor's advice • Ages 30 to 65: Every 5 years if combined Pap and HPV are negative • Ages 65 and older: Per doctor's advice
 Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV and Syphilis)	Sexually active males and females

Immunizations

 Chicken Pox (Varicella)	Adults with no history of chicken pox: One 2-dose series
 Diphtheria, Tetanus (Td/Tdap)	<ul style="list-style-type: none"> • One-time Tdap • Td booster every 10 years
 Flu (Influenza)	Every year (Must get at your PCP's office or designated pharmacy vaccination provider; call Member Service to verify that your vaccination provider is in the Highmark network)
 Haemophilus Influenzae Type B (Hib)	For adults with certain medical conditions to prevent meningitis, pneumonia and other serious infections; this vaccine does not provide protection against the flu and does not replace the annual flu vaccine
 Hepatitis A	At-risk or per doctor's advice: One 2-dose series
 Hepatitis B	At-risk or per doctor's advice: One 3-dose series
 Human Papillomavirus (HPV)	To age 26: One 3-dose series
 Measles, Mumps, Rubella (MMR)	One or two doses
 Meningitis*	At-risk or per doctor's advice
 Pneumonia	High-risk or ages 65 and older: One or two doses, per lifetime
 Shingles (Zoster)	Ages 60 and older: One dose

Preventive Drug Measures That Require a Doctor's Prescription

 Aspirin	<ul style="list-style-type: none"> • Ages 50 to 59 to reduce the risk of stroke and heart attack • Pregnant women at risk for preeclampsia
 Folic Acid	Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid
 Raloxifene Tamoxifen	At-risk for breast cancer, without a cancer diagnosis, ages 35 and older
 Tobacco Cessation (Counseling and medication)	Adults who use tobacco products
 Vitamin D Supplements	Ages 65 and older who are at risk for falls
 Low to Moderate Dose Select Generic Statin Drugs For Prevention of Cardiovascular Disease (CVD)	Ages 40 to 75 years with 1 or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and have calculated 10-year risk of a cardiovascular event of 10% or greater.

* Meningococcal B vaccine per doctor's advice.

Preventive Care for Pregnant Women



Screenings and Procedures

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

Prevention of Obesity, Heart Disease and Diabetes



Adults With BMI 25 to 29.9 (Overweight) and 30 to 39.9 (Obese) Are Eligible For:

- Additional annual preventive office visits specifically for obesity and blood pressure measurement
- Additional nutritional counseling visits specifically for obesity
- Recommended lab tests:
 - ALT
 - AST
 - Hemoglobin A1c or fasting glucose
 - Cholesterol screening

Adult Diabetes Prevention Program (DPP)



Applies to Adults

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

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




2018 Preventive Schedule

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

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

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

QUESTIONS?

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

Children: Birth to 30 Months¹

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

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

Children: 3 Years to 18 Years¹

General Health Care	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	15Y	18Y
Routine Checkup* (This exam is not the preschool- or day care-related physical)	●	●	●	●	●	●	●	●	Once a year from ages 11 to 18			
Ambulatory Blood Pressure Monitoring**												●
Depression Screening									Once a year from ages 11 to 18			
Hearing Screening		●	●	●		●		●		●	●	
Visual Screening***	●	●	●	●		●		●		●	●	●

Screenings												
Hematocrit or Hemoglobin Screening			Annually for females during adolescence and when indicated									
Lead Screening	When indicated (Please also refer to your state-specific recommendations)											

Immunizations													
Chicken Pox		Dose 2									If not previously vaccinated: Dose 1 and 2 (4 weeks apart)		
Diphtheria, Tetanus, Pertussis (DTaP)		Dose 5				1 dose of Tdap if 5 doses were not received previously						1 dose every 10 yrs.	
Flu (Influenza)****	Ages 3 to 18: 1 or 2 doses annually												
Human Papillomavirus (HPV)							Provides long-term protection against cervical and other cancers. 2 doses when started ages 9-14. 3 doses all other ages.						
Measles, Mumps, Rubella (MMR)		Dose 2 (at least 1 month apart from dose 1)											
Meningitis*****									Dose 1		Age 16: One-time booster		
Pneumonia	Per doctor's advice												
Polio (IPV)		Dose 4											

Care for Patients With Risk Factors												
BRCA Mutation Screening (Requires prior authorization)					Per doctor's advice							
Cholesterol Screening	Screening will be done based on the child's family history and risk factors											
Fluoride Varnish (Must use primary care doctor)	Ages 5 and younger											
Hepatitis B Screening									Per doctor's advice			
Hepatitis C Screening											High-risk	
Latent Tuberculosis Screening												High-risk
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV and Syphilis)									For all sexually active individuals			
Tuberculin Test	Per doctor's advice											

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

Children: 6 Months to 18 Years¹


Preventive Drug Measures That Require a Doctor's Prescription

Oral Fluoride	For preschool children older than 6 months whose primary water source is deficient in fluoride
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Prevention of Obesity and Heart Disease

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

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

Services

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

Screenings/Procedures

Diabetes Screening	<ul style="list-style-type: none"> • All women between 24 and 28 weeks pregnant • High-risk: At the first prenatal visit
HIV Screening and Discussion	All sexually active women: Once a year
Human Papillomavirus (HPV) Screening Testing	Beginning at age 30: Every 3 years
Domestic and Intimate Partner Violence Screening and Discussion	Once a year
Breast-feeding (Lactation) Support and Counseling, and Costs for Equipment	During pregnancy and/or after delivery (postpartum)
Sexually Transmitted Infections (STI) Discussion	All sexually active women: Once a year

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



Prescription Drug Coverage

Your prescription drug program

Your retail pharmacy benefits

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

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

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

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

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

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



Prescription drug benefit feature helps you save

Your prescription drug benefit helps you continue to get the medications you need at a cost that's more affordable for you and your employer.

