2024 Annual Notices

Inside this issue:

BENECON

Introduction

This newsletter contains important information. We encourage you to read all sections. If you have questions regarding any items contained in this newsletter, please contact your Human Resources office or plan administrator for more information.

We hope you find this information helpful and informative.

Summary of Benefits and Coverage

The Health Care Reform law states that all groups must implement the requirement that health plans and health insurers provide consumers with a Summary of Benefits and Coverage (SBC). The stated purpose of the SBC is to "accurately describe the benefits and coverage under the applicable plan or coverage," which will allow participants to better compare plan terms and benefits.

In addition, all group health plans will have to distribute a brief standard summary of benefits and must use and distribute a uniform glossary containing definitions for common terms (e.g. "copay", "deductible", etc.).

This should be distributed annually, no later than December 1st and within seven days per any employee request. The medical SBC will be created by the insurance carrier and provided to each group for distribution.

In addition, if your group has a stand-alone HRA or FSA that covers expenses beyond excepted benefits, then the plan sponsor, not the insurance carrier, will create and distribute that SBC.

Special Enrollment Rights Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days of the other coverage end date (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption. .

To request special enrollment or obtain more information, contact your Human Resources Office or Plan Administrator.

WHCRA Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For more information on WHCRA benefits, contact your Plan Administrator.

Patient Protections Disclosure Notice

You do not need prior authorization from the carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your insurance carrier by calling the number on the back of your ID card.

FOR GROUPS WITH HMO PLANS:
The employer's group health plan generally requires or allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carrier by calling the number on the back of your ID card.

Notice of Availability of Notice of Privacy Practices

This Notice of Privacy Practices (the "Notice") describes the legal obligations of your group health plan (the Plan) and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, this Notice describes how your protected health information (PHI) may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information" or "PHI" PHI is any individually identifiable information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan that relates to:

◊ Your past, present or future physical or mental health or condition;
◊ The provision of health care to you; or
◊ The past, present or future payment for the provision of health care to you.

A copy of the Notice of Privacy Practices is available to all individuals whose PHI will be used or maintained by the Plan. If you any questions about this Notice, please contact your Human Resources office or plan administrator.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, **visit www.pennie.com(in Pennsylvania) or www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDSNOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA** (**3272**).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your state for more information on eligibility -

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NEW JERSEY – Medicaid and CHIP

Medicaid Website:

http://www.state.nj.us/humanservices/dmahs/clients/medicaid/

Medicaid Phone: 609-631-2392

CHIP Website:

http://www.njfamilycare.org/index.html

CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website:

https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

PENNSYLVANIA – Medicaid

Website:

https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx

Phone: 1-800-692-7462

To see if any other states have added a premium assistance program since July 31, 2023 or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 01/31/2026)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

FLORIDA– Medicaid
Website: **https://www.flmedicaidtplrecovery.com/hipp/index/html** Phone: 1-877-357-3268

VIRGINIA – Medicaid and CHIP
Website: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select** **https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs** Medicaid/CHIP Phone: 1-800-432-5924

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U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an innetwork facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network. Contact the Pennsylvania Insurance Department at www.insurance.pa.gov/nosurprises or by phone at 1-877-881-6388 or TTY/TDD: 717-783-3898 if you have difficulty finding a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  * Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  * Cover emergency services by out-of-network providers.
  * Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  * Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Pennsylvania Insurance Department at **www.insurance.pa.gov/nosurprises** or by phone at **1-877-881-6388 or TTY/TDD: 717-783-3898.**

Visit **www.insurance.pa.gov/nosurprises** for more information about your rights under federal and state law. You may also visit https://www.cms.gov/nosurprises for information from the federal government.

Notice of Dependent Enrollment Limitations

Newborns: Must be enrolled within **30 days** of birth. If they are not enrolled within this time frame, they are not eligible until the next open enrollment period. If no open enrollment period exists, they are not eligible until a Life Status Event occurs (which may not occur in many instances).

Adoption/Judgments/Decrees/Etc.: Must be enrolled as of effective date listed on legal documentation. Refer to Plan Document on day limitation (i.e. 30 or 60 days to enroll).

