CHAPTER 2: PRODUCT INFORMATION

UNIT 4: BENEFIT PLAN PROGRAMS

IN THIS UNIT

ALL PROVIDER TYPES

What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information maybe designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**

The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.

The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.

The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

2.4 BABY BLUEPRINTS

Overview

Baby Blueprints® is a maternity education and support program available to expectant Highmark members. This free program is designed to help expectant families better understand and enjoy every stage of pregnancy and make more informed care and lifestyle decisions.

Program details

Baby Blueprints is a free program that offers expectant Highmark members educational information on all aspects of pregnancy through online resources during each trimester of pregnancy. Topics include prenatal care, proper use of medications, avoiding alcohol and tobacco, working, travel considerations, nutrition and weight gain, exercise, body changes, and many others.

Baby Blueprints will also provide program participants access to individualized support from a nurse Health Coach.

Providers are encouraged to promote patient enrollment to reinforce medical care and maternity information so that pregnant women may "have a greater hand in their health."

What Is My Service Area?

Member fliers

Please click on the applicable link for your service area for a printable Baby Blueprints flier for your eligible Highmark members:

- Pennsylvania:
  - **Highmark Blue Cross Blue Shield Baby Blueprints Flier**
  - **Highmark Blue Shield Baby Blueprints Flier**
- **Highmark Delaware Baby Blueprints Flier**
- **Highmark West Virginia Baby Blueprints Flier**

Who is eligible for Baby Blueprints?

Baby Blueprints is available to expectant Highmark members enrolled in a commercial group product, direct pay product, or social mission product.

Baby Blueprints is not available for members enrolled in a Medicare/Medicare Advantage product, Federal Employee Program (FEP), or any self-funded employer groups that have opted out.

How members can enroll

Enrollment in Baby Blueprints is simple and convenient. Expectant mothers can enroll at no cost over the phone by calling toll free **1-866-918-5267**.

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2.4 BABY BLUEPRINTS, Continued

What can members expect?

Upon enrollment members will receive a confirmation mailing that contains:

- Enrollment confirmation letter
- Information on various educational resources and online support programs found on the Highmark member site
- Information on a childbirth education class reimbursement form, which is available online
- Child immunization and preventive care pamphlet

Members will also receive access to pregnancy-related information on the member website and the *Pregnancy Building Blocks* maternity booklet. The program also includes proactive outreach from a nurse health coach. After delivery, members may also be referred to enroll in a post-partum depression program, if appropriate.

If the member's program includes Blues On Call, she can call the toll-free number at any time to talk to a health coach about any questions/concerns she may have following pregnancy. (For more information on Blues On Call, please see the "Blues On Call" section within this unit.)

Quick Reference

FOR MORE INFORMATION

If you have questions about Baby Blueprints, please contact the Provider Service Center.

If members have further questions about Baby Blueprints, please encourage them to call Member Services at the number on their ID card.

2.4 BLUES ON CALL

What is Blues On Call?

Highmark has an integrated program, Blues On Call, to attempt to address the total health care needs of the patient rather than focusing on one specific condition. Highmark members may contact Blues On Call 24 hours a day, every day of the year.

The Blues On Call team includes Health Coaches who provide support over the telephone to discuss health information and assist with health care decisions.

Who is eligible?

Most Highmark members are automatically eligible to make use of Blues On Call services. No registration is required and the service is free.

Chronic condition support

Blues On Call focuses on helping members manage their chronic illnesses, placing special emphasis on the importance of dealing with the co-morbidities that face many seriously ill individuals. Since most chronically ill members have more than one chronic condition, the Blues On Call "whole patient" approach is a significant improvement over "silo-structured" disease management programs.

The program content is objective and evidence-based. Information and material is from national sources such as the American Diabetes Association. The scope of chronic condition support through Blues On Call includes:

- Condition-specific standards of care
- Medication adherence
- Specific activities related to medical condition monitoring (weight monitoring, blood sugar monitoring)
- Regular physician visits
- Flu and pneumonia vaccines

Medical decision support

Blues On Call Health Coaches educate and support those facing significant medical decisions related to conditions such as:

- Back pain (spinal stenosis, herniated disc, and chronic low back pain)
- Breast cancer (adjuvant therapy, choosing your surgery, choosing your treatment)
- Benign uterine problems
- End-of-life care
- Prostate issues (benign prostatic hyperplasia, prostate-specific antigen [PSA] decision)
- Knee osteoarthritis
- Coronary artery disease

