# Highmark
# Employee Educational Material

AssuredPartners

# Care that keeps up with your life.

**Wherever you are, we've got you covered.**

BLUES ON CALL℠

## Answers from a health pro, 24/7.

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

MY CARE NAVIGATOR℠

## Your appointments, booked for you.

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

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.

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. With Highmark, you can expect expert care from:

- OB-GYNs specializing in high-risk pregnancy, maternal fetal medicine, and fertility.
- Board-certified pediatricians and pediatric subspecialists.
- Childbirth and certified lactation experts.

## 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.**

SUPER BLUE PLUS (PPO)

# Here's how Highmark 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.

Our West Virginia network includes 67 community and specialty hospitals, and more than 11,000 practitioners, giving 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.

## Easy access to top-performing specialists.

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

## Total support, day or night.

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.

## Need help finding top-quality doctors and hospitals?

To search for in-network providers:

1. Go to **highmarkbcbswv.com/find-a-doctor**.
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 will cost you more, and you may face certain obstacles when it's time to submit a claim or be admitted to a hospital. 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.

# 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<br>• 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<br>• High-risk: More often |
| **Colon Cancer Screening** (Including Colonoscopy) | • Ages 45 and older: Every 1 to 10 years, depending on screening test<br>• 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<br>• 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

HIGHMARK WEST VIRGINIA

# 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 40 and older: Once a year including 3D |
| **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<br>• Ages 30 to 65: Every 5 years if HPV only or combined Pap and HPV are negative<br>• Ages 65 and older: Per doctor's advice |
| **Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)** | • Sexually active males and females<br>• 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<br>• Ages 60 and older: High-risk per doctor's advice |
| **Human Papillomavirus (HPV)** | • To age 26: One 3-dose series<br>• 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 |
| **Shingles** | • Shingrix - Ages 50 and older: Two doses<br>• Ages 19 to 49: Immunocompromised per doctor's advice |

* 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

| 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<br>• Hepatitis B screening and immunization, if needed<br>• HIV screening<br>• Syphilis screening<br>• Smoking cessation counseling<br>• Depression screening during pregnancy and postpartum<br>• Depression prevention counseling during pregnancy and postpartum | • Rh typing at first visit<br>• Rh antibody testing for Rh-negative women<br>• Tdap with every pregnancy<br>• Urine culture and sensitivity at first visit<br>• Alcohol misuse screening and counseling<br>• 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<br>• Additional nutritional counseling visits specifically for obesity | • Recommended lab tests:<br>– ALT<br>– AST<br>– Hemoglobin A1c or fasting glucose<br>– 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 | |

| ADULT DIABETES PREVENTION PROGRAM (DPP) | |
|---|---|
| **Applies to Adults**<br>• Without a diagnosis of diabetes (does not include a history of gestational diabetes)<br>• Overweight or obese (determined by BMI)<br>• Fasting Blood Glucose of 100–125 mg/dl or HGBA1c of 5.7% to 6.4% or Impaired Glucose Tolerance Test of 140–199mg/dl | Enrollment in certain select CDC-recognized lifestyle change DPP programs for weight loss |

*** 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<br>HIV routine check, once between ages 15 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<br>• Additional nutritional counseling visits specifically for obesity<br>• Recommended lab tests:<br>– Alanine aminotransferase (ALT)<br>– Aspartate aminotransferase (AST)<br>– Hemoglobin A1c or fasting glucose (FBS)<br>– Cholesterol screening |
| **Age 18 with a diagnosis of Hypertension, High Blood Pressure, Dyslipidemia, or Metabolic Syndrome** | Nutritional counseling |
| **ADULT DIABETES PREVENTION PROGRAM (DPP) AGE 18** | |
| **Applies to Adults**<br>• Without a diagnosis of diabetes (does not include a history of gestational diabetes)<br>• Overweight or obese (determined by BMI)<br>• Fasting Blood Glucose of 100–125 mg/dl or HGBA1c of 5.7% to 6.4% or Impaired Glucose Tolerance Test of 140–199mg/dl | Enrollment in certain select CDC-recognized lifestyle change DPP programs for weight loss |

