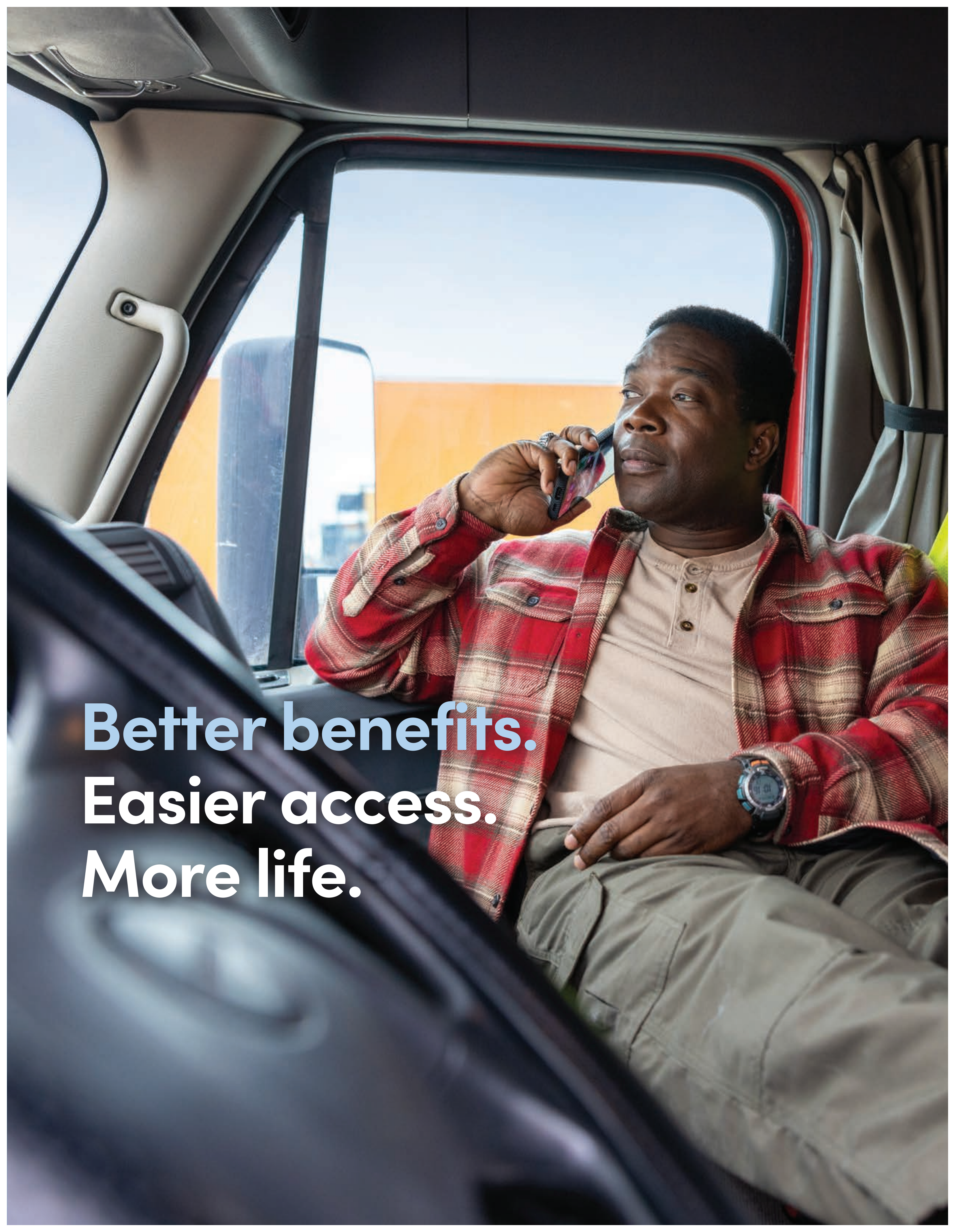
Better benefits.
Easier access.
More life.

Care that keeps up with your life.

Wherever you are, we've got you covered.

POS 200 Copay with Rx/POS 7200 HDHP Copay with Rx/PPO 800 Blended with Rx

Lewiston-Porter Central School District

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

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Why Highmark

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, wherever you get it. So don't hesitate. If it's an emergency, go straight to the nearest emergency room or dial 911. Also, your plan may cover emergency care received outside of the United States. Check your Summary of Benefits for more information.

WORLDWIDE CARE

Support around the globe.

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

MENTAL HEALTH CARE

Get care for your mind, too.

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

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.

Product Information /Benefit Summary

POS 200 Copay with Rx

Here's how Highmark Blue Cross Blue Shield WNY makes it simple for you:

Nationwide access to providers through the BlueCard® program.

Access to the largest physician and hospital networks in the U.S. with over 1.7 million providers, including 95% of all hospitals.*

And when you travel globally, you're covered in 190 countries through the Blue Cross Blue Shield Global® Core program.

Close-to-home coverage.

Whether it's 24/7 answers from registered nurses, a diagnosis or prescription over video visit, or just some help booking your doctor visits, when you need us, we're there.

Easy access to top-performing specialists.

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

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.

Need help finding top-quality doctors and hospitals?

To search for in-network providers:

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

You can still use out-of-network providers, but it may cost you more. So, check that a provider is in network before you get care.

For over-the-phone help, call Member Service at the number on the back of your ID card.

*According to the Blue Cross Blue Shield Association.

POS 7200 HDHP Copay with Rx

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Nationwide access to providers through the BlueCard® program.

Access to the largest physician and hospital networks in the U.S. with over 1.7 million providers, including 95% of all hospitals.*

And when you travel globally, you're covered in 190 countries through the Blue Cross Blue Shield Global® Core program.

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2. Choose **Medical** and select **Continue**.
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4. Enter your ZIP code.
5. Choose a plan from the list.
6. Type a name or specialty into the search window.

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*According to the Blue Cross Blue Shield Association.

PPO 800 Blended with Rx

Here's how Highmark Blue Cross Blue Shield WNY makes it simple for you:

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

You can still use out-of-network providers, but it may cost you more. So, check that a provider is in network before you get care.

For over-the-phone help, call Member Service at the number on the back of your ID card.

*According to the Blue Cross Blue Shield Association.

Lewistown-Porter Central School District
POS 200 $0/$0 - 10653005, 10653010, 10653000 - Plan A

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

Benefit	In Network	Out of Network
General Provisions		
Effective Date	**July 1, 2023**	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual Family	 None None	 $1,000 $2,000
Deductible Accumulation (2)	Not applicable	Embedded
Coinsurance - payment based on the plan allowance	Not applicable	25% after deductible
Out-of-Pocket Maximum (Includes coinsurance, copays, deductible, prescription drug cost sharing and other qualified medical expenses). Once met, plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $5,000 $10,000	 $5,000 $10,000
Out-of-Pocket Accumulation (2)	Embedded	Embedded
Office/Urgent Care Visits		
Primary Care Provider Office Visits & Virtual Visits	covered in full	25% after deductible
Specialist Office Visits & Virtual Visits	covered in full	25% after deductible
Virtual Visit Provider Originating Site Fee	covered in full	25% after deductible
Urgent Care Center Visits	covered in full	0% after in-network deductible
Telemedicine Services (3)	covered in full	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 covered in full	 not covered
Adult Immunizations	covered in full	25% after deductible
Routine Gynecological Exams, including a Pap Test	covered in full	25% after deductible
Mammograms, Annual Routine	covered in full	25% after deductible
Mammograms, Medically Necessary	covered in full	25% after deductible
Diagnostic Services and Procedures	covered in full	25% after deductible
Routine Pediatric Physical Exams	 covered in full	 25% after deductible
Pediatric Immunizations	covered in full	25% after deductible
Diagnostic Services and Procedures	covered in full	25% after deductible
Emergency Services		
Emergency Room Services	$50 copay (waived if admitted);	$50 copay (waived if admitted); after in-network deductible
Ambulance - Emergency and Non-Emergency	$25 copay	$25 copay after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	covered in full	25% after deductible
Hospital Outpatient	covered in full	25% after deductible
Maternity (non-preventive professional services) including dependent daughter	covered in full	25% after deductible
Medical Care (including inpatient visits and consultations)	covered in full	25% after deductible

