

A man with short dark hair, wearing a red and white plaid shirt over a beige t-shirt and khaki pants, is sitting in the driver's seat of a truck. He is holding a smartphone to his ear with his right hand and looking out the window. The interior of the truck is visible, including the steering wheel and dashboard. The background outside the window shows a bright orange wall and a clear blue sky.

Better benefits.
Easier access.
More life.

Care that keeps up with your life.

Wherever you are, we've got you covered.



PPO 800 Copay

Scotia Glenville Central School District

PPO 800

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 Shield of Northeastern 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.

A handwritten signature in black ink, appearing to read "Dr. Edbauer". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Dr. Michael Edbauer

President, Highmark Western and Northeastern New York

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Why Highmark



BLUES ON CALLSM

Answers from a health pro, 24/7.

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



DIABETES PREVENTION PROGRAM

Tips on how to avoid diabetes.

Lower your risk with simple, effective, practical strategies.



DISEASE MANAGEMENT PROGRAMS

Help managing chronic conditions.

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



EMERGENCY CARE

When you need it most, you're covered.

Emergency care is always covered at the in-network level, 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.



MATERNITY CARE

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

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

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

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

Baby Blueprints® Program

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

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



Women's health

The importance of regular mammograms.

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

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

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

Your health and your rights.

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

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

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



Women's health (cont.)

The breast-feeding law and you.

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

Hospital stays for new mothers.

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

Product Information /Benefit Summary



PPO 800 Copay

Here's how Highmark Blue Shield NENY 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/blueshieldnyny](https://www.highmark.com/blueshieldnyny).
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.



**Benefit Summary for Group:
CASHIC-Scotia-Glenville CSD
Effective Date: 7/1/2023**

	PPO 800		
	In-Network	Out-of-Network	Additional Information
General Information			
Provider Network	PPO Network		
Deductible	N/A	\$250 single / \$500 family	
Deductible Administration Type	None	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	
Coinsurance	N/A	20% coinsurance after deductible	
Out of Pocket Maximum	\$6,850 single / \$13,700 family	\$2,500 single / \$5,000 family	
Out of Pocket Administration Type	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	
Benefit Administration Date	1/1		
Dependent Coverage			
Dependent Age	26/26		
Dependent Coverage Ends	End of birth month		
Domestic Partner and Children	Includes coverage for domestic partner and children		
Prescription Drug Coverage			
Prescription Drugs	\$5/\$20/\$35	Not Covered	
Mail Order	2 copays per 90 day supply	Not Covered	

	PPO 800		
	In-Network	Out-of-Network	Additional Information
Physician and Other Services			
Primary Office Visit	\$25 copayment	20% coinsurance after deductible	
Specialist Office Visit	\$25 copayment	20% coinsurance after deductible	
Telemedicine	Covered in full	Not covered	
Allergy Injections	Covered in full	20% coinsurance after deductible	
Allergy Testing	Covered in full	20% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	\$25 copayment/\$25 copayment	20% coinsurance after deductible	
PCP Copay/Coinsurance for Dependents up to age 19	\$25 copayment	20% coinsurance after deductible	
Specialist Copay/Coinsurance for Dependents up to age 19	\$25 copayment	20% coinsurance after deductible	
Emergency and Urgent Care Services			
Emergency Room	\$150 copayment	Covered as in-network	Prudent layperson language applies. Emergency Room cost-share waived if admitted; inpatient benefits now apply.
Ambulance	\$150 copayment	Covered as in-network	
Urgent Care Center	\$35 copayment	Covered as in-network	
Preventive Services			
Bone mineral density measurement or test	Covered in full	20% coinsurance after deductible	
Cholesterol Test (lipid panel)	Covered in full	20% coinsurance after deductible	
Immunizations	Covered in full	20% coinsurance after deductible	
Mammogram	Covered in full	20% coinsurance after deductible	
Pap Smear	Covered in full	20% coinsurance after deductible	
Routine Physical Exam	Covered in full	Not covered	
Prostate Test (Prostate Specific Antigen "PSA")	Covered in full	20% coinsurance after deductible	
Well Child Visits	Covered in full	20% coinsurance after deductible	
Hospital Services			
Inpatient Hospital	\$250 per admission, not to exceed \$500 single/\$750 family	20% coinsurance after deductible	

