All these benefits.
All for you.

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

That’s why whoever you are, we make it easy to find affordable, quality care.

HIGHMARK
WESTERN NEW YORK

HMO NYSHIP Copay with Rx

NYSHIP

Hi there,

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

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

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

Dr. Michael Edbauer
President, Highmark Western and Northeastern New York

Contents

Why Highmark

BLUES ON CALL℠

Answers from a health pro, 24/7.

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

MY CARE NAVIGATOR℠

Your appointments, booked for you.

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

Doctor on Demand® by Included Health

Face-to-face with a doctor, 24/7.

Need to see a doctor but can't get to their office? Get a diagnosis, treatment plan, or prescription any time, right from your phone or computer. You can register at **doctorondemand.com** via the mobile app, or over the phone using the number on the back of your member ID card. That's laid-back-in-a-recliner easy.

DIABETES PREVENTION PROGRAM

Tips on how to avoid diabetes.

Lower your risk with simple, effective, practical strategies.

DISEASE MANAGEMENT PROGRAMS

Help managing chronic conditions.

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

EMERGENCY CARE

When you need it most, you're covered.

Emergency care is always covered at the in-network level of benefits, wherever you get it. So don't hesitate. If it's an emergency, go straight to the nearest emergency room or dial 911.

WORLDWIDE CARE

Support around the globe.

No matter where you travel, the Blue Cross Blue Shield Global® Core Program gives you access to providers for your health care needs. For worldwide help, just call 1-800-810-BLUE.

MENTAL HEALTH CARE

Get care for your mind, too.

Highmark covers a wide range of mental health services, including counseling and treatment. You get a choice of providers within your plan for the type of care that fits your situation best.

SUBSTANCE ABUSE CARE

Guidance to keep you on track.

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

MATERNITY CARE

Caring for moms is about so much more than labor and delivery.

With Highmark, you get access to numerous facilities designed around comprehensive women's care, personal attention, and a family-centered approach during this special time.

You also have access to programs focused on advanced technology and expertise in neonatal care and OB-GYN specialty care.

- OB-GYNs specializing in high-risk pregnancy, maternal fetal medicine, and fertility.
- Board-certified pediatricians and pediatric subspecialists.
- Childbirth and certified lactation experts.
- Behavioral health specialists for emotional support.

Baby Blueprints® Program

Pregnancy can be exciting and overwhelming all at once. That's why Highmark's Baby Blueprints program guides you every step of the way. It's a no-cost program that provides you with educational resources and personalized attention from your own specially trained health coach.

Call 1-866-918-5267 to take advantage of Baby Blueprints today.

Women's health

The importance of regular mammograms.

Breast cancer is the second most common cancer among women. Mammography screenings do save lives. Preventive health services like mammographies increase the likelihood of identifying abnormalities so they can be treated early, which results in more positive outcomes. The Centers for Disease Control and Prevention (CDC) recommends women have mammograms as follows:

- Between 40 and 49 years of age: every 1–2 years.
- Between 50 and 64 years of age: annually.
- After age 65: as recommended by your physician.

Most health plan benefits include routine mammogram screening, which is generally covered in full. To make sure this benefit is included in your health coverage, call the customer service number on the back of your member ID card.

Your health and your rights.

Did you know that the Women's Health and Cancer Rights Act of 1998 requires health plans that cover mastectomies to also cover breast reconstruction and prostheses? Under this law, Highmark Blue Cross Blue Shield of Western NY provides coverage to all members for the following services in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedema.

We encourage you to discuss treatment options with your physician and to refer to your contract for details about coverage for breast reconstruction. This coverage is subject to the deductibles, coinsurance, and copayments of your contract.

Women's health (cont.)

The breast-feeding law and you.

To promote breast-feeding in the state of New York, the state legislature has enacted into law the Breastfeeding Mothers' Bill of Rights, which applies to all maternal health care providers and facilities, effective May 1, 2010. The Breastfeeding Mothers' Bill of Rights is intended to inform new mothers about the benefits of breast-feeding and have health care providers and maternal health care facilities encourage and support breast-feeding. To learn more about this law and your options, please visit the state's website at: **health.ny.gov/community/pregnancy/breastfeeding**.

Hospital stays for new mothers.

Except for prenatal complications, we cover inpatient hospital maternity care for covered mothers and newborns. The duration of care is a minimum 48 hours for vaginal delivery and at least 96 hours for Cesarean section delivery. We also cover any additional days of care we deem medically necessary.