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2.4 BLUES ON CALL, Continued

Medical decision support (continued)	Health Coaches provide objective, evidence-based information to help individuals understand their situation, including the potential benefits and potential harms of treatment choices. Health Coaches also help patients gain insights into their choices and provide a framework to think through the decision. Most importantly, members can incorporate their personal values and preferences into the decision and communicate more effectively with their provider.
Symptom management support	Blues On Call Health Coaches provide support over the telephone to help members interpret and act on symptoms. Coaches are available 24 hours a day, every day of the year. Health Coaches use algorithms to educate and support patients to help them make informed decisions about their current situation. This approach provides patients with the opportunity to learn skills that can be used when similar situations arise in the future.
What Blues On Call is not	Blues On Call does not: • Address benefit issues • Address claims issues • Provide diagnosis or medical advice
When to refer a patient	Refer a patient to Blues On Call any time he or she needs more information or assistance about a health care topic or if support by a Blues On Call Health Coach would benefit the patient.
Links to other Highmark resources	Blues On Call Health Coaches can provide information on a variety of health and wellness topics. They also work closely with other Highmark resources for members.
How to refer to Blues On Call	Encourage your patient to call the Blues On Call phone line (this number is also located on the back of the member ID card**): 1-888-BLUE-428** (1-888-258-3428).
Poster available	The **Blues On Call poster** can be printed for your office or to give to a Highmark member. The poster is also available on the Provider Resource Center – select **EDUCATION/MANUALS**, and then **Prevention 101 Awareness Posters**.

2.4 DIABETES PREVENTION PROGRAM

Introduction

Effective January 1, 2018, certain Highmark members have access to a diabetes prevention program as part of their Highmark preventive benefits schedule. Self-funded employer groups may choose to opt out of the program.

The program is available to Highmark members who have coverage under their preventive benefits and meet the program's eligibility criteria. Eligible members can choose between attending in-person classes in the community or an option with online classes and support.

Note: The program was effective for State of Delaware employees with coverage under a State of Delaware Group Health Insurance Program administered by Highmark Delaware beginning August 1, 2017.

What Is My Service Area?

What is the Diabetes Prevention Program?

The Diabetes Prevention Program (DPP) is a structured lifestyle and health behavior change program with the goal of preventing the onset of type 2diabetes in individuals who are prediabetic. The program is certified by the Centers for Disease Control and Prevention (CDC). The 12-month program includes:

- Choice of an in-person classroom setting or an online/mobile app program
- Sixteen "core" sessions
- Monthly follow-up meetings

The program's primary goal is to attain at least five percent (5%) average weight loss among participants. According to the CDC, losing five percent of your weight can help prevent diabetes.

Highmark has partnered exclusively with two vendors to deliver the Diabetes Prevention Program to our members. Members can choose the in-person classroom program available at participating YMCA locations **or** the online program through Retrofit.℠

Program eligibility criteria

The vendor of the program option the member chooses, YMCA or Retrofit, will confirm a member's program eligibility prior to offering program enrollment. Eligible members must be at least eighteen (18) years of age and meet criteria of being "prediabetic," which includes:

- Body Mass Index (BMI) of 25 or greater;
- Fasting blood glucose of 100-125mg/dl; and
- No previous diagnosis of diabetes.

Members may also be Identified as at-risk via the CDC risk screening questionnaire tool available on the YMCA and Retrofit websites as part of the enrollment process.

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2.4 DIABETES PREVENTION PROGRAM, Continued

YMCA's classroom program

The YMCA Diabetes Prevention Program provides a supportive environment where participants work together in a small group to learn about healthier eating and increasing their physical activity in order to reduce their risk for developing diabetes. The program is led by a trained Lifestyle Coach in a classroom setting over a 12-month period, beginning with sixteen (16) weekly sessions followed by monthly maintenance. The program is offered at select YMCA locations.

Under the YMCA in-person classroom program, the benefits/services include:

- Member attends structured sessions at an on-site location
- Led by a trained Lifestyle Coach
- Year-long program of twenty-five (25) sessions
- Food, weight, and activity tracking
- Peer support and accountability
- CDC-approved curriculum

Retrofit's online/mobile program

Retrofit is a leading provider of weight-management and disease-prevention solutions. Retrofit's online 12-month Diabetes Prevention Program provides personalized coaching from experienced clinicians through online sessions, personalized one-on-one coaching, tracking tools, and peer support.