Therapy and Rehabilitation Services		
Physical Therapy	covered in full	25% after deductible
	limit: 30 visits/benefit period aggregate with occupational therapy and speech therapy	
Respiratory Therapy	covered in full	25% after deductible
	limit: 24 visits within a 12 week period for pulmonary rehabilitation	
Speech Therapy	covered in full	25% after deductible
	limit: 30 visits/benefit period aggregate with occupational therapy and physical medicine	
Occupational Therapy	covered in full	25% after deductible
	limit: 30 visits/benefit period aggregate with speech therapy and physical medicine	
Spinal Manipulations	covered in full	25% after deductible
Cardiac Rehabilitation Therapy	covered in full	25% after deductible
	limit: 24 visits per plan year in a 12 week period. Aggregate IN + OON	
Infusion Therapy	covered in full	25% after deductible
Chemotherapy	covered in full	25% after deductible
Radiation Therapy	covered in full	25% after deductible
Dialysis	covered in full	25% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	covered in full	25% after deductible
Inpatient Detoxification / Rehabilitation	covered in full	25% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	covered in full	25% after deductible
Outpatient Substance Abuse Services	covered in full	25% after deductible
Other Services		
Allergy Extracts and Injections	covered in full	25% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder	covered in full	25% after deductible
Assisted Fertilization Procedures (GIFT & ZIFT excluded)	See Service Category (i.e. lab, surgery, radiology)	
	Limit: 3 cycles/lifetime for in vitro fertilization	
Dental Services Related to Accidental Injury	See Service Category (i.e. lab, surgery, radiology)	
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	covered in full	25% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	covered in full	25% after deductible
Durable Medical Equipment and Supplies	50%	50% after deductible; 25% after deductible for diabetic equipment and supplies
Orthotics	50%	50% after deductible
Prosthetic Devices	covered in full; 50% for external prosthetics	25% after deductible; 50% after deductible for external prosthetics
Home Health Care	covered in full	25% after deductible benefit maximum of 365 visits/benefit period includes in-network visits
Hospice	covered in full	25% after deductible
	limit: 210 days/benefit period	
Infertility Counseling, Testing and Treatment	See Service Category (i.e. lab, surgery, radiology)	
Skilled Nursing Facility Care	covered in full	25% after deductible
Transplant Services	covered in full	25% after deductible

Prescription Drugs	
Prescription Drug Deductible Individual Family	 none none
Prescription Drug Program (5) Defined by the National Plus NY 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 (30/60/90-day Supply)** $0 / $0 / $0 Formulary generic copay $30 / $60 / $90 Non-Formulary generic copay $15 / $30 / $45 Formulary brand copay $30 / $60 / $90 Non-Formulary brand copay Cost-sharing for prescription insulin drugs will not exceed $100 for a 30-day supply **Select Specialty Drugs (31-day Supply)** $30 Non-Formulary copay $0 Formulary generic copay $15 Formulary brand copay **Maintenance Drugs through Mail Order (30/60/90-day Supply)** $0 / $0 / $0 Formulary generic copay $30 / $60 / $60 Non-Formulary generic copay $15 / $30 / $30 Formulary brand copay $30 / $60 / $60 Non-Formulary brand copay Cost-sharing for prescription insulin drugs will not exceed $100 for a 30-day supply

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

(1) Your group's benefit period is based on a 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) If you are enrolled in a "Family" plan, with your embedded deductible, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. With your embedded out-of-pocket maximum, once any eligible family member satisfies his/her individual out-of-pocket maximum, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family out-of-pocket maximum amount is met.

(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider.

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

(5) 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. Your plan requires that you use Accredo specialty pharmacy for select specialty medications. Your specialty medication may also qualify for additional savings facilitated by SaveOn SP. Contact member services for more detail.

Highmark Blue Cross Blue Shield of Western New York is a trade name of Highmark Western and Northeastern New York Inc., which is an independent licensee of the Blue Cross Blue Shield Association.

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.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা 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.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

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

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں.

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´dóó´ Customer Service bibéésh bee hane´é bikáʼígíí bich´j´dahodootnih.

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Lewistown-Porter Central School District
POS 200 $5/$10 - 10653006, 10653011, 10653001 - Plan B

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

Benefit	In Network	Out of Network
General Provisions		
Effective Date	**July 1, 2023**	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual Family	 None None	 $1,500 $3,000
Deductible Accumulation (2)	Not applicable	Embedded
Coinsurance - payment based on the plan allowance	Not applicable	25% after deductible
Out-of-Pocket Maximum (Includes coinsurance, copays, deductible, prescription drug cost sharing, and other qualified medical expenses). Once met, plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $6,350 $12,700	 $10,000 $20,000
Out-of-Pocket Accumulation (2)	Embedded	Embedded
Office/Urgent Care Visits		
Primary Care Provider Office Visits & Virtual Visits	$5 copay	25% after deductible
Specialist Office Visits & Virtual Visits	$10 copay	25% after deductible
Virtual Visit Provider Originating Site Fee	$10 copay	25% after deductible
Urgent Care Center Visits	$25 copay	$25 copay after in-network deductible
Telemedicine Services (3)	$5 copay	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 covered in full	 not covered
Adult Immunizations	covered in full	25% after deductible
Routine Gynecological Exams, including a Pap Test	covered in full	25% after deductible
Mammograms, Annual Routine	covered in full	25% after deductible
Mammograms, Medically Necessary	$10 copay for specialist; $5 copay for pcp	25% after deductible
Diagnostic Services and Procedures	covered in full	25% after deductible
Routine Pediatric Physical Exams	 covered in full	 25% after deductible
Pediatric Immunizations	covered in full	25% after deductible
Diagnostic Services and Procedures	covered in full	25% after deductible
Emergency Services		
Emergency Room Services	$150 copay (waived if admitted); $25 copay for freestanding urgent care facility	$150 copay (waived if admitted); $25 copay for freestanding urgent care facility after in-network deductible
Ambulance - Emergency and Non-Emergency	$50 copay	$50 copay after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	covered in full	25% after deductible
Outpatient Surgery	$75 copay	25% after deductible
Maternity (non-preventive professional services) including dependent daughter	$5 copay (copay on initial visit only)	25% after deductible
Medical Care (including inpatient visits and consultations)	covered in full	25% after deductible
Therapy and Rehabilitation Services		
Physical Therapy	$10 copay	25% after deductible

Benefit	In Network	Out of Network
	limit: 30 visits/benefit period aggregate with occupational therapy and speech therapy	
Respiratory Therapy	$10 copay	25% after deductible
	limit: 24 visits/benefit period for pulmonary rehabilitation	
Speech Therapy	$10 copay	25% after deductible
	limit: 30 visits/benefit period aggregate with occupational therapy and physical medicine	
Occupational Therapy	$10 copay	25% after deductible
	limit: 30 visits/benefit period aggregate with speech therapy and physical medicine	
Spinal Manipulations	$10 copay for specialist; $5 copay for pcp	25% after deductible
Cardiac Rehabilitation Therapy	$10 copay	25% after deductible
	limit: 24 visits/benefit period within a 12 week period	
Infusion Therapy	$10 copay	25% after deductible
Chemotherapy	$10 copay	25% after deductible
Radiation Therapy	$10 copay for specialist; $5 copay for pcp	25% after deductible
Dialysis	covered in full	25% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	covered in full	25% after deductible
Inpatient Detoxification / Rehabilitation	covered in full	25% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	$5 copay	25% after deductible
Outpatient Substance Abuse Services	$5 copay	25% after deductible
Other Services		
Allergy Extracts	covered in full	25% after deductible
Allergy Injections	$10 copay for specialist; $5 copay for pcp	25% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder	$5 copay	25% after deductible
Assisted Fertilization Procedures (GIFT & ZIFT excluded)	See Service Category (i.e. lab, surgery, radiology)	
	Limit: 3 cycles/lifetime for in vitro fertilization	
Dental Services Related to Accidental Injury	See Service Category (i.e. lab, surgery, radiology)	
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	$10 copay for specialist; $5 copay for pcp	25% after deductible
Standard Imaging	$10 copay for specialist; $5 copay for pcp	25% after deductible
Diagnostic Medical	$10 copay for specialist; $5 copay for pcp; $10 copay for sleep studies	25% after deductible
Pathology/Laboratory	covered in full	25% after deductible
Allergy Testing	$10 copay for specialist; $5 copay for pcp	25% after deductible
Durable Medical Equipment and Supplies	20%; $5 copay for diabetic supplies; $5 copay for diabetic equipment	50% after deductible; 25% after deductible for diabetic equipment and supplies
Orthotics	20%	not covered
Prosthetic Devices	covered in full; 20% for external prosthetics	25% after deductible
Home Health Care	$10 copay	25% after deductible benefit maximum of 365 visits/benefit period includes in-network visits
Hospice	covered in full	25% after deductible
	limit: 210 days/benefit period	
Infertility Counseling, Testing and Treatment	See Service Category (i.e. lab, surgery, radiology)	
Skilled Nursing Facility Care	covered in full	25% after deductible
Transplant Services	covered in full	25% after deductible

Prescription Drugs	
Prescription Drug Deductible Individual Family	 none none
Prescription Drug Program (5) Defined by the National Plus NY 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 (30/60/90-day Supply)** $5 / $10 / $15 Formulary generic copay $35 / $70 / $105 Non-Formulary generic copay $15 / $30 / $45 Formulary brand copay $35 / $70 / $105 Non-Formulary brand copay Cost-sharing for prescription insulin drugs will not exceed $100 for a 30-day supply **Select Specialty Drugs (31-day Supply)** $35 Non-Formulary copay $5 Formulary generic copay $15 Formulary brand copay **Maintenance Drugs through Mail Order (30/60/90-day Supply)** $5 / $10 / $10 Formulary generic copay $35 / $70 / $70 Non-Formulary generic copay $15 / $30 / $30 Formulary brand copay $35 / $70 / $70 Non-Formulary brand copay Cost-sharing for prescription insulin drugs will not exceed $100 for a 30-day supply

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

(1) Your group's benefit period is based on a 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) If you are enrolled in a "Family" plan, with your embedded deductible, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. With your embedded out-of-pocket maximum, once any eligible family member satisfies his/her individual out-of-pocket maximum, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family out-of-pocket maximum amount is met.