# Women's Health Preventive Schedule

| SERVICES | |
|---|---|
| **Well-Woman Visits** (Includes: preconception and first prenatal visit, urinary incontinence screening) | Up to 4 visits each year for developmentally and age-appropriate preventive services |
| **Contraception (Birth Control) Methods and Discussion*** | All women planning or capable of pregnancy |
| **SCREENINGS/PROCEDURES** | |
| **Diabetes Screening** | • High-risk: At the first prenatal visit |
| **HIV Screening and Discussion** | • All sexually active women: Once a year<br>• Ages 15 and older, receive a screening test for HIV at least once during their lifetime<br>• Risk assessment and prevention education for HIV infection beginning at age 13<br>• Screen for HIV in all pregnant women upon initiation of prenatal care with rescreening during pregnancy based on risk factors |
| **Human Papillomavirus (HPV) Screening Testing** | Beginning at age 30: Every 3 years |
| **Domestic and Intimate Partner Violence Screening and Counseling** | Once a year |
| **Breast-feeding (Lactation) Support and Counseling, and Costs for Equipment** | During pregnancy and/or after delivery (postpartum) |
| **Sexually Transmitted Infections (STI) Discussion** | All sexually active women: Once a year |
| **Screening for Anxiety** | The Women's Preventive Services Initiative recommends screening for anxiety in adolescent girls and adult women, including those who are pregnant or postpartum. |
| **Nutritional Counseling** | Ages 40–60 with normal BMI and overweight BMI |

* FDA-approved contraceptive methods may include sterilization and procedures as prescribed. One or more forms of contraception in each of the 18 FDA-approved methods, as well as any particular service or FDA approved, cleared or granted contraceptive product that an individual's provider determines is medically appropriate, are covered without cost sharing. Exception Process: Your provider may request an exception for use of a prescribed nonformulary contraception drug due to medical necessity by completing the online request form. When approved, the prescribed drug will then be made available to you with zero-dollar cost share. An initial 'Fail First' is not required, only provider determined medical necessity is needed when completing the exception form. The provider may note if there was a failed initial formulary drug, however it is not necessary for the formulary exception process for contraceptive drugs. https://content.highmarkprc.com/Files/Region/NY/Forms/Pharmacy/Prescription%20Drug%20Medication%20Request%20Form.pdfOnly FDA approved contraception apps, which are not part of the 18 method categories, and are available for download to a cell phone are reimbursable through the paper claim process with a prescription. Members need to submit three documents to obtain reimbursement; 1) completed the paper Claim Form: https://www.highmarkbcbs.com/redesign/pdfs/mhs/Medical_Claim_Form.pdf (this link can be used for NY) Under section DIAGNOSIS OR NATURE OF ILLNESS OR INJURY – write "contraception app purchase" 2) receipt of payment for the FDA approved contraception app, 3) provider prescription for the FDA approved contraception app.

## 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.

**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. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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, 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).

## [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.

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.

HIGHMARK WEST VIRGINIA

highmarkbcbswv.com

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 copy 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.**
- **Compare cost savings with mail order.**
- **Access forms needed for your coverage.**

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

# Programs to keep you safe while keeping drug costs down.

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

## Prior Authorization:

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

## Quantity Limits:

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

## Step Therapy:

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

### If your prescription drug requires prior authorization, tell your doctor. There are three options for obtaining prior authorization:

1. **Send a request online by using CoverMyMeds® (covermymeds.com).**
2. **Call the Pharmacy Hotline at 800-600-2227.**
3. **Fax a request form to the Hotline staff at 866-240-8123.**
   **(Get a form at highmarkbcbswv.com by clicking Helpful Links, Forms Library, then Pharmacy Forms.)**

**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
Kroger
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

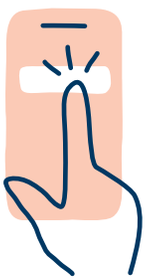
## Personalized support for health goals.

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 **highmarkbcbswv.com**.

**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, **highmarkbcbswv.com**.

**MY CARE NAVIGATOR℠**

## Your appointments, booked for you.

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

**BLUE365®**

## Discounts to help you stay healthy and active.

From workout gear to 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**.

**HIGHMARK 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.

### NETWORK TYPES
**Broad** – The network that provides access to many doctors and facilities in your area.

**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.

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

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

## 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.

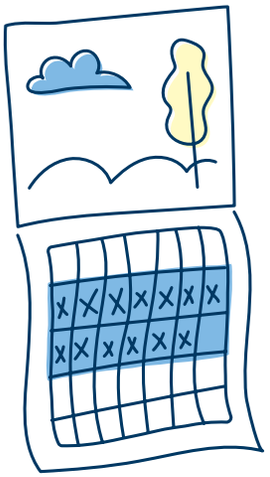
You've trusted us with your personal information and we take protecting it very seriously. We follow very strict policies for handling and protecting Protected Health Information (PHI).