	PPO 800		
	In-Network	Out-of-Network	Additional Information
Hospital Services			
Outpatient Surgical Procedure (Facility)	\$100 copayment	20% coinsurance after deductible	Prior auth required for certain procedures. Follow Corporate guidelines.
Skilled Nursing Facility	\$250 per admission, not to exceed \$500 single/\$750 family	20% coinsurance after deductible	Unlimited Days
Diagnostic Testing Services			
Laboratory Tests	\$25 copayment	20% coinsurance after deductible	
Radiology	\$25 copayment	20% coinsurance after deductible	
Maternity Services			
Physician Services: Prenatal and Postnatal Care (initial visit)	\$25 copayment/\$25 copayment	20% coinsurance after deductible	
Inpatient Maternity	\$250 per admission, not to exceed \$500 single/\$750 family	20% coinsurance after deductible	One cost share applies to both maternity and newborn services. No separate cost share for newborns, but will apply to NICU.
Mental Health and Substance Abuse			
Inpatient Mental Health	\$250 per admission, not to exceed \$500 single/\$750 family	20% coinsurance after deductible	
Outpatient Mental Health	Covered in full	20% coinsurance after deductible	
Inpatient Substance Abuse - Rehab	\$250 per admission, not to exceed \$500 single/\$750 family	20% coinsurance after deductible	
Inpatient Substance Abuse - Detox	\$250 per admission, not to exceed \$500 single/\$750 family	20% coinsurance after deductible	
Outpatient Substance Abuse	Covered in full	20% coinsurance after deductible	
Diabetic Supplies and Services			
Diabetic Equipment	\$25 copayment	20% coinsurance after deductible	
Insulin and Other Oral Agents	\$25 copayment	20% coinsurance after deductible	If administered by pharmacy vendor copay is lesser of Rx or office visit copay.
Diabetic Medical Supplies (Test strips, Syringes, etc)	\$25 copayment	20% coinsurance after deductible	

	PPO 800		
	In-Network	Out-of-Network	Additional Information
Rehabilitation Services			
Chiropractic Care	\$25 copayment/\$25 copayment	20% coinsurance after deductible	
Physical - Occupational - Speech Therapies	\$25 copayment/\$25 copayment	20% coinsurance after deductible	60 visits, aggregate IN & OON with PT/OT/ST, per plan year
Pulmonary Rehabilitation	\$25 copayment/\$25 copayment	20% coinsurance after deductible	
Additional Services			
Chemotherapy - Outpatient Facility	Covered in full	20% coinsurance after deductible	
Durable Medical Equipment	Covered in full	50% coinsurance after deductible	
Home Health Care	\$25 copayment/\$25 copayment	20% coinsurance after deductible	100 Visits IN & OON
Hospice	\$25 copayment/\$25 copayment	20% coinsurance after deductible	
Prosthetics & orthotics	20% coinsurance	Not covered	
Dialysis	Covered in full	20% coinsurance after deductible	
Wellness Card	Not covered	Not covered	
Pediatric Vision Services			
Routine Exam	Covered in full	Not covered	1 every calendar year
Medical Eye Exam	\$25 copayment/\$25 copayment	20% coinsurance after deductible	
Adult Vision Services			
Routine Exam	Covered in full	Not covered	1 every calendar year
Medical Eye Exam	\$25 copayment/\$25 copayment	20% coinsurance after deductible	

*Cost share may vary based on place of service for services listed above.

**For a list of Medicare Part D creditable coverage prescription drug plans, please refer to our website.

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Wellness



HEALTH COACHES

Personalized support for health goals.

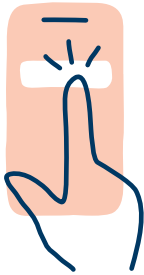
Looking to lose weight? Quit smoking? Be more active? A wellness coach can create a personalized plan for you, right over the phone, on your schedule. Sessions are free and confidential.



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/blueshieldnyny.

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/blueshieldnyny.

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/bsnyny.

HIGHMARK BSNENY 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.

*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.

Determining care for coverage

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

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

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

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

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

How we keep your information safe.

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

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

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

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

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



Care and case management

Programs for care support and complex condition management.

CARE MANAGEMENT PROGRAM

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

Services under the Care Management Program:

Precertification Review starts before you get care and:

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

Concurrent Review happens during the course of treatment to:

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

Discharge Planning occurs throughout the course of treatment to:

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

Retrospective Review happens after services have been provided and:

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



CASE MANAGEMENT PROGRAM

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

Individual goals of Case Management:

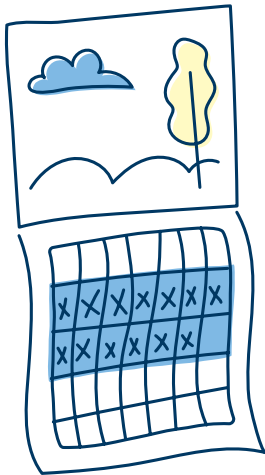
- Identify and resolve gaps in care
- Assure the right care at the right time through appropriate facilities and providers
- Increase members' understanding of their condition or situation
- Reduce medication inconsistencies and ensure correct use of prescribed medications
- Address any caregiver issues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

How the Case Management Program works:

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

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

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



Prior authorization for out-of-area services

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

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

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

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

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

Let's break this down a little more.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*This is not a contract.