Newborns' Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less cesarean section.

However, Federal law generally does not prohibit the mother's or newborns attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or96 hours).

BENECON

Save on your health journey.

Join Blue365℠ for FREE to get the savings you need and achieve a healthier you.

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Simply register at **blue365deals.com** for offers like up to 55% off select Garmin® and Fitbit® products through Heart Rate Monitors USA. You also have access to thousands of gyms nationwide for a low monthly fee through Tivity Health.

It's exclusively for members, so make sure to have your member ID handy when you sign up.

Once you've registered at blue365deals.com, you'll receive weekly deals in your inbox.

Blue365 offers exclusive savings opportunities from over 70 partners, including:

fitness your way by Tivity Health

Reebok

jenny CRAIG

GARMIN.

SKECHERS

TruHearing

crocs™

sunbasket

Use this checklist to save money on your prescriptions.

If you're struggling with the cost of prescription drugs, check out these six easy ways to save. Check with your plan to see if they offer similar options.

Go generic.

Review your medications with your doctor or pharmacist regularly to see if new generic drugs are available.

Use your FSA, HSA, or HRA.

Spending accounts let you set aside money before taxes, so you can use those tax-free dollars to help pay for your prescriptions.

Research reward programs.

Most retail pharmacies offer reward programs with discounts on purchases.

Get copay assistance.

Manufacturer assistance programs can help reduce or eliminate your copays and other out-of-pocket costs.

Ask for a 90-day supply.*

Your plan may offer a 90-day supply of routine medications for a lower copay — leading to significant savings over the year.

Sign up for home delivery.**

Skip a trip to the pharmacy and you could save even more.

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Because Life.™

DIAGNOSTIC VERSUS PREVENTIVE CARE

Find the right provider for you.

Having a PCP you can count on makes all the difference.

Your primary care provider (PCP) is your first line of defense and key to navigating the health care system. Over time, they'll get to know your health history, which helps them guide you and catch any changes or problems early.

If you're not sure where to start, our **Find a Doctor** tool makes it easy to search for an in-network PCP close to home. Here's how it works:

To find a PCP, visit **highmarkbcbs.com**.

Select the **Find a Doctor or Pharmacy** tab.

Search by specialty, location, and more.

We can help with your search. Just call the number on the back of your member ID card and we can walk you through finding a PCP.

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Quick tip:

At your first appointment, talk to your PCP about virtual health options, so you can get care without even leaving home.

Because Life.™

Health benefits or health benefit administration may be provided by or through Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Coverage Advantage, Highmark Benefits Group, First Priority Health, First Priority Life or Highmark Senior Health Company, all of which are independent licensees of the Blue Cross Blue Shield Association.

Highmark Choice Company and Highmark Senior Health Company are Medicare Advantage plans with a Medicare contract. Enrollment in Highmark Choice Company and Highmark Senior Health Company depends on contract renewal.

All references to "Highmark" in this communication are references to Highmark Inc., an independent licensee of the Blue Cross Blue Shield Association, and/or to one or more of its affiliated Blue companies.

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.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

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How Can I Pay Two Different Amounts for the Same Procedure?

YOUR BENEFIT PAYMENT DEPENDS ON HOW YOUR DOCTOR CODES YOUR PROCEDURE

Preventive care, or routine care, is typically covered at 100%. Diagnostic tests — screenings performed for treating or diagnosing a medical condition — are typically covered at your plan's standard benefit level.

WHAT'S THE DIFFERENCE?

In general, the reason for the exam. When you see a doctor for routine care, you would not have symptoms or a previous medical history that would require the doctor to perform the procedure(s). When you receive diagnostic care, the doctor is performing the procedure(s) to find out what is wrong with you or to treat your condition.

QUESTIONS?

If you or your doctor have questions about the administration of the care as listed on the schedule, please call Member Service at the number listed on the back of your ID card.

TO ACCESS THE BLUE CROSS BLUE SHIELD PREVENTIVE SCHEDULE ON OUR WEBSITE:

Log on to **highmarkbcbs.com** (If you do not have a login ID, you'll need to click on the "Register Now" link). Click on the "Health & Wellness," "Healthy Living" and "Prevention" links. You can also call Member Service for a copy of the schedule.