Product Information

HMO NYSHIP Copay with Rx

Here's how Highmark makes it simple for you:

Easy access to top-performing specialists.

Many of our participating specialists have earned Blue Distinction status for their exceptional safety and results. That means great specialty care for you, across the board. Easy-peasy.

And you're covered close to home, too.

Our local provider network gives you easy access to hospitals and doctors right in your community. From behavioral health to cancer care to cardiology, children's health to neuroscience to women's care, we've got you covered for local specialty care, too.

It's all about your network.

To search for participating physicians or hospitals, you can visit **member.highmark.com** or call Customer Service at the number on the back of your member ID card. Remember, to keep out-of-pocket expenses at a minimum, you should seek care from participating providers.

1. Log in at **member.highmark.com**.
2. Choose **Find Care**.
3. Select **SEARCH NOW** under **Find a Provider**.
4. Choose **Continue**.
5. Enter the city, state or zip where you want to search for care and select **Continue**.
6. Choose your network and select **Continue**. You can find it on the back of your member ID card or in the Highmark Plan app.
7. Use the search window to type in a name, specialty, or procedure and choose a provider from the pop-up list.

Choosing the right PCP is an important part of your **HMO** plan: you'll need an in-network provider who can help coordinate your care. If you don't have an in-network PCP, use the above search process to find one.

You won't have coverage if you go out-of-network (unless for urgent or emergency care), so check that a provider is in-network before you get care.

Long-term travelers, separated families, or students who live outside of the service area for at least 90 days can become guest members in their residence's local Blue Cross and/or Blue Shield HMO, if one is available. Guest members will also remain enrolled in the original HMO plan.

For more information, please call Member Service at the number on the back of your ID card.

*According to the Blue Cross Blue Shield Association.

HIGHMARK
WESTERN NEW YORK

2023 New York State Employees HMO Plan 067 Benefit Summary

Physician and other health professional services	Cost
Primary care office visit copayment	$10
Primary care office visit for children age 19 and under	$0
Specialty care office visit	$15
In-network out-of-pocket maximum	$3,000 single/$6,000 family
Telemedicine hosted by Doctor on Demand®	$0

Prescription drugs	Cost
Retail, 30-day supply	$5 generic $30 brand $60 non-formulary $0 preventive Rx drug list
Mail order, 90-day supply	$12.50 generic $75 brand $150 non-formulary

Office or outpatient hospital-based health services	Cost
Routine physical exam	$0
Routine gynecological physical exam	$0
Diagnostic services; radiology and imaging, including X-rays, ultrasounds, diagnostic nuclear medicine, MRIs, and CT scans	$15
Mammograms	$0
Bone mineral density measurements and tests	$0
Cervical cytology screenings	$0
Well child visits	$0
Immunizations	$0
In-office surgical procedures	$15
Chiropractic services	$15
Standard diagnostic testing for prostatic cancer	$0
Chemotherapy	$15
Radiation therapy	$15
Urgent care services	$25
Physical therapy	$15
Occupational therapy	$15
Speech therapy	$15
Laboratory services	**Cost**
Office laboratory services	$0

Outpatient hospital laboratory services	$0

Inpatient hospital services	Cost
Inpatient hospital service	$0
Maternity care	$0
Skilled nursing facility services	$0

Outpatient hospital surgery and ambulatory surgery facility services	Cost
Hospital	$100
Physician’s office	$15
Outpatient surgery facility	$100

Emergency services	Cost
Emergency department services	$100
Professional ambulance services	$100

Additional services	Cost
Home health care	$15
Durable medical equipment	50%
Prosthetic and orthotic devices	20%
Hospice care*	$0

Hearing aid benefit – TruHearing™	Cost
Hearing aids	$699/$999 per aid
Routine hearing exam – TruHearing™	$15

Wellness	Cost
Wellness card	$600 Single/ $750 Family Allowance

Changes to your coverage

Highmark Blue Cross Blue Shield of Western NY offers you opportunities to enroll additional members to your policy or make other contract changes at times other than the regular open enrollment periods. These off-cycle contract changes may only be processed for "qualifying events," which include:

- Marriage.
- Birth.
- Adoption of a child (requires legal documentation).
- Legal guardianship (requires legal documentation).
- Divorce.
- Death.
- National support notice (requires legal documentation).
- Involuntary loss of coverage (requires proof of loss of coverage).