To give you the best value for your pharmacy benefit, these programs strive to give you the right drug, at the right time, in the right amount, and at the right price.

- **Step Therapy:** At the pharmacy, the system looks back in time to see if one or more less expensive, first-line drugs have been tried before covering a more expensive drug that can work just as well. If the first-line drugs are not found in your history, your doctor can contact us to let us know if they have been tried, or why they shouldn't be.
- **Prior Authorization:** Information must first be provided by your doctor before your drug can be covered at the pharmacy. You and your doctor can find out if your drug requires prior authorization by visiting our formulary website. If your drug requires prior authorization, the prescription will be rejected for payment, and the pharmacist will receive a message about why it was rejected.
- **Quantity Limits:** Some drugs have limits on how many can be dispensed at one time. This makes sure that they are used safely and prevents waste. You and your doctor can find out if your drug has a quantity limit by visiting our formulary website. If the amount of drug is greater than policies allow, the prescription will be rejected for payment, and the pharmacist will receive a message about why it was rejected.

These prescription drug management programs operate automatically at the time your prescription is filled at the pharmacy.

What to do if your prescription drug requires preauthorization

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

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



National Network Retail Pharmacy Chains

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

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



A

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

B

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

C

- Coborns
- CostCo
- CVS

D

- Discount Drug Mart

F

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

G

- Giant Eagle

H

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

I

- Infusion Partners
- Ingles Markets
- Instymeds

K

- Kinney Drugs
- Kmart Pharmacy
- Kroger

M

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

O

- Omnicare

P

- Patient First
- Pharmerica
- Price Chopper Pharmacy
- Publix

R

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

S

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

T

- Texas Oncology Pharmacy
- Thrifty White Drug
- Tops Pharmacy

U

- United Pharmacy

V

- Value Drugs

W

- Wakefern
- Wal-Mart
- Wegmans Pharmacy
- Weis

Save through a mail order pharmacy

If you take medications on an ongoing basis, you can save by using the mail order pharmacy.

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

Choose a convenient payment option

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

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

How to start using the mail order pharmacy

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

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

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

You can mail your completed forms to:

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

Learn more online

Your member website, **Highmarkbcbs.com**, has helpful information about your prescription drug program, along with easy-to-use tools to manage your benefits and prescriptions. Once you are a member, you can log in to:

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

Find answers to common questions about your benefits and prescriptions

Protecting your safety and privacy

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

Your plan may have coverage limits

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

HOME DELIVERY ORDER FORM



1 Member information: Please verify or provide member information below.

Member ID: _____

Group: _____

Name: _____

Street Address: _____

Street Address: _____

Street Address: _____

City, ST, ZIP: _____

Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at: _____@_____.

New shipping address: _____

(Express Scripts will keep this address on file for all orders from this membership until another shipping address is provided by any person in this membership.)

Evening phone: _____

Daytime phone: _____

2 Patient/doctor information: Complete **one section** for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in the envelope provided.

First name

Last name

Birth date (MM/DD/YYYY)

Sex
 M F

Patient's relationship to member
 Self Spouse Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex
 M F

Patient's relationship to member
 Self Spouse Dependent

Doctor's last name

1st initial

Doctor's phone number

3 Complete your order: You can pay by e-check, check, money order, or credit card. Make checks and money orders payable to **Express Scripts**, and write your member ID number on the front. You can enroll for e-check payments and price medications at Express-Scripts.com, or call the Member Services phone number found on your ID card.

Number of prescriptions sent with this order:

Payment options: e-check Payment enclosed Credit card Send bill

For credit card payments:

Visa MC Discover Amex Diners

Credit card number

Expiration date

M M Y Y

Cardholder signature _____

I authorize Express Scripts to charge this card for all orders from any person in this membership.

Rush the mailing of this shipment (\$21, cost subject to change). NOTE: This will only rush the shipping, not the processing of your order. Street address is required; P.O. box is not allowed.

FOLD HERE

FOLD HERE

Patient/doctor information continued

First name

Last name

Birth date (MM/DD/YYYY)

Sex

 M F

Patient's relationship to member

 Self Spouse Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex

 M F

Patient's relationship to member

 Self Spouse Dependent

Doctor's last name

1st initial

Doctor's phone number

Important reminders and other information

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

Complete the Health, Allergy & Medication Questionnaire.

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

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

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

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

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

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

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

Federal law prohibits the return of dispensed controlled substances.