If you are a 50-year-old male, you should have the following preventive care:

- ❑ Routine physical exam
- ❑ Colorectal cancer screening
- ❑ Cholesterol screening

If you are a 40-year-old female, you should have the following preventive care:

- ❑ Routine physical exam
- ❑ Pap test
- ❑ Mammogram
- ❑ Pelvic exam

If you are a 50-year-old female, you should have the following preventive care:

- ❑ Routine physical exam
- ❑ Colorectal cancer screening
- ❑ Pap test
- ❑ Mammogram
- ❑ Cholesterol screening

SEE THE FOLLOWING EXAMPLES:

John, Janice, and Judy have procedures performed by their network physicians. All three have the same PPO plan. However, they pay different amounts for their care because John is receiving preventive care, Janice is receiving diagnostic care, and Judy is receiving both.

John	Janice	Judy
Reason for exam: John turned 40 and figured he should have an annual exam and "once over" to see how his health is.	**Reason for exam:** Janice is a diabetic and is recovering from a near heart attack. The doctor put her on a strict diet and exercise regime and wants to perform follow-up tests to measure her improvement.	**Reason for exam:** Judy needs to follow up with her doctor to see if the cholesterol-reducing medication is working. While there, she decides to take care of her routine physical and get a flu shot, because flu season is coming.
Procedures performed: • Physical Exam • Blood Pressure • Cholesterol Screening • Lipid Panel • Fasting Blood Glucose • Urinalysis	**Procedures performed:** • Physical Exam • Blood Pressure • Cholesterol Screening • Lipid Panel • Fasting Blood Glucose • Urinalysis	**Procedures performed:** • Lipid Panel • Physical Exam • Flu Shot • Urinalysis
Doctor codes and submits as: Routine	**Doctor codes and submits as:** Diagnostic	**Doctor codes and submits as:** Some procedures as diagnostic, some as routine.
Benefit payment: All of these procedures are covered at 100%.	**Benefit payment:** All of these procedures and office visits are covered at the standard benefit level.	**Benefit payment:** Procedures billed as routine will be covered at 100%. Procedures billed as diagnostic will be covered at the standard benefit level.

What Preventive Care Do I Have Coverage For?

The Blue Cross Blue Shield Preventive Schedule is a list of general care guidelines. We encourage you to take a copy of the schedule with you when you or a family member visits their medical provider.

The schedule includes tests that are performed for both routine and diagnostic reasons. If you are seeing your doctor and have not been diagnosed with a medical condition, you should expect the services to be performed for routine/preventive care and covered at 100%, not subject to deductible or coinsurance. Only those procedures that are listed on the Preventive Schedule are covered at 100% with no deductible during a preventive exam. If your doctor orders other tests, those tests may be subject to your deductible and/or coinsurance, or they may be denied in certain instances. If you have a medical condition and the tests are being done to monitor the condition, then the services would be performed for diagnostic reasons and subject to your program's deductible and coinsurance.

Sample of Preventive Benefits

Benefits for adults	**When submitted by your doctor as routine**	**When submitted by your doctor as diagnostic**
Routine physical exams	100%	standard plan payment level
Routine gynecological exams, including a Pap Test	100%	standard plan payment level
Mammograms, as required*	100%	standard plan payment level
Colorectal Cancer Screening*	100%	standard plan payment level

Insurance carriers may differ in their preventive care schedules. If you or your doctor has questions about the administration of the care as listed on the schedule, please call Member Service at the number listed on the back of your ID card.

* See the Preventive Schedule for specific procedures and risk factors.

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

Discrimination is Against the Law

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

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

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

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

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

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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09/20 Z MX135204

Because Life.™

*90-day supply does not apply to Delaware fully insured members.

**Home delivery does not apply to West Virginia and Delaware fully insured members.

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07/22 MX1766258

01/23 MX2275086

Not feeling up to leaving your couch?

