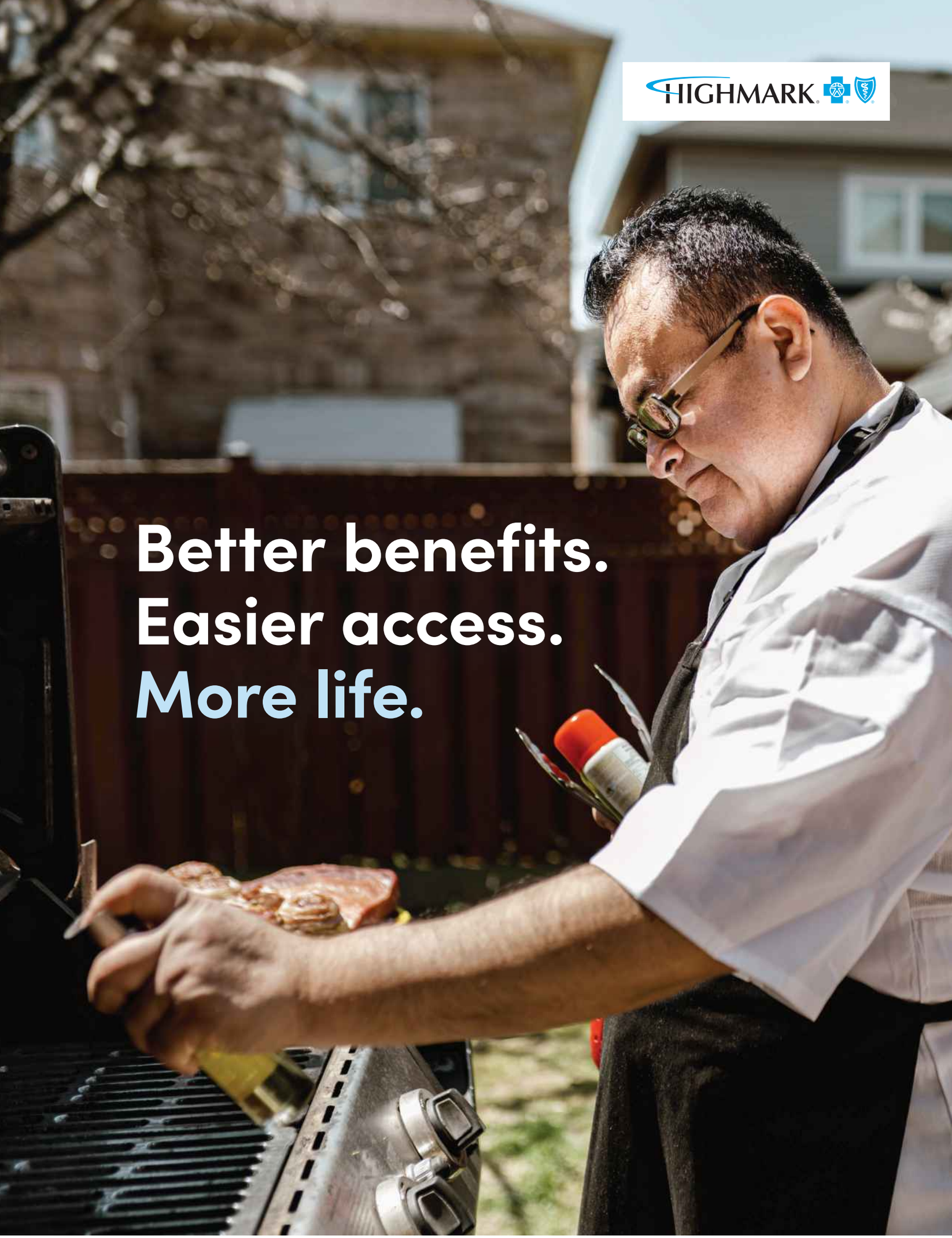

HIGHMARK
Better benefits.
Easier access.
More life.

Care that keeps up with your life.

Wherever you are,
we've got you covered.

HIGHMARK

Because Life.™

PPO Blue

University of Delaware

Nick Moriello

President, Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield

Hi there,

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

With Highmark, you get access to personalized wellness programs, handy online tools, and 24/7 support for any questions you might have along the way. And, as always, you get convenient access to more than 8,000 doctors in Delaware and across the U.S. Additionally, with your coverage, you get access to the largest physician and hospital networks in the U.S. with over 1.8 million providers, including 97% of all hospitals through the BlueCard® program.* And when you travel globally, you're covered in 190 countries through the Blue Cross Blue Shield Global® Core program.

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

Nick Moriello

President, Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield

*According to the Blue Cross Blue Shield Association.

Contents

Why Highmark

MY HIGHMARK 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. Scan the QR code to download the MyHighmark app or go to **MyHighmark.com** to get started.

TOTAL CARE

Get care that gets results.

Total Care is a national value-based care designation program that recognizes doctors and hospitals for their efforts in coordinating care and focusing on prevention and wellness.

Total Care designations:

- **Total Care:** This designation recognizes doctors and hospitals using patient-centered and data-driven practices to better coordinate care while improving quality, safety, and affordability of care.

When searching on the Highmark member website, Total Care icons indicate doctors and facilities that have earned the status for exceptional safety and results.

DIABETES PREVENTION PROGRAM

Tips on how to avoid diabetes.

Lower your risk for prediabetes with simple, effective, practical strategies using this lifestyle program. Get started at **myhighmark.com** or on the MyHighmark app.

WELL360 VIRTUAL HEALTH

Personalized care when and where you want it.

Get care 24/7, wherever you are, with Well360 Virtual Health. A board-certified doctor can see you in minutes for virtual urgent care visits and more. Scan the QR code to download the MyHighmark app or go to **MyHighmark.com** to get started.

BLUE DISTINCTION® SPECIALTY CARE

See specialists who get better results.

When you or your family need specialty care, you want to know which doctors deliver consistent, high-quality care.

That's why Blue Cross and/or Blue Shield companies created a national recognition program — Blue Distinction Specialty Care — to make it easier for you to find quality care that's right for you.