(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider.

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

(5) 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. Your plan requires that you use Accredo specialty pharmacy for select specialty medications. Your specialty medication may also qualify for additional savings facilitated by SaveOn SP. Contact member services for more detail.

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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.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা 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.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

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

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں.

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 bíká'ígíí bich´j´dahodootnih.

11699_09_21

Lewistown-Porter Central School District
POS 200 $25/$40 - 10653007, 10653012, 10653002 - Plan C

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

Benefit	In Network	Out of Network
General Provisions		
Effective Date	**July 1, 2023**	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual Family	 None None	 $1,500 $3,000
Deductible Accumulation (2)	Not applicable	Embedded
Coinsurance - payment based on the plan allowance	Not applicable	25% after deductible
Out-of-Pocket Maximum (Includes coinsurance, copays, deductible, prescription drug cost sharing and other qualified medical expenses). Once met, plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $6,350 $12,700	 $10,000 $20,000
Out-of-Pocket Accumulation (2)	Embedded	Embedded
Office/Urgent Care Visits		
Primary Care Provider Office Visits & Virtual Visits	$25 copay	25% after deductible
Specialist Office Visits & Virtual Visits	$40 copay	25% after deductible
Virtual Visit Provider Originating Site Fee	$40 copay for specialist; $25 copay for pcp	25% after deductible
Urgent Care Center Visits	$50 copay	$50 copay after in-network deductible
Telemedicine Services (3)	$25 copay	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 covered in full	 not covered
Adult Immunizations	covered in full	25% after deductible
Routine Gynecological Exams, including a Pap Test	covered in full	25% after deductible
Mammograms, Annual Routine	covered in full	25% after deductible
Mammograms, Medically Necessary	$40 copay for specialist; $25 copay for pcp	25% after deductible
Diagnostic Services and Procedures	covered in full	25% after deductible
Routine Pediatric Physical Exams	 covered in full	 25% after deductible
Pediatric Immunizations	covered in full	25% after deductible
Diagnostic Services and Procedures	covered in full	25% after deductible
Emergency Services		
Emergency Room Services	$150 copay (waived if admitted); $50 copay for freestanding urgent care facility	$150 copay (waived if admitted); $50 copay for freestanding urgent care facility after in-network deductible
Ambulance - Emergency and Non-Emergency	$150 copay	$150 copay after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	$500 inpatient copay/admission	25% after deductible
Outpatient Surgery	$150 copay	25% after deductible
Maternity (non-preventive professional services) including dependent daughter	$25 copay (copay on initial visit only)	25% after deductible
Medical Care (including inpatient visits and consultations)	covered in full	25% after deductible

Therapy and Rehabilitation Services		
Physical Therapy	$40 copay	25% after deductible
	limit: 30 visits/benefit period aggregate with occupational therapy and speech therapy	
Respiratory Therapy	$40 copay	25% after deductible
	limit: 24 visits per year in a 12 week period. for pulmonary rehabilitation	
Speech Therapy	$40 copay	25% after deductible
	limit: 30 visits/benefit period aggregate with occupational therapy and physical medicine	
Occupational Therapy	$40 copay	25% after deductible
	limit: 30 visits/benefit period aggregate with speech therapy and physical medicine	
Spinal Manipulations	$40 copay	25% after deductible
Cardiac Rehabilitation Therapy	$40 copay	25% after deductible
	limit: 24 visits per plan year in a 12 week period. Aggregate IN + OON	
Infusion Therapy	$40 copay for specialist; $25 copay for pcp	25% after deductible
Chemotherapy	$40 copay	25% after deductible
Radiation Therapy	$40 copay for specialist; $25 copay for pcp	25% after deductible
Dialysis	covered in full	25% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	$500 inpatient copay/admission	25% after deductible
Inpatient Detoxification / Rehabilitation	$500 inpatient copay/admission	25% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	$25 copay	25% after deductible
Outpatient Substance Abuse Services	$25 copay	25% after deductible
Other Services		
Allergy Extracts	covered in full	25% after deductible
Allergy Injections	$40 copay for specialist; $25 copay for pcp	25% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder	$25 copay	25% after deductible
Assisted Fertilization Procedures (GIFT & ZIFT excluded)	See Service Category (i.e. lab, surgery, radiology)	
	Limit: 3 cycles/lifetime for in vitro fertilization	
Dental Services Related to Accidental Injury	See Service Category (i.e. lab, surgery, radiology)	
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	$40 copay for specialist; $25 copay for pcp	25% after deductible
Standard Imaging	$40 copay for specialist; $25 copay for pcp	25% after deductible
Diagnostic Medical	$40 copay for specialist; $25 copay for pcp; $40 copay for sleep studies	25% after deductible
Pathology/Laboratory	covered in full	25% after deductible
Allergy Testing	$40 copay for specialist; $25 copay for pcp	25% after deductible
Durable Medical Equipment and Supplies	20%; $25 copay for diabetic supplies; $25 copay for diabetic equipment	50% after deductible; 25% after deductible for diabetic equipment and supplies
Orthotics	20%	not covered
Prosthetic Devices	covered in full; 20% for external prosthetics	25% after deductible
Home Health Care	$40 copay	25% after deductible benefit maximum of 365 visits/benefit period includes in-network visits
Hospice	covered in full	25% after deductible
	limit: 210 days/benefit period. IN & OON aggregate	
Infertility Counseling, Testing and Treatment	See Service Category (i.e. lab, surgery, radiology)	
Skilled Nursing Facility Care	$500 inpatient copay/admission	25% after deductible
Transplant Services	$500 inpatient copay/admission	25% after deductible

Prescription Drugs	
Prescription Drug Deductible Individual Family	 none none
Prescription Drug Program (5) Defined by the National Plus NY 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 (30/60/90-day Supply)** $10 / $20 / $30 Formulary generic copay $40 / $80 / $120 Non-Formulary generic copay $20 / $40 / $60 Formulary brand copay $40 / $80 / $120 Non-Formulary brand copay Cost-sharing for prescription insulin drugs will not exceed $100 for a 30-day supply **Select Specialty Drugs (31-day Supply)** $40 Non-Formulary copay $10 Formulary generic copay $20 Formulary brand copay **Maintenance Drugs through Mail Order (30/60/90-day Supply)** $10 / $20 / $20 Formulary generic copay $40 / $80 / $80 Non-Formulary generic copay $20 / $40 / $40 Formulary brand copay $40 / $80 / $80 Non-Formulary brand copay Cost-sharing for prescription insulin drugs will not exceed $100 for a 30-day supply

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.
(1) Your group's benefit period is based on a 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) If you are enrolled in a "Family" plan, with your embedded deductible, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. With your embedded out-of-pocket maximum, once any eligible family member satisfies his/her individual out-of-pocket maximum, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family out-of-pocket maximum amount is met.
(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) 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. Your plan requires that you use Accredo specialty pharmacy for select specialty medications. Your specialty medication may also qualify for additional savings facilitated by SaveOn SP. Contact member services for more detail.

Highmark Blue Cross Blue Shield of Western New York is a trade name of Highmark Western and Northeastern New York Inc., which is an independent licensee of the Blue Cross Blue Shield Association.

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)
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  - Qualified interpreters
  - Information written in other languages

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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.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা 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.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

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

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

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.