FOLD HERE

FOLD HERE

Place your prescription(s), this form, and your payment in the envelope provided. Be sure the address shows through the window. Do not use staples or paper clips.

EXPRESS SCRIPTS
PO BOX 747000
CINCINNATI, OH 45274-7000



Patient name:

Date of birth:
 Month Day Year

SECTION 5: Your medical conditions

Has your doctor ever told you that you have any of the conditions listed below? If so, fill the oval completely next to all that apply.

<input type="radio"/>	Allergies, hay fever (allergic rhinitis)	<input type="radio"/>	Heart failure (CHF)
<input type="radio"/>	Arthritis	<input type="radio"/>	Hemophilia and hemophilia-like conditions
<input type="radio"/>	Asthma	<input type="radio"/>	High blood pressure (hypertension)
<input type="radio"/>	Bladder control problem (urinary incontinence)	<input type="radio"/>	High blood sugar (diabetes)
<input type="radio"/>	Brittle bones (osteoporosis)	<input type="radio"/>	High cholesterol (hypercholesterolemia)
<input type="radio"/>	Chest pain (angina)	<input type="radio"/>	Inflammatory bowel disease
<input type="radio"/>	Crohn's disease	<input type="radio"/>	Migraine headache
<input type="radio"/>	Depression	<input type="radio"/>	Overactive thyroid (hyperthyroid)
<input type="radio"/>	Emphysema (COPD, chronic bronchitis)	<input type="radio"/>	Peptic, stomach, or duodenal ulcer
<input type="radio"/>	Enlarged prostate (benign prostatic hyperplasia, BPH)	<input type="radio"/>	Poor circulation in the legs (peripheral vascular disease)
<input type="radio"/>	Gastric reflux, heartburn, or esophagitis (GERD)	<input type="radio"/>	Seizures (epilepsy)
<input type="radio"/>	Glaucoma	<input type="radio"/>	Stroke (TIA)
<input type="radio"/>	Heart attack (myocardial infarction)	<input type="radio"/>	Underactive thyroid (hypothyroid)

Additional health information

If you have any other medication allergies, medical conditions, prescription medications not filled under your pharmacy benefit, or nonprescription medications not listed above, please call 877.438.4417.

End of Express Scripts Health, Allergy & Medication Questionnaire

Information Sharing Authorization

I hereby authorize Express Scripts to disclose to its subsidiaries and affiliates my health information in its entirety for the purpose of providing me with educational, informational, and promotional communications specific to my health. This authorization will be effective for five (5) years from the date this form is processed by Express Scripts and may be revoked by me at any time by submitting a letter in writing to Express Scripts, 4865 Dixie Highway, Fairfield, OH 45014. I understand that if I revoke this authorization it will not affect any action that Express Scripts may have taken prior to Express Scripts' receipt of the written notice of revocation. I understand that I will still be eligible for the same health plan benefits from Express Scripts whether or not I authorize information sharing. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or any other health information privacy laws. I affirm that the signature below is mine and that I am authorizing for myself or my minor dependent child named below.

Patient name:

Signature _____

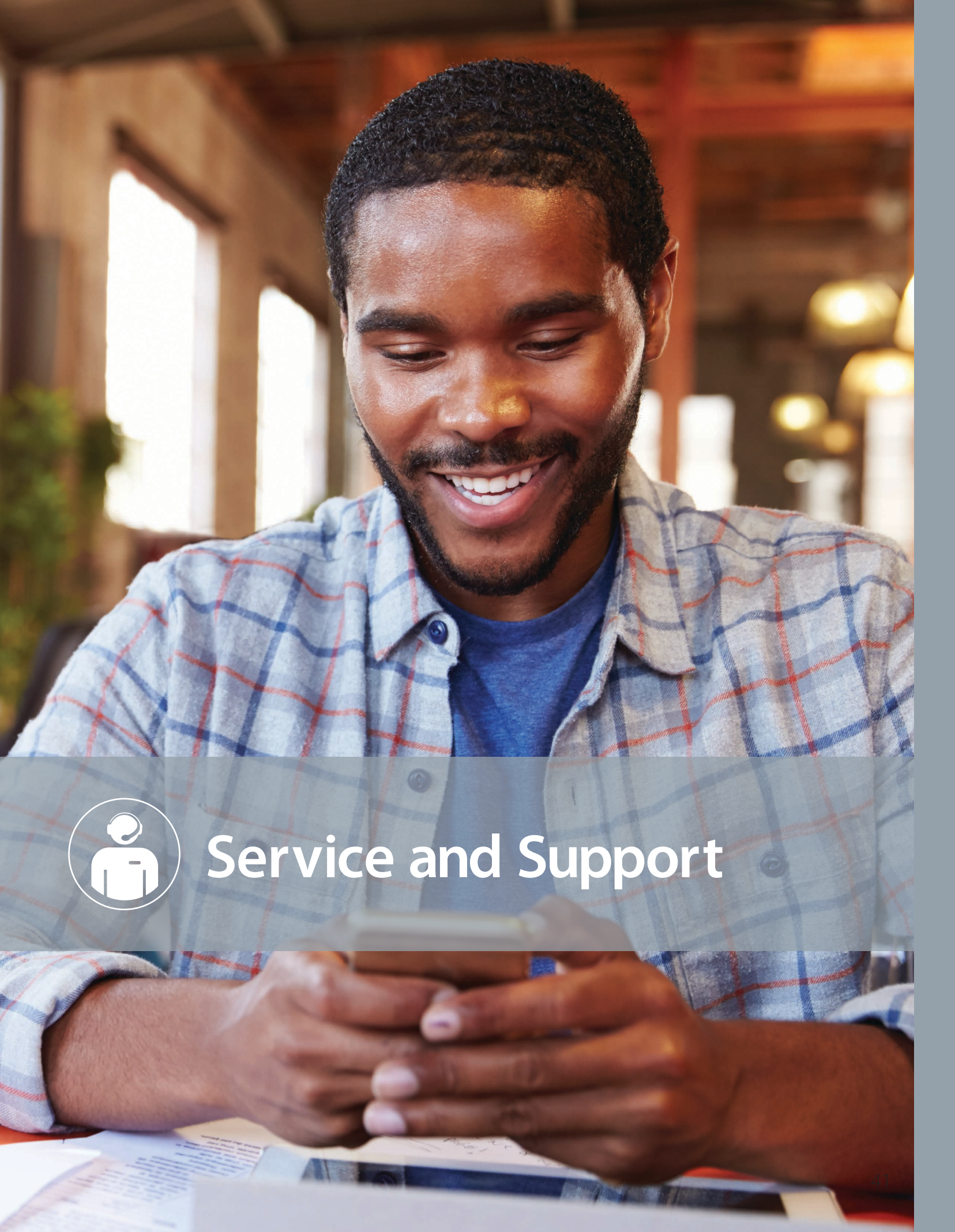
Place your completed questionnaire in the envelope marked HMQ. Do not send prescriptions, refill slips, or correspondence with this questionnaire. Be sure the address shows through the window.