Blue Distinction Specialty Care designations:

- **Blue Distinction Centers:*** Health care providers demonstrate quality care and treatment expertise.

Only providers who consistently deliver safe, effective treatments make our Blue Distinction list. When you use our Provider search tool, a special logo will appear by their names to help you choose a top-performing specialist for any care you need.

*Blue Distinction Center specialists are available across 11 areas of specialty care.

DISEASE MANAGEMENT PROGRAMS

Help managing chronic conditions.

Receive one-on-one nurse support for conditions like asthma, diabetes, heart disease, and other chronic conditions. Get started at **myhighmark.com** or on the MyHighmark app.

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 you think it's an emergency, go straight to the nearest emergency room or dial 911. Your plan may also cover emergency care received outside 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.

CARE FOR SUBSTANCE USE DISORDERS

Guidance to keep you on track.

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

DIABETES MANAGEMENT POWERED BY ONDUO™

Manage your diabetes from wherever you are.

Type 2 diabetes is manageable — especially when you can manage it on your own terms.

Diabetes Management powered by Onduo is a virtual care program that:

- Comes with your plan and helps you manage your care from anywhere.*
- Provides you with a smart blood glucose meter and unlimited test strips at no additional cost to you.
- Uses the Onduo app to provide access to the virtual health clinic and a team of care leads that can answer your questions and guide you through your health journey.
- Gives you a personalized plan and ongoing support between visits to your doctor.

*There is no additional cost for most health plan members. If you have a qualified high deductible plan, you may have to pay out of pocket for some services until you meet your deductible. To check your costs, call the Member Service team at the number on the back of your member ID card.

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 program that provides you with educational resources and personalized attention from your own specially trained health coach at no additional cost.

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

Product Information /Benefit Summary


Norman Leslie

PPOBLUE

Here's how Highmark makes it simple for you:

Nationwide access to providers through the BlueCard® program.

You get access to the largest physician and hospital networks in the U.S. with over 1.8 million providers, including 97% of all hospitals.*

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

And you're covered close to home, too.

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

Easy access to top-performing specialists.

Many of our network doctors and hospitals have earned Blue Distinction status for their exceptional safety and 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 **highmark.com/find-a-doctor** .
2. Locate your region and select **FIND CARE**.
3. Under **Find Care**, select **FIND A DOCTOR**.
4. Select **Continue** under Just Browsing or **Log In** if you're already a member.
5. Enter city, state, or ZIP and Select **Continue**.
6. Choose a **Network** from the list.
7. Type a name or specialty into the search window.

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

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

DE

*According to the Blue Cross Blue Shield Association.

Group #'s: 10636049, 10636050, 10636051, and 10636057

Highmark Blue Choice PPO Plan

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

Benefit	In Network	Out of Network
General Provisions		
Effective Date	July 1, 2025	
Benefit Period (1)	July Contract Year	
Deductible (per benefit period) Individual Family	 None None	 $300 $600
Plan Pays – payment based on the plan allowance	100%	80% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 None None
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $4,500 $9,000	 $7,500 $15,000
Office/Clinic/Urgent Care Visits		
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $20 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after $30 copay	80% after deductible
Virtual Visit Provider Originating Site Fee	100%	80% (deductible does not apply)
Urgent Care Center Visits	100% after $20 copay	80% after deductible
Telemedicine Services - Vendor (3)	100%	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100%	 80% after deductible
Adult Immunizations	100%	80% after deductible
Routine Gynecological Exams, including a Pap Test	100%	80% after deductible
Mammograms, Annual Routine	100%	80% after deductible
Colorectal Cancer Screening	100%	80% after deductible
Diagnostic Services and Procedures	100%	80% after deductible
Vision Exam	not covered	not covered
Routine Pediatric Physical Exams	 100%	 80% after deductible
Pediatric Immunizations	100%	80% after deductible
Diagnostic Services and Procedures	100%	80% after deductible
Vision Exam	not covered	not covered
Emergency Services		
Emergency Room Facility – Acute Hospital (5)	100% after $200 copay (waived if admitted)	
Medical Emergency Care (Doctor's care in an emergency facility (5)	100% Covered (deductible does not apply)	
Ambulance - Emergency and Non-Emergency (6)	100% (deductible does not apply)	100% (deductible does not apply)
Ambulance - Emergency and Non-Emergency (6) (air ambulance)	$50 copay after deductible, 100% thereafter	$50 copay after deductible, 100% thereafter
Hospital and Medical / Surgical Expenses (including maternity) (5)		

Benefit	In Network	Out of Network
Hospital Inpatient	100% after $100 inpatient copay/day up to $200 inpatient copay/admission 100% after $100 inpatient copay/day up to $200 inpatient copay/admission for elective orthopaedic/spine procedures performed at preferred Blue Distinction Centers (BDC) 100% after $500 inpatient copay/admission for elective orthopaedic spine procedures performed at non-preferred non-BDC facilities	80% after deductible
Outpatient Surgery (facility)	100% after $150 copay; $50 copay for ambulatory surgery center	80% after deductible
Maternity (non-preventive professional services) including dependent daughter	100%	80% after deductible
Medical Care (including inpatient visits and consultations)	100%	80% after deductible
Therapy Services		
Physical Therapy	85% services related to treatment of back pain are excluded from visit limits	80% after deductible services related to treatment of back pain are excluded from visit limits
Speech Therapy	85%	80% after deductible
Occupational Therapy	85% services related to treatment of back pain are excluded from visit limits	80% after deductible services related to treatment of back pain are excluded from visit limits
Respiratory Therapy	100%	80% after deductible
Spinal Manipulations	85%	80% after deductible
	limit: 30 visits/benefit period; services related to treatment of back pain are excluded from visit limits	
Cardiac Rehabilitation Therapy	85%	80% after deductible
Infusion Therapy	100%	80% after deductible
Radiation Therapy	100%	80% after deductible
Dialysis	100%	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after $100 inpatient copay/day up to $200 inpatient copay/admission	80% after deductible
Inpatient Detoxification / Rehabilitation	100% after $100 inpatient copay/day up to $200 inpatient copay/admission	80% after deductible
Intensive Inpatient Mental Health (Partial Hospitalization/Outpatient) visits	100% Covered	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $20 copay for svcs performed in an office setting	80% after deductible
Outpatient Substance Abuse Services	100% after $20 copay for svcs performed in an office setting	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after $5 copay	80% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	100%	80% after deductible
Assisted Fertilization Procedures	100%	80% after deductible (coinsurance does not accrue toward the TMOOP)
	limit: $30,000/lifetime	
Dental Services Related to Accidental Injury	100%	80% after deductible
Diagnostic Services		