The benefits/services of the Retrofit program for eligible Highmark members include:

- Welcome kit with wireless scale, activity tracker
- One-on-one expert coaching sessions for nutrition, behavior, exercise physiology
- Expert-led classes
- Expert moderated online community (peer support)
- Online dashboard and mobile app, including food, weight, and activity tracking
- Online proactive and reactive messaging
- Video (live) coaching sessions (telephonic support when preferred)
- Text messaging for "in the moment" personalized coaching
- CDC-approved curriculum

What Is My Service Area?

Member flier

Please click on the applicable link for your service area for a printable Diabetes Prevention Program flier for your eligible Highmark members:

- Pennsylvania:
  - **Highmark Blue Cross Blue Shield Diabetes Prevention Program Flier**
  - **Highmark Blue Shield Diabetes Prevention Program Flier**
- **Highmark Delaware Diabetes Prevention Program Flier**
- **Highmark West Virginia Diabetes Prevention Program Flier**

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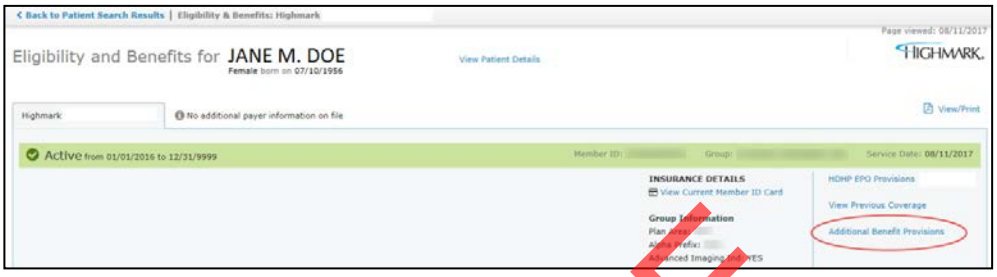
2.4 DIABETES PREVENTION PROGRAM, Continued

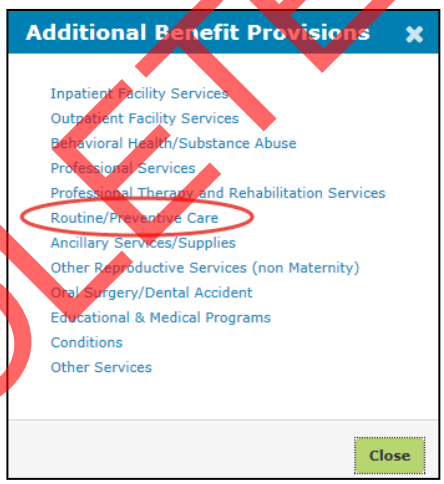
Verify program eligibility via NaviNet®

Providers can verify a member's coverage for the Diabetes Prevention Program in NaviNet's Eligibility and Benefits.

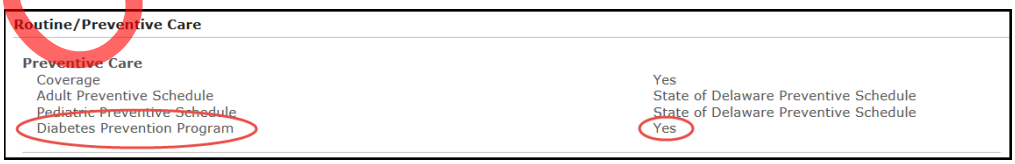
From the main Eligibility and Benefits screen, select **Additional Benefit Provisions**:



And then select **Routine/Preventive Care** from the pop-up box.



Scroll down to the **Preventive Care** benefit, "Diabetes Prevention Program" will be listed under the Preventive Schedule categories and will indicate **"Yes"** if the member's plan provides coverage.



2.4 HEALTH PROMOTION PROGRAMS

Introduction

Health promotion and risk reduction is part of the overall health management program. Highmark's Health Management Services (HMS) department offers a variety of condition management, case management, and wellness programs. Services and programs are offered on-line, in the community, at the workplace, and telephonically.

Health Promotion programs

Programs are designed to raise member awareness of healthy versus unhealthy habits, make healthy choices, reduce risk of injury and help members with an acute or chronic condition.