When your status changes, an Enrollment Application Form must be completed and submitted promptly to Highmark Blue Cross Blue Shield of Western NY within 30 days of the qualifying event. Status changes may include:

- Name change.
- Changing to COBRA.
- Address change.*
- Adding a dependent.
- Removing a dependent.
- Changing to Medicare coverage.
- Retirement.

*You can change your address by calling the customer service number on the back of your member ID card.

Consult your contract for more information.

Changes to your coverage (cont.)

Timeline for subscriber changes.

Policies purchased through your employer

Prior to the "qualifying event" and up to 30 days after the event	The change will be added to your coverage as of the date of the event
More than 30 days after the "qualifying event"	The change will be processed to be effective on the first of the month following the date the notification is received

The ins and outs of the certificate of creditable coverage.

If, for any reason, you lose coverage under a Highmark Blue Cross Blue Shield of Western NY plan or otherwise become entitled to elect COBRA continuation coverage, or when COBRA continuation coverage ceases, you will automatically receive a certificate (or statement) of creditable coverage that affirms your prior health coverage.

You may also request a certificate, free of charge, up to 24 months after the time your coverage ended. You may also request a certificate even before your coverage ends. To order a certificate of creditable coverage, call customer service at the number on your member ID card.

Coverage limitations

Some limitations to this health plan are outlined below.

Please note that your coverage may be different based on your specific plan design. Consult your contract for a complete list of benefits.

- Admission to a hospital before you become covered under this contract.
- Government hospitals.
- No-fault automobile insurance.
- Workers' compensation.
- Free care.
- Government programs.
- Blood supply (unless part of inpatient hospital care).
- Routine foot care.
- Non-covered physical examinations.
- Non-covered benefits.
- Methadone maintenance.
- Reversal of elective sterilization.
- Cosmetic surgery.

Prescription Drug Coverage

PRESCRIPTION DRUG BENEFITS

Here's how your drug coverage works.

First off, you'll use the same ID card for your medications as you do for your medical coverage. When you go to an in-network pharmacy, depending on your plan and the prescription, you might have a copay or need to pay a percentage of the drug's cost.

Knowing that, here are two important things to remember:

1. You'll usually save money by choosing a generic drug over a brand-name drug.
2. You can save even more by using mail order for maintenance prescription drugs.

And when it comes to staying on top of your coverage, your member website has details on your drug coverage and easy-to-use tools to manage your benefits and prescriptions.

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

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

Programs to keep you safe while keeping drug costs down.

When it comes to your medications, Highmark uses programs to help you make safer, more cost-effective drug choices. In the course of getting you the right drug, at the right time, in the right amount, at the right price, you might run into one of the following programs:

Prior Authorization:

When you're enrolled and it's time to fill a prescription, we'll automatically check to be sure it's the best way to treat your diagnosed condition (or that you've tried other treatments before that didn't work for you). If the prescription isn't right for you, you'll need to get a Prior Authorization from your doctor. It's our way of double-checking that you're getting safe, effective, medically necessary drugs.

Quantity Limits:

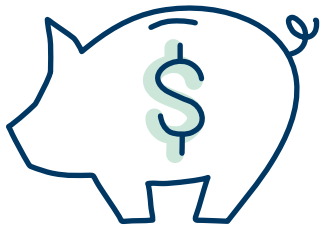
Some drugs are regulated to make sure you get the right dosage. Limits can be based on gender, age, or other factors that restrict how often or how much of a refill you can get. They're in place to keep you safe.

Step Therapy:

For certain medications, our drug programs use a "step" approach. That means you'll need to try preferred medications first before less-preferred medications are covered. Preferred medications tend to be the lower-cost generic drugs that have already been clinically proven to be safe and just as effective as their more expensive counterparts. Step Therapy is designed to help lower costs while still providing access to non-preferred medications.

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

1. Call the Pharmacy Hotline at **800-600-2227.**
2. Send a request online by using the **NaviNet® program.**
3. Fax a request form to the Hotline staff at **866-240-8123.**
   (Get a form at **member.highmark.com** by selecting the **Resources** tab and choosing **Forms Library** from the left menu. Select GET YOUR FORMS from the Health Care Forms Library and choose **Pharmacy/Rx**.)



Save even more with the mail order pharmacy.

If you take medications regularly, the mail order pharmacy can make life simpler and help you save with:

- 90-day drug refill available.
- 24/7 ordering online, by mail, or by phone.
- Typical delivery in three to five days.
- Free standard shipping.
- Helpful pharmacists available to you 24/7.
- Simple payments via e-check, credit card, or a health spending account.