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.



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

**SUMMARY OF THE**
**WEST VIRGINIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**
**(Effective July 1, 2019)**

Residents of West Virginia who purchase life insurance, annuities or health insurance should know that the insurance companies and health maintenance organizations licensed in this state to write these types of insurance are members of the West Virginia Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policy and contract owners, certificate holders and enrollees of covered policies and contracts will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurers for the money to pay the claims of covered persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these member insurers through the Guaranty Association is not unlimited, however, and, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The West Virginia Life and Health Insurance Guaranty Association may not provide coverage for this policy or contract. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in West Virginia. You should not rely on coverage by the West Virginia Life and Health Insurance Guaranty Association in selecting an insurance company or health maintenance organization or in selecting an insurance policy or contract. For a complete description of coverage, consult Article 26A, Chapter 33 of the West Virginia Code.

**Coverage is NOT provided for any portion OF YOUR CONTRACT that is not guaranteed by the insurer or for which you have assumed the risk.**

Insurance companies and health maintenance organizations or their agents are required by law to give or send you this notice. *However, insurance companies, health maintenance organizations and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy or health maintenance organization coverage.*

The Guaranty Association or the West Virginia Insurance Commission will respond to questions you may have that are not answered by this document. Policyholders with additional questions may contact:

West Virginia Life and Health Insurance Guaranty Association
P.O. Box 816
Huntington, West Virginia 25712

West Virginia Insurance Commissioner
Consumer Services Division
900 Pennsylvania Avenue
P.O. Box 50540
Charleston, West Virginia 25305-0540 (304) 558-3386
Toll Free 1-888-879-9842
TDD 1-800-435-7381

The state law that provides for this safety-net coverage is called the West Virginia Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

## COVERAGE

Generally, individuals will be protected by the West Virginia Life and Health Insurance Guaranty Association if they live in West Virginia and hold a life, health or annuity policy, plan or contract, or if they are insured under a group life, health or annuity policy, plan or contract, issued by a member insurer. Member insurer also includes non-profit service corporations (W. Va. Code §33-24), health care corporations (W. Va. Code §33-25) and health maintenance organizations (W. Va. Code §33-25A). The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

However, persons holding such policies, plans or contracts are not protected by this Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent member insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The member insurer was not authorized to do business in this state;
- The policy, plan or contract was issued at a time when the member insurer was not licensed or authorized to do business in the state;
- The policy, plan or contract was issued by a fraternal benefit society, mandatory state pooling plan, a mutual protective association or similar plan in which the policy, plan or contract holder is subject to future assessments, an insurance exchange, an organization that has a certificate or license limited to the issuance of charitable gift annuities or any entity similar to the above.

The Guaranty Association also does not provide coverage for:

- Any policy, plan or contract, or portion of a policy, plan or contract that is not guaranteed by the member insurer or for which the individual or contract holder has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends;
- Credits given in connection with the administration of a policy, plan or contract by a group contract holder;
- Employer or association plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured, including:
    i. multiple employer welfare arrangement;
    ii. minimum premium group insurance plan;
    iii. stop loss group insurance plan; or
    iv. administrative services only contract;
- Any unallocated annuity contract issued to or in connection with a benefit plan protected under the federal pension guaranty corporation;
- Any portion of any unallocated contract that is not issued to or in connection with a specific employee, union or association's benefit plan or a governmental lottery;
- Any policy, plan or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C and D or Medicaid;
- An obligation that does not arise under the written terms of the policy, plan or contract, including claims based on marketing materials, claims based on side letters or riders not approved by the Commissioner, misrepresentations regarding policy benefits, extracontractual claims or claims for penalties or consequential or incidental damages;

- A contractual agreement that establishes the member insurer's obligation to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or trustee, which is not an affiliate of the insurer;
- Structured settlement annuity benefits, the rights to which have been transferred by the payee or beneficiary in a structured settlement factoring transaction.