Benefit	In Network	Out of Network
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% covered at an independent non-hospital owned provider. 100% after $100 copay for hospital-owned providers Copay does not apply to diagnostic services prescribed for the treatment of mental health or substance abuse	80% after deductible
Standard Imaging	100% covered at an independent non-hospital owned provider. 100% after $50 copay for hospital-owned providers Copay does not apply to diagnostic services prescribed for the treatment of mental health or substance abuse	80% after deductible
Diagnostic Medical	100%	80% after deductible
Pathology/Laboratory	$10 copay at an independent non-hosp-owned providers 100% after $50 copay for hospital-owned providers Copay does not apply to diagnostic services prescribed for the treatment of mental health or substance abuse	80% after deductible
Allergy Testing	100% after $30 copay Copay does not apply to diagnostic services prescribed for the treatment of mental health or substance abuse	80% after deductible
Mammograms, Medically Necessary	100% covered at an independent non-hospital owned provider. 100% after $50 copay for hospital-owned providers Copay does not apply to diagnostic services prescribed for the treatment of mental health or substance abuse	80% after deductible
Durable Medical Equipment and Supplies	100% Covered 100% for insulin infusion pumps	80% after deductible
Foot Orthotics	not covered	not covered
Prosthetic Devices	100% Covered	80% after deductible
Home Health Care	100% Covered	80% after deductible
	limit: 240 visits/benefit period aggregate with visiting nurse	
Hospice	100% Covered	80% after deductible
	Covered for up to 365 days	
Infertility Counseling, Testing and Treatment (8)	100% Covered	80% after deductible
Inpatient Private Duty Nursing	100% Covered	80% after deductible
	limit: 240 hours/12 month period	
Skilled Nursing Facility Care	100% Covered	80% after deductible
	limit: 120 days/confinement; benefits renew after 180 days without care	
Transplant Services	100% after $100 inpatient copay/day up to $200 inpatient copay/admission for services received at BDCT (Blue Distinction Center for Transplant); 80% after deductible for services received at non-BDCT facilities	80% after deductible
Precertification/Authorization Requirements (9)	Yes	Yes

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.
(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays and any qualified medical expense. Prescription drug expenses are subject to a separate prescription drug TMOOP.
(3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
(4) Services are limited to those listed on the University of Delaware Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
(6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
(7) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist, or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant, or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services-Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g., speech therapy, diagnostic services). Services for the treatment of Autism Spectrum Disorders do not reduce visit/day limits.
(8) Treatment includes coverage for the correction of a physical or medical problem associated with infertility.
(9) Precertification or preauthorization requirements may apply to certain inpatient admissions, outpatient procedures, or covered services (including covered medications).

Group #'s: 10636052, 10636053, 10636054 and 10636058

HIGHMARK DELAWARE

Highmark Blue Choice Deductible PPO Plan

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

Benefit	In Network	Out of Network
General Provisions		
Effective Date	July 1, 2025	
Benefit Period (1)	July Contract Year	
Deductible (per benefit period) (All services are credited to both in-network and out-of-network deductibles.) Individual Family	 $500 $1,000	 $1,000 $2,000
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) (All services are credited to both in-network and out-of-network out-of-pocket limits.) Individual Family	 $1,500 $3,000	 $3,000 $6,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $2,000 $4,000	 $4,000 $8,000
Office/Clinic/Urgent Care Visits		
Primary Care Provider (PCP) Office Visits & Virtual Visits	90% after deductible	70% after deductible
Specialist Office Visits & Virtual Visits	90% after deductible	70% after deductible
Virtual Visit Provider Originating Site Fee	90% after deductible	70% after deductible
Urgent Care Center Visits	100% after $25 copay	100% after $25 copay
Telemedicine Services - Vendor (3)	90% after deductible	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 70% (deductible does not apply)
Adult Immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	70% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	70% (deductible does not apply)
Colorectal Cancer Screening	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	70% (deductible does not apply)
Vision Exam	not covered	not covered
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 70% (deductible does not apply)
Pediatric Immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	70% (deductible does not apply)
Vision Exam	not covered	not covered
Emergency Services		
Emergency Room Facility – Acute Hospital (5)	90% after deductible	90% after in-network deductible
Medical Emergency Care (Doctor's care in an emergency facility (5)	90% after deductible	90% after in-network deductible
Ambulance - Emergency and Non-Emergency (6)	90% after deductible	90% after in-network deductible
Ambulance - Emergency and Non-Emergency (6) (air ambulance)	90% after deductible	90% after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity) (5)		