How to start using the mail order pharmacy

Get a new prescription for up to a 90-day supply, plus refills for up to one year from your doctor. Then:

- Have your doctor fax in your new prescription or submit it as an e-prescription.

Or

- Use it to file your Pharmacy Mail Order Form and Health, Allergy, and Medication Questionnaire.

You'll find those forms at the end of this Pharmacy Benefits section. They're also available at **member.highmark.com** by selecting the **Resources** tab and choosing **Forms Library** from the left menu. Select **GET YOUR FORMS** from the Health Care Forms Library and choose **Pharmacy/Rx**.

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

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

PARTICIPATING ADVANTAGE NETWORK PHARMACIES:

Over 34,000 pharmacies are in the Advantage network, including:

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

HOME DELIVERY ORDER FORM

EXPRESS SCRIPTS®

Home Delivery Order Options

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

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

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

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

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

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

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

1 Member Information

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

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

2 Shipping Address

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

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

Primary Phone Number	Choose One MO HO WO	Secondary Phone Number	Choose One MO HO WO

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

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

3 Patient Information

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

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

 EME47693 CRP1808_0413 STLF14WB

4 Payment Method — Do not send cash

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

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

Signature X _____

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

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

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

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

5 Health History

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

6 Important reminders and other information

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

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

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

7 Generic Substitution

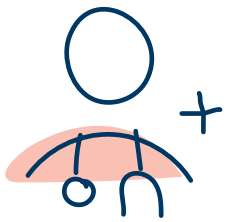
State law permits a pharmacist to substitute a less expensive generic equivalent drug for a brand-name drug unless you or your physician directs otherwise. Please note that this applies to new prescriptions and to any future refills of that prescription. Also be aware that you may pay more for a brand-name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

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

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

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

Wellness



BEST DOCTORS®

Expert consultations from top doctors.

Talk to a case manager who can help confirm a diagnosis when you're facing a difficult health condition.

HEALTH COACHES

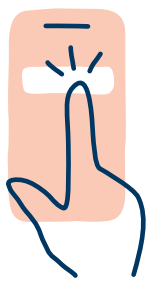
Personalized support for health goals.

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

BABY BLUEPRINTS®

Pregnancy advice, answers, and support.

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



SHARECARE®

Say hello to your online health and wellness hub.

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

Health Tools & Resources

HIGHMARK CONCIERGE

Get the VIP treatment.

Your specialized team of coverage experts dedicated to answering all of your questions. Help finding cost-effective care, setting appointments, and navigating wellness programs are just the beginning. Call the phone number on the back of your ID card or from the Highmark app.

ONLINE TOOLS & MEMBER WEBSITE

Your entire plan at your fingertips.

No more searching for old files or waiting on snail mail. Your digital ID card, Find a Doctor tool, deductible progress, and claims status are all available online at **member.highmark.com**.

CARE COST ESTIMATOR

See what care might cost you.

Before making an appointment for a test, scan, or procedure, Care Cost Estimator helps you estimate what that care may cost. Available on your member website, **member.highmark.com**.

MY CARE NAVIGATOR℠

Your appointments, booked for you.

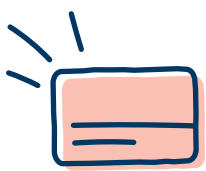
It's as simple as calling the phone number on the back of your member ID card or from the Highmark app. We'll help you find the in-network doctor you need and reserve some space on their calendar for a checkup. Which means less on-hold music for you.

BLUE365®

Discounts to help you stay healthy and active.

From workout gear to gym memberships to healthy meal services, we'll take a little off the top while you're taking a little off your middle. Member-only deals are at **blue365deals.com**.

WELLNESS CARD



One little card. Big health benefits.

Highmark's wellness card helps your employees live a healthier life with an annual allowance for wellness products and services.

HIGHMARK PLAN APP

Your health plan in your pocket.

Get instant access to your digital member ID card, care-finding tools, and claims updates right on your mobile device. To start, just download the Highmark Plan app from the App Store or Google Play and set up your profile.

Additional Important Information

Health care lingo, translated.

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

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

COINSURANCE
The percentage you owe, after your deductible. For example, if your plan pays 80%, you pay 20%.

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

COVERED SERVICES
All the care, drugs, supplies, and equipment that are paid for, at least in some part, by your health plan after you've met your deductible.

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

The deductible applies before any coinsurance or copayments are applied. The deductible may not apply to all covered services. You may also have a deductible that applies to a specific covered service (e.g., a prescription drug deductible) that you owe before we begin to pay for a particular covered service.