11699_09_21

Lewistown-Porter Central School District
POS 7200 $0/$0 - 10653004, 10653009, 10652999 - Plan D

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 you pay for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Effective Date	**July 1, 2023**	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual Family	 $1,400 $2,800	
Deductible Accumulation (2)	Non-Embedded	
Coinsurance - payment based on the plan allowance	0% after deductible	20% after deductible
Out-of-Pocket Maximum (Includes coinsurance, copays, deductible, prescription drug cost sharing, and other qualified medical expenses). Once met, plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $5,000 $10,000	 $10,000 $20,000
Out-of-Pocket Accumulation (2)	Embedded	Embedded
Office/Urgent Care Visits		
Primary Care Provider Office Visits & Virtual Visits	0% after deductible	20% after deductible
Specialist Office Visits & Virtual Visits	0% after deductible	20% after deductible
Virtual Visit Provider Originating Site Fee	0% after deductible	20% after deductible
Urgent Care Center Visits	0% after deductible	0% after in-network deductible
Telemedicine Services (3)	0% after deductible	not covered
Preventive Care (4)		
Routine Adult Physical Exams	covered in full	not covered
Adult Immunizations	covered in full	20% after deductible
Routine Gynecological Exams, including a Pap Test	covered in full	20% after deductible
Mammograms, Annual Routine	covered in full	20% after deductible
Mammograms, Medically Necessary	0% after deductible	20% after deductible
Diagnostic Services and Procedures	covered in full	20% after deductible
Routine Pediatric Physical Exams	covered in full	20% after deductible
Pediatric Immunizations	covered in full	20% after deductible
Diagnostic Services and Procedures	covered in full	20% after deductible
Emergency Services		
Emergency Room Services	0% after deductible	0% after in-network deductible
Ambulance - Emergency and Non-Emergency	0% after deductible	0% after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	$250 inpatient copay/admission after deductible	20% after deductible
Hospital Outpatient	0% after deductible	20% after deductible
Maternity (non-preventive professional services) including dependent daughter	0% after deductible	20% after deductible
Medical Care (including inpatient visits and consultations)	0% after deductible	20% after deductible
Therapy and Rehabilitation Services		
Physical Therapy	0% after deductible	20% after deductible
	limit: 60 visits/benefit period aggregate with occupational therapy and speech therapy	
Respiratory Therapy	0% after deductible	20% after deductible
	limit: 24 visits/benefit period for pulmonary rehabilitation	

Benefit	In Network	Out of Network
Speech Therapy	0% after deductible	20% after deductible
	limit: 60 visits/benefit period aggregate with occupational therapy and physical medicine	
Occupational Therapy	0% after deductible	20% after deductible
	limit: 60 visits/benefit period aggregate with speech therapy and physical medicine	
Spinal Manipulations	0% after deductible	20% after deductible
Cardiac Rehabilitation Therapy	0% after deductible	20% after deductible
	limit: 24 visits/benefit period	
Infusion Therapy	0% after deductible	20% after deductible
Chemotherapy	0% after deductible	20% after deductible
Radiation Therapy	0% after deductible	20% after deductible
Dialysis	0% after deductible	20% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	$250 inpatient copay/admission after deductible	20% after deductible
Inpatient Detoxification / Rehabilitation	$250 inpatient copay/admission after deductible	20% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	0% after deductible	20% after deductible
Outpatient Substance Abuse Services	0% after deductible	20% after deductible
Other Services		
Allergy Extracts and Injections	0% after deductible	20% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder	0% after deductible	20% after deductible
Assisted Fertilization Procedures (GIFT & ZIFT excluded)	See Service Category (i.e. lab, surgery, radiology)	
	Limit: 3 cycles/lifetime for in vitro fertilization	
Dental Services Related to Accidental Injury	See Service Category (i.e. lab, surgery, radiology)	
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	0% after deductible	20% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	0% after deductible	20% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	0% after deductible	20% after deductible
Home Health Care	0% after deductible	20% after deductible
	limit: 100 visits/benefit period aggregate with visiting nurse	
Hospice	0% after deductible	20% after deductible
Infertility Counseling, Testing and Treatment	See Service Category (i.e. lab, surgery, radiology)	
Skilled Nursing Facility Care	$250 inpatient copay/admission after deductible	20% after deductible
Transplant Services	$250 inpatient copay/admission after deductible	20% after deductible
Prescription Drugs		
Prescription Drug Deductible Individual Family	 Integrated with medical deductible Integrated with medical deductible	
Prescription Drug Program (5) Defined by the National Plus NY 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 (30/60/90-day Supply)** $0 / $0 / $0 Formulary generic copay after in-network deductible $50 / $100 / $150 Non-Formulary generic copay after in-network deductible $30 / $60 / $90 Formulary brand copay after in-network deductible $50 / $100 / $150 Non-Formulary brand copay after in-network deductible Cost-sharing for prescription insulin drugs will not exceed $100 for a 30-day supply **Select Specialty Drugs (31-day Supply)** $50 Non-Formulary copay after in-network deductible $0 Formulary generic copay after in-network deductible $30 Formulary brand copay after in-network deductible **Maintenance Drugs through Mail Order (30/60/90-day Supply)** $0 / $0 / $0 Formulary generic copay after in-network deductible $50 / $100 / $100 Non-Formulary generic copay after in-network deductible $30 / $60 / $50 Formulary brand copay after in-network deductible $50 / $100 / $100 Non-Formulary brand copay after in-network deductible	

Benefit	In Network	Out of Network
	Cost-sharing for prescription insulin drugs will not exceed $100 for a 30-day supply	

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(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) If you are enrolled in a "Family" plan, with your non-embedded deductible, the entire family deductible must be satisfied before claims reimbursement begins. With your embedded out-of-pocket maximum, once any eligible family member satisfies his/her individual out-of-pocket maximum, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family out-of-pocket maximum amount is met.
(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) 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. 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. Your plan requires that you use Accredo specialty pharmacy for select specialty medications.

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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.

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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.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা 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.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

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

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

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 bika'ígíí bich´j´ dahodootnih.

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Lewistown-Porter Central School District
PPO 800 $0/$0 - 10653008, 10653013, 10653003

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

Benefit	In Network	Out of Network
General Provisions		
Effective Date	**July 1, 2023**	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual Family	 None None	 $1,000 $2,000
Deductible Accumulation (2)	Not applicable	Embedded
Coinsurance - payment based on the plan allowance	Not applicable	25% after deductible
Out-of-Pocket Maximum (Includes coinsurance, copays, deductible, prescription drug cost sharing and other qualified medical expenses). Once met, plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $5,000 $10,000	 $5,000 $10,000
Out-of-Pocket Accumulation (2)	Embedded	Embedded
Office/Urgent Care Visits		
Primary Care Provider Office Visits & Virtual Visits	covered in full	25% after deductible
Specialist Office Visits & Virtual Visits	covered in full	25% after deductible
Virtual Visit Provider Originating Site Fee	covered in full	25% after deductible
Urgent Care Center Visits	covered in full	covered in full
Telemedicine Services (3)	covered in full	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 covered in full	 not covered
Adult Immunizations	covered in full	25% after deductible
Routine Gynecological Exams, including a Pap Test	covered in full	25% after deductible
Mammograms, Annual Routine	covered in full	25% after deductible
Mammograms, Medically Necessary	covered in full	25% after deductible
Diagnostic Services and Procedures	covered in full	25% after deductible
Routine Pediatric Physical Exams	 covered in full	 25% after deductible
Pediatric Immunizations	covered in full	25% after deductible
Diagnostic Services and Procedures	covered in full	25% after deductible
Emergency Services		
Emergency Room Services	$50 copay (waived if admitted);	
Ambulance - Emergency and Non-Emergency	$25 copay	$25 copay after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	covered in full	25% after deductible
Hospital Outpatient	covered in full	25% after deductible
Maternity (non-preventive professional services) including dependent daughter	covered in full	25% after deductible
Medical Care (including inpatient visits and consultations)	covered in full	25% after deductible