Benefit	In Network	Out of Network
Hospital Inpatient	90% after deductible	70% after deductible
Outpatient Surgery (facility)	90% after deductible	70% after deductible
Surgical Services (professional)	90% after deductible	70% after deductible
Maternity (non-preventive professional services) including dependent daughter	90% after deductible	70% after deductible
Medical Care (including inpatient visits and consultations)	90% after deductible	70% after deductible
Therapy Services		
Physical Therapy	90% after deductible services related to treatment of back pain are excluded from visit limits	70% after deductible services related to treatment of back pain are excluded from visit limits
Speech Therapy	90% after deductible	70% after deductible
Occupational Therapy	90% after deductible services related to treatment of back pain are excluded from visit limits	70% after deductible services related to treatment of back pain are excluded from visit limits
Respiratory Therapy	90% after deductible	70% after deductible
Spinal Manipulations	90% after deductible	75% after deductible
	limit: 30 visits/benefit period; services related to treatment of back pain are excluded from visit limits	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	90% after deductible	70% after deductible
Inpatient Detoxification / Rehabilitation	90% after deductible	70% after deductible
Intensive Inpatient Mental Health (Partial Hospitalization/Outpatient) visits	90% after deductible	70% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	90% after deductible	70% after deductible
Outpatient Substance Abuse Services	90% after deductible	70% after deductible
Other Services		
Allergy Extracts and Injections	90% after deductible	70% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	90% after deductible	70% after deductible
Assisted Fertilization Procedures	90% after deductible (coinsurance does not accrue toward the TMOOP)	70% after deductible (coinsurance does not accrue toward the TMOOP)
	limit: $30,000/lifetime	
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
Mammograms, Medically Necessary	90% after deductible	70% after deductible
Durable Medical Equipment and Supplies	90% after deductible; 100% (deductible does not apply) for insulin infusion pumps	70% after deductible
Foot Orthotics	not covered	not covered
Prosthetic Devices	90% after deductible	70% after deductible
Home Health Care	90% after deductible	70% after deductible
	limit: 240 visits/benefit period aggregate with visiting nurse	
Hospice	90% after deductible	70% after deductible
	Covered for up to 365 days	
Infertility Counseling, Testing and Treatment (8)	90% after deductible	70% after deductible
Inpatient Private Duty Nursing	90% after deductible	70% after deductible
	Limit: 240 hours/12 month period	
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	limit: 120 days/confinement; benefits renew after 180 days without care	
Transplant Services	90% after deductible for services received at BDCT (Blue Distinction Center for Transplant); 70% after deductible for non-BDCT facilities	70% after deductible
Precertification/Authorization Requirements (9)	Yes	Yes

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.
(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.

(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays and any qualified medical expense. Prescription drug expenses are subject to a separate prescription drug TMOOP.
(3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
(4) Services are limited to those listed on the University of Delaware Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
(6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
(7) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist, or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant, or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services-Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g., speech therapy, diagnostic services). Services for the treatment of Autism Spectrum Disorders do not reduce visit/day limits.
(8) Treatment includes coverage for the correction of a physical or medical problem associated with infertility.
(9) Precertification or preauthorization requirements may apply to certain inpatient admissions, outpatient procedures, or covered services (including covered medications).

Preventive Schedule

What's preventive care?

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

2025 Preventive Schedule

Effective 1/1/2025

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. 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. All benefits for over the counter drugs and supplies must be purchased through in-network pharmacy providers in order to be covered, unless such requirement is prohibited by law. Make sure you know what is covered by your health plan and any requirements before you receive any of these services. Recommended annual services are based on a calendar year resetting January 1 of every year.

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 your age, gender, and family history. 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 – 49: Every one to two years • Ages 50 and older: Once a year
Behavioral Health Well Check (Delaware State Law)	Once a year visit with a licensed mental health clinician with at minimum a master's level degree.
Depression Screening and Anxiety Screening	Once a year
Illicit Drug-Use Screening	Once a year
Pelvic and Breast Exam	Once a year
SCREENINGS/PROCEDURES	
Abdominal Aortic Aneurysm Screening	Ages 65 – 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 five years • High-risk: More often
Colon Cancer Screening (Including colonoscopy)	• Ages 45 and older: Every one to 10 years, depending on screening test • High-risk: Earlier or more frequently
Colon Cancer Screening	Ages 45 and older: Colonoscopy following a positive result obtained within one year by other mandated screening method
Certain Colonoscopy Preps With Prescription	• Ages 45 and older: Once every 10 years • High-risk: Earlier or more frequently
Diabetes Screening	High-risk: Ages 40 and older, once every three years

* 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

Adults: Ages 19+

SCREENINGS/PROCEDURES	
Hepatitis B Screening	• Once per lifetime for adults • High-risk: More often
Hepatitis C Screening	Ages 18 – 79
Latent Tuberculosis Screening	High-risk
Lung Cancer Screening (Requires prior authorization and use of authorized facility)	Ages 50 – 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	• Baseline mammogram: Ages 35 – 39 • Ages 40 and older: Once a year includes 3D, follow-up mammogram, MRI • Ultrasound as recommended by physician
Osteoporosis (Bone Mineral Density) Screening	Ages 65 and older: Once every two years, or younger if at risk as recommended by physician
Ovarian Cancer Screening (Delaware State Law)	• High risk, without cancer diagnosis: Twice a year – Certain screening labs, tumor marker tests, transvaginal ultrasound, pelvic exam
Cervical Cancer Screening	• Ages 21 – 65 Pap: Every three years, or annually, per doctor's advice • Ages 30 – 65: Every five years if HPV only or combined Pap and HPV are negative • 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 • 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 two-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
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 two-, three-, or four-dose series
Hepatitis B	• Ages 19 – 59: Two to four doses per doctor's advice • Ages 60 and older: High-risk per doctor's advice
Human Papillomavirus (HPV)	• To age 26: One three-dose series • Ages 27 – 45, at-risk or per doctor's advice
Measles, Mumps, Rubella (MMR)	One or two doses
Meningitis*	At-risk or per doctor's advice
Pneumonia	High-risk or ages 65 and older: One or two doses, per lifetime

* Meningococcal B vaccine per doctor's advice.

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

IMMUNIZATIONS**

RSV Vaccine	• Ages 60 and older • Pregnant women
Shingles	• Shingrix — Ages 50 and older: Two doses • Ages 19 to 49: Immunocompromised per doctor's advice

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION

Aspirin	Pregnant women at risk for preeclampsia
Folic Acid	Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid
Chemoprevention drugs such as raloxifene, tamoxifen, or aromatase inhibitors* **	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 – 75 years with one or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and have calculated 10-year risk of a cardiovascular event of 10% or greater
Select PrEP Drugs and Certain Related Services for Prevention of HIV Infection	Adults at risk for HIV infection, without an HIV diagnosis

PREVENTIVE CARE FOR PREGNANT WOMEN

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

PREVENTION OF OBESITY, HEART DISEASE, DIABETES, AND STROKE

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

ADULT DIABETES PREVENTION PROGRAM (DPP)

Applies to Adults • Without a diagnosis of diabetes (does not include a history of gestational diabetes) • Overweight or obese (determined by BMI) • 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