**LIMITS ON AMOUNT OF COVERAGE**

The Act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the member insurer would owe under a policy, plan or contract. Also, for any one insured life, regardless of the number of policies, plans or contracts, the Guaranty Association will only pay:

- $300,000 in life insurance benefits, but no more than $100,000 in net cash surrender and net cash withdrawal values;
- $300,000 for disability income insurance;
- $300,000 for long term care insurance;
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;
- $500,000 for health benefit plans (W. Va. Code §33-26A-5(10)); and
- $100,000 for all other types of accident and sickness insurance coverages not defined as disability income insurance, long term care insurance, or health benefit plans.

Also, for any one insured life, the Guaranty Association will only pay a maximum of $300,000—no matter how many policies and contracts there were with the same company—for all policies or contracts other than health benefit plans, in which case the aggregate limit shall not exceed $500,000 with respect to any one individual.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund governmental retirement plans under §§ 401(k), 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, per participating individual. In no event shall the Guaranty Association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

*Sí necesita ayuda para traducir esta información, por favor comuníquese con el departamento de Servicios a miembros de Highmark West Virginia al número al réves de su tarjeta de identificación de Highmark West Virginia. Estos servicios están disponibles de lunes a viernes, de 8:00 a 16:00.*

# HIGHMARK BLUE CROSS BLUE SHIELD WEST VIRGINIA

# NOTICE OF PRIVACY PRACTICES

# PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**THIS NOTICE ALSO DESCRIBES HOW WE COLLECT, USE AND DISCLOSE NON-PUBLIC PERSONAL FINANCIAL INFORMATION.**

## Our Legal Duties

At Highmark Blue Cross Blue Shield West Virginia (Highmark WV), we are committed to protecting the privacy of your protected health information. "Protected health information" (PHI) is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members' protected health information. We are required by applicable federal and state laws to maintain the privacy of your protected health information. We also are required by the HIPAA Privacy Rule (45 C.F.R. parts 160 and 164, as amended) to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We are also required to notify affected individuals following a breach of unsecured health information.

We will inform you of these practices the first time you become a Highmark WV customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice becomes effective September 23, 2013, and will remain in effect unless we replace it.

On an ongoing basis, we will review and monitor our privacy practices to ensure the privacy of our members' protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this Notice. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will become effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. Before we make a material change in our privacy practices, we will change this Notice and notify all affected members in writing in advance of the change.

Any change to this notice will be posted on our website and we will further notify you of any changes in our annual mailing.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

## I. Uses and Disclosures of Protected Health Information

In order to administer our health benefit programs effectively, we will collect, use and disclose protected health information for certain of our activities, including payment and health care operations.

### A. Uses and Disclosures of Protected Health Information for Payment and Health Care Operations

The following is a description of how we may use and/or disclose protected health information about you for payment and health care operations:

#### Payment

We may use and disclose your protected health information for all activities that are included within the definition of "payment" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "payment," so please refer to 45 C.F.R. § 164.501 for a complete list.

*For example:*

We may use and disclose your protected health information to pay claims from doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and/or to issue explanations of benefits/payments to the person who subscribes to the health plan in which you participate.

#### Health Care Operations

We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "health care operations," so please refer to 45 C.F.R. § 164.501 for a complete list.

*For example:*

We may use and disclose your protected health information to rate our risk and determine the premium for your health plan, to conduct quality assessment and improvement activities, to credential health care providers, to engage in care coordination or case management, and/or to manage our business.

### B. Uses and Disclosures of Protected Health Information To Other Entities

We also may use and disclose protected health information to other covered entities, business associates, or other individuals (as permitted by the HIPAA Privacy Rule) who assist us in administering our programs and delivering services to our members.

#### *(i) Business Associates*

In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation, or pharmacy benefit management). To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

*(ii) Other Covered Entities*

In addition, we may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain of their health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

## II. Other Possible Uses and Disclosures of Protected Health Information

In addition to uses and disclosures for payment and health care operations, we may use and/or disclose your protected health information for the following purposes.

**A. To Plan Sponsors**

We may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us regarding a member's question, concern, issue regarding claim, benefits, service, coverage, etc. We may also disclose summary health information (this type of information is defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

**B. Required by Law**

We may use or disclose your protected health information to the extent that federal or state law requires the use or disclosure. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.

**C. Public Health Activities**

We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability.

**D. Health Oversight Activities**

We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee:

- the health care system;
- government benefit programs;
- other government regulatory programs; and
- compliance with civil rights laws.

**E. Abuse or Neglect**

We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence.