Did you complete both sides?

Thank you very much.

HMQ PROCESSING CENTER
PO BOX 14238
LEXINGTON, KY 40512-4238





Service and Support

Get service & support whenever you need it

Live healthier with your online tools

You'll have a wealth of health resources available at the member website, **Highmarkbcbs.com**. Take a few minutes to establish your password and register online. Then you can log in from any computer, smart phone, tablet, or other mobile device.

While you are there, make sure we can contact you about your plan and your health. Tell us your preferences for digital communications and the best phone number to reach you.

Tell us more about you!

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

If you would like to share this background information, it will help us serve all our members' needs. Providing this information is voluntary. Your responses will not affect your benefits in any way. We are committed to protecting all your personal information with respect and integrity.



WebMD® Health and Wellness Library

Begin by logging in to [Highmarkbcbs.com](https://www.highmarkbcbs.com).

Enjoy a healthier lifestyle with resources powered by WebMD®, a trusted name in online health and wellness.

- **Wellness Profile** — This confidential questionnaire covers all aspects of your lifestyle and health habits. It includes nutrition, weight management, physical activity, stress, injury prevention, skin protection, immunizations, blood pressure, and cholesterol. Your answers will show you how you can reduce your health risks. It creates a personal action plan based on online health and wellness activities.
- **Health and wellness** — We have health coaching programs offered online or by phone. You can learn how to get healthy, get active, manage stress, lose weight, and quit tobacco. And if you have a chronic health condition, such as asthma or diabetes, there are programs to help you and your doctor manage your condition.
- **Health education** — You can look up symptoms, and read articles on illnesses, surgeries, procedures, and medications. Review treatment options and connect to the latest health news.

WebMD Health Services is a registered trademark of WebMD, LLC., an independent and separate company that supports your health plan online wellness services. WebMD Health Services is solely responsible for its programs and services, which are not a substitute for professional medical advice, diagnosis or treatment. WebMD Health Services does not endorse any specific product, service or treatment.

Online health tools for health care decisions

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

- **Care Cost Estimator** — Compare prices and quality for different health care providers. You can do side-by-side comparisons for quality ratings, convenience, and cost for doctors and hospitals, for hundreds of medical services. The cost estimates include all services related to a procedure — like physician fees, supplies, and medications. It uses your own specific coverage to calculate what your out-of-pocket costs might be.
- **Personal health record** — See your history of health conditions; this feature pulls together your history of health conditions, office visits, procedures, tests, medications, and immunizations in one location.
- **Find a doctor** — Select health care professionals based on their quality, experience, location, and more.
- **Patient experience ratings** — See how other people rate doctors and medical facilities.
- **Online Plan Activity Statement** — Review claims information and spending account information (if applicable) in one user-friendly document.
- **Compare prescription costs** — Learn how much medications cost and how to save money by using generics.

Need Support? Call Blues On CallSM

Call **1-888-BLUE-428 (1-888-258-3428)** to connect with Blues On CallSM.

This dedicated member service puts you in touch with a specially trained health coach who can discuss, in confidence, any health topic that concerns you. This could be:

- A rash, possible earache, or how to take medication safely
- Your concerns about a recent diagnosis, a scheduled medical test, or surgery
- How to best care for a child or an older adult

You don't have to be ill to talk to health coaches. They can also help you maintain your health with programs for stress management, personal nutrition, weight control, and physical fitness.