Embedded deductible
No single individual on a family plan will have to pay a deductible higher than the individual deductible amount.

True family deductible
A family can meet the deductible by pooling expenses. There is no limit to the amount one member can pay toward the family deductible.

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

EXPANDED NETWORK (EX)
You must live and/or work in the Highmark Western NY and Northeastern NY service areas. It is ideal for those living in remote areas of or in border counties of this service area as well as those who have dependents attending college outside of the service area. Members who permanently live outside of the service area should select a PPO plan, must select a PCP, and visit their PCP for a yearly physical.

INDEMNITY
Members can obtain services from any provider at the same benefit and payment level. If services are obtained from a participating provider, local or national, the provider will accept the negotiated fee as payment in full; you only have to pay the applicable cost-shares. If you visit a non-participating provider, you may be billed by the provider for the difference between the negotiated fee and their charge for service.

IN-NETWORK PROVIDER (PARTICIPATING PROVIDER)
A doctor, hospital, or other facility that has an agreement with your plan to accept your plan allowance and cost sharing as full payment. They won't bill you extra for covered services, but you could still have to pay your deductible, coinsurance, or copays.

A list of participating providers and their locations is available at **member.highmark.com** or upon your request to us. We will occasionally revise the list.

MAXIMUM OUT-OF-POCKET (OUT-OF-POCKET LIMIT)
The most you pay during a plan year in cost-sharing before we begin to pay 100% of the allowed amount for covered services is the out-of-pocket limit. This limit never includes your premium, balance billing charges, or the cost of health care services that we do not cover.

OUT-OF-NETWORK (NON PARTICIPATING) PROVIDER
A provider that can charge more than your plan allowance for their services. If they do, you'll most likely be responsible for additional costs.

PLAN ALLOWANCE
The set amount you and your plan will pay for a health service. In-network providers aren't allowed to bill you more than this amount.

POINT OF SERVICE (POS)
A type of plan that requires membership to use local providers to obtain in-network coverage at the lowest cost share. Participating providers are located in the counties of the within a plan's local service area. You must designate a primary care physician (PCP). You may have a higher cost share when you obtain services from a non-participating provider. There is an exception, which is the Away From Home Care Program for family members living in counties outside the designated plan service area. The program is available to members, and can be set up as a guest membership in a Blue Cross Blue Shield plan in the area where they reside. Guest memberships are not available in all areas and do not apply to high deductible plans.

PRECERTIFICATION
A decision made ahead of time — by your health plan — that a service, treatment, or drug is medically necessary for you. It can be called prior authorization or prior approval, but it's not a promise that anything will be fully covered.

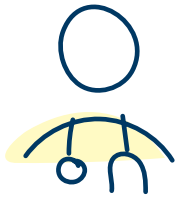
PREFERRED PROVIDER ORGANIZATION (PPO)
A type of plan that offers more flexibility in choosing providers, usually with the added security of coverage for care you might need when you're away from home.

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

PROVIDER
Whether it's your primary doctor, a lab technician, or a physical therapist, the person or facility where you get care is referred to as a health care provider.

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

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



Keep your doctors informed

In today's world of high-tech medicine and specialty care and services, communication among doctors is an essential ingredient in the provision of safe and coordinated medical care.

Communication can help.

- Your doctors make safe and appropriate decisions and recommendations based on your medical history and current diagnoses and treatments.
- Assure coordination of all your health care needs, especially in an emergency.
- Prevent duplication of services.
- Decrease costs.

What you can do to promote communication.

- Update your medical information every time you visit your doctor.
- Speak to all your doctors to ensure that information is shared for continuity and coordination of care.
- When receiving inpatient, urgent, or emergency care services, provide an accurate list of all doctors involved in your care. If you have established a relationship with a primary care doctor, make sure the facility has that individual's name. Request that hospital, emergency room, and urgent care summaries are forwarded to your doctors.
- Make it known that you want those providing care to you to communicate with one another. When receiving care or services, ask that diagnostic and screening tests be shared with other doctors currently involved in your care.

How we approve what's covered.

Determining care for coverage

We have a group of experts called Clinical Services. Their job is to make sure you're receiving care that is medically necessary and appropriate. What that means, generally, is that care is:

- **A standard medical practice.**
- **Proven to be effective.**
- **Not just done out of convenience for you or your doctor.**
- **Not more expensive than something else that would be just as effective.**

Most of the care covered by your plan meets these guidelines, so you can have it done and covered without needing to do anything else.