** 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.

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

2025 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.)	●	●	●	●	●	●	●	●	●	●	●
Behavioral Health Well Check (Delaware State Law)	Once a year visit with a licensed mental health clinician with at minimum a master's level degree.										
Hearing Screening	●										
SCREENINGS											
Autism Screening									●	●	
Critical Congenital Heart Disease (CCHD) Screening With Pulse Oximetry	●										
Developmental Screening						●			●		●
Hematocrit or Hemoglobin Anemia Screening							●				
Hepatitis C Screening			Per MD recommendation with material exposure during pregnancy								
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 3 or 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						
RSV Vaccine	Per MD recommendation following CDC guidelines										

* 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. 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 – 18			
Ambulatory Blood Pressure Monitoring**												●
Anxiety Screening						Once a year from ages 8 – 18						
Behavioral Health Well Check (Delaware State Law)	Once a year visit with a licensed mental health clinician with at minimum a master's level degree.											
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 – 11 and ages 17 – 21					
IMMUNIZATIONS												
Chicken Pox		Dose 2										
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 – 18: 1 or 2 doses annually											
Human Papillomavirus (HPV)							Provides long-term protection against cervical and other cancers. 2 doses when started ages 9 – 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	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	15Y	18Y
BRCA Mutation Screening (Requires prior authorization)					Per doctor's advice							
Cholesterol Screening	Screening will be done based on the child's family history and risk factors											
Fluoride Varnish (Must use primary care doctor)	Ages 5 and younger											
Hepatitis B Screening									Per doctor's advice			
Hepatitis C Screening												●
Latent Tuberculosis Screening												High-risk
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)									For all sexually active individuals HIV routine check, once between ages 15 – 21			
Tuberculin Test	Per doctor's advice											

Children: 6 Months to 18 Years[1]

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Oral Fluoride	For ages 6 months to 16 years whose primary water source is deficient in fluoride
PREVENTION OF OBESITY, HEART DISEASE, DIABETES, AND STROKE	
Children with a BMI in the 85th to 94th percentile (overweight) and the 95th to 98th percentile (obese) are eligible for:	• Additional annual preventive office visits specifically for obesity • Additional nutritional counseling visits specifically for obesity • Recommended lab tests: – Alanine aminotransferase (ALT) – Aspartate aminotransferase (AST) – Hemoglobin A1c or fasting glucose (FBS) – Cholesterol screening
Age 18 with a diagnosis of Hypertension, High Blood Pressure, Dyslipidemia, or Metabolic Syndrome	Nutritional counseling
ADULT DIABETES PREVENTION PROGRAM (DPP) AGE 18	
Applies to Adults • Without a diagnosis of diabetes (does not include a history of gestational diabetes) • Overweight or obese (determined by BMI) • 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 four 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	Screen for diabetes in pregnancy at first prenatal visit or at weeks 24 – 28 and after pregnancy in women with a history of gestational diabetes and no diagnosis of diabetes.
HIV Screening and Discussion	• All sexually active women: Once a year • Ages 15 and older, receive a screening test for HIV at least once during their lifetime • Risk assessment and prevention education for HIV infection beginning at age 13 • 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 three years
Domestic and Intimate Partner Violence Screening and Counseling	Once a year
Breastfeeding (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. Note: On page 2 of the form under the title Prior Authorization reads "Contraceptives require a statement of medical necessity only". The following link works for all states. [https://content.highmarkprc.com/Files/Region/PA/Forms/MM-056.pdf] Only 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] 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.

Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield serves the state of Delaware and is an independent licensee of the Blue Cross Blue Shield Association.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

Discrimination is Against the Law

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

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

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

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

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

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

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

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

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.

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

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).

אכטונג: אויב איר רעדט אידיש, זענען שפראך הילף סערוויסעס, פריי פון אפצאל, אוועילעבל פאר אייך. רופט די נומער וואס איז אויף די פארקערטע זייט פון אייער ID קארטל (TTY:711).

মনোযোগ দিন: আপনি যদি বাংলা ভাষায় কথা বলেন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ রয়েছে। আপনার আইডি কার্ডের পিছনে থাকা নম্বরে ফোন করুন। (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).

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

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (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).

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).

ΠΡΟΣΟΧΗ: Σε περίπτωση που μιλάτε Ελληνικά, οι διαθέσιμες υπηρεσίες γλωσσικής βοήθειας σας παρέχονται δωρεάν. Καλέστε τον αριθμό στο πίσω μέρος της ταυτότητας σας (TTY:711).

Information About the Affordable Care Act (ACA)

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

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

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

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

Wellness

WELLNESS COACHES

Personalized support for health goals.

