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

HIGHMARK

Community Blue Flex PPO

Empyrean

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 Call℠ 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,

Deborah L. Rice-Johnson

Deborah L. Rice-Johnson
President
Highmark Health Plans

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Community Blue Flex PPO

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.

In-network vs. out-of-network

The health care providers that participate with this plan 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.

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

Select from two levels for lower costs

You can choose a health care provider from the Community Blue network in western Pennsylvania that includes more than 50 community and specialty hospitals and more than 7,600 physicians. 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.

Your plan gives you the ability to lower your out-of-pocket costs based on the providers you choose. You still have access to the full network of providers.

With this plan, you have two levels of in-network benefits and one level of out-of-network benefits.

- At the **Enhanced Value benefit level**, you have lower cost-sharing because you receive care from in-network providers who deliver care more cost-effectively.
- At the **Standard Value benefit level**, you have higher out-of-pocket costs but can select from additional providers.
- For **out-of-network** health care providers, your out-of-pocket expenses are the highest.

Need help finding top-quality physicians and hospitals?

You can search for in-network doctors and hospitals with our online provider directory at **highmarkbcbs.com**.

When you click on **Find a doctor or Rx**, search under the ***Community Blue Flex PPO*** plan. In-network providers will be labeled as Enhanced and Standard.

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

Community Blue Flex in-network hospitals

These community and specialty hospitals are at the Enhanced Value benefit level unless noted otherwise. Those who participate at the Standard Value benefit level are indicated with an asterisk.

Allegheny County

Allegheny General Hospital

Allegheny Valley Hospital

Children's Hospital of Pittsburgh of UPMC

Forbes Hospital

Heritage Valley Sewickley

Jefferson Hospital

Ohio Valley Hospital

St. Clair Hospital

West Penn Hospital

Western Psychiatric Institute and Clinic

Armstrong County

Armstrong County Memorial Hospital

Beaver County

Heritage Valley Beaver

Bedford County

UPMC Bedford Memorial

Blair County

Nason Hospital

Tyrone Hospital

UPMC Altoona

Butler County

Butler Memorial Hospital

Cambria County

Conemaugh Memorial Medical Center

Conemaugh Miners Medical Center

Clarion County

Clarion Hospital

Clearfield County

Clearfield Hospital

Penn Highlands Dubois

Crawford County

Meadville Medical Center

Titusville Area Hospital

Elk County

Elk Regional Health Center

Erie County

Corry Memorial Hospital

Millcreek Community Hospital

Saint Vincent Hospital

*UPMC Hamot**

Fayette County

Highlands Hospital

Uniontown Hospital

Greene County

Washington Health System - Greene

Huntingdon County

J. C. Blair Memorial Hospital

Indiana County

Indiana Regional Medical Center

Jefferson County

Penn Highlands Brookville

Punxsutawney Area Hospital

Lawrence County

Ellwood City Hospital

*UPMC Jameson**

McKean County

Bradford Regional Medical Center

Kane Community Hospital

Mercer County

Edgewood Surgical Hospital

Grove City Medical Center

Sharon Regional Health System

*UPMC Horizon**

Potter County

Cole Memorial Hospital

Somerset County

Chan Soon Shiong Medical Center at Windber

Conemaugh Meyersdale Medical Center

Somerset Hospital

Venango County

UPMC Northwest

Warren County

Warren General Hospital

Washington County

Advanced Surgical Hospital

Canonsburg Hospital

Monongahela Valley Hospital

Washington Hospital

Westmoreland County

Excela Frick Hospital

Excela Latrobe Hospital

Excela Westmoreland Hospital

* = standard level of benefits

PLEASE NOTE: The following UPMC western Pennsylvania hospitals are out-of-network for *Community Blue Flex*:

- Magee - Womens Hospital of UPMC
- UPMC Presbyterian-Shadyside
- UPMC East
- UPMC McKeesport
- UPMC Mercy
- UPMC St. Margaret
- UPMC Passavant

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.

Your plan's network includes Allegheny Health Network

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

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

AHN comprises more than 2,800 physicians with a geographical footprint that touches virtually every community in western Pennsylvania. The network also includes eight hospitals with nearly 2,400 licensed beds:

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

Additional world-class partnerships

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

West Penn Hospital

Regionally and nationally recognized for excellence in nursing, burn care, maternity, diabetes, cardiovascular, lupus, neurology, and cancer care. In addition, West Penn offers a Level-3 neonatal intensive care unit — the highest and most sophisticated level of care.

Allegheny General Hospital

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

Jefferson Hospital

Offers a new Women and Infants Center featuring the latest technology and many amenities to bring a new era of exceptional and compassionate care for our region's women and their growing families.

AHN Sports Complex at Cool Springs

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

Allegheny Health Network Health + Wellness Pavilions

Offering a one-stop health care experience where you can receive many health care services at the in-network benefit level. Here is a list of locations and some of the services available.

Locations

- Bethel Park
- Peters Township
- Wexford
- Erie

Classes and events

- C3 Logix Baseline Concussion Testing
- Heart health cooking demonstration
- Understanding heart failure
- Newborn basics (Wexford)

Did you know?

AHN's Wexford Health + Wellness Pavilion is the first site in the nation to install SenoClaire, GE Healthcare's new breast tomosynthesis solution designed with three-dimensional imaging technology. 3-D mammography is now available in eight AHN locations.

Features and services

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

Medical and surgical specialties

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

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

Maternity care

Pregnant, or plan to become pregnant?

You've got questions... Baby Blueprints® has answers

To help you understand every stage of pregnancy and make informed care- and lifestyle-related decisions, we're offering Baby Blueprints® Maternity Education and Support Program.

Your free program gives you access to in-depth educational information and helpful pregnancy tips through your member website. You also get dedicated support throughout your pregnancy from a nurse health coach.

If you are currently pregnant or considering becoming pregnant and being treating by a UPMC physician, please refer to the Your Access to UPMC Providers section of this brochure.

Access to high-quality care for your special delivery

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

- Forbes Hospital in Monroeville
- West Penn Hospital in Pittsburgh
- Jefferson Hospital, southern Pittsburgh region
- St. Clair Hospital, southern Pittsburgh region
- Excela Health System
- Heritage Valley, Sewickley and Beaver

For more information, visit **highmarkbcbs.com**.

Our network providers feature:

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

- Mothers labor and deliver in the same spacious, light-filled room
- Mothers and babies bond with skin-to-skin contact immediately following birth
- Newborns and parents room together in quiet, family-centered comfort

Physicians and other professionals offer expert care

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

Physicians and other professionals offer expert care

- Level-3 neonatal intensive care unit (NICU) — the highest and most sophisticated level of care — at West Penn Hospital, the region's largest referral center for babies who need special care
- Collaboration with Children's Hospital of Pittsburgh for expertise in infant surgery
- Level-2 NICUs at Forbes Hospital and Jefferson Hospital
- Neonatal development follow-up program

Just call toll-free at 1-866-918-5267 to take advantage of all the program's offerings.

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 services, including counseling and treatment services. To assure members get responsive, appropriate care, the program offers a choice of mental health 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 care from Allegheny Health Network physicians and other independent specialists in western Pennsylvania. You'll get access to excellent women's and children's care, as well as key specialties like cancer, heart, and orthopedic care, rehabilitation, and more.

Exceptional cancer services are available through Allegheny Health Network and Johns Hopkins Kimmel Cancer Center. You can also get care from eight cancer centers jointly operated by UPMC and other community hospitals. You'll also have access to oncology services at Hillman Cancer Center and all other UPMC-owned or managed care facilities and from UPMC-employed physicians at a lower level of coverage.

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.

Virtual medicine services

We make care more convenient by covering virtual medicine services. This medical service lets you talk to a doctor anytime, via web-based video and telephone calls. You can contact a virtual medicine physician from your home, office, or just about anywhere, when you are experiencing a minor illness.

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

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

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

What's not covered?

Some services are not covered under your 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
- 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

Community Blue Flex PPO Blue $1,000 Benefit Summary

On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out-of-pocket. 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.

Group Number(s): 104276-73; - 77

Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
General Provisions			
Benefit Period(1)	Contract Year		
Deductible (per benefit period) (All in-network services are credited to both the enhanced and the standard deductibles.) Individual Family	 $1,000 $2,000	 $2,000 $4,000	 $4,000 $8,000
Plan Pays – payment based on the plan allowance	100% after deductible	70% after deductible	50% after deductible
Out-of-Pocket Limit (Once met, plan pays100% coinsurance for the rest of the benefit period) (All in-network services are credited to both the standard and the enhanced out-of-pocket limits) Individual Family	 None None	 $3,000 $6,000	 $6,000 $12,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $7,350 $14,700		 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	100% after $10 copay	100% after $20 copay	50% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $10 copay	100% after $20 copay	50% after deductible
Specialist Office Visits & Virtual Visits	100% after $25 copay	100% after $50 copay	50% after deductible
Virtual Visit Originating Site Fee	100% after deductible	70% after deductible	50% after deductible
Urgent Care Center Visits	100% after $35 copay	100% after $70 copay	50% after deductible
Telemedicine Services (3)	100% after $5 copay		Not Covered
Preventive Care (4)			
Routine Adult Physical Exams	100% (deductible does not apply)		50% after deductible
Adult Immunizations	100% (deductible does not apply)		50% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)		50% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)		50% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)		50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)		50% after deductible
Routine Pediatric Physical Exams	100% (deductible does not apply)		50% after deductible
Pediatric Immunizations	100% (deductible does not apply)		50% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)		50% after deductible
Emergency Services			
Emergency Room Services	100% after $100 copay (waived if admitted)		
Ambulance- Emergency	100% after enhanced deductible		
Ambulance- Non-Emergency	100% after enhanced deductible		
Hospital and Medical / Surgical Expenses (including maternity)			
Hospital Inpatient	100% after deductible	70% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	70% after deductible	50% after deductible
Therapy and Rehabilitation Services			
Physical Medicine	100% after $25 copay	100% after $50 copay	50% after deductible
	limit: 20 visits/benefit period		
Respiratory Therapy	100% after deductible	70% after deductible	50% after deductible
Speech Therapy	100% after $25 copay	100% after $50 copay	50% after deductible
	limit: 20 visits/benefit period		
Occupational Therapy	100% after $25 copay	100% after $50 copay	50% after deductible
	limit: 20 visits/benefit period		

Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
Spinal Manipulations	100% after $25 copay	100% after $50 copay	50% after deductible
	limit: 20 visits/benefit period		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	70% after deductible	50% after deductible
Mental Health / Substance Abuse			
Inpatient Mental Health Services	100% after enhanced deductible		50% after deductible
Inpatient Detoxification / Rehabilitation	100% after enhanced deductible		50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after enhanced deductible		50% after deductible
Outpatient Substance Abuse Services	100% after enhanced deductible		50% after deductible
Other Services			
Allergy Extracts and Injections	100% after deductible	70% after deductible	50% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	100% after deductible	70% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	Not Covered		
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	70% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	70% after deductible	50% after deductible
Home Health Care	100% after deductible	70% after deductible	50% after deductible
	limit: 90 visits/benefit period		
Hospice	100% after deductible	70% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (6)	100% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	70% after deductible	50% after deductible
	limit: 240 hours/benefit period		
Skilled Nursing Facility Care	100% after deductible	70% after deductible	50% after deductible
	limit: 100 days/benefit period		
Transplant Services	100% after deductible	70% after deductible	50% after deductible
Precertification Requirements (7)	Yes		
Prescription Drugs			
Prescription Drug Deductible Individual Family	None None		
Prescription Drug Program (8) Soft Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (31/60/90-day Supply)** $8 / $16 / $24 generic copay $35 / $70 / $105 formulary brand copay $50 / $100 / $150 non-formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $20 generic copay $90 formulary brand copay $125 non-formulary brand copay		

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.
*The terms "Enhanced Value" and "Standard Value" are not descriptors of the provider's ability.
(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense..
(3) 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/Substance Abuse benefit.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Coverage for eligible members to age 21. 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 formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copay or coinsurance amounts listed above. Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copay or coinsurance amounts, which may apply.

Community Blue Flex PPO Blue $1,500 Benefit Summary

On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out-of-pocket. 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.

Group Number(s): 104276-74, -78

Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
General Provisions			
Benefit Period(1)	Contract Year		
Deductible (per benefit period) (All in-network services are credited to both the enhanced and the standard deductibles.) Individual Family	 $1,500 $3,000	 $4,500 $9,000	 $9,000 $18,000
Plan Pays – payment based on the plan allowance	100% after deductible	70% after deductible	50% after deductible
Out-of-Pocket Limit (Once met, plan pays100% coinsurance for the rest of the benefit period) (All in-network services are credited to both the standard and the enhanced out-of-pocket limits) Individual Family	 None None	 $1,500 $3,000	 $3,000 $6,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $7,350 $14,700		 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	100% after $10 copay	100% after $20 copay	50% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $10 copay	100% after $20 copay	50% after deductible
Specialist Office Visits & Virtual Visits	100% after $25 copay	100% after $50 copay	50% after deductible
Virtual Visit Originating Site Fee	100% after deductible	70% after deductible	50% after deductible
Urgent Care Center Visits	100% after $35 copay	100% after $70 copay	50% after deductible
Telemedicine Services (3)	100% after $5 copay		Not Covered
Preventive Care (4)			
Routine Adult Physical Exams	100% (deductible does not apply)		50% after deductible
Adult Immunizations	100% (deductible does not apply)		50% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)		50% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)		50% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)		50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)		50% after deductible
Routine Pediatric Physical Exams	100% (deductible does not apply)		50% after deductible
Pediatric Immunizations	100% (deductible does not apply)		50% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)		50% after deductible
Emergency Services			
Emergency Room Services	100% after $100 copay (waived if admitted)		
Ambulance-Emergency	100% after enhanced deductible		
Ambulance-Non-Emergency	100% after enhanced deductible		
Hospital and Medical / Surgical Expenses (including maternity)			
Hospital Inpatient	100% after deductible	70% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	70% after deductible	50% after deductible
Therapy and Rehabilitation Services			
Physical Medicine	100% after $25 copay	100% after $50 copay	50% after deductible
	limit: 20 visits/benefit period		
Respiratory Therapy	100% after deductible	70% after deductible	50% after deductible
Speech Therapy	100% after $25 copay	100% after $50 copay	50% after deductible
	limit: 20 visits/benefit period		
Occupational Therapy	100% after $25 copay	100% after $50 copay	50% after deductible

Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
	limit: 20 visits/benefit period		
Spinal Manipulations	100% after $25 copay	100% after $50 copay	50% after deductible
	limit: 20 visits/benefit period		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	70% after deductible	50% after deductible
Mental Health / Substance Abuse			
Inpatient Mental Health Services	100% after enhanced deductible		50% after deductible
Inpatient Detoxification / Rehabilitation	100% after enhanced deductible		50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after enhanced deductible		50% after deductible
Outpatient Substance Abuse Services	100% after enhanced deductible		50% after deductible
Other Services			
Allergy Extracts and Injections	100% after deductible	70% after deductible	50% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	100% after deductible	70% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	Not Covered		
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	70% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	70% after deductible	50% after deductible
Home Health Care	100% after deductible	70% after deductible	50% after deductible
	limit: 90 visits/benefit period		
Hospice	100% after deductible	70% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (6)	100% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	70% after deductible	50% after deductible
	limit: 240 hours/benefit period		
Skilled Nursing Facility Care	100% after deductible	70% after deductible	50% after deductible
	limit: 100 days/benefit period		
Transplant Services	100% after deductible	70% after deductible	50% after deductible
Precertification Requirements (7)	Yes		
Prescription Drugs			
Prescription Drug Deductible Individual Family	None None		
Prescription Drug Program (8) Soft Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (31/60/90-day Supply)** $8 / $16 / $24 generic copay $35 / $70 / $105 formulary brand copay $50 / $100 / $150 non-formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $20 generic copay $90 formulary brand copay $125 non-formulary brand copay		

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.
*The terms "Enhanced Value" and "Standard Value" are not descriptors of the provider's ability.
(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) 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/Substance Abuse benefit.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Coverage for eligible members to age 21. 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 soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed.

Community Blue Flex PPO Healthy Savings $2,000Q Benefit Summary

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out-of-pocket. 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.

Group Number(s): 104276-76, -80

Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
General Provisions			
Benefit Period(1)	Contract Year		
Deductible (per benefit period) (All in-network services are credited to both the enhanced and the standard deductibles.) Employee Only Plan Family Plan	 $2,000 $4,000	 $4,500 $4,500	 $9,000 $18,000
Plan Pays – payment based on the plan allowance	100% after deductible	70% after deductible	50% after deductible
Out-of-Pocket Limit (Includes prescription drug expenses, coinsurance and copays. Once met, plan pays100% coinsurance for the rest of the benefit period) (All in-network services are credited to both the enhanced and the standard out-of-pocket limits) Employee Only Plan Family Plan	 None None	 $1,500 $1,500	 $3,000 $6,000
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. Employee Only Plan Family Plan	 $6,000 $6,000		 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	100% after deductible	70% after deductible	50% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after deductible	70% after deductible	50% after deductible
Specialist Office Visits & Virtual Visits	100% after deductible	70% after deductible	50% after deductible
Virtual Visit Originating Site Fee	100% after deductible	70% after deductible	50% after deductible
Urgent Care Center Visits	100% after deductible	70% after deductible	50% after deductible
Telemedicine Services (3)	70% after enhanced in-network deductible		Not Covered
Preventive Care (4)			
Routine Adult Physical Exams	100% (deductible does not apply)		50% after deductible
Adult Immunizations	100% (deductible does not apply)		50% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)		50% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)		50% after deductible
Mammograms, Medically Necessary	100% after deductible		50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)		50% after deductible
Routine Pediatric Physical Exams	100% (deductible does not apply)		50% after deductible
Pediatric Immunizations	100% (deductible does not apply)		50% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)		50% after deductible
Emergency Services			
Emergency Room Services	100% after enhanced deductible		
Ambulance-Emergency	100% after enhanced deductible		
Ambulance-Non-Emergency	100% after enhanced deductible		
Hospital and Medical / Surgical Expenses (including maternity)			
Hospital Inpatient	100% after deductible	70% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	70% after deductible	50% after deductible
Therapy and Rehabilitation Services			
Physical Medicine	100% after deductible	70% after deductible	50% after deductible
	limit: 20 visits/benefit period		
Respiratory Therapy	100% after deductible	70% after deductible	50% after deductible
Speech Therapy	100% after deductible	70% after deductible	50% after deductible

Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
	limit: 20 visits/benefit period		
Occupational Therapy	100% after deductible	70% after deductible	50% after deductible
	limit: 20 visits/benefit period		
Spinal Manipulations	100% after deductible	70% after deductible	50% after deductible
	limit: 20 visits/benefit period		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	70% after deductible	50% after deductible
Mental Health / Substance Abuse			
Inpatient Mental Health Services	100% after enhanced deductible		50% after deductible
Inpatient Detoxification / Rehabilitation	100% after enhanced deductible		50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after enhanced deductible		50% after deductible
Outpatient Substance Abuse Services	100% after enhanced deductible		50% after deductible
Other Services			
Allergy Extracts and Injections	100% after deductible	70% after deductible	50% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	100% after deductible	70% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	Not Covered		
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	70% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	70% after deductible	50% after deductible
Home Health Care	100% after deductible	70% after deductible	50% after deductible
	limit: 90 visits/benefit period		
Hospice	100% after deductible	70% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (6)	100% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	70% after deductible	50% after deductible
	limit: 240 hours/benefit period		
Skilled Nursing Facility Care	100% after deductible	70% after deductible	50% after deductible
	limit: 100 days/benefit period		
Transplant Services	100% after deductible	70% after deductible	50% after deductible
Precertification Requirements (7)	Yes		
Prescription Drugs			
Prescription Drug Deductible Individual Family	Integrated with medical deductible Integrated with medical deductible		
Prescription Drug Program (8) 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 Open Benefit Design	**Retail Drugs (31/60/90-day Supply)** Plan pays 100% after deductible **Maintenance Drugs through Mail Order (90-day Supply)** Plan pays 100% after deductible		

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*The terms "Enhanced Value" and "Standard Value" are not descriptors of the provider's ability.
(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. If you are enrolled as an individual, the deductible, out-of-pocket maximum and Total Maximum Out-of-Pocket (TMOOP) for the "Employee Only" plan apply. If you are enrolled in a "Family" plan, the entire family deductible must be satisfied before any claim reimbursement begins. In addition the entire family out-of-pocket maximum must be satisfied for additional claim reimbursement. Once the entire family TMOOP is satisfied, claims will pay at 100% of the plan allowance for covered expenses for the family, regardless of whether the individual deductible, individual out-of-pocket maximum and individual TMOOP have been satisfied.
(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/Substance Abuse benefit.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Coverage for eligible members to age 21. 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) At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled.