My Highmark brings together everything you need to manage your health — all in one place. You can:

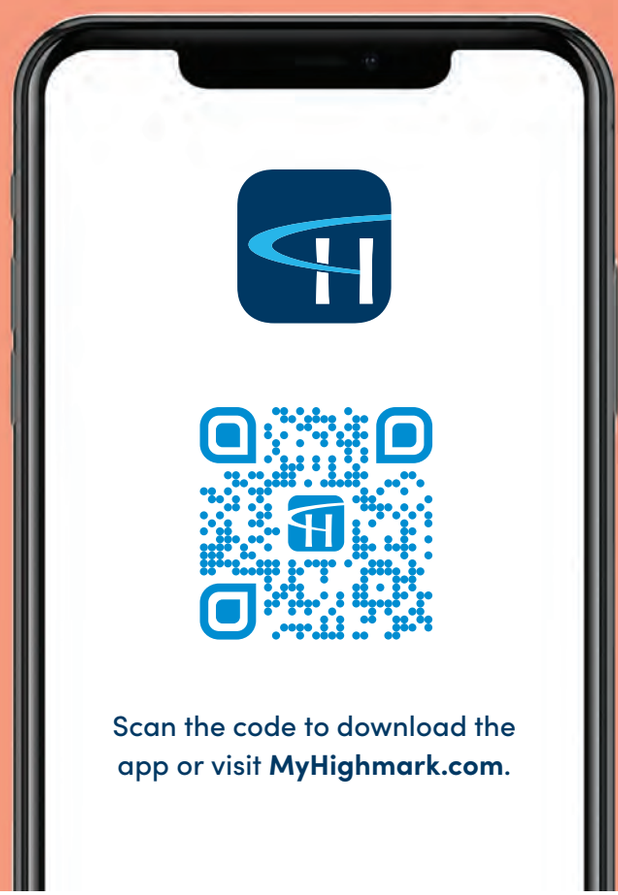
- **Access your virtual member ID card, manage your costs, and search for care.**
- **Receive personalized recommendations for health programs.**
- **Find virtual health tools and activities to help you reach your goals.**

Download the My Highmark app or visit MyHighmark.com today.

HIGHMARK.

Because Life.™

Schedule a virtual health visit with My Highmark.



Scan the code to download the app or visit **MyHighmark.com**.

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请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。

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WELLNESS SOLUTIONS

Wellness Coaching

REACH YOUR GOALS WITH PERSONALIZED SUPPORT.

Get personalized coaching from your own Highmark wellness coach.

A coach can create a customized plan or recommend a program to help you:

- Lose weight.
- Quit smoking.
- Sleep better.
- Reduce stress.
- Manage chronic conditions.

And more. The best part? It's all included with your health insurance.

Call **1-800-650-8442**, Monday – Friday, to get connected with a coach or visit **HighmarkHealthCoachBCBS.com** to learn more.

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Where to go for care when you need help.

Your symptoms or condition determine your best setting for care.




	Telemedicine	Doctor's Office	Urgent/Express Care	Emergency Room (ER)
When and where to visit	Convenient, at-home care for minor illnesses and behavioral health care	Sick visits, checkups, and care for chronic conditions	Urgent, but not life-threatening	Serious, life-threatening, or involving severe pain
Symptoms/ conditions	Cold, flu, and other minor illnesses that don't require an office visit	Cold/sinus symptoms, stomach problems, high blood pressure, other chronic conditions	Headaches/ migraines, asthma/ breathing conditions, flu, urinary tract infection	Difficulty breathing, uncontrolled bleeding, chest pain, severe injury stroke symptoms*
Estimated cost by comparison	Lowest	Lower	Moderate	Highest
Hours of operation	24/7 (behavioral health care must be scheduled)	Business hours (generally)	Mornings, evenings, and weekends	24/7

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

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* Numbness or weakness in your face, arm, or leg, especially on one side. Confusion or trouble understanding other people. Difficulty speaking. Trouble seeing with one or both eyes.

Source: Vorvick, L. J, Sieve, D.,& Conaway, B. (2019). When to use the emergency room-adult. Retrieved from: https://medlineplus.gov/ency/patientinstructions/000593.htm.

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