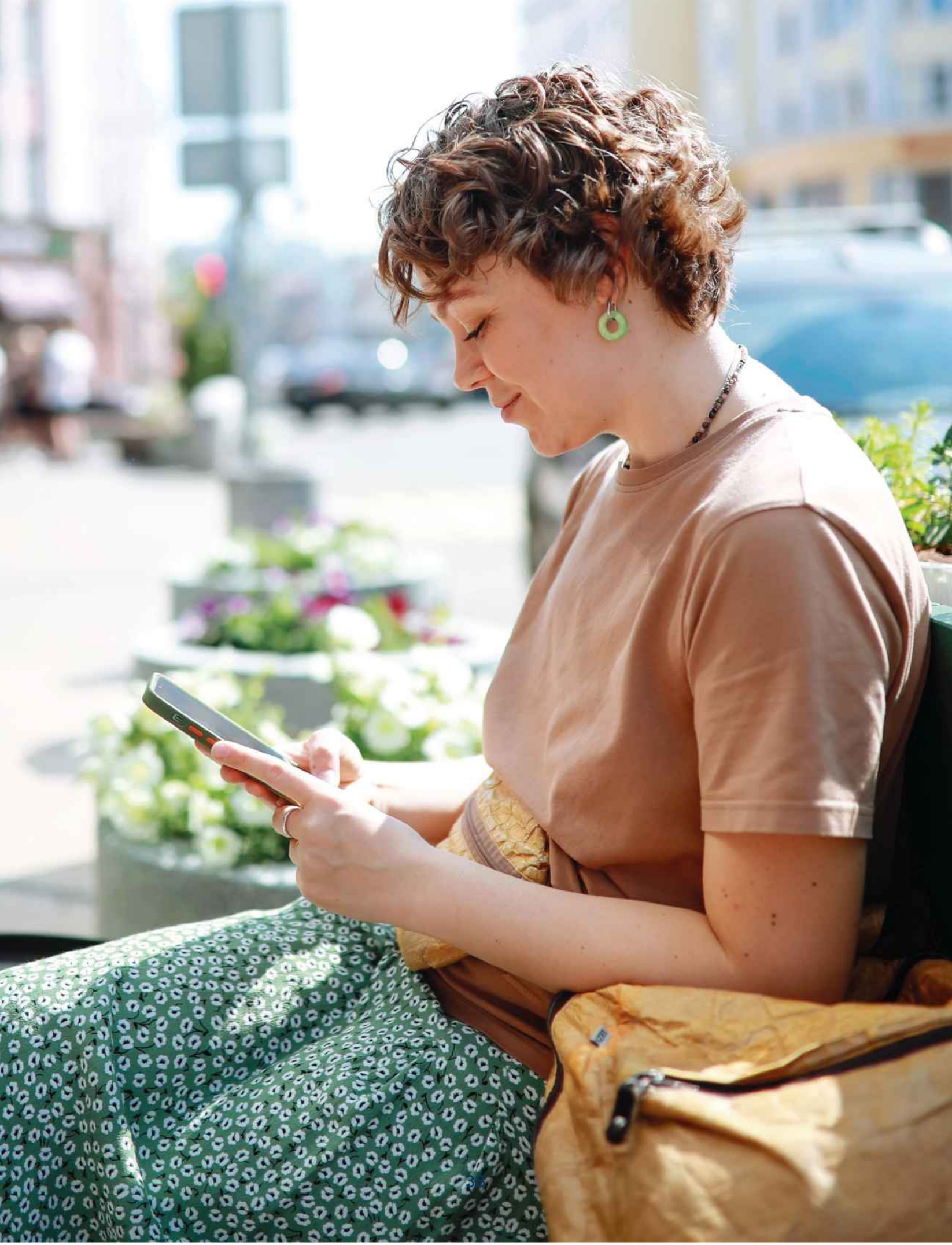
Looking to lose weight? Quit smoking? Be more active? Balance stress? A wellness coach can create a personalized plan for you, right over the phone, on your schedule. Sessions are free and confidential. Call 1-800-650-8442, Monday – Friday, or visit **HighmarkHealthCoachBCBS.com**.

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.

Health Tools and Resources



ONLINE TOOLS AND 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 **myhighmark.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, **myhighmark.com**.

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 COMMUNITY SUPPORT PLATFORM

We're here when you need us.

The Highmark Community Support Platform connects you to organizations that offer free or reduced cost services for food, housing, transportation, and more. Visit **highmarkcommunitysupport.com** and enter your ZIP code to search anonymously for resources in your community.

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.

EXPLANATION OF BENEFITS (EOB)
A statement from your insurance company that shows services you received, including the amount your insurance covers and what you'll owe.

HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)
A plan that usually comes with a lower premium because you pay more for health care services upfront before the insurance company starts to pay. These plans are often combined with a health savings account.

IN-NETWORK PROVIDER
A doctor, hospital, or other provider 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
Out-of-network providers are not in the program's network. You may be responsible for paying any differences between the program's payments and the provider's actual charges.

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 providing your 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.

Determining care for coverage

How we approve what's covered:

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 receive care and have it 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. This also includes advanced radiology and cardiac imaging. Call the Member Service number on the back of your member ID card or in the My 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 your care doesn't meet those qualifications, you always have the right to appeal that decision.

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

How we keep your information safe:

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

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

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

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

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

Care and case management

Programs for care support and complex condition management:

CARE MANAGEMENT PROGRAM

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

Services under the Care Management Program:

Precertification Review starts before you get care and:

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

Concurrent Review happens during the course of treatment to:

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

Discharge Planning occurs throughout the course of treatment to:

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

Retrospective Review happens after services have been provided and:

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

CASE MANAGEMENT PROGRAM

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

Individual goals of Case Management include:

- Identifying and resolving gaps in care.
- Assuring the right care at the right time through appropriate facilities and providers.
- Increasing members' understanding of their condition or situation.
- Reducing medication inconsistencies and ensuring correct use of prescribed medications.
- Addressing any caregiver issues that may affect members' conditions.
- Improving members' ability to self-manage their conditions and wellness focus.
- Reducing potentially avoidable emergency room visits and hospital readmissions.
- Assessing medication needs and consulting with the Highmark pharmacy team as deemed necessary.

How the Case Management Program works:

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

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

Case management is voluntary and meant to support members. They can opt out of the program at any time.

Prior authorization for out-of-area services

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

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

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

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

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

Let's break this down a little more.

1. You and your provider agree on a service that you need.
2. Your provider lets Highmark 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.

All your resources, all in one place

Keep this page handy. It lists the tools and programs available to you and how to find them.

My Highmark App

It's your health plan at your fingertips. Visit **myhighmark.com** or download the My Highmark app from the Apple App Store or Google Play.

Well360 Virtual Health

Get care from wherever you are. Visit **myhighmark.com** or use the MyHighmark app.

Blues On Call

A registered nurse is ready to answer your questions.
Call **1-888-BLUE-428** or use the My Highmark app or website.

Blue365

For discounts to help you stay healthy and active, visit **blue365deals.com**.