Community Blue Flex PPO Blue $2,500 Benefit Summary

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.

Group Number(s): 104276-75, -79

Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
General Provisions			
Benefit Period(1)	Contract Year		
Deductible (per benefit period) Individual Family	 $2,500 $5,000	 $5,000 $10,000	 $10,000 $20,000
Plan Pays – payment based on the plan allowance	100% after deductible	70% after deductible	50% after deductible
Out-of-Pocket Limit (Once met, plan pays100% coinsurance for the rest of the benefit period) (All in-network services are credited to both the standard and the enhanced out-of-pocket limits) Individual Family	 None None	 $1,500 $3,000	 $3,000 $6,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $7,900 $15,800		 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	100% after $30 copay	100% after $50 copay	50% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $30 copay	100% after $50 copay	50% after deductible
Specialist Office Visits & Virtual Visits	100% after $40 copay	100% after $75 copay	50% after deductible
Virtual Visit Originating Site Fee	100% after deductible	70% after deductible	50% after deductible
Urgent Care Center Visits	100% after $50 copay	100% after $100 copay	50% after deductible
Telemedicine Services (3)	100% after $20 copay		Not Covered
Preventive Care (4)			
Routine Adult Physical Exams	100% (deductible does not apply)		50% after deductible
Adult Immunizations	100% (deductible does not apply)		50% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)		50% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)		50% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)		50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)		50% after deductible
Routine Pediatric Physical Exams	100% (deductible does not apply)		50% after deductible
Pediatric Immunizations	100% (deductible does not apply)		50% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)		50% after deductible
Emergency Services			
Emergency Room Services	100% after $150 copay (waived if admitted)		
Ambulance-Emergency	100% after enhanced deductible		
Ambulance-Non-Emergency	100% after enhanced deductible		
Hospital and Medical / Surgical Expenses (including maternity)			
Hospital Inpatient	100% after deductible	70% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	70% after deductible	50% after deductible
Therapy and Rehabilitation Services			
Physical Medicine	100% after $40 copay	100% after $75 copay	50% after deductible
	limit: 20 visits/benefit period		
Respiratory Therapy	100% after deductible	70% after deductible	50% after deductible
Speech Therapy	100% after $40 copay	100% after $75 copay	50% after deductible
	limit: 20 visits/benefit period		
Occupational Therapy	100% after $40 copay	100% after $75 copay	50% after deductible
	limit: 20 visits/benefit period		
Spinal Manipulations	100% after $40 copay	100% after $75 copay	50% after deductible
	limit: 20 visits/benefit period		

Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	70% after deductible	50% after deductible
Mental Health / Substance Abuse			
Inpatient Mental Health Services	100% after enhanced deductible		50% after deductible
Inpatient Detoxification / Rehabilitation	100% after enhanced deductible		50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after enhanced deductible		50% after deductible
Outpatient Substance Abuse Services	100% after enhanced deductible		50% after deductible
Other Services			
Allergy Extracts and Injections	100% after deductible	70% after deductible	50% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	100% after deductible	70% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	Not Covered		
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	70% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	70% after deductible	50% after deductible
Home Health Care	100% after deductible	70% after deductible	50% after deductible
	limit: 90 visits/benefit period		
Hospice	100% after deductible	70% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (6)	100% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	70% after deductible	50% after deductible
	limit: 240 hours/benefit period		
Skilled Nursing Facility Care	100% after deductible	70% after deductible	50% after deductible
	limit: 100 days/benefit period		
Transplant Services	100% after deductible	70% after deductible	50% after deductible
Precertification Requirements (7)	Yes		
Prescription Drugs			
Prescription Drug Deductible Individual Family	None None		
Prescription Drug Program (8) Soft Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (31/60/90-day Supply)** $8 / $16 / $24 generic copay $35 / $70 / $105 formulary brand copay $50 / $100 / $150 non-formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $20 generic copay $90 formulary brand copay $125 non-formulary brand copay		

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.
(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) 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/Substance Abuse benefit.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Coverage for eligible members to age 21. 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 soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed.

Community Blue Flex PPO Health Savings $3,000Q Benefit Summary

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out-of-pocket. 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.

Group Number(s): 104276-81, -82

Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
General Provisions			
Benefit Period(1)	Contract Year		
Deductible (per benefit period) (All in-network services are credited to both the enhanced and the standard deductibles.) Employee Only Plan Family Plan	 $3,000 $6,000	 $6,000 $12,000	 $12,000 $24,000
Plan Pays – payment based on the plan allowance	100% after deductible	70% after deductible	50% after deductible
Out-of-Pocket Limit (Includes prescription drug expenses, coinsurance and copays. Once met, plan pays100% coinsurance for the rest of the benefit period) (All in-network services are credited to both the enhanced and the standard out-of-pocket limits) Employee Only Plan Family Plan	 None None	 $450 $900	 $900 $1,800
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. Employee Only Plan Family Plan	 $6,650 $13,300		 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	100% after deductible	70% after deductible	50% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after deductible	70% after deductible	50% after deductible
Specialist Office Visits & Virtual Visits	100% after deductible	70% after deductible	50% after deductible
Virtual Visit Originating Site Fee	100% after deductible	70% after deductible	50% after deductible
Urgent Care Center Visits	100% after deductible	70% after deductible	50% after deductible
Telemedicine Services (3)	100% after enhanced in-network deductible		Not Covered
Preventive Care (4)			
Routine Adult Physical Exams	100% (deductible does not apply)		50% after deductible
Adult Immunizations	100% (deductible does not apply)		50% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)		50% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)		50% after deductible
Mammograms, Medically Necessary	100% after enhanced in-network deductible		50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)		50% after deductible
Routine Pediatric Physical Exams	100% (deductible does not apply)		50% after deductible
Pediatric Immunizations	100% (deductible does not apply)		50% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)		50% after deductible
Emergency Services			
Emergency Room Services	100% after enhanced deductible		
Ambulance- Emergency	100% after enhanced deductible		
Ambulance- Non-Emergency	100% after enhanced deductible		
Hospital and Medical / Surgical Expenses (including maternity)			
Hospital Inpatient	100% after deductible	70% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	70% after deductible	50% after deductible
Therapy and Rehabilitation Services			
Physical Medicine	100% after deductible	70% after deductible	50% after deductible
	limit: 20 visits/benefit period		
Respiratory Therapy	100% after deductible	70% after deductible	50% after deductible
Speech Therapy	100% after deductible	70% after deductible	50% after deductible
	limit: 20 visits/benefit period		

Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
Occupational Therapy	100% after deductible	70% after deductible	50% after deductible
	limit: 20 visits/benefit period		
Spinal Manipulations	100% after deductible	70% after deductible	50% after deductible
	limit: 20 visits/benefit period		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	70% after deductible	50% after deductible
Mental Health / Substance Abuse			
Inpatient Mental Health Services	100% after enhanced deductible		50% after deductible
Inpatient Detoxification / Rehabilitation	100% after enhanced deductible		50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after enhanced deductible		50% after deductible
Outpatient Substance Abuse Services	100% after enhanced deductible		50% after deductible
Other Services			
Allergy Extracts and Injections	100% after deductible	70% after deductible	50% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	100% after deductible	70% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	Not Covered		
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	70% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	70% after deductible	50% after deductible
Home Health Care	100% after deductible	70% after deductible	50% after deductible
	limit: 90 visits/benefit period		
Hospice	100% after deductible	70% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (6)	100% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	70% after deductible	50% after deductible
	limit: 240 hours/benefit period		
Skilled Nursing Facility Care	100% after deductible	70% after deductible	50% after deductible
	limit: 100 days/benefit period		
Transplant Services	100% after deductible	70% after deductible	50% after deductible
Precertification Requirements (7)	Yes		
Prescription Drugs			
Prescription Drug Deductible Individual Family	Integrated with medical deductible Integrated with medical deductible		
Prescription Drug Program (8) 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 Open Benefit Design	**Retail Drugs (31/60/90-day Supply)** Plan pays 100% after deductible **Maintenance Drugs through Mail Order (90-day Supply)** Plan pays 100% after dedcutible		

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.
*The terms "Enhanced Value" and "Standard Value" are not descriptors of the provider's ability.
(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. If you are enrolled as an individual, the deductible, out-of-pocket maximum and Total Maximum Out-of-Pocket (TMOOP) for the "Employee Only" plan apply. If you are enrolled in a "Family" plan, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. Once his/her individual out-of-pocket maximum is satisfied additional claims reimbursement begins. Once the individual TMOOP is satisfied that individual's claims will pay at 100% of the plan allowance for covered expenses, regardless of whether the family deductible, family out-of-pocket maximum and family TMOOP have been satisfied.
(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/Substance Abuse benefit.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Coverage for eligible members to age 21. 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) At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled.

Preventive Care

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

Preventive care matters for everyone, at every stage of life

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

Preventive vs. diagnostic care

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

Some examples of preventive care are:
• Routine wellness exams
• Immunizations
• Screenings such as blood tests for cholesterol and blood sugar, mammograms, and colonoscopies

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

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

Some examples of diagnostic care are:
• An MRI for back pain
• A blood test to measure your blood sugar when you have diabetes
• A doctor's visit for a cough, fever, and runny nose

Things to know

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

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

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

2019 Preventive Schedule

Effective 1/1/2019

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

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

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

QUESTIONS?