**F. Legal Proceedings**

We may disclose your protected health information:

(1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information.

**G. Law Enforcement**

Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; or (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person.

**H. Coroners, Medical Examiners, Funeral Directors, and Organ Donation**

We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

**I. Research**

We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

**J. To Prevent a Serious Threat to Health or Safety**

Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

**K. Military Activity and National Security, Protective Services**

Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

**L. Inmates**

If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

**M. Workers' Compensation**

We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

**N. Others Involved in Your Health Care**

Unless you object, we may disclose your protected health information to a friend or family member that you have identified as being involved in your health care. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

**O. Underwriting**

We may disclose your protected health information for underwriting purposes; however, we are prohibited from using or disclosing your genetic information for these purposes.

**P. Health Information Exchange**

We will participate in a Health Information Exchange (HIE). An HIE is primarily a secure electronic data sharing network. In accordance with federal and state privacy regulations, regional health care providers participate in the HIE to exchange patient information in order to facilitate health care, avoid duplication of services, such as tests, and to reduce the likelihood that medical errors will occur.

The HIE allows your health information to be shared among authorized participating healthcare providers, such as health systems, hospitals and physicians, for the purposes of Treatment, Payment or Healthcare Operations purposes. Examples of this health information may include:

- General laboratory, pathology, transcribed radiology reports and EKG Images.
- Results of outpatient diagnostic testing (GI testing, etc.)
- Health Maintenance documentation/Medication
- Allergy documentation/Immunization profiles
- Progress notes/Urgent Care visit progress notes
- Consultation notes
- Inpatient operative reports
- Discharge summary/Emergency room visit discharge summary notes

All participating providers who provide services to you will have the ability to access your information. Providers that do not provide services to you will not have access to your information. Information may be provided to others as necessary for referral, consultation, treatment or the provision of other healthcare services, such as pharmacy or laboratory services. All participating providers have agreed to a set of standards relating to their use and disclosure of the information available through the HIE. Your health information shall be available to all participating providers through the HIE.

You cannot choose to have only certain providers access your information. Patients who do not want their health information to be accessible through the HIE may choose not to participate or may "opt-out."

In order to opt-out, you must complete an opt-out form, which is available at **highmarkbcbswv.com** or by calling the customer service number located on the back of your membership card. You should be aware, if you choose to opt-out, your health care providers will not be able to access your health information through the HIE. Even if you chose to opt-out, your information will be sent to the HIE, but providers will not be able to access this information. Additionally, your opt-out does not affect the ability of participating providers to access health information entered into the HIE prior to your opt-out submission.

## III. Required Disclosures of Your Protected Health Information

The following is a description of disclosures that we are required by law to make:

**A. Disclosures to the Secretary of the U.S. Department of Health and Human Services**

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

**B. Disclosures to You**

We are required to disclose to you most of your protected health information that is in a "designated record set" (defined below) when you request access to this information. We also are required to provide, upon your request, an accounting of many disclosures of your protected health information that are for reasons other than payment and health care operations.

## IV. Other Uses and Disclosures of Your Protected Health Information

Sometimes we are required to obtain your written authorization for use or disclosure of your health information. The uses and disclosures that require an authorization under 45 C.F.R. § 164.508(a) are:

1. For marketing purposes

2. If we intend to sell your PHI

3. For use of Psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. An Authorization for use of psychotherapy notes is required unless:

a. Used by the person who created the psychotherapy note for treatment purposes, or

b. Used or disclosed for the following purposes:

(i) the provider's own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;

(ii) for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;

(iii) if required for enforcement purposes;

(iv) if mandated by law;

(v) if permitted for oversight of the provider that created the note,
(vi) to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or (vi) if needed to avert a serious and imminent threat to health or safety.

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

## V. Your Individual Rights

The following is a description of your rights with respect to your protected health information:

**A. Right to Access**

You have the right to look at or get copies of your protected health information in a designated record set. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. If you request the information in an electronic format that is not readily producible, we will provide the information in a readable electronic format as mutually agreed upon. You must make a request in writing to obtain access to your protected health information.

To inspect and/or copy your protected health information, you may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. The first request within a 12-month period will be free. If you request access to your designated record set more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. If you request an alternative format, we will charge a cost-based fee for providing your protected health information in that format.

If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request.

Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

**B. Right to an Accounting**

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment or health care operations. You should know that most disclosures of protected health information will be for purposes of payment or health care operations.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or by submitting your request in writing to the Highmark West Virginia Privacy Office, 614 Market Street, Parkersburg, WV 26101. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

The first list you request within a 12-month period will be free. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

**C. Right to Request a Restriction**

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing. We have a right to terminate this restriction; however, if we do so, we must inform you of this restriction.

You may request a restriction by contacting us at the Customer Service phone number on the back of your identification card, or writing to the Highmark West Virginia Privacy Office, 614 Market Street, Parkersburg, WV 26101. In your request tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

**D. Right to Request Confidential Communications**

If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. For example, you may ask that we contact you only at your work address or via your work e-mail.

You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence by the alternative means or to the alternative location you want. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits/payments to the subscriber of the health plan in which you participate.

In the event that a Confidential Communication is placed against you, then you will no longer have the ability to access any of your health and/or policy information online.

**E. Right to Request Amendment**

If you believe that your protected health information is incorrect or incomplete, you have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended.

We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

**F. Right to a Paper Copy of this Notice**

If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. Please contact us using the information listed at the end of this Notice to obtain this Notice in written form.

## VI. Questions and Complaints

If you want more information about our privacy policies or practices or have questions or concerns, please contact us using the information listed below.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made to amend or restrict the use or disclosure of your protected health information or to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed below.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Highmark West Virginia Privacy Office

Telephone: **1-304-424-9026**

Fax: **1-304-424-0322**

Address: 614 Market Street
Parkersburg, WV 26101

## PART II – NOTICE OF PRIVACY PRACTICES (GRAMM-LEACH-BLILEY)

Highmark Blue Cross Blue Shield West Virginia is committed to protecting its members' privacy. This notice describes our policies and practices for collecting, handling and protecting personal information about our members. We will inform each group of these policies the first time the group becomes a Highmark WV member and will annually reaffirm our privacy policy for as long as the group remains a Highmark WV customer. We will continually review our privacy policy and monitor our business practices to help ensure the security of our members' personal information. Due to changing circumstances, it may become necessary to revise our privacy policy in the future. Should such a change be required, we will notify all affected customers in writing in advance of the change.

In order to administer our health benefit programs effectively, we must collect, use and disclose non-public personal financial information. Non-public personal financial information is information that identifies an individual member of a Highmark WV health plan. It may include the member's name, address, telephone number and Social Security number or it may relate to the member's participation in the plan, the provision of health care services or the payment for health care services. Non-public personal financial information does not include publicly available information or statistical information that does not identify individual persons.

**Information we collect and maintain:** We collect nonpublic personal financial information about our members from the following sources:

- We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.
- We collect and create information about our members' transactions with Highmark WV, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits/ payments (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.
- We use personal information internally to manage enrollment, process claims, monitor the quality of the health services provided to our members, prevent fraud, audit our own performance or to respond to members' requests for information, products or services.
- We share personal information with our affiliated companies, health care providers, agents, other insurers, peer review organizations, auditors, attorneys or consultants who assist us in administering our programs and delivering health services to our members. Our contracts with all such service providers require them to protect the confidentiality of our members' personal information.
- We may share personal information with other insurers that cooperate with us to jointly market or administer health insurance products or services. All contracts with other insurers for this purpose require them to protect the confidentiality of our members' personal information.
- We may disclose information under order of a court of law in connection with a legal proceeding.
- We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.
- We may disclose information under a subpoena or summons to government agencies that investigate fraud or other violations of law.

**How we protect information:** We restrict access to our members' non-public personal information to those employees, agents, consultants and health care providers who need to know that information to provide health products or services. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to guard non-public personal financial information from unauthorized access, use and disclosure. For questions about this Privacy Notice, please contact:

Contact Office:

Highmark West Virginia Privacy Office

| | |
|---|---|
| Telephone: | **1-304-424-9026** |
| Fax: | **1-304-424-0322** |
| Address: | 614 Market Street<br>Parkersburg, WV 26101 |

# 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.

American Well is an independent company that provides virtual health services. American Well does not provide Blue Cross and/or Blue Shield products or services and it is solely responsible for its telemedicine services.

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
WEST VIRGINIA

**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. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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, 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.

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

If you speak English, language assistance services, free of charge, are available to you. Call 1-877-959-2562.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-877-959-2562.

如果您说中文，可向您提供免费语言协助服务。 請致電 1-877-959-2562.