The health promotion activities focus on three (3) key areas:

- Wellness Profile (health risk and productivity assessments)
- Worksite Health Promotion Programs
- Lifestyle Improvement Programs

Web-based programs

Web-based programs, powered by Web-MD, are available to all medically insured members. The programs are designed to guide members in developing a personal plan for implementing a healthier lifestyle and reinforce their healthcare provider's instructions for managing chronic conditions.

Members start with the completion of a Wellness Profile. A Digital Health Assistant (DHA) may then provide an online experience emulating one on one personal coaching. The DHA helps members take action, set goals, track progress, and create weekly plans that support longer-term goals.

Worksite programs

Worksite programs are offered as an optional service to employers wishing to promote a healthy culture among their employees through awareness, education, and activities to encourage engagement.

Services that encourage awareness include on-site biometric screenings and health fairs. Education services include individual coaching in conjunction with the biometric screening experience, live classes pertaining to weight, stress, or nutrition management delivered either on-site or via webinar, and newsletter campaigns.

Engagement is encouraged through a variety of "Reward" programs that track participation for incentive purposes, and activity based "Challenges" that promote increased exercise through friendly competition.

Continued on next page

2.4 HEALTH PROMOTION PROGRAMS, Continued

Primary Health Coach Model

HMS uses the primary health coach model along with various clinical platforms to support its health promotion programs.

Employer groups are given the option to select a model to engage their employees in condition and case management, and wellness activities.

In all models, a Primary Health Coach provides a single point of contact for members for both condition and case management to further enhance the seamlessness of the member experience. Members are encouraged to develop collaborative relationships with their Health Coaches.

Co-morbidities addressed

The Health Coach addresses co-morbidities that many seriously ill individuals face. The Primary Health Coach Model uses motivational interviewing and coaching techniques, and focuses on the whole person. These techniques allow the Health Coach to address the member's full spectrum of healthcare issues rather than focusing on a single issue or condition.

Enrollment time period

The time period a member is enrolled in a condition management program varies, and is specific to the member's needs. The Health Coach assists the member in developing care goals whose focus is member self-management. Once these goals are accomplished, the program is closed.

Members are encouraged to re-engage with the Health Coach at any time that their clinical condition requires, or when they simply want the additional support of the Health Coach to work toward attainment of their goals.

Components of the Primary Health Coach Model

There are three main components in the Primary Health Coach Model.

High Risk Member Outreach
High risk members are coached using motivational interviewing techniques with a focus on self-management. Health coaches assess members using questionnaires then, in collaboration with the member, develop goal directed plans of care.

Health coaches individualize the length and frequency of each call based on member need or request.

Moderate Risk Member Outreach
Eligible moderate risk members are targeted for Interactive Voice Response (IVR) calls. The goals of these calls are to provide the member with basic information about their condition, to review the member's perception of their self-management and overall health, to provide health tips and reminders specific to

Continued on next page

2.4 HEALTH PROMOTION PROGRAMS, Continued

Components of the Primary Health Coach Model (continued)

their condition, and to offer the member the opportunity to transfer to speak directly to a Health Coach.

When the member accepts the opportunity to speak to a Health Coach, the member can be enrolled in a condition management program. This enrollment enables the member to have ongoing access to a Primary Health Coach who will assist the member to develop short and long-term self-management goals and to develop strategies for overall health improvement.

The Health Coach uses the member contacts focused on condition management to assist the member with any gaps in care that may be impacting their overall health as well as any screening recommendations that may result in earlier detection of potential health concerns.

Low Risk Member Outreach

Low risk members are targeted for condition-specific mail campaigns. The materials include condition specific topics/questions to discuss with their doctor and a variety of health promotion educational topics such as smoking cessation, nutritional needs, and physical activity recommendations.

2.4 HEALTH SPENDING ACCOUNTS

Overview

In today's health care market, employers and consumers are looking for options to lower their health care costs and have more control over their health care spending. Highmark offers the following health spending account options to respond to those needs:

- Health Savings Accounts (HSAs)
- Health Reimbursement Accounts (HRAs)
- Flexible Spending Accounts (FSAs)

Health spending accounts help Highmark members to save money to cover their out-of-pocket medical costs, to better manage their health-related expenses, and to be more involved in their health care decisions while also receiving significant tax savings. Members are able to track all of their health care spending online at their secure Highmark member website.