Therapy and Rehabilitation Services		
Physical Therapy	covered in full	25% after deductible
	limit: 45 visits/benefit period aggregate with occupational therapy and speech therapy	
Respiratory Therapy	covered in full	25% after deductible
	limit: 24 visits/benefit period for pulmonary rehabilitation	
Speech Therapy	covered in full	25% after deductible
	limit: 45 visits/benefit period aggregate with occupational therapy and physical medicine	
Occupational Therapy	covered in full	25% after deductible
	limit: 45 visits/benefit period aggregate with speech therapy and physical medicine	
Spinal Manipulations	covered in full	25% after deductible
Cardiac Rehabilitation Therapy	covered in full	25% after deductible
	limit: 24 visits/benefit period in a 12 week period. Aggregate IN + OON	
Infusion Therapy	covered in full	25% after deductible
Chemotherapy	covered in full	25% after deductible
Radiation Therapy	covered in full	25% after deductible
Dialysis	covered in full	25% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	covered in full	25% after deductible
Inpatient Detoxification / Rehabilitation	covered in full	25% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	covered in full	25% after deductible
Outpatient Substance Abuse Services	covered in full	25% after deductible
Other Services		
Allergy Extracts and Injections	covered in full	25% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder	covered in full	25% after deductible
Assisted Fertilization Procedures (GIFT & ZIFT excluded)	See Service Category (i.e. lab, surgery, radiology)	
	Limit: 3 cycles/lifetime for in vitro fertilization	
Dental Services Related to Accidental Injury	See Service Category (i.e. lab, surgery, radiology)	
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	covered in full	25% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	covered in full	25% after deductible
Durable Medical Equipment and Supplies	50%	50% after deductible; 25% after deductible for diabetic equipment and supplies
Orthotics	50%	50% after deductible
Prosthetic Devices	covered in full; 50% for external prosthetics	25% after deductible; 50% after deductible for external prosthetics
Home Health Care	covered in full	25% after deductible
Hospice	covered in full	25% after deductible
Infertility Counseling, Testing and Treatment	See Service Category (i.e. lab, surgery, radiology)	
Skilled Nursing Facility Care	covered in full	25% after deductible
Transplant Services	covered in full	25% after deductible

Prescription Drugs	
Prescription Drug Deductible Individual Family	 none none
Prescription Drug Program (5) Defined by the National Plus NY 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 (30/60/90-day Supply)** $0 / $0 / $0 Formulary generic copay $30 / $60 / $90 Non-Formulary generic copay $15 / $30 / $45 Formulary brand copay $30 / $60 / $90 Non-Formulary brand copay Cost-sharing for prescription insulin drugs will not exceed $100 for a 30-day supply **Select Specialty Drugs (31-day Supply)** $30 Non-Formulary copay $0 Formulary generic copay $15 Formulary brand copay **Maintenance Drugs through Mail Order (30/60/90-day Supply)** $0 / $0 / $0 Formulary generic copay $30 / $60 / $60 Non-Formulary generic copay $15 / $30 / $30 Formulary brand copay $30 / $60 / $60 Non-Formulary brand copay Cost-sharing for prescription insulin drugs will not exceed $100 for a 30-day supply

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.
(1) Your group's benefit period is based on a 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) If you are enrolled in a "Family" plan, with your embedded deductible, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. With your embedded out-of-pocket maximum, once any eligible family member satisfies his/her individual out-of-pocket maximum, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family out-of-pocket maximum amount is met.
(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) 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. Your plan requires that you use Accredo specialty pharmacy for select specialty medications. Your specialty medication may also qualify for additional savings facilitated by SaveOn SP. Contact member services for more detail.

Highmark Blue Cross Blue Shield of Western New York is a trade name of Highmark Western and Northeastern New York Inc., which is an independent licensee of the Blue Cross Blue Shield Association.

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).

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

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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.

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Vision Benefits for Large Groups Comprehensive Rider

Benefits	In-Network Member Cost		
Services			
Eye exam	Covered in full every year (includes dilated fundus evaluation)		
Frames			
Independent practitioners	Fashion and Designer Frames covered in full Premium Frames $25 member cost-share		
Retail	Covered in full up to $130, then 20% discount over $130		
Lens (uncoated plastic)			
Single vision	$0 member cost-share, 20% discount off retail on second purchase		
Bifocal	$0 member cost-share, 20% discount off retail on second purchase		
Trifocal	$0 member cost-share, 20% discount off retail on second purchase		
Lenticular	$0 member cost-share, 20% discount off retail on second purchase		
Lens Options (add to lens prices above)			
Antireflective coating (premium)	$48		
Antireflective coating (standard)	$35		
Blended segment lenses	$20		
Glass lenses	$0		
Gradient tint	$0		
Hi-index lenses	$55		
Polarized lenses	$75		
Solid tint	$0		
Standard scratch-resistant	$20		
Standard polycarbonate	$30		
Standard progressive (add-on to bifocal)	$50		
Transition lenses	$65		
UV coating	$12		
Contact Lens (available in lieu of spectacles)			
Conventional/disposable/planned replacement	Formulary: Four boxes/multipacks covered in full Non-formulary: $105 allowance (plus 15% discount on coverage)		
Other Add-Ons and Services			
Nonprescription sunglasses	10–20% discount off retail		
Other ancillary products/solutions	10–20% discount off retail		
Laser Vision Correction			
Laser vision correction procedure	Up to 40–50% discount off retail		
Frequency			
Examination	Annual		
Frames	Annual		
Lenses	Annual		
Contact lenses	Annual		
Out-of-Network Reimbursement			
Eye Examination: $30 / Single Vision Lenses: $25	Trifocal Lenses: $45	Disposable Contact Lenses: $75	
Frames: $30 / Bifocal Lenses: $35	Lenticular Lenses: $60	Conventional Contact Lenses: $75	

Davis Vision, an independent company, administers vision benefits on behalf of Highmark Blue Cross Blue Shield of Western New York. Members must receive services from a Davis Vision provider. Services out-of-network are reimbursed by Davis Vision. For more information on the Laser Vision Correction Discount Program available through Davis Vision, call 1-800-328-4728. To locate a provider near you, visit **Highmark.com/bcbswny**, **davisvision.com**, or contact Davis Vision at 1-800-999-5431.

You may choose any Fashion or Designer level frame from Davis Vision's Frame Collection, covered in full. If you select another frame in the network provider's office, a $130 credit and 20% discount[1] will be applied to any overage. This credit will also apply at retail locations that do not carry the Davis Vision Exclusive Collection. Members are responsible for the amount over $130 (less the applicable discount). Additional eyeglass purchases are subject to a 30% discount on the same transaction; additional eyeglass purchases on separate transactions are subject to a 20% discount.

1. Discounts not applicable at Walmart®, Sam's Club, or Costco locations or where limited by law or manufacturer restrictions.
2. Contact lens coverage varies by product selection.
3. Visually required contacts require prior approval.
4. Provider promotions and/or discounts may not be combined with insurance benefits or discounts.
5. Some limitations apply to additional discounts; discounts not applicable at all in-network providers. Davis Vision has done its best to accurately reflect plan coverage herein. If differences exist between this document and the plan contract, the contract will prevail.

No benefits shall be provided for:

- Vision services received or prescribed before the effective date of coverage or ordered after termination of coverage
- Examinations, frames, or lenses that are not necessary according to accepted standards of ophthalmic practice or that are not prescribed by the attending physician or by the optometrist
- Replacement of lost, stolen, broken, or damaged lenses, contact lenses, or frames, unless at the time of replacement the subscriber is otherwise entitled to benefits for the lenses for frames
- Industrial safety glasses, safety goggles, or sunglasses, whether or not they require a prescription
- Examinations, frames, or lenses required by the subscriber's employment
- Duplication of services: the benefits covered under this amendment are reduced by any benefits received under your contract or group plan