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

Adults: Ages 19+

Male Female

General Health Care	
Routine Checkup* (This exam is not the work- or school-related physical)	• 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	• Ages 20 and older: Once every 5 years • High-risk: More often
Colon Cancer Screening (Including Colonoscopy)	• Ages 50 and older: Every 1 to 10 years, depending on screening test • High-risk: Earlier or more frequently
Certain Colonoscopy Preps With Prescription	• Ages 50 and older: Once every 10 years • High-risk: Earlier or more frequently
Diabetes Screening	High-risk: Ages 40 and older, once every 3 years
Hepatitis B Screening	High-risk
Hepatitis C Screening	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	• 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)	• 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	• Zostavax - Ages 60 and older: One dose • Shingrix - Ages 50 and older: Two doses
Preventive Drug Measures That Require a Doctor's Prescription	
Aspirin	• Ages 50 to 59 to reduce the risk of stroke and heart attack • Pregnant women at risk for preeclampsia
Folic Acid	Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid
Raloxifene Tamoxifen	At-risk for breast cancer, without a cancer diagnosis, ages 35 and older
Tobacco Cessation (Counseling and medication)	Adults who use tobacco products
Low to Moderate Dose Select Generic Statin Drugs For Prevention of Cardiovascular Disease (CVD)	Ages 40 to 75 years with 1 or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and have calculated 10-year risk of a cardiovascular event of 10% or greater.

* Meningococcal B vaccine per doctor's advice.

Preventive Care for Pregnant Women

Screenings and Procedures

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

Prevention of Obesity, Heart Disease and Diabetes

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

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

Adult Diabetes Prevention Program (DPP)

Applies to Adults

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

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

2019 Preventive Schedule

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

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

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

QUESTIONS?

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

Children: Birth to 30 Months[1]

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

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

Children: 3 Years to 18 Years[1]

General Health Care	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	15Y	18Y
Routine Checkup* (This exam is not the preschool- or day care-related physical)	●	●	●	●	●	●	●	●	Once a year from ages 11 to 18			
Ambulatory Blood Pressure Monitoring**												●
Depression Screening									Once a year from ages 11 to 18			
Hearing Screening***		●	●	●		●		●		●	●	●
Visual Screening***	●	●	●	●		●		●		●	●	●
Screenings												
Hematocrit or Hemoglobin Screening			Annually for females during adolescence and when indicated									
Lead Screening	When indicated (Please also refer to your state-specific recommendations)											
Cholesterol (Lipid) Screening							Once between ages 9-11 and ages 17-21					
Immunizations												
Chicken Pox		Dose 2								If not previously vaccinated: Dose 1 and 2 (4 weeks apart)		
Diphtheria, Tetanus, Pertussis (DTaP)		Dose 5			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 • HIV routine check once between ages 15-18			
Tuberculin Test	Per doctor's advice											

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

Children: 6 Months to 18 Years[1]

Preventive Drug Measures That Require a Doctor's Prescription	
Oral Fluoride	For preschool children older than 6 months whose primary water source is deficient in fluoride

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:	• Additional annual preventive office visits specifically for obesity • Additional nutritional counseling visits specifically for obesity • Recommended lab tests: – Alanine aminotransferase (ALT) – Aspartate aminotransferase (AST) – Hemoglobin A1c or fasting glucose (FBS) – Cholesterol screening

Adult Diabetes Prevention Program (DPP) Age 18	
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.

Women's Health Preventive Schedule

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

Screenings/Procedures	
Diabetes Screening	• High-risk: At the first prenatal visit • All women between 24 and 28 weeks pregnant • Postpartum women without Diabetes but with a history of gestational diabetes
HIV Screening and Discussion	All sexually active women: Once a year
Human Papillomavirus (HPV) Screening Testing	Beginning at age 30: Every 3 years
Domestic and Intimate Partner Violence Screening and 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** 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, this program strives to give you the right drug, at the right time, in the right amount, and at the right price.

This prescription drug management program operates automatically at the time your prescription is filled at the pharmacy

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 in this booklet. You can also find this form at **Highmarkbcbs.com**. Click on Important Forms under the Helpful Hints link at the bottom of the page. You can then find the form needed under the Prescription Drug Forms section.

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

You can mail your completed form to:

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

Learn more online

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

EXPRESS SCRIPTS®

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.)

Daytime phone: ☐☐☐ ☐☐☐ ☐☐☐☐

Evening phone: ☐☐☐ ☐☐☐ ☐☐☐☐

FOLD HERE

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 ☐☐☐ ☐☐☐ ☐☐☐☐

FOLD HERE

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

X _____
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.

MLRFOHNW

Mailing instructions are provided on the back of this form.

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

FOLD HERE

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

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

MLRFOHNW

Vision

Get the care you need with comprehensive vision benefits

Vision care and regular eye exams are an important part of preventive health care.

According to the Vision Council of America, vision problems affect more than 120 million people and are the second most common health problem in the country. Plus, regular eye exams can detect diabetes, hypertension, arteriosclerosis, tumors and cancer.

Vision coverage can make it easier for you to get this important health care, while helping to control your costs and to keep them predictable. Your coverage is affordable and convenient.

Use your coverage more easily

Get the vision care you need, when you need it, and pay low or no out-of-pocket costs.

Manage your coverage more easily

- Use the same member website to conveniently access and maintain all of your health coverage benefits and claims information.
- Access the convenient Interactive Voice Response System toll-free customer service number 24 hours a day, seven days a week for comprehensive, up-to-date information, including a summary of your vision benefits, claims status, and network providers.
- Speak with knowledgeable customer service representatives who can answer your benefit questions and give you the information you need.

Get the flexibility you need

Choose an eye care professional that's right for you from an extensive national network of more than 70,000 points of access. This includes independent optometrists, ophthalmologists, in addition to regional and national retailers, including Visionworks.

Flexible coverage for glasses or contacts

Your vision coverage includes benefits for an exam, eyeglass lenses and frames, and contact lenses.

Use your Visionworks frame benefit to get an extra $50 allowance toward eyeglass frames purchased at a Visionworks store.

To use your independent network provider frame benefit:

- May choose from the Davis Vision Collection of frames found in most vision care offices.
- You can also apply the program allowance toward a network provider's own frames.
- Many Davis Vision Collection frames are covered in full or have a nominal copayment, which helps you select high-quality frames, with low out-of-pocket expenses.
- If the frame you choose exceeds the allowance, you will be responsible for any remaining balance.

To use your contact lens benefit:

- You may select contact lenses instead of eyeglasses.
- The contact lens "formulary" is a list of all the types of contact lenses that are covered by the plan.
- The formulary includes many of the most popular disposable and planned replacement contact lenses, including standard, multifocal, and toric lenses.
- If you choose contact lenses from the provider's own supply, you will receive a preset amount of funds (program allowance) toward your purchase (which may or may not include fitting/follow-up charges).
- At a network chain store or retail location, you will receive an allowance toward the cost of lenses from the retailer's supply.

Receiving services from a network provider is easy

To provide you with the greatest amount of flexibility and convenience, you have access to licensed network vision providers in both private practice and retail establishments. Network providers are reviewed and credentialed to ensure that they meet our standards for quality and service.

To find a network provider:

- Go to **Highmarkbcbs.com.**
- Click on **Find a Doctor or Rx** followed by **Find an Eye Care Provider**.
- Enter your ZIP code and mile radius.
- Click on **Search Now** to see the current listing of providers that will accept your vision plan.

To receive services from a network provider, choose a network provider and schedule an appointment.

- Tell them you are a Highmark member.
- Tell them the ID number on your medical plan card.
- Tell them the name and birthdate of the covered member receiving services.

The provider's office will confirm that you are eligible for services. No claim forms are required when using a participating network provider.

Contact Member Service if you need an out-of-network provider reimbursement form.

Additional valuable services

When receiving services from a Visionworks location, members will receive an additional $50 to apply toward the cost of their frame purchase.

As a vision member, you can participate in the mail order contact lens replacement program (Davis Vision Contacts®). Just call **1-855-589-7911** or visit **Davisvisioncontacts.com** with a current prescription. Every order comes with a complimentary starter kit.

In addition, you and your covered dependents can receive savings up to 25 percent off the providers' usual fees for laser vision correction procedures (or a five percent discount on any advertised special). This is offered through a network of credentialed physicians affiliated with Eye Centers of Excellence. (Some centers provide a flat fee equal to these discount levels.)

Take a minute to learn about the value of Highmark vision coverage

Review these vision benefits your employer has selected for you. Then enroll by following the instructions your employer provides.

Benefits received at regional chain stores and national retailers may vary slightly from those of an independent provider.

Your vision program excludes coverage for certain items and services, including: medical treatment of eye disease or injury; vision therapy; special lens designs or coatings other than those described in the Benefits Summary; replacement of lost or stolen eyewear; nonprescription lenses; and services not performed by licensed personnel.

The Davis Vision provider network is being used through a contractual agreement between Davis Vision and Highmark. Davis Vision is an independent company that manages a network of licensed vision providers in both private practice and retail locations. Visionworks is a separate company that does not provide Blue Cross and/or Blue Shield products. Visionworks is solely responsible for its products and services.