Health Savings Account (HSA)

A Health Savings Account (HSA) can be offered with a federally-qualified high-deductible health plan (QHDHP). The Internal Revenue Service (IRS) determines the annual maximum contribution. HSAs must be linked with a qualified high-deductible health insurance plan, and both the employer and the employee can contribute to it.

Pre-tax income can be set aside to spend on eligible medical expenses and there is no tax on account withdrawals as long as they are used for eligible expenses. The member may invest savings in a variety of mutual funds offered through the HSA. Interest or investment earnings also accumulate tax-free.

The employer may establish payroll deduction for employee contributions and may also opt to contribute to the accounts. The member owns and manages the HSA and decides how and when to use account funds. The account funds accumulate year after year. The funds move with the employee when he/she changes jobs.

Health Reimbursement Account (HRA)

A Health Reimbursement Account (HRA) is a health spending account funded by the employer. The employer decides how much to fund the account, which types of expenses may be paid using the account funds, and whether funds roll over at the end of the benefit period.

By offering an HRA along with a health plan that includes employee cost sharing, employers are able to share more of the health care costs while providing employees with health care coverage they value. The employer can designate the funds to be used for the member's cost sharing for covered services and also for expenses not covered by their medical plan such as dental or vision care services. Employees are encouraged to be more involved in their spending decisions and better able to monitor their health care costs.

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2.4 HEALTH SPENDING ACCOUNTS, Continued

Flexible Spending Account (FSA)

Flexible Spending Accounts (FSAs) allow members to set aside a specified amount from their paycheck to pay for out-of-pocket medical and health-related expenses not fully reimbursed by their health coverage. An FSA offers a practical solution for those who have additional or special care needs, or for those who would like a vehicle to help budget their medical and health-related costs.

An employer can offer an optional FSA to their employees with any Highmark health plan. A Limited Purpose Medical Care FSA is another option that can be offered with a qualified high deductible health plan in addition to an HSA; however, it can be used for dental, vision, and preventive care expenses only.

The employee determines the amount to contribute to the FSA (up to a maximum set by the IRS), and their pre-tax contributions through payroll deduction are not subject to taxes. The money is the employee's to manage and use during the plan year. Funds must be used by the end of the benefit year since account balances do not carry over; any unused balance at the end of the benefit period is forfeited back to the plan.

Plan Activity Statement for members

Highmark health spending account members can view their account and claims information in a single, user-friendly document. Plan Activity Statements replace Explanation of Benefits (EOB); they capture multiple processed claims and spending account transactions in one document. They are available to members who are enrolled in both a Highmark medical benefit plan and a Highmark health spending account product (HSAs, HRAs, and FSAs).

The statements are written in simple language with clear explanations of claims payments and health spending account activity. The Plan Activity Statement offers many benefits to members, including:

- An easy to use and understand format that gives members a clear, comprehensive view of what services have been performed, what they cost, what has been paid, and the amount they may owe;
- Fewer statements to manage since the Plan Activity Statement consolidates multiple processed medical claims and spending account transactions into one document; and
- One statement for the whole family that clearly outlines the activity for each family member who is covered under the policy holder's plan.

Members who elect to receive the Plan Activity Statements electronically can access them with their logon and password via the secure Highmark member website. Members who request paper copies of their EOBs will receive a paper version of the Plan Activity Statement through the mail.

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2.4 HEALTH SPENDING ACCOUNTS, Continued

Payment options

All members with HSA accounts receive a debit card which allows them to make payments at the time of service if they choose. Members with HSAs can also manage payments through the Highmark member website. They can designate payment to providers from their accounts on a claim by claim basis, or they can request payment "to self" and reimburse providers with a personal check.

Another payment option available to members with HSAs is "Direct Payment to Provider" – claims are then automatically submitted for payment to providers directly from their accounts.

For HRAs and FSAs, the employer determines how their employees have access to the funds. The employer can choose from the following options:

- Manual claim submission, with or without a debit card; or
- Automatic submission of claims, with or without "Direct Payment to Provider."

An employer could choose the manual claim submission option if they would like their employees to have more control of HRA and FSA funds. This would allow their employees to manage payments themselves through the Highmark member website. With this option, members can designate payment from their accounts to providers on a claim by claim basis, or they can elect to pay themselves and reimburse providers with personal checks. And, if the employer chooses to offer a debit card, they would also be able to make payments at the time of service using the debit card.