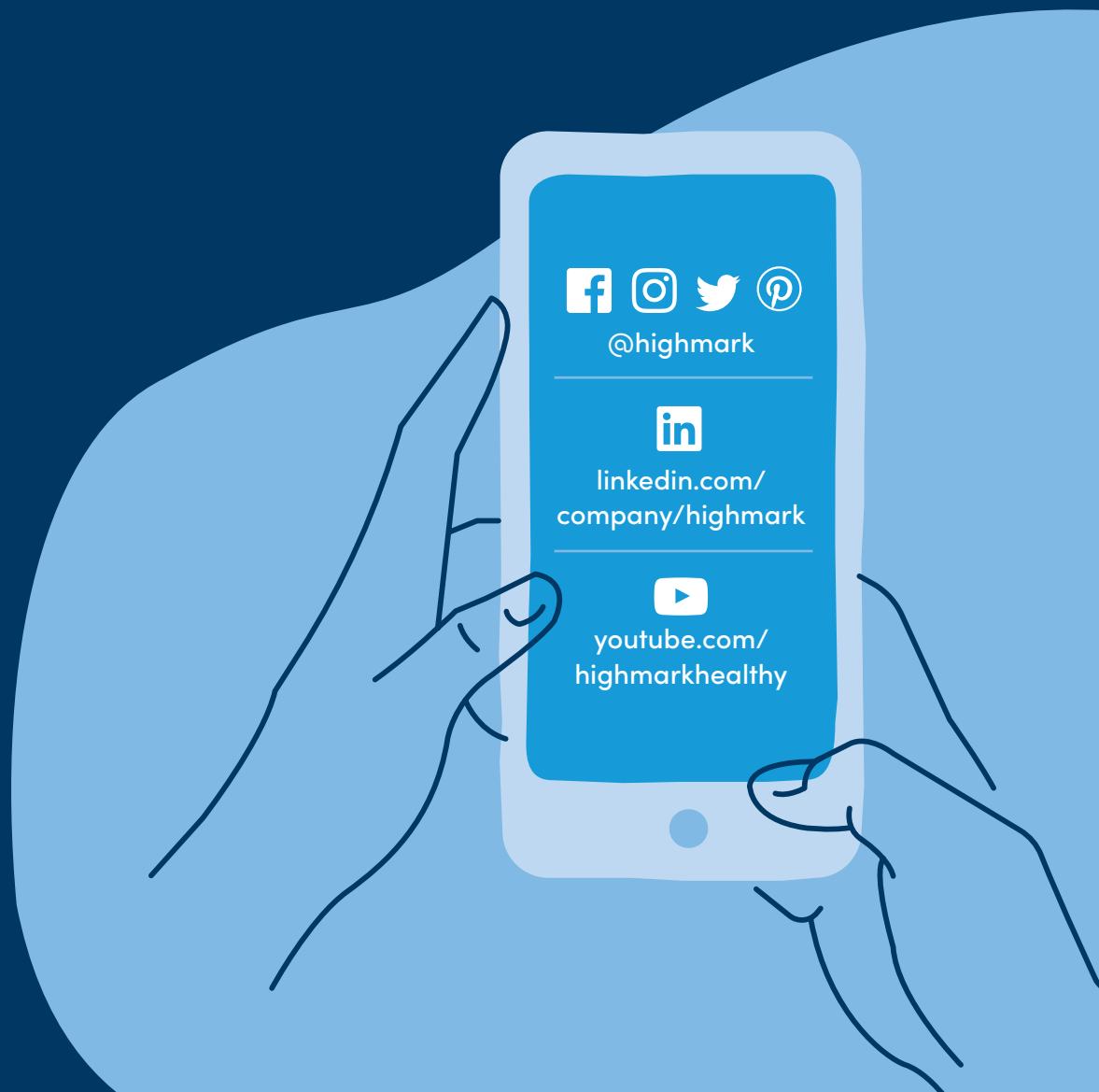
Highmark Blue Shield of Northeastern New York is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association.

Highmark Blue Shield of Northeastern 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.**