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

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

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

How we keep your information confidential.

You've trusted us with your personal information and we take protecting it very seriously. We follow very strict policies for handling and protecting Protected Health Information (PHI).

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

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

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

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

How we keep your information confidential (cont.)

Highmark Blue Cross Blue Shield of Western NY is committed to maintaining the confidentiality of patient information in all situations. That applies to your doctor's office, the hospital, our employees, and everyone we contract with to provide and manage your health care. We will only release such information in accordance with state and federal law and the guidelines established by Highmark Blue Cross Blue Shield of Western NY. Here's a summary of some of the guidelines we follow to keep your personal information confidential:

Inclusions in routine notifications of privacy practices.

The Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information–for example, Uses and Disclosures of Protected Health Information (e.g., treatment,payment, health care operations) or Individual Rights (e.g., member access, accounting of disclosures, confidential communications). A copy of the Notice of Privacy Practices is included in our initial enrollment package and is available at **member.highmark.com** or by calling the customer service number on the back of your member ID card.

The right to approve release of information (use of authorizations).

An authorization is not required for treatment, payment, or health care operations and in other instances as required by law. An authorization is required for the release of information in certain circumstances — for example, when releasing information to someone other than the individual and as otherwise permitted by law, or when releasing sensitive information (e.g., HIV/AIDS, alcohol/ substance abuse).

How we keep your information confidential (cont.)

Access to medical records.

Highmark Blue Cross Blue Shield of Western NY does not generate, modify, or maintain complete copies of your medical records. We receive copies of your medical records in order to process claims and perform other routine functions in the normal course of business. If you want to obtain copies of your medical records, you should contact the practitioner or facility considered to be the source of these documents.

Protection of oral, written, and electronic information across the organization.

Corporate information assets in oral, written, and electronic form are protected by establishing and enforcing corporate security and privacy policies and procedures, implementing security and privacy awareness training for all workforce members, and deploying the appropriate physical, administrative, and technical security mechanisms.

Information for employers.

Protected health information is not released to employers unless you have authorized the release and/or the proper agreements are in place as permitted by law. When information is released to employers, it is released with certain restrictions so confidentiality will be maintained. However, enrollment/disenrollment and premium quote information are allowable disclosures under certain law.

Care and case management

Programs for care support and complex condition management.

CARE MANAGEMENT PROGRAM

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

Services under the Care Management Program:

Precertification Review starts before you get care and:

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

Concurrent Review happens during the course of treatment to:

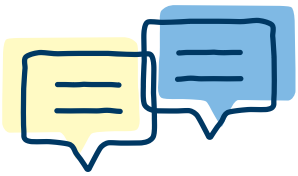
- Assess the medical need to continue treatment.
- Evaluate the right level of care for treatment.
- Foresee any possible quality of care concerns.
- Identify situations that require a physician consultation.
- Determine potential case or condition management benefits.
- Update and/or revise the discharge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

Discharge Planning occurs throughout the course of treatment to:

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

Retrospective Review happens after services have been provided and:

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

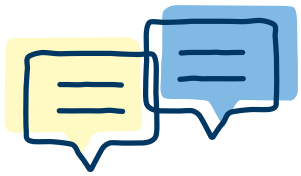


CASE MANAGEMENT PROGRAM

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

Individual Goals of Case Management:

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



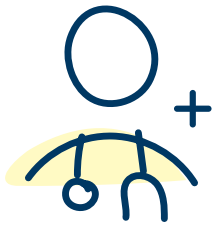
CASE MANAGEMENT PROGRAM (cont.)

How the Case Management Program Works:

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

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

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



We help you choose a primary doctor

Choosing the doctor that best meets your needs can be challenging.

You may select one of the following types of doctors as your primary doctor:

- Family practitioner.
- General practitioner.
- Internist.
- Pediatrician.

You and your dependents may each choose a different primary doctor.

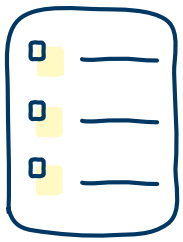
For help choosing a doctor, call the customer service number on the back of your member ID card.

For help locating participating providers, visit **member.highmark.com**.

What to do when you change primary doctors.

After you select a doctor:

1. **Contact your new doctor**.
   Find out if he or she is accepting new patients.
2. **Who will I be seeing?**
   Ask what type of practitioners will provide your care. Doctors often rely on the help of physician assistants and/ or nurse practitioners to make sure patients can be seen right away when they are sick.