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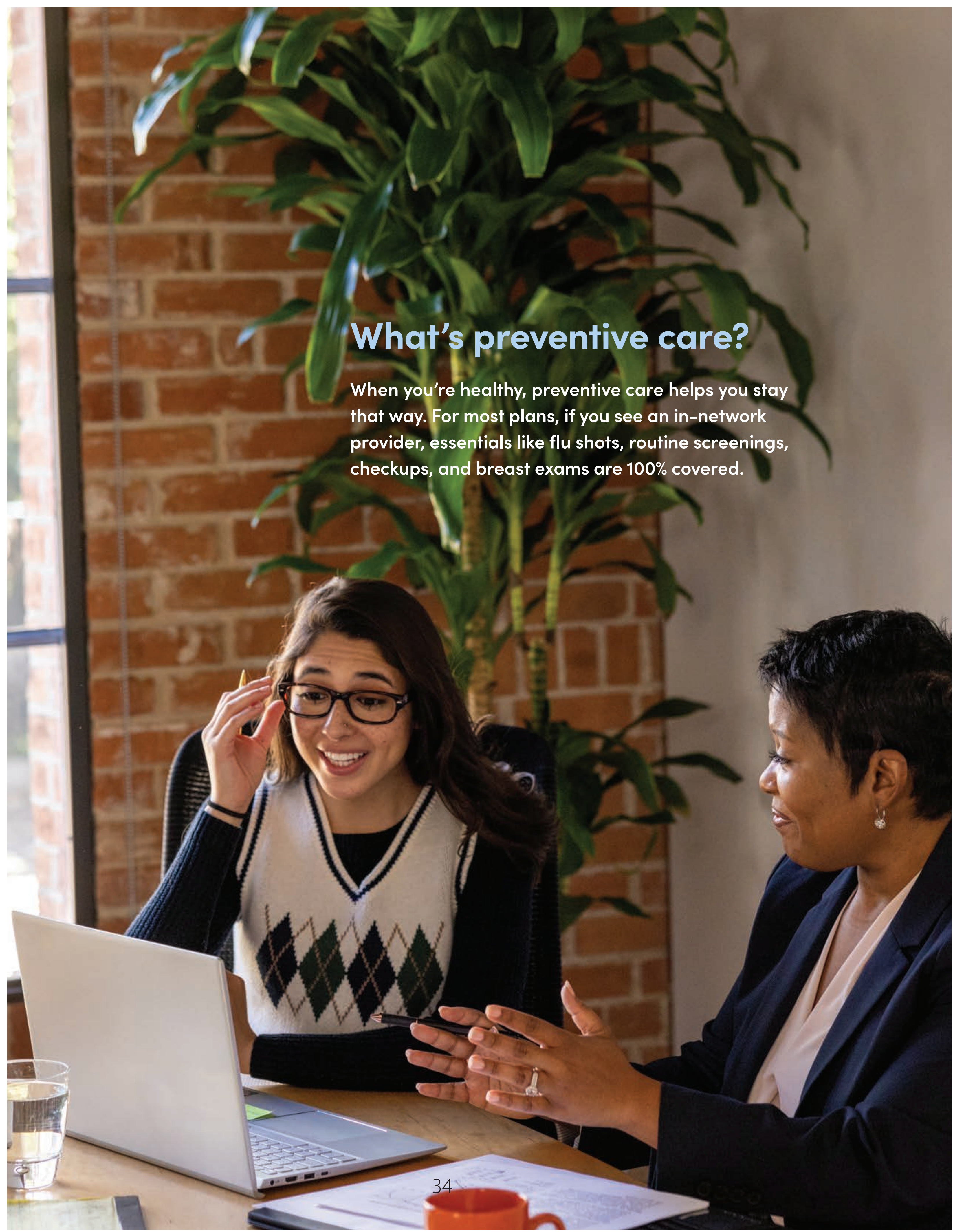
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-544-2583 (TTY 711).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-544-2583 (TTY 711)。

Preventive Schedule



What's preventive care?

When you're healthy, preventive care helps you stay that way. For most plans, if you see an in-network provider, essentials like flu shots, routine screenings, checkups, and breast exams are 100% covered.

2023 Preventive Schedule

Effective 1/1/2023

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

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

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

Questions?

Call Member Service

Ask your doctor

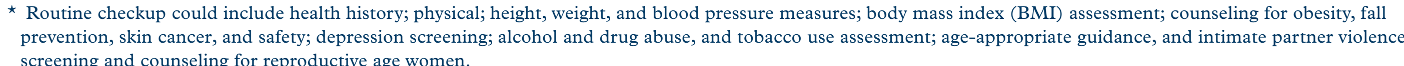
Log in to your account

Adults: Ages 19+

Female Male

GENERAL HEALTH CARE	
Routine Checkup* (This exam is not the work- or school-related physical)	• Ages 19 to 49: Every 1 to 2 years • Ages 50 and older: Once a year
Depression Screening	Once a year
Illicit Drug Use Screening	Once a year
Pelvic, Breast Exam	Once a year

SCREENINGS/PROCEDURES	
Abdominal Aortic Aneurysm Screening	Ages 65 to 75 who have ever smoked: One-time screening
Ambulatory Blood Pressure Monitoring	To confirm new diagnosis of high blood pressure before starting treatment
Breast Cancer Genetic (BRCA) Screening (Requires prior authorization)	Those meeting specific high-risk criteria: One-time genetic assessment for breast and ovarian cancer risk
Cholesterol (Lipid) Screening	• Ages 20 and older: Once every 5 years • High-risk: More often
Colon Cancer Screening (Including Colonoscopy)	• Ages 45 and older: Every 1 to 10 years, depending on screening test • High-risk: Earlier or more frequently
Colon Cancer Screening	Ages 45 and older: Colonoscopy following a positive result obtained within 1 year by other mandated screening method
Certain Colonoscopy Preps With Prescription	• Ages 45 and older: Once every 10 years • High-risk: Earlier or more frequently
Diabetes Screening	High-risk: Ages 40 and older, once every 3 years
Hepatitis B Screening	High-risk


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

* USPSTF mandated Routine Labs

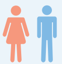
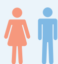
Adults: Ages 19+

SCREENINGS/PROCEDURES	
Hepatitis C Screening	Ages 18 to 79
Latent Tuberculosis Screening	High-risk
Lung Cancer Screening (Requires prior authorization and use of authorized facility)	Ages 50 to 80 with 20-pack per year history: Once a year for current smokers, or once a year if currently smoking or quit within past 15 years
Mammogram	Ages 35 and older: Once a year including 3D, breast MRIs and ultrasound
Osteoporosis (Bone Mineral Density) Screening	Ages 65 and older: Once every 2 years, or younger if at risk as recommended by physician
Cervical Cancer Screening	• Ages 21 to 65 Pap: Every 3 years, or annually, per doctor's advice • Ages 30 to 65: Every 5 years if HPV only or combined Pap and HPV are negative • Ages 65 and older: Per doctor's advice
Prostate Cancer Screening	Age 50 and over without symptoms, age 40 and over with family history of prostate cancer or other risk factors, or for any man with prior history of prostate cancer
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)	• Sexually active males and females • HIV screening for adults to age 65 in the general population and those at risk, then screening over age 65 with risk factors
IMMUNIZATIONS**	
Chicken Pox (Varicella)	Adults with no history of chicken pox: One 2-dose series
COVID-19 Vaccine	Per doctor's advice following CDC and Emergency Use Authorization Guidelines
Diphtheria, Tetanus (Td/Tdap)	One dose Tdap, then Td or Tdap booster every 10 years
Flu (Influenza)	Every year (Must get at your PCP's office or designated pharmacy vaccination provider; call Member Service to verify that your vaccination provider is in the Highmark network)
Haemophilus Influenzae Type B (Hib)	For adults with certain medical conditions to prevent meningitis, pneumonia, and other serious infections; this vaccine does not provide protection against the flu and does not replace the annual flu vaccine
Hepatitis A	At-risk or per doctor's advice: One 2- or 3-dose series
Hepatitis B	• Ages 19–59: 2 to 4 doses per doctor's advice • Ages 60 and older: High-risk per doctor's advice
Human Papillomavirus (HPV)	• To age 26: One 3-dose series • Ages 27 to 45, at-risk or per doctor's advice
Measles, Mumps, Rubella (MMR)	One or two doses
Meningitis*	At-risk or per doctor's advice
Pneumonia	High-risk or ages 65 and older: One or two doses, per lifetime

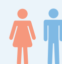
* Meningococcal B vaccine per doctor's advice.

** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network

IMMUNIZATIONS**		
	Shingles	• Shingrix - Ages 50 and older: Two doses • Ages 19 to 49: Immunocompromised per doctor's advice

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION		
	**Aspirin**	Pregnant women at risk for preeclampsia
	Folic Acid	Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid
	Chemoprevention drugs such as raloxifene, tamoxifen, or aromatase* inhibitor**	At risk for breast cancer, without a cancer diagnosis, ages 35 and older
	Tobacco Cessation (Counseling and medication)	Adults who use tobacco products
	**Low to Moderate Dose Select Generic Statin Drugs for Prevention of Cardiovascular Disease (CVD)**	Ages 40 to 75 years with 1 or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and have calculated 10-year risk of a cardiovascular event of 10% or greater
	Select PrEP Drugs and Certain Related Services for Prevention of HIV Infection	Adults at risk for HIV infection, without an HIV diagnosis

PREVENTIVE CARE FOR PREGNANT WOMEN			
	Screenings and Procedures	• Gestational diabetes screening • Hepatitis B screening and immunization, if needed • HIV screening • Syphilis screening • Smoking cessation counseling • Depression screening during pregnancy and postpartum • Depression prevention counseling during pregnancy and postpartum	• Rh typing at first visit • Rh antibody testing for Rh-negative women • Tdap with every pregnancy • Urine culture and sensitivity at first visit • Alcohol misuse screening and counseling • Nutritional counseling for pregnant women to promote healthy weight during the pregnancy

PREVENTION OF OBESITY, HEART DISEASE, DIABETES, AND STROKE			
	**Adults with BMI 25 to 29.9 (overweight) and 30 to 39.9 (obese) are eligible for:**	• Additional annual preventive office visits specifically for obesity and blood pressure measurement • Additional nutritional counseling visits specifically for obesity	• Recommended lab tests: – ALT – AST – Hemoglobin A1c or fasting glucose – Cholesterol screening
	Adults with a diagnosis of Hypertension, High Blood Pressure, Dyslipidemia, or Metabolic Syndrome	Nutritional counseling	
	Adults with BMI 40 and over	Nutritional counseling and fasting glucose screening	

*** Aromatase inhibitors when the other drugs can't be used such as when there is a contraindication or they are not tolerated.