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-877-959-2562.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-877-959-2562 로 전화.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-877-959-2562.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-877-959-2562.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-877-959-2562 .

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-877-959-2562.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-877-959-2562.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-877-959-2562.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-877-959-2562.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-877-959-2562.

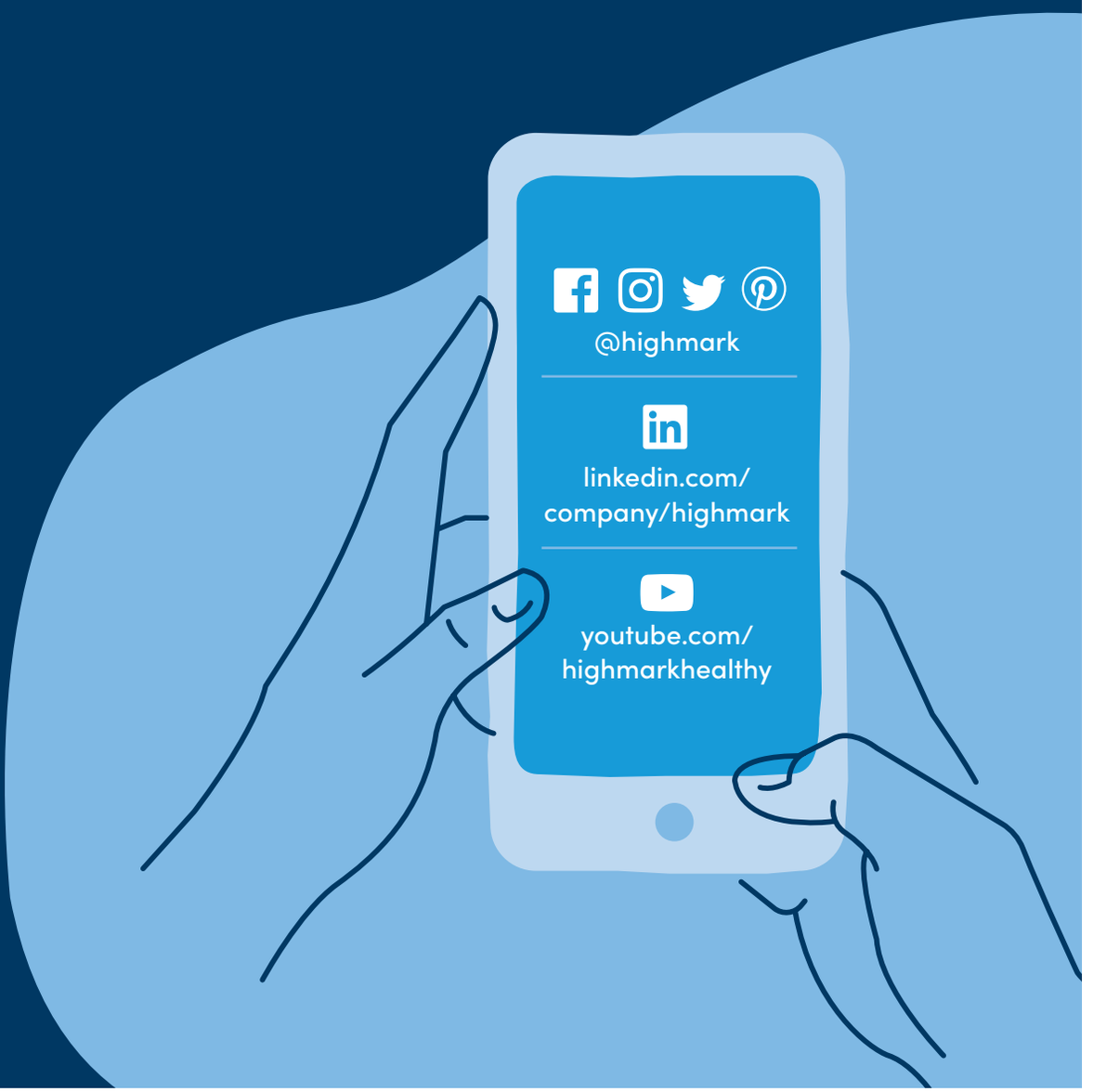
Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-877-959-2562.

日本語が母国語の方は言語アシスタンス・ サービスを無料でご利用いただけます。 1-877-959-2562 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-877-959-2562 .

# 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.**