In-Network Benefits – Non-Voluntary			Designer Advantage I
Frequency – Once Every:			
Eye Examination (including dilation when professionally indicated)			12 months under age 19/ 24 months age 19 or older
Spectacle Lenses			12 months under age 19/ 24 months age 19 or older
Frame			24 months
Contact Lenses (in lieu of eyeglass lenses)			12 months under age 19/ 24 months age 19 or older
Copayments			
Eye Examination			$0
Spectacle Lenses			$0
Contact Lens Evaluation, Fitting & Follow-Up Care			n/a
Eyeglass Benefit - Frame	**Average Retail Value**		
Non-Collection Frame Allowance (Retail):	Up to $130		Up to $120
Davis Vision Frame Collection[1] (in lieu of Allowance):			
- Fashion level	Up to $125		Included
- Designer level	Up to $175		Included
- Premier level	Up to $225		$25 copayment
Eyeglass Benefit - Spectacle Lenses	**Average Retail Value**		**Member Charges**
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any Rx)	$60-$120		Included
Oversize Lenses	$20		Included
Tinting of Plastic Lenses	$20		Included
Scratch-Resistant Coating	$25-$40		Included
Scratch Protection Plan Single Vision	$60 - $120		$20
Scratch Protection Plan Multifocal	$60 - $120		$40
Polycarbonate Lenses[2]	$60-$75		$0 or $30
Ultraviolet Coating	$25-$30		$12
Standard Anti-Reflective (AR) Coating	$50-$70		$35
Premium AR Coating	$65-$90		$48
Ultra AR Coating	$100-$125		$60
Standard Progressive Lenses	$150-$195		$50
Premium Progressives (Varilux®, etc.)	$195-$225		$90
Ultra Progressive Lenses	$225-$300		$140
Intermediate-Vision Lenses	$150-$175		$30
High-Index Lenses	$90-$150		$55
Polarized Lenses	$95-$110		$75
Plastic Photosensitive Lenses	$95-$150		$65
Contact Lens Benefit (in lieu of eyeglasses)			
Non-Collection Contact Lenses: Materials Allowance			Up to $120
- Evaluation, Fitting & Follow-Up Care – Standard Lens Types			Not Covered
- Evaluation, Fitting & Follow-Up Care – Specialty Lens Types			Not Covered
Collection Contact Lenses/[1] (in lieu of Allowance): Materials			
- Disposable			Covered In Full
- Planned Replacement			Covered In Full
- Evaluation, Fitting & Follow-up Care			Included
Medically Necessary Contact Lenses (with prior approval)			
- Materials, Evaluation, Fitting & Follow-Up Care			Included
Out-of-Network Reimbursement Schedule: up to			
Eye Examination: $30	Single Vision Lenses: $25	Trifocal Lenses: $45	Elective Contact Lenses: $75
Frame: $30	Bifocal/Progressive Lenses: $35	Lenticular Lenses: $60	Medically Necessary CL: $225

[1]/Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select torics and multifocals.

[2]/Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

One-year eyeglass breakage warranty included

Network providers—The Davis Vision provider network is being used through a contractual arrangement between Davis Vision and Highmark. Davis Vision is an independent company that manages a network of licensed vision providers in both private practice and retail locations. Network providers are reviewed and credentialed to ensure that standards for quality and service are maintained.

Network retail locations—In order to provide you with the greatest amount of flexibility and convenience, the network includes a number of retail establishments. Benefits at the retail locations may vary slightly from other locations, as noted in this benefit description. However, your value is comparable.

Locating a network provider—To find a network provider, go to www.highmarkbcbs.com and click on "Find a Doctor or Rx." Click on "Find an Eyecare Provider". Enter your zip code and mile radius then click on "Search" to see the most current listing of providers that will accept your vision plan.

Receiving services from a network provider:

- Call the network provider of your choice and schedule an appointment.
- Identify yourself as a Highmark member, or eligible dependent, in a vision plan administered by Davis Vision.
- Provide the office with your identification (ID) number (located on your Highmark ID card), and the name and birth date of the covered dependent receiving services.

It's that easy! The provider's office will verify your eligibility for services. No claim forms are required!

Frame benefit—You may choose from 'The Collection' in most independent network provider offices or a program allowance will be applied toward a network provider's own frames. Many Collection frames are covered in full or have a nominal copayment which helps you select high-quality frames, while minimizing out-of-pocket expenses. Network retail providers typically do not display the Collection. You will instead be given a program allowance toward your frame purchase. If the chosen frame exceeds the allowance, you will be responsible for any remaining balance.

Contact lenses benefit—Contact lenses may be selected in lieu of eyeglass lenses. No copayment applies towards the initial supply of formulary contact lenses (many of the most popular standard, soft daily wear; disposable or planned replacement) including fitting/follow-up charges. A program allowance will be applied toward contact lenses from the provider's own supply (which may or may not include fitting/follow-up charges). At a network retail location, you will receive an allowance toward the cost of lenses from the retailer's supply. With prior approval, medically necessary contact lenses will be covered in full at all network provider locations.

Low vision services—You and your covered dependents are entitled to a comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Up to four follow-up visits will be covered during the five-year period.

Exclusions—This vision program excludes coverage for certain items and services, including: medical treatment of eye disease or injury; vision therapy; special lens designs or coatings other than those previously described; replacement of lost or stolen eyewear; non-prescription (Plano) lenses; and services not performed by licensed personnel.

VALUE-ADDED FEATURES

Replacement contact lens program—Highmark offers a contact lens replacement program to members. This mail order program exclusively allows you to enjoy the guaranteed lowest prices on contact lens replacement materials. Visit *www.davisvisioncontacts.com* or call 1-855-589-7911with a current prescription. Every order comes with a complimentary starter kit.

Laser Vision Correction —Highmark members enjoy lower prices on LASIK procedures than other carriers, along with flexible financing options – up to 12 months interest free. These savings are up to 40%-50% off the national average price of traditional LASIK and are available at over 1,000 locations across our nationwide network of laser vision correction providers. Laser vision correction services are administered by QualSight, LLC. Terms and conditions are subject to change.

Call Member Service Monday through Friday, 8:00 am to 5:00 pm, Eastern Standard Time (EST) at 1-800-223-4795 (TTY users call 1-800-523-2847) to find a network provider, ask benefit questions, verify eligibility or request an out-of-network provider reimbursement form.

For information prior to enrolling, call 1-800-223-4795.

In-Network Benefits – Non-Voluntary		Fashion Advantage Gold V
Frequency – Once Every:		
Eye Examination (including dilation when professionally indicated)		12 months
Spectacle Lenses		12 months
Frame		12 months
Contact Lenses (in lieu of eyeglass lenses)		12 months
Copayments		
Eye Examination		$0
Spectacle Lenses		$0
Contact Lens Evaluation, Fitting & Follow-Up Care		n/a
Eyeglass Benefit - Frame	**Average Retail Value**	
Non-Collection Frame Allowance (Retail):	Up to $130	Up to $100
Davis Vision Frame Collection/[1] (in lieu of Allowance):		
- Fashion level	Up to $125	Included
- Designer level	Up to $175	$20 copayment
- Premier level	Up to $225	$40 copayment
Eyeglass Benefit - Spectacle Lenses	**Average Retail Value**	**Member Charges**
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any Rx)	$60-$120	Included
Oversize Lenses	$20	Included
Tinting of Plastic Lenses	$20	$11
Scratch-Resistant Coating	$25-$40	Included
Scratch Protection Plan Single Vision	$60-$120	$20
Scratch Protection Plan Multifocal	$60-$120	$40
Polycarbonate Lenses/[2]	$60-$75	$0 or $30
Ultraviolet Coating	$25-$30	$12
Standard Anti-Reflective (AR) Coating	$50-$70	$35
Premium AR Coating	$65-$90	$48
Ultra AR Coating	$100-$125	$60
Standard Progressive Lenses	$150-$195	Included
Premium Progressives (Varilux®, etc.)	$195-$225	$40
Ultra Progressive Lenses	$225-$300	$90
Intermediate-Vision Lenses	$150-$175	$30
High-Index Lenses	$90-$150	$55
Polarized Lenses	$95-$110	$75
Plastic Photosensitive Lenses	$95-$150	$65
Contact Lens Benefit (in lieu of eyeglasses)		
Non-Collection Contact Lenses: Materials Allowance		Up to $130
- Evaluation, Fitting & Follow-Up Care – Standard Lens Types		Not Covered
- Evaluation, Fitting & Follow-Up Care – Specialty Lens Types		Not Covered
Collection Contact Lenses/[1] (in lieu of Allowance): Materials		
- Disposable		Covered In Full
- Planned Replacement		Covered In Full
- Evaluation, Fitting & Follow-up Care		Included
Medically Necessary Contact Lenses (with prior approval)		
- Materials, Evaluation, Fitting & Follow-Up Care		Included

Out-of-Network Reimbursement Schedule: up to			
Eye Examination: $40	Single Vision Lenses: $30	Trifocal Lenses: $60	Elective Contact Lenses: $115
Frame: $64	Bifocal Lenses: $40	Lenticular Lenses: $80	Medically Necessary CL: $225
Standard Progressive Lenses: $130		Single Vision Polycarbonate Lenses/[2]: $70	
Bifocal Polycarbonate Lenses/[2]: $80		Trifocal Polycarbonate Lenses/[2]: $95	

[1]/Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select torics and multifocals.

[2]/Polycarbonate lenses are covered for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

One-year eyeglass breakage warranty included

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Network retail locations—In order to provide you with the greatest amount of flexibility and convenience, the network includes a number of retail establishments. Benefits at the retail locations may vary slightly from other locations, as noted in this benefit description. However, your value is comparable.

Locating a network provider—To find a network provider, go to www.highmarkblueshield.com and click on "Find a Doctor or Rx." Click on "Find an Eyecare Provider". Enter your zip code and mile radius then click on "Search" to see the most current listing of providers that will accept your vision plan.

Receiving services from a network provider:

- Call the network provider of your choice and schedule an appointment.
- Identify yourself as a Highmark member, or eligible dependent, in a vision plan administered by Davis Vision.
- Provide the office with your identification (ID) number (located on your Highmark ID card), and the name and birth date of the covered dependent receiving services.

It's that easy! The provider's office will verify your eligibility for services. No claim forms are required!

Frame benefit—You may choose from 'The Collection' in most independent network provider offices or a program allowance will be applied toward a network provider's own frames. Many Collection frames are covered in full or have a nominal copayment which helps you select high-quality frames, while minimizing out-of-pocket expenses. Network retail providers typically do not display the Collection. You will instead be given a program allowance toward your frame purchase. If the chosen frame exceeds the allowance, you will be responsible for any remaining balance.

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Low vision services—You and your covered dependents are entitled to a comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Up to four follow-up visits will be covered during the five-year period.

Exclusions—This vision program excludes coverage for certain items and services, including: medical treatment of eye disease or injury; vision therapy; special lens designs or coatings other than those previously described; replacement of lost or stolen eyewear; non-prescription (Plano) lenses; and services not performed by licensed personnel.

VALUE-ADDED FEATURES

Replacement contact lens program—Highmark offers a contact lens replacement program to members. This mail order program exclusively allows you to enjoy the guaranteed lowest prices on contact lens replacement materials. Visit *www.davisvisioncontacts.com* or call 1-855-589-7911with a current prescription. Every order comes with a complimentary starter kit.

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Call Member Service Monday through Friday, 8:00 am to 5:00 pm, Eastern Standard Time (EST) at 1-800-223-4795 (TTY users call 1-800-523-2847) to find a network provider, ask benefit questions, verify eligibility or request an out-of-network provider reimbursement form.