If an employer chooses automatic submission of claims, they have two options for setting up automatic payment from HRA and FSA accounts. They can choose to have payments sent directly to providers ("Direct Payment to Provider"), or they could choose for payment from the accounts to go to employees who would then be responsible for payment to providers.

Direct Payment to Provider

If a member's health spending account is set up for "Direct Payment to Provider" and money is available in the account, you will receive a separate payment (check or Electronic Funds Transfer, or EFT) and notice (known as an Explanation of Payment, or EOP) for claims paid under a member's spending account.

If the member's HSA, HRA, or FSA does not have sufficient funds for the entire amount due, you will receive whatever amount is available in the account. You can then bill the member directly for the remaining balance due. As subsequent deposits are made and additional funds become available in the account, the remaining portion of the payment will be distributed to the member.

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2.4 HEALTH SPENDING ACCOUNTS, Continued

Explanation of Payment (EOP)

Whenever a full or a partial payment is made to you from a member's health spending account, you will receive an EOP to document the transaction while the member receives notification through their Plan Activity Statement. NaviNet-enabled providers will receive their EOPs via the NaviNet **EOB and Remittance Inquiry** function.

This Direct Payment to Provider option from a member's health spending account does not eliminate your ability to collect patient liability, such as copayments or other outstanding balances, due at the time of service. Highmark provides "Real-Time" tools, accessed via NaviNet, that help providers determine member responsibility prior to or at the time of services.

- The *1500 Estimate Submission* function can assist you in estimating the member's financial responsibility. The estimate will consider any deductible, coinsurance, and/or copayments included in the member's plan benefits.
- The *Claim Submission* function gives providers the added ability to submit claims for specific health care services and receive a fully adjudicated response within seconds. This allows providers to determine, at the time of service, the correct amount the member owes.

These Real-Time estimation and adjudication tools provide immediate responses and give providers the ability to discuss member financial liability with patients when services are scheduled or provided. They also enable providers to collect payment or make payment arrangements for the member's share of the cost at the time of service. Please note, however, that if you collected payment upfront for member liability, and subsequently receive payment from the member's health spending account, the refund must be issued directly to the member.

Another helpful tool on NaviNet is the *Benefit Accumulator* which is available on a member's *Eligibility and Benefits Details* page. This tool provides the status of the member's deductible and coinsurance accumulation for the benefit period, if applicable, based on all claims finalized to date.

Please note that *Benefit Accumulator* and *Real-Time Estimation* are accurate at the time of viewing or request. The member's liability status could change by the time your claim is adjudicated based on claims received but not yet processed, additional services received prior to the adjudication of your claim, or if services rendered are different than those estimated.

For additional information about the Real-Time Tools available via NaviNet, please see **Chapter 1.3: Electronic Solutions -- EDI & NaviNet**.

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2.4 HEALTH SPENDING ACCOUNTS, Continued

Spending account inquiries

For spending account questions or issues in, contact the dedicated Provider Spending Account Information Line:

- Pennsylvania and West Virginia: **1-800-652-9478**
- Delaware: **1-800-346-6262**

What Is My Service Area?

Refund checks for HSA, HRA, and FSA overpayments

If you receive an overpayment from a member's HSA, HRA, or FSA, it will be necessary for you to submit this overpayment back to Highmark at the applicable postal address below. **Please do not send any overpayments directly to the member**. Highmark will ensure that the proper monies are deposited back into the member's account.

PENNSYLVANIA & WEST VIRGINIA:	DELAWARE:
Highmark Attention: Cashier P.O. Box 890150 Camp Hill, PA 17001-9774	Highmark Delaware Attention: Treasury P.O. Box 1991 Wilmington, DE 19899-1991

2.4 HIGHMARK WELLNESS REWARDS

Overview

Highmark Wellness Rewards is an optional program available to employer groups which encourages members to take more personal responsibility for their health. It promotes behavior change and provides members with incentives for making real, constructive health and lifestyle changes.

The program is part of a wholly integrated online health platform, developed in conjunction with WebMD®, complete with wellness programs to address issues like tobacco cessation, diet, exercise, and stress management. It is connected to helpful online tools that can help Highmark members identify health risks, track progress, and provide them with information on relevant health issues.