Best of all, once you've established a relationship with your health coach, she or he is then familiar with your concerns or health conditions. Of course, you can always speak with any health coach at any time. Blues On Call knows how hectic your daily schedule can be, so health coaches are available when you have the time, early in the morning or late at night, 24 hours a day, as often as you want.

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

Find a provider with My Care NavigatorSM

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

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

Through My Care Navigator, you can:

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

My Care Navigator is a service mark of Highmark Health.

Where to turn for help

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

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

If you are pregnant, you'll want to join the free Baby Blueprints[®] Maternity Education and Support Program. By enrolling in Baby Blueprints, you'll connect to online information on all aspects of pregnancy and childbirth. You'll receive individualized support from a health coach throughout your pregnancy and after your child is born. To enroll in Baby Blueprints, just call toll-free **1-866-918-5267**.



Additional Important Information

Determining your care coverage

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

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

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

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



How We Protect Your Rights to Confidentiality

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

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

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

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

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

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

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

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

Members' Rights & Responsibilities

You have the right to:

1. Receive information about your plan, its products and services, and your rights and responsibilities as members.
2. Be treated with respect and recognition of your dignity and right to privacy.
3. Participate with practitioners in making decisions about your health care.
4. Be informed of your diagnosis and treatment plan in terms that you understand.
5. Have a candid discussion of appropriate and/or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage.
6. Voice a complaint about your plan and any care provided, appeal decisions your plan makes, and receive a reply within a reasonable period of time.
7. Make recommendations for changes to plan policies and Members' Rights and Responsibilities.

You have the responsibility to:

1. Supply to the extent possible, information that the organization needs in order to make care available to you, and that its practitioners and providers need in order to care for you.
2. Follow the plans and instructions for care that you have agreed on with your practitioners.
3. Communicate openly with the practitioners you choose.
4. Ask questions and make sure you understand the explanations and instructions you are given, and participate in developing mutually agreed upon treatment goals.
5. Develop a relationship with practitioners based on trust and cooperation.

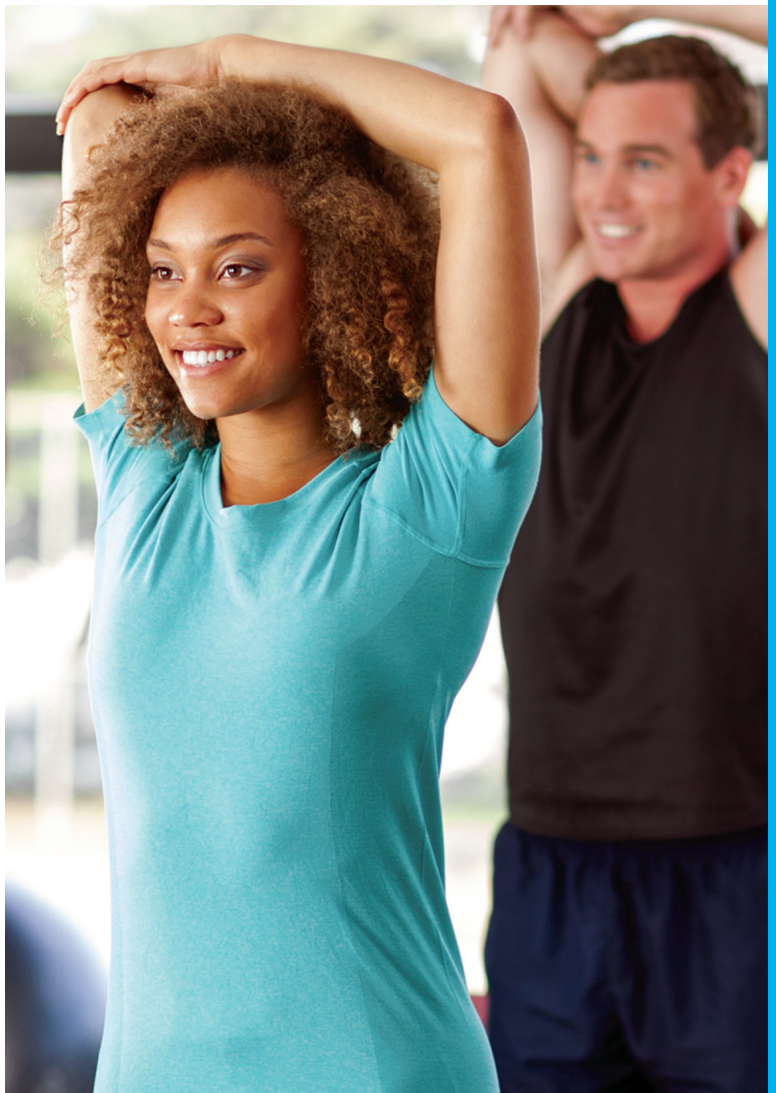
Care & Case Management

Care Management Program

Everyone has different needs at different times. Our Care Management program represents an integrated, comprehensive approach to providing care support and ensuring care is responsive and appropriate.

Services listed below are part of this program.

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



Case Management Program

The Case Management Program supports members with serious and complex medical conditions by helping them navigate the health care system and make informed care decisions.