For information prior to enrolling, call 1-800-223-4795.

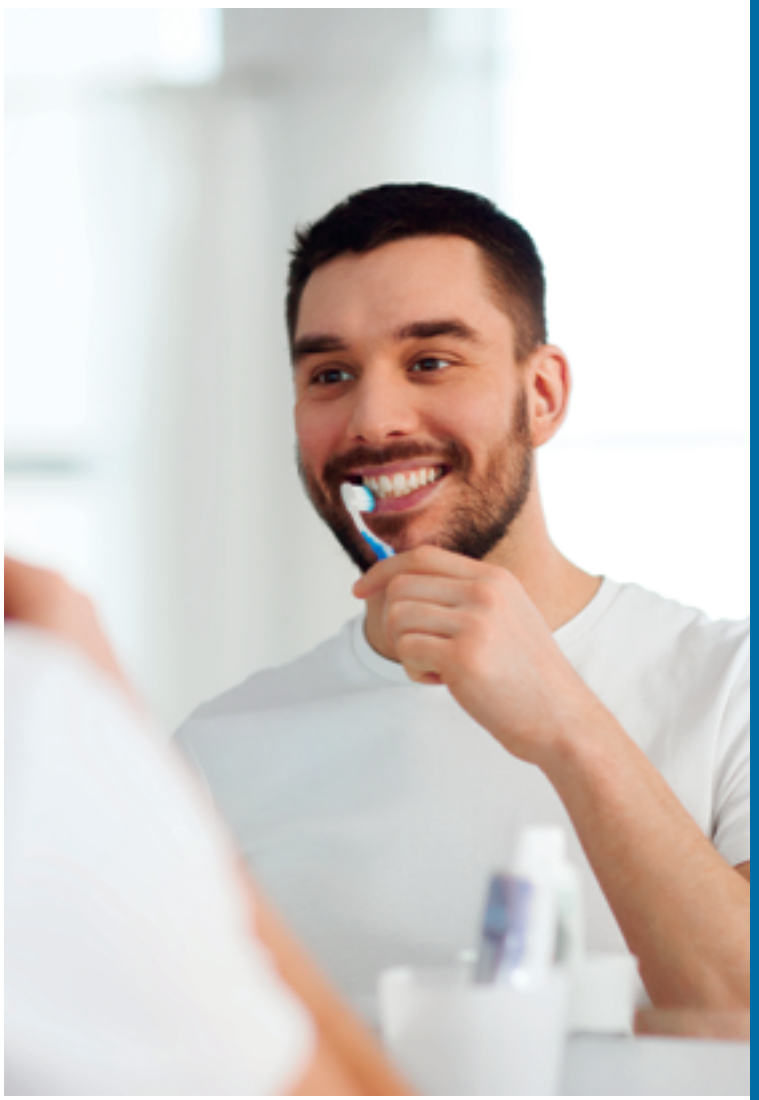
Blue Edge Dental Coverage

Blue Edge Dental℠ — A healthy addition to your medical coverage

Dental coverage, like Blue Edge Dental, is an important part of your overall health care coverage. Why?

- Employed adults lose more than 164 million hours of work each year because of oral health problems.*
- Employees value dental insurance as the second most important benefit following medical insurance.*

You should know that oral health goes beyond your teeth and gums. Infections of the mouth can cause disease in other organs. This is why your dentist may be the first care provider to find a serious health problem.



Blue Edge Dental National Network

- Broad choice of dentists: More than 96,000 dentists nationwide at more than 260,000 locations
- Easy: No claims to file
- Affordable: You are only responsible for deductibles and coinsurance

You may use any licensed dentist, but if you choose a dentist who does not participate in our network, you may need to pay more and submit your own claims.

Online and mobile app

Our member website and mobile app give you:

- Access to your benefit details
- Explanations of dental benefits, virtual ID card, and claims
- The ability to find a dentist by specialty, ZIP code, or network

Customer service and education

If you have questions about your dental coverage, you can speak with one of our representatives. You can even talk to a dental professional to find out if you need care right away for a dental emergency. You can get help finding a dentist, check claim status, and get benefit details.

Visit our online Dental Health Center to learn about nutrition and dental care, preventive dental care, cosmetic dentistry, and even emergency dental care.

*U.S. Surgeon General report on oral health

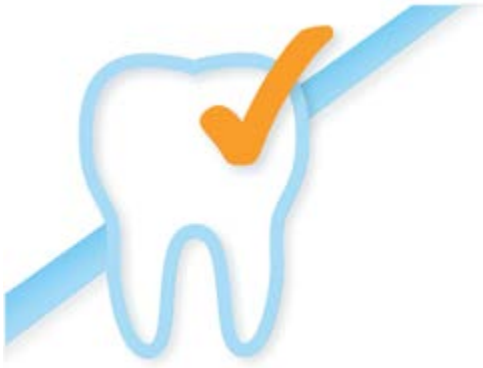
Questions?

If you have questions about your Blue Edge Dental benefits, please call **1-866-568-6008**.

GIVE YOURSELF SOMETHING TO SMILE ABOUT!

Review these Blue Edge Dental benefits your employer has selected for you. Then enroll by following instructions your employer provides.

HIGHMARK. | Blue Edge Dental



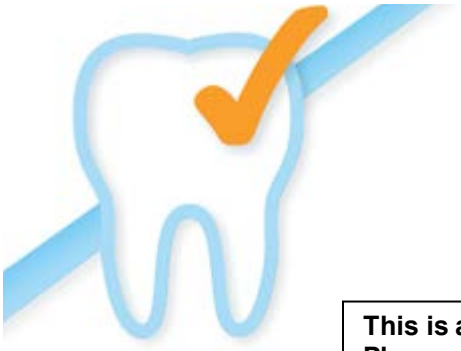
Summary of Benefits:
Blue Edge Dental Flex

Blue Edge Dental Flex plan options provide you maximum flexibility. Benefits are paid at the same level for care received from any provider. The listed percentages represent the portion of the maximum allowable charge (MAC) for which the plan is responsible. Network providers agree to accept the MAC as payment in full and also agree to file your claims. ***If you receive covered services from an out-of-network provider, the plan will apply the percentages shown to the MAC for covered services and you will be responsible for the difference, up to the provider's charge****. Standard deductibles, exclusions and limitations apply. Network dentists may elect to discount non-covered services and services above the annual maximum. Discounts vary by service and region and when agreed to by the provider; not permitted in all jurisdictions.*

Blue Edge **Dental Flex 3W with Orthodontia**	
Network	Advantage
Deductible – Individual/Family (waived for In-network Class I services)	$50 / $150
Benefit Period Maximum per member	$1,500
Class I Services	
Exams	100%
X-rays	100%
Cleanings	100%
Fluoride Treatment	100%
Sealants	100%
Space Maintainers	100%
Palliative Treatment (Emergency)	100%
Class II Services	
Basic Restorative (Fillings), Posterior Resins	80%
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures	80%
Oral Surgery (including Simple and Surgical Extractions)	80%
General Anesthesia	80%
Endodontics	80%
Periodontics (Surgical and Nonsurgical)	80%
Class III Services	
Inlays, Onlays, Crowns	50%
Prosthetics (Bridges, Dentures)	50%
Orthodontics (dependents to age 19)	
Diagnostic, Active, Retention Treatment	50%
Orthodontic Lifetime Maximum per covered dependent	$1,000
Implants	
Implant Surgery, Supported Restoration	Not Covered
Smile for Health®--Wellness and Pregnancy Benefit	
• Provides periodontal care for people with certain chronic medical conditions: diabetes, heart disease, lupus, oral cancer, organ transplant, rheumatoid arthritis and stroke • Provides periodontal care for expectant mothers	• One additional periodontal maintenance per year covered at 100% • Scaling and root planning covered at 100% • Four periodontal surgery procedures are covered at 100%

Insurance may be provided by Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage, First Priority Life Insurance Company or First Priority Health, all of which are independent licensees of the Blue Cross and Blue Shield Association. United Concordia is a separate company that administers Highmark dental benefits.

Smile for Health–Wellness is a registered service mark of United Concordia Companies, Inc.

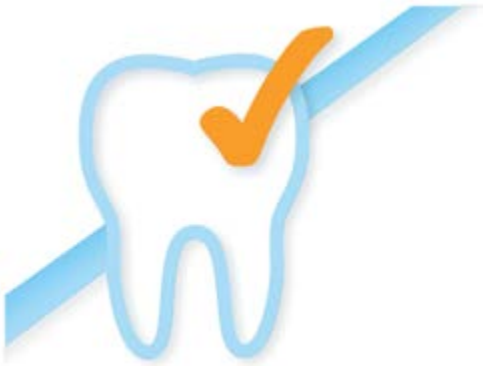


Summary of Limitations:
Blue Edge Dental

This is an abbreviated list of Highmark's Standard Limitations.
Please refer to your specific benefit design as to what services are covered.

***Blue Edge* Dental**	
Benefit Category	Highmark's Standard Frequency Limitations
Exams	2 every 12 months
X-rays (Bitewings Only)	1 set every 12 months under age 19 and one set every 18 months age 19 and over
X-rays (All Others)	1 every 5 years for Full Mouth and Panoramic X-rays Limitations may apply to other types of X-rays
Cleanings; Fluoride Treatment	2 every 12 months; 1 every 12 months under age 14
Sealants	1 per tooth every 3 years to age 16 on permanent first and second molars
Space Maintainers	1 every 5 years under age 14
Palliative Treatment (Emergency)	2 per 12 months in combination with pulpal debridement
Basic Restorative	Not within 24 months of previous placement. Includes coverage for posterior resins
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures	1 per 36 months
Simple Extractions	Any frequency (no limitations)
General Anesthesia	Limited to 60 minutes per session
Endodontics	Pulpal therapy: primary teeth that have no permanent tooth to replace it Root canal treatment: 1 per tooth per lifetime
Periodontics (Nonsurgical)	Full mouth debridement: 1 per lifetime Scaling and root planing: 1 per 36 months (per area of mouth) Periodontal maintenance: 2 every 12 months (in addition to routine prophylaxis following active periodontal therapy)
Periodontics (Surgical)	Surgical periodontal procedures: 1 per 36 months (per area of mouth) Guided tissue regeneration: 1 per tooth per lifetime
Complex Oral Surgery	May vary by procedure
Inlays, Onlays, Crowns	Not within 5 years of previous placement
Prosthetics (Bridges, Dentures)	Not within 5 years of previous placement
Orthodontics (dependents to age 19) Diagnostic, Active, Retention Treatment	Payment for orthodontic services, if covered, shall cease at the end of the month after termination by the Company.
Alternative Benefit Provision	An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.