What you need to know about authorizations and claims

How to obtain a prior authorization.

A prior authorization is an approval from us that your doctor or hospital needs to obtain before they may perform the service. Have your doctor or hospital contact customer service to obtain prior authorization.

The term "claim" applies to both requests for coverage and requests for payment.

Pre-service claims.

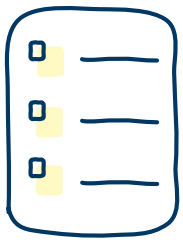
- Necessary for procedures or treatments that require authorization prior to care being rendered.
- We make a determination regarding your pre-service claim. We then notify you, your representative, and/or your doctor or hospital by telephone and/or in writing within three business days after receiving all necessary information.

Urgent care claims.

- Involve life-threatening situations. If the ability to regain maximum function is in question, or if severe pain cannot be adequately managed, urgent care may be required.
- No prior authorization is needed for urgent care or emergency room services.
- We will make a determination on your claim and notify you or your representative by telephone and in writing within 72 hours after we receive your claim.

Concurrent care claims.

- Involve continued or extended health care services or additional services during a course of continued treatment for a specific period of time or a specified number of treatments.
- For non-urgent concurrent care claims, we notify you or your designee by telephone and in writing within one business day of receipt of all necessary information.
- For urgent concurrent claims, we notify you or your designee within 24 hours of receipt of your claim.



What you need to know about authorizations and claims (cont.)

Post-service claims.

- A review involving services that have already been provided.
- Decisions are made within 30 calendar days after receiving all necessary information.

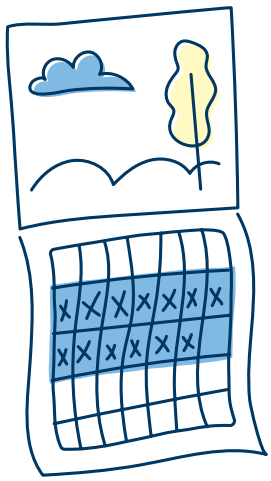
Being admitted to the hospital.

Your doctor or hospital will arrange your admission with us by obtaining a prior authorization and discussing the procedure and length of your stay.

How we determine if a new treatment or drug is covered.

To continue to provide you with the most up-to- date treatment methods, we continually monitor new technology and methods, and new drugs.

A team of medical experts then uses this information to update covered benefits. Decisions to not cover new treatments or drugs may change as new scientific literature supporting safe and effective outcomes is documented. In these cases, decisions are re-evaluated as new information becomes available.



Prior authorization for out-of-area services

You are required to confirm that your provider obtained a prior authorization for any out-of-area services requiring authorization *in advance of receiving the service*. Beginning August 8, 2021, this will also include advanced radiology and cardiac imaging. A prior authorization just means that we work with your provider before you receive the proposed service to make sure that the procedure is medically necessary. Your out-of-area provider will be expected to reach out to us about that, but it is important that you stay in contact with them.

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

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

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

Let's break this down a little more.

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

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

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

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

Best Doctors is an independent company that manage the virtual second medical consultation program on behalf of Highmark.

Sapphire Digital is an independent company that administers the SmartShopper program for your health plan. Pricing may not be available on all medical procedures, tests or healthcare providers.

Doctor On Demand by Included Health is a separate company that provides telemedicine services to Highmark BCBSWNY and BSNENY members.

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

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

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

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

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

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

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

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

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

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

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

The programs discussed herein are not intended to be a substitute for professional medical advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health provider with any questions or concerns regarding a medical condition. Health plan coverage is subject to the terms of your health plan benefit agreement.

*This is not a contract.

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HIGHMARK
WESTERN NEW YORK

Notice of Nondiscrimination

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

The plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other)
- 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, please call the customer service number on the back of your member ID card or contact the Civil Rights Coordinator.