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

Goals of the Case Management Program

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

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

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

How the Case Management Program Works

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

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

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



How to Enroll

Fill in all of the information requested on your Enrollment Application. Be sure to accurately fill in all the requested information. Return your completed application as instructed by your employer.



HOW TO COMPLETE YOUR HIGHMARK BLUE CROSS BLUE SHIELD ENROLLMENT APPLICATION

FOLLOWING ARE INSTRUCTIONS FOR COMPLETING THE HIGHMARK BLUE CROSS BLUE SHIELD ENROLLMENT APPLICATION. ALL INFORMATION MUST BE COMPLETED AS INDICATED.

EMPLOYEE INFORMATION

The first thirteen (13) items ask for information regarding the employee. The information you must complete includes:

- 1) Employer Name and Reason for Application
- 2) Employee First Name, Middle Initial, Last Name.
- 3) Employee Street Address
- 4) City
- 5) State
- 6) Zip Code
- 7) Employee Social Security Number
- 8) Effective Date of Coverage
- 9) Employee Status: Please check (✓) the appropriate box indicating whether you are an Active, Retired, Hourly or Salary employee. If retired, please indicate retirement date.
- 10) Employee Home Phone Number (including area code) – Please provide so that we may contact you if we have questions about your application and to better serve you.
- 11) Employee Work Phone Number (including area code)
- 12) Employee Hire Date (i.e., date employee first eligible to enroll for benefits) – Specify month/day/year. Required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- 13) Check Type of Coverage for which you are enrolling, using the appropriate category (employee, two person or family).
- 14) To be completed by Account/Administrator only

Items 15 through 18 ask for important information about yourself and each eligible member of your family (15 yourself, 16 your spouse/ domestic partner, 17-18 your dependents). Please complete all requested information. If relationship is "other", please indicate the dependent's relationship to the employee according to the codes provided on the application.

- **First Name/Middle Initial/Last Name** — Complete the First Name, Middle Initial and Last Name for each eligible person listed.
- **Social Security Number** — Please include the Social Security Number of each person.
- **Do you have other insurance?** — If you or a family member have other medical insurance including Medicare, respond "yes". If not, you must respond "No".
- **Birth Date** (month/day/year)
- **Sex** (female or male)

- **Check if: Student over Maximum Regular Dependent Age, Disabled and/or Act 4 dependent**
If your dependent is over the Maximum Regular Dependent Age and is a full time student or a disabled dependent of any age or an Act 4 dependent to the age of 30 (see your benefit administrator for eligibility), please check (✓) the appropriate column by that dependent's name.

Physician of Record (POR) Information — A Physician of Record is the physician selected by the member, who provides routine care and coordinates other specialized care. Please note that choosing a POR does not impact your benefits or claims payment in any way. Choosing a POR simply helps us to better serve you by connecting you to the practice where most of your health care is received.

- a) **Full Name of Physician of Record (POR) Group Practice** — Indicate the name of the POR Group Practice selected from the Online Provider Directory for yourself and each of your dependents. You and your dependents can each choose a different POR.
- b) **Physician of Record (POR) Number from Provider Directory** — Please indicate the corresponding number for the physician practice you or your dependent chose as a POR from the Online Provider Directory, Practice Information tab.
- c) **Are you an existing Patient of this POR?** — Please check "Yes" or "No" to indicate if you are currently a patient of the POR you chose for yourself or your dependents.

For online provider lookup, go to www.highmarkbcbs.com and search under the "Find a Doctor or Rx" tab. If you need assistance with choosing a POR, please call Member Service at 1-800-241-5704.

Disclaimer: Please note that a provider number may not be available for providers that are located outside of the local servicing area. In this case, a POR cannot be chosen.

- 19) Needs to be completed if you, your spouse/domestic partner or one of your eligible dependents has other health insurance coverage or is eligible for Medicare. Please complete all information requested. Refer to your Medicare card to complete the Medicare Information section.

- 20) Should be completed by your Account Administrator.
- 21) You must sign and date the form where indicated.

Once the form is completed, retain the last copy for your records.

HIGHMARK BLUE CROSS BLUE SHIELD ENROLLMENT APPLICATION

Membership Department
P.O. Box 535193
Pittsburgh, PA 15253-5193



EMPLOYEE INFORMATION — Employee must complete items 1 through 17 and sign.

1) Employer Name: _____ Reason for Application: New Hire Act 4 Rehire Other: _____ Enrollment COBRA

2) Employee First Name / Middle Initial / Last Name: _____

3) Street Address: _____ 4) City: _____ 5) State: _____ 6) Zip: _____

7) Social Security Number: _____ 8) Effective Date of Coverage: Month _____ Day _____ Year _____ 9) Employee Status: Active Retired (Date) _____ Hourly Salary

10) Employee Phone #—Home: () _____ 11) Employee Phone #—Work: () _____ Day _____ Year _____

12) Employee Hire Date: Month _____ Day _____ Year _____

13) Check Type of Coverage: Employee Only Insured & Spouse/Domestic Partner Family Parent & Child Parent & Children