Group #s: 017561-13, -17



Summary of Benefits:
Blue Edge Dental Flex

Blue Edge Dental Flex plan options provide you maximum flexibility. Benefits are paid at the same level for care received from any provider. The listed percentages represent the portion of the maximum allowable charge (MAC) for which the plan is responsible. Network providers agree to accept the MAC as payment in full and also agree to file your claims. ***If you receive covered services from an out-of-network provider, the plan will apply the percentages shown to the MAC for covered services and you will be responsible for the difference, up to the provider's charge****. Standard deductibles, exclusions and limitations apply. Network dentists may elect to discount non-covered services and services above the annual maximum. Discounts vary by service and region and when agreed to by the provider; not permitted in all jurisdictions.*

***Blue Edge* Dental Flex Value 1**	
Network	Advantage
Deductible – Individual/Family (waived for In-network Class I services)	$0
Benefit Period Maximum per member	$1,000
Class I Services	
Exams	100%
X-rays	100%
Cleanings	100%
Fluoride Treatment	100%
Sealants	100%
Space Maintainers	100%
Palliative Treatment (Emergency)	100%
Class II Services	
Simple Extractions	Not Covered
Basic Restorative (Fillings), Posterior Resins	Not Covered
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures	Not Covered
General Anesthesia	Not Covered
Class III Services	
Oral Surgery (including Surgical Extractions)	Not Covered
Endodontics	Not Covered
Periodontics (Surgical and Nonsurgical)	Not Covered
Inlays, Onlays, Crowns	Not Covered
Prosthetics (Bridges, Dentures)	Not Covered
Orthodontics (dependents to age 19)	
Diagnostic, Active, Retention Treatment	Not Covered
Orthodontic Lifetime Maximum per covered dependent	Not Applicable
Implants	
Implant Surgery, Supported Restoration	Not Covered

Smile for Health Wellness is not covered.

Insurance may be provided by Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage, First Priority Life Insurance Company or First Priority Health, all of which are independent licensees of the Blue Cross and Blue Shield Association. United Concordia is a separate company that administers Highmark dental benefits.

Summary of Limitations: *Blue Edge Dental*

This is an abbreviated list of Highmark's Standard Limitations.
Please refer to your specific benefit design as to what services are covered.

***Blue Edge* Dental**	
Benefit Category	Highmark's Standard Frequency Limitations
Exams	2 every 12 months
X-rays (Bitewings Only)	1 set every 12 months under age 19 and one set every 18 months age 19 and over
X-rays (All Others)	1 every 5 years for Full Mouth and Panoramic X-rays Limitations may apply to other types of X-rays
Cleanings; Fluoride Treatment	2 every 12 months; 1 every 12 months under age 14
Sealants	1 per tooth every 3 years to age 16 on permanent first and second molars
Space Maintainers	1 every 5 years under age 14
Palliative Treatment (Emergency)	2 per 12 months in combination with pulpal debridement
Basic Restorative	Not within 24 months of previous placement. Includes coverage for posterior resins
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures	1 per 36 months
Simple Extractions	Any frequency (no limitations)
General Anesthesia	Limited to 60 minutes per session
Endodontics	Pulpal therapy: primary teeth that have no permanent tooth to replace it Root canal treatment: 1 per tooth per lifetime
Periodontics (Nonsurgical)	Full mouth debridement: 1 per lifetime Scaling and root planing: 1 per 36 months (per area of mouth) Periodontal maintenance: 2 every 12 months (in addition to routine prophylaxis following active periodontal therapy)
Periodontics (Surgical)	Surgical periodontal procedures: 1 per 36 months (per area of mouth) Guided tissue regeneration: 1 per tooth per lifetime
Complex Oral Surgery	May vary by procedure
Inlays, Onlays, Crowns	Not within 5 years of previous placement
Prosthetics (Bridges, Dentures)	Not within 5 years of previous placement
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Alternative Benefit Provision	An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.

Group #s: 017561-12, 16

Spending Accounts

Spending Accounts

A smart, simple way to save money

Spending accounts allow you to easily plan and manage your everyday expenses for health care, child, and elder care expenses. These accounts are designed to help you save money by using tax-free funds to pay for these expenses. You have choice and control for when and how you use your money.

Discover the value of a spending account

Learn more about the value of a spending account by visiting **highmarkspendingaccounts.com**. **You can take advantage of resources to help you plan and make informed spending and saving decisions.** *You'll learn:*

- How to save on taxes
- What expenses are covered
- How to use your account

Online and mobile access

Your member website provides personalized support that offers self-service account tools, plus educational resources to help optimize your unique spending and savings needs. Get account information you need, right when you need it most.

- Check balances
- Track and pay claims
- Manage debit cards (if applicable)
- Download forms
- Upload receipts
- And more!

Log in any time from your computer or mobile device.

Health Savings Account (HSA)

An HSA is a personal savings account that can be used to pay for medical, dental, vision, prescriptions, and other qualified medical expenses now or later in life. If you contribute on a pre-tax basis, you will save money by reducing your taxable gross income, spending pre-tax dollars for medical care, and growing your HSA tax-free.

Qualified High Deductible Health Plans (QHDHPs) and HSAs go hand-in-hand. They were designed to be used together to help you save. Because QHDHPs generally have lower monthly premiums and more out-of-pocket costs, HSAs are intended to help you pay for out-of-pocket medical expenses. You have the choice and the control over when and how you use your HSA dollars.

HSAs offer triple tax advantages

Money can go in tax-free.
Any contributions you make through a pre-tax payroll deduction program may reduce your taxable income. And, any money you contribute on your own is tax-deductible., subject to annual contribution limits.

Money comes out tax-free.
You will never be taxed when you use your HSA dollars for qualified medical expenses.

Interest and earnings are tax-free.
You won't be taxed on interest and earnings on your account — your money grows tax-free.

Qualified health expenses

Money in your HSA can be used to pay for current qualified medical expenses, such as:

- Medical deductibles
- Prescriptions
- Dental care
- Contacts and eyeglasses
- Laser eye surgery
- Orthodontia
- Over-the-counter products

Maximize your savings

HSAs are powerful investment vehicles that can help you save for the long-term. Money used for qualified medical expenses is always tax-free whether you use the money today, five years from now, or when you retire.

Contribute to your HSA and watch your savings grow.

- Earn interest on your account balance tax-free, like a savings account.
- Take advantage of integrated investment options, much like a 401(k).
- Make catch-up contributions at age 55 or older.

HSAs can be a great addition to your retirement strategy, along with your IRA or 401(k) plan. After age 65, you can withdraw money to pay for non-medical expenses, but the funds will be taxed as income (similar to an IRA).

Who can open an HSA?

You ***must*** have a QHDHP. You ***cannot*** open an HSA if you are:

- Covered by any health plan other than a QHDHP (dental and vision plans are not included in this restriction)
- Enrolled in Medicare
- Claimed as a dependent on another individual's tax return

Contributing to your HSA

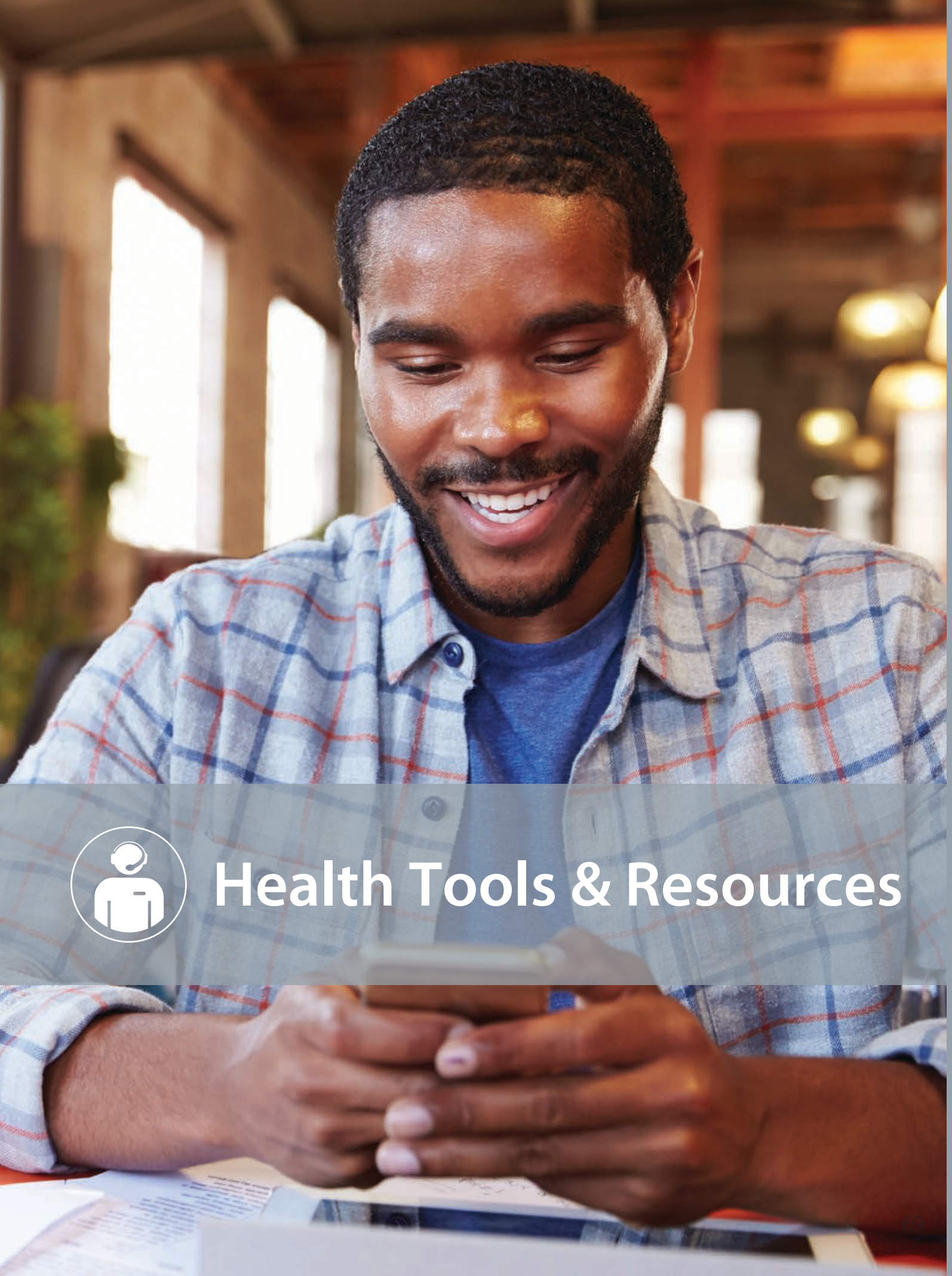
The IRS sets a limit on how much you can contribute to an HSA during a calendar year. If you are 55 or older, you can add an extra amount each year. This is called a "catch-up" deposit.