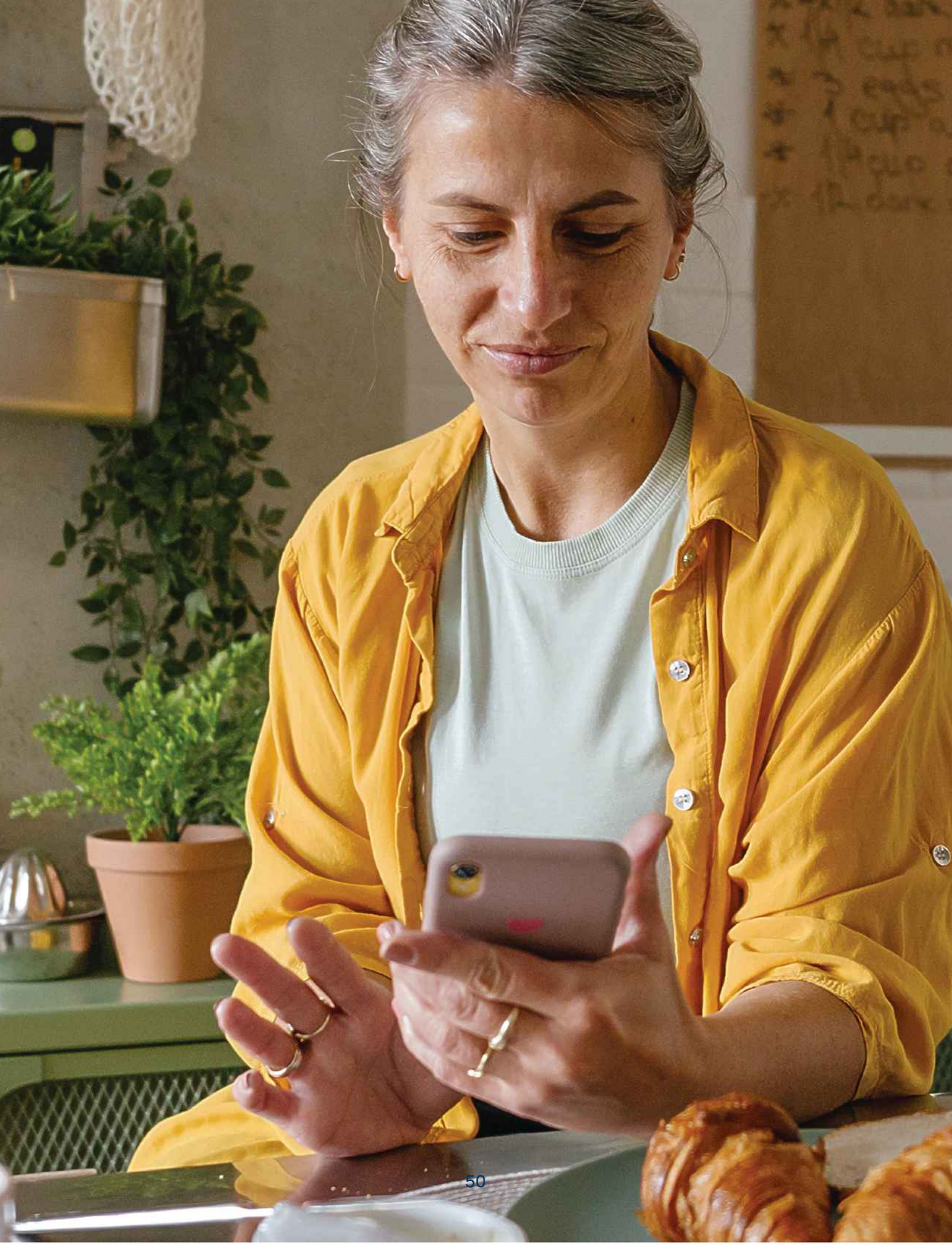
Baby BluePrints

Our no-cost maternity program provides support from specially trained health coaches. Call **1-866-918-5267** to enroll.

Member Service

Have questions about your plan? Call the number on the back of your ID card or use the My Highmark app. You can also view a digital copy of your ID card on the member website at **myhighmark.com**.

Enrollment Application



HIGHMARK DELAWARE

ENROLLMENT/WAIVE FORM

I. EMPLOYEE INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer Name	Group Number	Payroll Location

Last Name	First Name	MI	Social Security No.

Address

City	State	Zip	Home Phone

Product Selection:
- ❑ Medical Product Name: _____
- ❑ Vision Product Name: _____
- ❑ Dental Product Name: _____

Employment Status	Date of Full-Time Hire (Mo / Day / Yr)	Hours Worked Per Week	❑ COBRA
❑ Active ❑ COBRA ❑ Disabled			Start Date _____ End Date _____

COBRA REASON:
❑ Deceased ❑ Involuntary Lay-Off Date of Event _____
❑ Left Employment ❑ Other _____

II ENROLLMENT INFORMATION AND COVERAGE SELECTION

List ALL Dependents, Relationship to Employee and Coverage Selection	First Name & Middle Initial (show Last Name if different from Subscriber)	Social Security #	Birthdate	Gender	Dependent Status If Over Age 26	Product Selection Med**	Vis	Den
Employee			/ /	❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
❑ Spouse ❑ Dom. Part.* ☐☐			/ /	❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
❑ Child ❑ Other* ☐☐			/ /	❑ M ❑ F	❑ Disabled	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
❑ Child ❑ Other* ☐☐			/ /	❑ M ❑ F	❑ Disabled	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
❑ Child ❑ Other* ☐☐			/ /	❑ M ❑ F	❑ Disabled	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

*If "domestic partner" or "other" applies, complete using one of the following codes: (02) Adopted Child, (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter and (29) Domestic Partner. Legal Documentation (Court Decree, Guardianship Papers, Domestic Partner Affidavit, etc.) must be provided prior to enrollment. ❑ Other: _____

If you answered No to Med** under Product Selection, please list reason: _____

I hereby certify that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/or any of my Eligible Dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a qualifying event occurs before coverage will be offered.

By entering your name on the signature line below, you understand that you are creating an electronic signature which has the same effect as a written signature, and you are representing that you have reviewed and submitted this form accordingly.

_____ _____

Employee Signature ONLY SIGN IF YOU ARE WAIVING COVERAGE Date

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, as long as you are covered by the group's health insurance plan provided by your employer, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association:

Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. **Your plan may not cover all your health care expenses. Read your plan materials carefully to determine which health care services are covered. For more information, call the number on the back of your member ID card or, if not a member, call 866-459-4418.**

Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield.

West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. **Visit https://www.highmarkbcbswv.com/NetworkAccessPlan to view the Access Plan required by the Health Benefit Plan Network Access and Adequacy Act. You may also request a copy by contacting us at the number on the back of your ID card.**

Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield.
Highmark Blue Cross Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

Onduo is a separate company that provides a virtual diabetes care program for your health plan.