If you believe that the plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email:

CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US 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 US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

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

For assistance in English, call the customer service number listed on your member ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

רעי לטר ID סאוו אוטיי סיוור רעמנופוי רעמוטסקאדי טפרו שיד, ר ילפ ן.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডের তালিকাভুক্ত নম্বরে কে্রতা পরিষেবায় ফোন করুন।

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

د ریم ودار ،ےیلا رمڈ جدرپرڈرکایختا کےآپسو ریہ لکاپرربنمھد

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

ودار ریم نا ،ےلئکے د رمڈ لکاپرربنمجدرپرڈرکایڈ یآنےناپکوسو ریہ۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

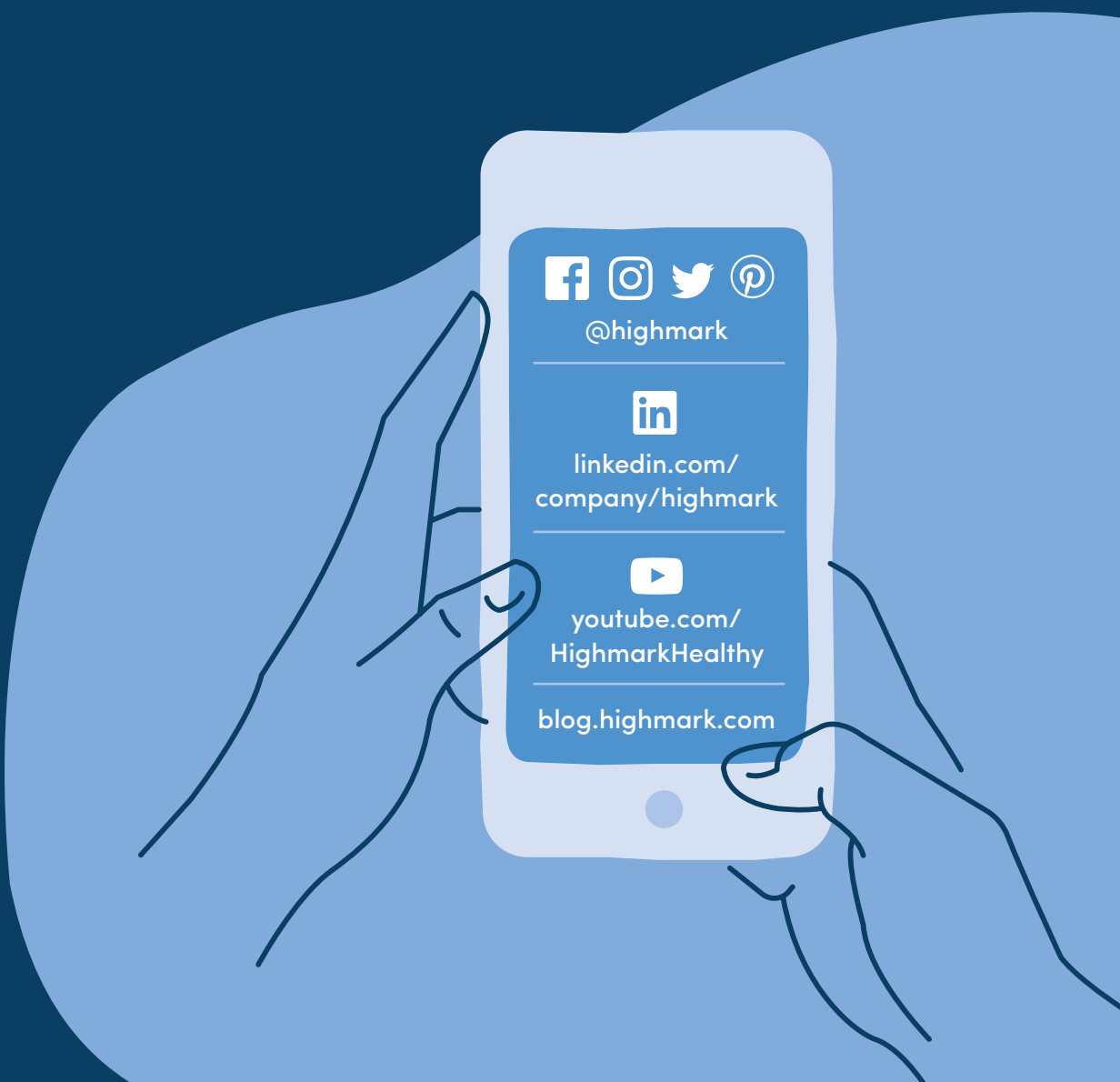
Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Diné k´ehjí yá´áti´bee shíká adoowot nohsingo naaltsoos nihaa halne´go nidaahtinígíí bine´déé´ Customer Service bibéésh bee hane´é biká'ígíí bich´j´dahodootnih.

Connect with us.

We're on most of your favorite social media sites, so contact us there if it's easier for you. You can say hi, ask questions, or give feedback. Find us here:



We’ve got your back.

For coverage questions, call the number on the back of your member ID card or talk with your plan administrator.