- In 2018, you can contribute a maximum of $3,450 for an individual and $6,850 for a family.
- The "catch-up" contribution for 2018 is $1,000.
- These amounts are adjusted yearly by the IRS for inflation.
- The maximums include any employer contribution.

Getting started

Your employer may choose to open an HSA for you, or you may have to open your HSA through your member website. More details will follow in the coming months.

Not all states follow federal tax rules with respect to contributions made to HSAs. Please consult your tax advisor to determine the extent to which these contributions may be subject to state income tax and wage withholding rules.



Health Tools & Resources

Take advantage of the many tools and resources available to you

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

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

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

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

Member Service: Where to turn for help

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

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

If English is not your native language

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

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

Online health tools put health care in your hands

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

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

Support at your fingertips

Blues On Call℠ is your 24/7 health resource

Call 1-888-BLUE-428 (1-888-258-3428).

Blues On Call health coaches are specially trained registered nurses who can provide you with up-to-date health information, offer support during treatment, help you to manage a health condition, and encourage you to stay healthy.

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.

Navigating health care is easy with My Care Navigator℠

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

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

My Care Navigator can help you:

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

Member discounts with Blue365®

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

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

Get started
To search the member discounts available to you or to find participants in this discount program:
- Log in or register at **Highmarkbcbs.com**
- Select the **Member Discounts** link
- Select the **Blue365 discounts** link

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

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

View your ID card on your mobile device

Your ID card information is available as soon as your coverage is effective. You can:
- View ID cards for everyone on your policy
- Fax your ID card information to doctors and hospitals
- Order replacement ID cards

Once you register and log in, follow these steps to view your ID card:
1. Click the **View ID Card** button
2. Click on the **name of the person** whose ID card you want to view

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

Find a Doctor

Find a Doctor is an online search tool that makes it easy to find the right providers for you. You can search for:
- Primary care providers
- Specialists
- Hospitals
- Imaging centers
- Urgent care centers and retail clinics
- Pharmacies
- …And more!

It all starts with a simple search.

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

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

Pregnant, or planning to become pregnant?

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.

Healthy behaviors to save you time and money

Choose in-network providers

Network providers are doctors, hospitals, and other health care professionals that have an agreement with your health plan to accept the amount the plan will pay for covered services. You have the highest level of coverage and pay the least when you go to an in-network provider. Out-of-network providers do not have an agreement with your health plan. If you are treated by an out-of-network provider, you are responsible for a larger share of the costs. You may also need to pay any difference between the amount your health plan pays and the provider's charge for the service, and you may have to file your own claims.

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

Tell your doctor your reason for visiting

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

Choose generic drugs

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

Go to urgent care centers for non-emergency care

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

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

Use virtual medicine services

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

Get blood tests at an independent lab

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

Get X-rays at an imaging center

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

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

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

Use mail order for maintenance medications

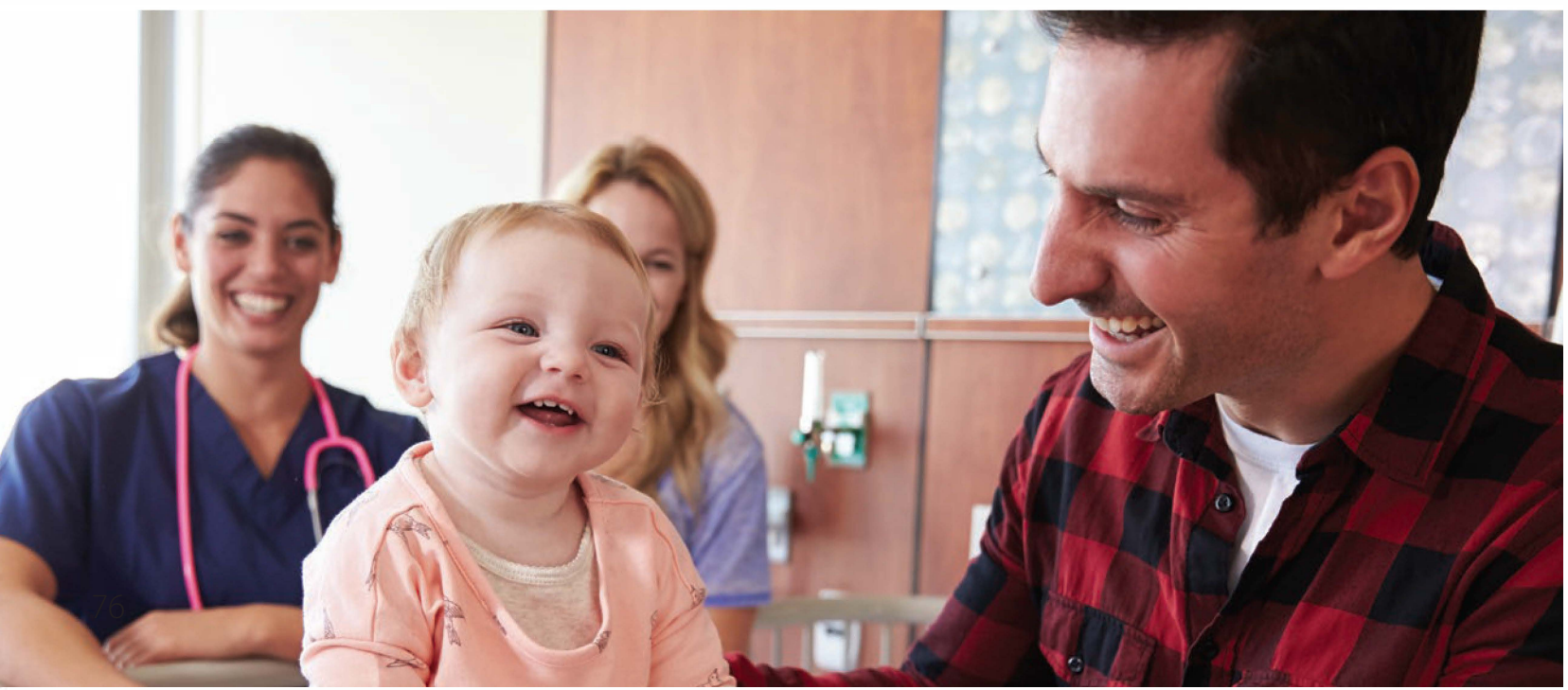
If you take a maintenance medication for a condition like high blood pressure, high cholesterol, or diabetes, getting your prescription by mail order can help you save not only the money but also the time spent going to your local pharmacy and waiting for refills.

Shop around for value

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

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

- Go to **Highmarkbcbs.com** and click the **Find a Doctor or Rx** tab.
- Call My Care Navigator at **1-888-BLUE-428**.



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 ❑Rehire ❑Enrollment ❑Act 4 ❑Other: ❑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 ( ) | **12)** Employee Hire Date Month / Day / Year

13) Check Type of Coverage	**MEDICAL**	**DENTAL**	**VISION**	**DRUG**	**PRODUCT NAME**
Employee Only	❑	❑	❑	❑	❑
Insured & Spouse/Domestic Partner	❑	❑	❑	❑	❑
Family	❑	❑	❑	❑	❑
Parent & Child	❑	❑	❑	❑	❑
Parent & Children	❑	❑	❑	❑	❑

14) To be completed by Account Administrator only

Group Number	Report Code Qualifier	Report Code Value

Complete items 15 through 18 where applicable. List eligible participants. (If you have additional dependents, attach separate sheet.)

	First Name / Middle Initial / Last Name	Social Security Number	Do you have other insurance?	Birth Date Mo / Dy / Yr	Sex F/M	Check If: Student Benefits Apply	Disabled	Act 4
15) Self			❑Yes ❑No If YES, then complete #19					
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory		c) Are you an Established Patient? ❑Yes ❑No					
16) ❑Spouse ❑Dom. Part.*			❑Yes ❑No If YES, then complete #19					
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory		c) Is Spouse/DP an Established Patient? ❑Yes ❑No					
17) ❑Child ❑Other*			❑Yes ❑No If YES, then complete #19					
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory		c) Is Dependent an Established Patient? ❑Yes ❑No					
18) ❑Child ❑Other*			❑Yes ❑No If YES, then complete #19					
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory		c) Is Dependent an Established Patient? ❑Yes ❑No					

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

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

Name of Insurance Carrier: _____

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) _____

MEDICARE INFORMATION: List any family member that is eligible for Medicare Benefits:

Name of Member Last / First	Health Insurance Claim Number	Part A Effective Date (Mo-Day-Yr)	Part B Effective Date (Mo-Day-Yr)	Part D Effective Date (Mo-Day-Yr)
		/ /	/ /	/ /
		/ /	/ /	/ /
		/ /	/ /	/ /

Why are you eligible for Medicare? ❑ Age ❑ Disability ❑ End Stage Renal Disease

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 coverage and recognize that I must formally enroll my dependents on this form or they will not be covered. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Health Services may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Health Services' Notice of Privacy Practices is available on Highmark Health Services' Web site, or from the Highmark Health Services Privacy Office.

20) _____ Authorized Employer Signature — Date

21) _____ Employee Signature — Date

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

Discrimination is Against the Law

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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…

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