Sword Health, Inc is an independent company that provides wellness services for your health plan.

Sword Health Professionals provides its services through a group of independently owned professional practices consisting of Sword Health Care Providers, P.A., Sword Health Care Providers of NJ, P.C., and Sword Health Care Physical Therapy Providers of CA, P.C.

Express Scripts is an independent company that administers the pharmacy benefit for your health plan.

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

Livongo is an independent company that provides a diabetes management program on behalf of Highmark.

Mental Well-Being is offered by your health plan and powered by Spring Health. Spring Health is an independent company that provides mental health care services through its agents. Spring Health does not provide Blue Cross and/or Blue Shield products or services. Spring Health is solely responsible for their mental health care services.

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.

Verily Life Sciences LLC ("Verily") is an independent company that offers virtual care management programs for eligible individuals. Verily collaborates with Onduo Management Services LLC ("OMS"), Onduo LLC, and a network of affiliated Professional Entities to offer the services. These services are not intended to replace routine care.

Vida is a separate company that provides cardiometabolic condition management services for certain eligible members of your health plan. There is no cost for most health plan members. If you have a qualified high-deductible plan, you may have to pay out of pocket for some services with this solution until you meet your deductible.

Well360 Virtual Health is offered by your health plan and powered by Amwell. Amwell is an independent company that provides telemedicine services and does not provide Blue Cross and/or Blue Shield products or services. Amwell is solely responsible for their 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.

Davis Vision provides the provider network for Blue Edge Vision and is a separate company that administers vision benefits.

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.

07/24 MX3458650

HIGHMARK DELAWARE

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 Delaware 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 1-877-959-2563.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-877-959-2563.

如果您说中文，可向您提供免费语言协助服务。 請致電 1-877-959-2563.

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-877-959-2563.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-877-959-2563 로 전화.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-877-959-2563.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-877-959-2563.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-877-959-2563 .

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-877-959-2563.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-877-959-2563.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-877-959-2563.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-877-959-2563.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-877-959-2563.

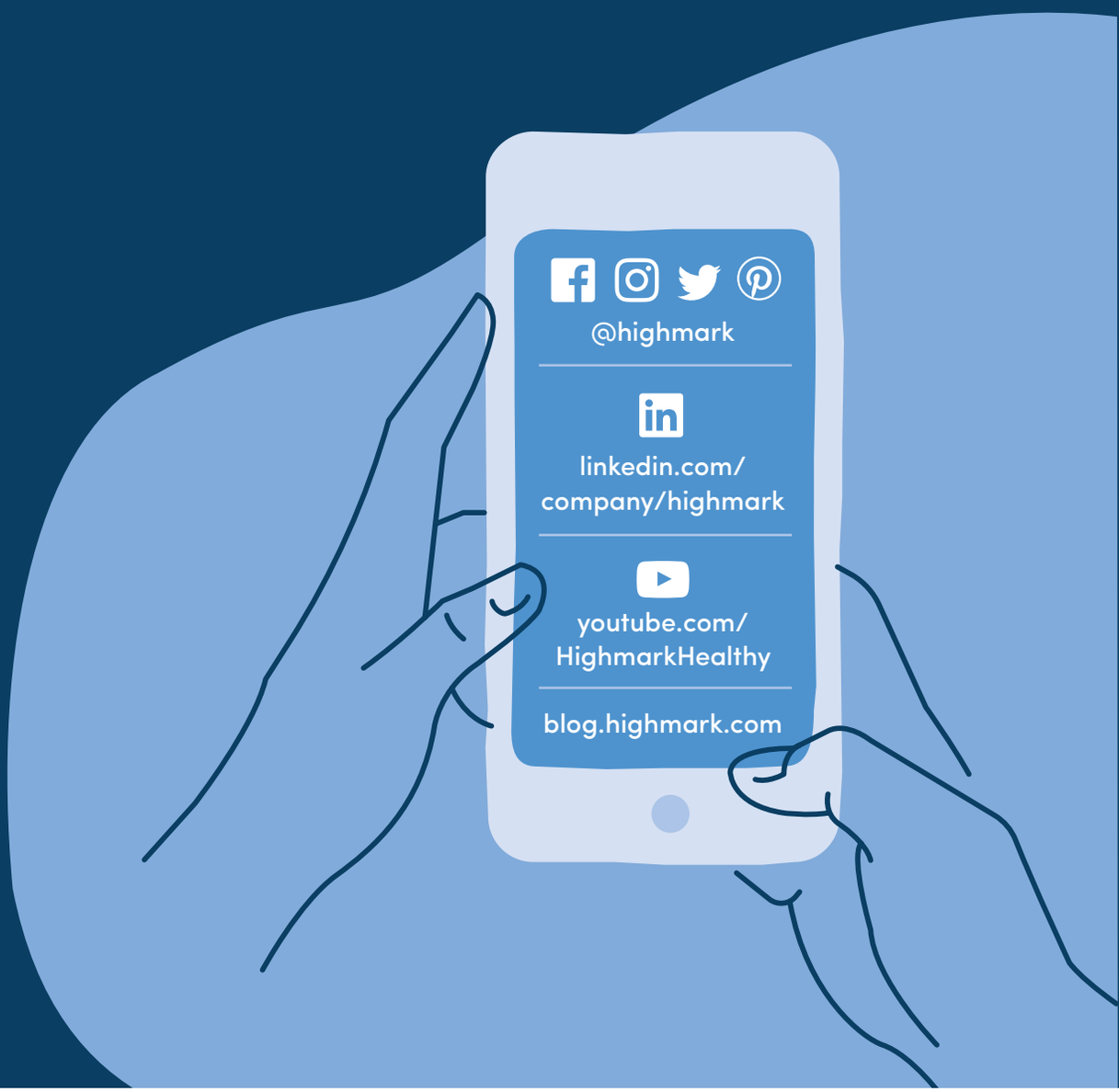
Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-877-959-2563.

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。 1-877-959-2563 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-877-959-2563 .

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.