14) To be completed by Account Administrator only: Report Code Qualifier: _____ Report Code Value: _____

15) MEDICAL: DENTAL: VISION: DRUG: PRODUCT NAME: _____

15) Self	First Name / Middle Initial / Last Name	Social Security Number	Do you have other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #24	Birth Date		Sex F/M	Check If	
				Mo	Dy		Yr	Student Benefits Apply
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory		<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #24	c) Are you an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No				
16) <input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.*	First Name / Middle Initial / Last Name	Social Security Number	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #24	c) Is Spouse/DP an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No				
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory		<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #24	c) Is Spouse/DP an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No				
17) <input type="checkbox"/> Child <input type="checkbox"/> Other*	First Name / Middle Initial / Last Name	Social Security Number	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #24	c) Is Dependent an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No				
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory		<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #24	c) Is Dependent an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No				
18) <input type="checkbox"/> Child <input type="checkbox"/> Other*	First Name / Middle Initial / Last Name	Social Security Number	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #24	c) Is Dependent an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No				
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory		<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #24	c) Is Dependent an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No				

*If "domestic partner" or "other" applies, complete using one of the following codes: (05) Grandchild, (07) Nephew or Niece, (17) Steppson or Stepdaughter, (29) Domestic Partner

19) If you checked YES to other insurance, fill in appropriate line:

Name of Insurance Carrier: _____ Health Insurance Claim Number: _____ Part A Effective Date (Mo-Day-Yr): _____ Part B Effective Date (Mo-Day-Yr): _____

Group No: _____ Effective Date: _____

Name of Policy Holder: _____

Policy Number: _____

Relationship to Highmark Policy Holder: _____

Policy Holder Date of Birth: _____

Policy Holder Employment Status: Active Retired (Date) _____ Disability End Stage Renal Disease No Medicare

Why are you eligible for Medicare? Age Disability End Stage Renal Disease No Medicare

Do you have a Medicare Supplement or other coverage that complements Medicare? Yes No

To the best of my knowledge and belief, the information provided on this application is true and correct. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I understand that this form enrolls those eligible persons listed above in the Medical Plan as described in the agreement between the plan and my employer. I authorize any payroll deductions required for the Highmark Health Services Web site, or from the Highmark Health Services Privacy Office.

20) _____ Date _____ Authorized Employer Signature _____

21) _____ Date _____ Employee Signature _____



WAIVER OF INSURANCE COVERAGE

A. APPLICANT INFORMATION (Please Print):

Employee Name: _____

Date of Birth: _____ SS #: _____

Employer Name: _____ Hire Date: _____

B. OTHER INSURANCE INFORMATION:

I elect to waive health care coverage offered by my employer through Highmark Blue Cross Blue Shield. I currently:

- Do not have health coverage under any health plan.
- Do have health coverage through (please complete the following information):

CONTRACT HOLDER NAME

NAME OF HEALTH CARE PLAN/INSURER

GROUP NUMBER

SUBSCRIBER ID NUMBER

RELATIONSHIP OF CONTRACT HOLDER TO YOU

- decline coverage for the following individuals. Please check (✓) types of coverage being waived for each individual.

COVERAGE WAIVED

	LAST NAME	FIRST NAME	MI	MEDICAL	DRUG	VISION	DENTAL
EMPLOYEE							
SPOUSE							
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							

C. VALIDATION/AUTHORIZATION STATEMENT:

- I hereby acknowledge 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 special enrollment (described below) occurs before coverage will be offered.

SPECIAL ENROLLMENT RIGHTS:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 31 days after you and your dependent's 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, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Employee Signature _____

Date _____

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield, First Priority Life Insurance Company (FPLIC) or First Priority Health (FPH). Information is issued by Highmark Blue Cross Blue Shield on behalf of these companies, which are independent licensees of Blue Cross and Blue Shield Association.

Employees and Employers: Please retain copies of this form for your records.

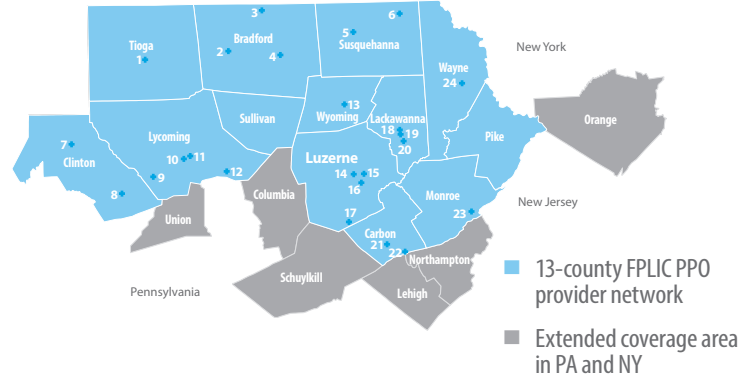
CUSTOM PPO PROVIDER NETWORK

PLANS: myBlue® Access, BlueCare® Custom PPO and BlueCare QHD Custom PPO

NETWORK PROVIDERS

The Custom PPO provider network includes:

- All of First Priority Life®'s (FPLIC) PPO network providers and Blue Distinction® Centers for Transplants