2023 Preventive Schedule

Plan your child's care:
Know what your child needs and when to get it

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

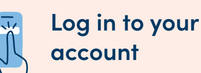
Services include Bright Futures recommendations. CHIP members may have additional preventive services and coverage. Please check the CHIP member booklet for further details of CHIP coverage of preventive services.

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

Questions?

Call Member Service

Ask your doctor



Log in to your account

Children: Birth to 30 Months[1]

GENERAL HEALTH CARE	BIRTH	1M	2M	4M	6M	9M	12M	15M	18M	24M	30M
Routine Checkup* (This exam is not the preschool- or day care-related physical.)	●	●	●	●	●	●	●	●	●	●	●
Hearing Screening	●										
SCREENINGS											
Autism Screening									●	●	
Critical Congenital Heart Disease (CCHD) Screening With Pulse Oximetry	●										
Developmental Screening						●			●		●
Hematocrit or Hemoglobin Anemia Screening							●				
Lead Screening**							●			●	
Newborn Blood Screening and Bilirubin	●										
IMMUNIZATIONS											
Chicken Pox							Dose 1				
COVID-19 Vaccine	Per doctor's advice following CDC and Emergency Use Authorization Guidelines										
Diphtheria, Tetanus, Pertussis (DTaP)			Dose 1	Dose 2	Dose 3			Dose 4			
Flu (Influenza)***					Ages 6 months to 30 months: 1 or 2 doses annually						
Haemophilus Influenzae Type B (Hib)			Dose 1	Dose 2	Dose 3		Dose 4				
Hepatitis A							Dose 1		Dose 2		
Hepatitis B	Dose 1	Dose 2			Dose 3						
Measles, Mumps, Rubella (MMR)							Dose 1				
Pneumonia			Dose 1	Dose 2	Dose 3		Dose 4				
Polio (IPV)			Dose 1	Dose 2	Ages 6 months to 18 months: Dose 3						
Rotavirus			Dose 1	Dose 2	Dose 3						

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance. Additional: Instrument vision screening to assess risk for ages 1 and 2 years.

** Per Bright Futures, and refer to state-specific recommendations as needed.

*** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.

Children: 3 Years to 18 Years[1]

GENERAL HEALTH CARE	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	15Y	18Y
Routine Checkup* (This exam is not the preschool- or day care-related physical)	●	●	●	●	●	●	●	●	Once a year from ages 11 to 18			
Ambulatory Blood Pressure Monitoring**												●
Depression Screening										Once a year from ages 12 to 18		
Illicit Drug Use Screening												●
Hearing Screening***		●	●	●		●		●		●	●	●
Visual Screening***	●	●	●	●		●		●		●	●	
SCREENINGS												
Hematocrit or Hemoglobin Anemia Screening			Annually for females during adolescence and when indicated									
Lead Screening	When indicated (Please also refer to your state-specific recommendations)											
Cholesterol (Lipid) Screening							Once between ages 9 to 11 and ages 17 to 21					
IMMUNIZATIONS												
Chicken Pox		Dose 2								If not previously vaccinated: Dose 1 and 2 (4 weeks apart)		
COVID-19 Vaccine	Per doctor's advice following CDC and Emergency Use Authorization Guidelines											
Dengue Vaccine							9–16 years living in dengue endemic areas in U.S. Territories AND have laboratory confirmation of previous dengue infection					
Diphtheria, Tetanus, Pertussis (DTaP)		Dose 5							One dose Tdap			
Flu (Influenza)****	Ages 3 to 18: 1 or 2 doses annually											
Human Papillomavirus (HPV)							Provides long-term protection against cervical and other cancers. 2 doses when started ages 9 to 14. 3 doses, all other ages.					
Measles, Mumps, Rubella (MMR)		Dose 2										
Meningitis*****									Dose 1		Age 16: One-time booster	
Pneumonia	Per doctor's advice											
Polio (IPV)		Dose 4										

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance; alcohol and drug abuse, and tobacco use assessment.

** To confirm new diagnosis of high blood pressure before starting treatment.

*** Hearing screening once between ages 11-14, 15-17, and 18-21. Vision screening covered when performed in doctor's office by having the child read letters of various sizes on a Snellen chart. Includes instrument vision screening for ages 3, 4, and 5 years. A comprehensive vision exam is performed by an ophthalmologist or optometrist and requires a vision benefit.

**** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.

*****Meningococcal B vaccine per doctor's advice.

CARE FOR PATIENTS WITH RISK FACTORS												
BRCA Mutation Screening (Requires prior authorization)					Per doctor's advice							
Cholesterol Screening	Screening will be done based on the child's family history and risk factors											
Fluoride Varnish (Must use primary care doctor)	Ages 5 and younger											
Hepatitis B Screening									Per doctor's advice			
Hepatitis C Screening												●
Latent Tuberculosis Screening												High-risk
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)									For all sexually active individuals HIV routine check, once between ages 13 to 18			
Tuberculin Test	Per doctor's advice											

Children: 6 Months to 18 Years[1]

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Oral Fluoride	For ages 6 months to 16 years whose primary water source is deficient in fluoride

PREVENTION OF OBESITY, HEART DISEASE, DIABETES, AND STROKE	
Children with a BMI in the 85th to 94th percentile (overweight) and the 95th to 98th percentile (obese) are eligible for:	• Additional annual preventive office visits specifically for obesity • Additional nutritional counseling visits specifically for obesity • Recommended lab tests: – Alanine aminotransferase (ALT) – Aspartate aminotransferase (AST) – Hemoglobin A1c or fasting glucose (FBS) – Cholesterol screening
Age 18 with a diagnosis of Hypertension, High Blood Pressure, Dyslipidemia, or Metabolic Syndrome	Nutritional counseling

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.

ר לף | דיש, ט קומער רוויס יער אין ייטוא יער ID רטל.

ব াংল ায় সহায়ত ার জন,, আপন ার আইিড কার 4ড তালক াভ 7 নঃরর ক র4 ত া পররর4 বায় ক ান ক:ন।

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

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

اومیں د لیے، ٹمر وس آپکےکارڈ ہنمبرپکال یں

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

رادو ان میں دکے، ٹمر وسکےلیے آئی ڈی کارڈ پردرج نمبرپکال یں.

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.

Information About the Affordable Care Act (ACA)

This schedule is a reference tool for planning your family's preventive care, and lists items and services required under the Affordable Care Act (ACA), as amended. It is reviewed and updated periodically based on the advice of the U.S. Preventive Services Task Force, laws and regulations, and updates to clinical guidelines established by national medical organizations. Accordingly, the content of this schedule is subject to change. Your specific needs for preventive services may vary according to your personal risk factors. Your doctor is always your best resource for determining if you're at increased risk for a condition. Some services may require prior authorization. If you have questions about this schedule, prior authorizations, or your benefit coverage, please call the Member Service number on the back of your member ID card.

[1]Information About Children's Health Insurance Program (CHIP)

Because the Children's Health Insurance Program (CHIP) is a government-sponsored program and not subject to ACA, certain preventive benefits may not apply to CHIP members and/or may be subject to copayments.

The ACA authorizes coverage for certain additional preventive care services. These services do not apply to "grandfathered" plans. These plans were established before March 23, 2010, and have not changed their benefit structure. If your health coverage is a grandfathered plan, you would have received notice of this in your benefit materials.

10/22 Z MX1950339

Prescription Drug Coverage

PRESCRIPTION DRUG BENEFITS

A pharmacy plan that fits your life.

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

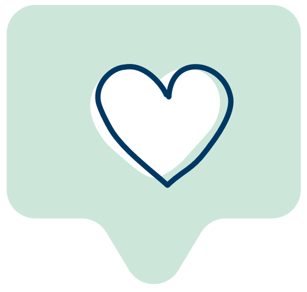
Knowing that, here are two important things to remember:

1. You'll usually save money by choosing a generic drug over a brand-name drug.
2. Our mail order service for maintenance prescription drugs is a convenient option that saves you trips to the pharmacy.

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

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

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



Programs to keep you safe while keeping drug costs down.

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

Prior Authorization:

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

Quantity Limits:

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

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

1. 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**.)

PARTICIPATING NATIONAL PLUS NETWORK PHARMACIES:

Over 63,000 pharmacies are in the National Plus network, including:

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

Wellness

HEALTH COACHES

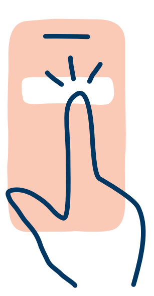
Personalized support for health goals.