FPLIC PPO network hospitals

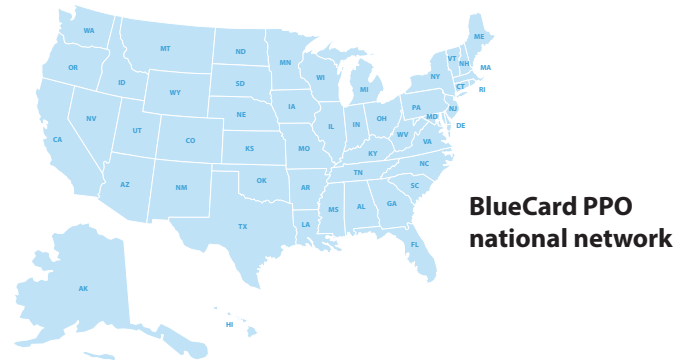
Counties	Tioga Bradford Susquehanna	Clinton Lycoming Sullivan	Luzerne Wyoming	Lackawanna	Carbon Monroe Pike Wayne
Hospitals	<ol style="list-style-type: none"> Soldiers + Sailors Memorial Hospital Troy Community Hospital Robert Packer Hospital Memorial Hospital—Towanda Endless Mountains Health System Barnes Kasson County Hospital 	<ol style="list-style-type: none"> Bucktail Medical Center Lock Haven Hospital Jersey Shore Hospital Williamsport Hospital Divine Providence Hospital Muncy Valley Hospital 	<ol style="list-style-type: none"> Tyler Memorial Hospital Wilkes-Barre General Hospital Geisinger Wyoming Valley Medical Center Department of Veterans Affairs Medical Center Lehigh Valley Hazleton, Hospital 	<ol style="list-style-type: none"> Regional Hospital of Scranton Moses Taylor Hospital Geisinger Community Medical Center 	<ol style="list-style-type: none"> Gnaden Huetten Memorial Hospital Palmerton Hospital Lehigh Valley Hospital—Pocono Wayne Memorial Hospital

AND, several hospitals and their participating doctors, located just beyond our 13-county service area:

PA					NY
Columbia County	Lehigh County	Northampton County	Schuylkill County	Union County	Orange County
Berwick Hospital Center Geisinger-Bloomsburg Hospital	Lehigh Valley Hospital, Allentown St. Luke's University Hospital, Allentown Campus	St. Luke's University Hospital, Bethlehem Campus St. Luke's University Hospital, Anderson Campus, Easton Lehigh Valley Hospital-Muhlenberg, Bethlehem	St. Luke's University Hospital, Miners Campus, Nesquehoning	Evangelical Community Hospital, Lewisburg	Bon Secours Community Hospital, Port Jervis This hospital is in network. Not all doctors affiliated with this hospital are in network.

OUT-OF-NETWORK

- BlueCard® PPO national network providers
- Any other non-participating providers



THE COST FOR CARE

Costs will always be the lowest when using in-network doctors, hospitals and health care providers. Coverage is provided for care out of the network, but at higher out-of-pocket costs.

Custom PPO network	Out-of-pocket costs for care	
FPLIC PPO network providers & some providers just outside our 13-county service area are in network	Lowest cost (deductibles, copays and coinsurance) for care from in-network providers	\$
BlueCard PPO network providers are out of network	You will pay more for care from BlueCard PPO network providers	\$\$\$
All other providers are out of network*	You can see providers NOT in the BlueCard PPO network, but you will pay the most out of your pocket for your care	\$\$\$\$

* Providers out of the Custom PPO and BlueCard PPO networks do not agree to accept Blue’s discounted “allowable charge” as payment in full. They may bill for a bigger share of the cost for care.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield, First Priority Life Insurance Company or First Priority Health, all of which are independent licensees of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement.

Discrimination is Against the Law

The Plan 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 Plan 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 Plan 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 Plan 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 Plan:

- 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 Plan 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).

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 Deutsch schwetzsch, kannsch du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kansch 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 المساعدة 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).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ប្រការចងចាំ: បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នក ដោយឥតគិតថ្លៃ។ សូមទូរសព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់លោកអ្នក (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 yánít'i'go, language assistance services, éí t'áá níik'eh, bee níká a'doowot, éí bee ná'ahóót'i'. ID bee nééhózingo nanitínígíí bine'déé' (TTY: 711) jí' hódílnih.

Discrimination is Against the Law

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

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)
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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.

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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.

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

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

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

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

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

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

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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 .

There's a lot to like about us

We like to share our passion for health and wellness. That's why we're on many of your favorite social media sites. Connecting with us through social media gives you access to important information on living healthier, helps you get the most from your health care coverage, and lets you give us feedback on how we can better serve you.

On our social media sites, you can:

- Get health and wellness information
- Keep up on community activities, special events, and the latest news
- Get answers to frequently asked questions about health, wellness, and health coverage
- And more...

Connect with us



<https://www.facebook.com/Highmark>



<https://www.instagram.com/highmark>



<https://twitter.com/Highmark>



<https://linkedin.com/company/highmark>



<https://www.youtube.com/user/HighmarkHealthy>



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<https://blog.highmark.com/>



CONNECT WITH US