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

BABY BLUEPRINTS®

Pregnancy advice, answers, and support.

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



SHARECARE®

Say hello to your online health and wellness hub.

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

Health Tools and Resources

ONLINE TOOLS & MEMBER WEBSITE

Your entire plan at your fingertips.

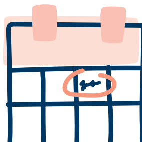
No more searching for old files or waiting on snail mail. Your digital ID card, Find a Doctor tool, deductible progress, and claims status are all available online at **highmark.com/bcbswny**.

CARE COST ESTIMATOR

Know what you'll owe for care.

Before making an appointment for a test, scan, or procedure, Care Cost Estimator helps you estimate your bill in advance.. Available on your member website, **highmark.com/bcbswny**.

MY CARE NAVIGATOR[SM]



Your appointments, booked for you.

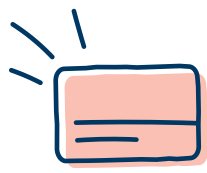
It's as simple as calling the phone number on the back of your member ID card or from the Highmark app. We'll help you find the in-network doctor you need and reserve some space on their calendar for a checkup. Which means less on-hold music for you.

BLUE365®

Discounts to help you stay healthy and active.

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

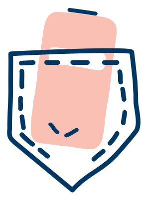
WELLNESS CARD



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 BCBSWNY PLAN APP



Your health plan in your pocket.

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

Additional Important Information

Health care lingo, translated.

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

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

COINSURANCE
The percentage you may owe for certain covered services after reaching your deductible. For example, if your plan pays 80%, you pay 20%.

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

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

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

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

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

MAXIMUM OUT-OF-POCKET
The most you'd pay for covered care. If you hit this amount, your plan pays after that.

Tiered – A network that offers access to most doctors and facilities in your area based on a tiered system — Enhanced and Standard. You generally pay less for the Enhanced level of benefits than the Standard level.

Narrow – Local networks specific to certain markets. They tend to be close to where you live. You have access to the doctors and facilities in that network.

OUT-OF-NETWORK PROVIDER
A doctor or hospital that generally charges more than your plan allowance for the same services.

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

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

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

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

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

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

How we approve what's covered.

Determining care for coverage

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

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

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

You are required to confirm that your provider obtained a prior authorization for any out-of-area services requiring authorization in advance of receiving the service. Beginning Aug. 8, 2021, this will also include advanced radiology and cardiac imaging. Call the Member Service number on the back of your member ID card or in the Highmark app to review your coverage and confirm if you need your provider to get a prior authorization.*

*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.

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

How we keep your information safe.

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

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

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

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

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

Care and case management

Programs for care support and complex condition management.

CARE MANAGEMENT PROGRAM

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

Services under the Care Management Program:

Precertification Review starts before you get care and:

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

Concurrent Review happens during the course of treatment to:

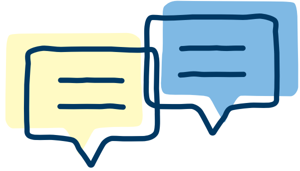
- Assess the medical need to continue treatment.
- Evaluate the right level of care for treatment.
- Foresee any possible quality of care concerns.
- Identify situations that require a physician consultation.
- Determine potential case or condition management benefits.
- Update and/or revise the discharge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

Discharge Planning occurs throughout the course of treatment to:

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

Retrospective Review happens after services have been provided and:

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



CASE MANAGEMENT PROGRAM

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

Individual goals of Case Management:

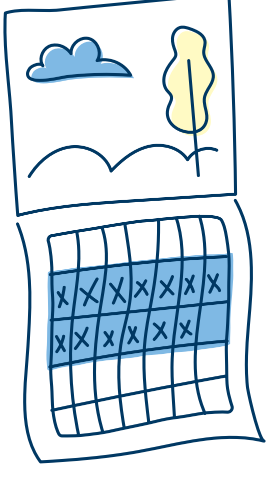
- Identify and resolve gaps in care
- Assure the right care at the right time through appropriate facilities and providers
- Increase members' understanding of their condition or situation
- Reduce medication inconsistencies and ensure correct use of prescribed medications
- Address any caregiver issues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

How the Case Management Program works:

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

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

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



Prior authorization for out-of-area services

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

The provider may also call Provider Services to determine if a prior authorization for proposed service is required.

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

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

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

Let's break this down a little more.

You and your provider agree on a service that you need.

Your provider lets Highmark BCBSWNY know all of the details about the procedure. **You should stay in contact with your provider.**

Highmark BCBSWNY will review your requested service.

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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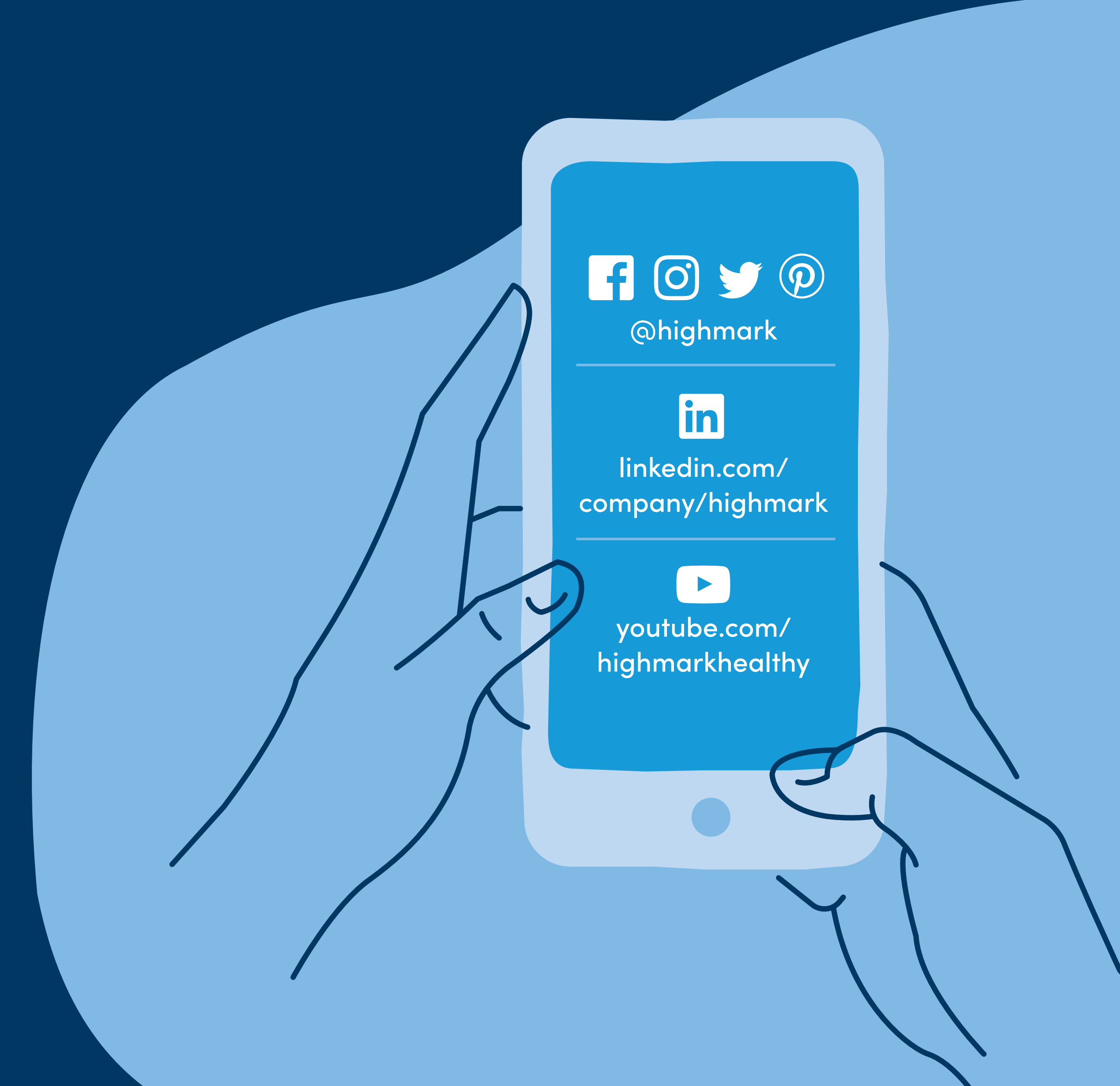
Highmark Blue Cross Blue Shield of Western New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-735-4515 (TTY 711).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-833-735-4515 (TTY 711)。

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.