Program benefits

The goal of Highmark Wellness Rewards is to affect long-term, healthy behavior change. The program focuses on assessing health risks and identifying unhealthy behaviors. And it gives Highmark members the tools they need to first understand their health status and then take necessary action to maintain or improve their health.

By offering Wellness Rewards in addition to a Highmark medical benefit plan, employers are providing their employees with a proven wellness program delivered through a trusted online resource. Healthy individuals have more energy and feel better physically and mentally. A rewards program enhances the role individuals play in their health so they lead healthier lifestyles and make more informed and appropriate care decisions.

For employers, a healthy workforce can translate into reduced absenteeism and lost time due to illness, better productivity, and happier employees on and off the job. And, by offering a Highmark Wellness Rewards program, employers are demonstrating their commitment and support of their employees' health and well-being.

Wellness Profile

A comprehensive Wellness Profile serves as the foundation of the Highmark Wellness Rewards program. It is a self-health analysis that covers all aspects of an individual's health including nutrition, weight management, and physical activity. The assessment takes only 15-20 minutes to complete and the member receives results online in minutes.

The data entered by the member in the Wellness Profile is used to generate a personalized action plan, or Wellness Profile Report. This is an in-depth, individualized health status report that identifies areas in need of health improvement and includes recommendations for health and wellness programs and activities.

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2.4 HIGHMARK WELLNESS REWARDS, Continued

How it works

Highmark Wellness Rewards engages our members in making healthy lifestyle choices by providing programs to educate and motivate them while their employers provide the incentives for participation. The programs are appropriate for every stage of health -- they address members who are healthy, members with chronic conditions, and those members who have short-term events that are affecting their health.

Because different organizations have different needs, Highmark Wellness Rewards offers two reward structures to match their needs: action-based rewards and points-based rewards. Both options can be chosen in a standard or customized format.

- An action-based program requires members to complete specific activities by a set date and earn rewards for completion.
- A points-based program allows an employer to offer a variety of activities, each with its own point value, and then members can choose which activities best suit their needs. As they complete tasks, they accumulate points to earn rewards as designated by their employer.

Employers are able to choose from a selection of standard program options that best suit their needs. The standard options provide a variety of programs and activities that require various levels of participation. A health awareness program simply requires the completion of the Wellness Profile to identify health risks and inspire healthy changes while other more engaging options require members to participate in worksite health screenings, preventive exams, health coaching, and health and wellness activities.

If an employer is looking for an even more personalized program, a customized program can be created to reward employees based on the company's own health strategy and organizational goals. For completing their program requirements, whether standard or customized, employees receive rewards predetermined by their employer -- such as an extra day off or financial rewards in the form of a gift card -- and, ultimately, better health.

With your help we can create rewards that last a lifetime

Highmark Wellness Rewards takes the proven data on health behavior change and creates a new opportunity for members, their employers, and Highmark to make a mutual commitment. And, with provider support, Wellness Rewards will proactively encourage healthier lifestyles to help prevent and control chronic illness.

2.4 MYCARE NAVIGATOR

Overview

MyCare Navigator is a telephone-based support service available to Highmark members and their families to help them make informed decisions and get the care that they need. This service is offered as part of our commitment to support health advocacy for our members. The service is free and is available Monday through Friday from 8 a.m. to 8 p.m.

MyCare Navigator℠

A dedicated myCare Navigator associate can assist members with specific health care issues such as finding a physician or pharmacy, verifying the network status of a physician or pharmacy, making appointments, transferring medical records or prescriptions, and arranging transportation for medical visits.

Who is eligible?

MyCare Navigator is available to Highmark members and their family members – including spouses and domestic partners, dependent children, parents, and parents-in-law. These family members may use the service even if they do not have their health insurance coverage with Highmark.

Program objective

The program objective of myCare Navigator focuses on offering services that help Highmark members to effectively navigate through the cumbersome and often confusing health care system. Assistance includes, but is not limited to, offering resource support services and guidance with obtaining provider and pharmacy information.

Health advocates provide personalized assistance

MyCare Navigator makes it easy for Highmark members and their families to get answers to health care questions and help with their health care needs. By calling a toll-free telephone line, the member is connected to a myCare Navigator health advocate who is most often a registered nurse supported by a physician. The health advocate then provides personalized service until the caller's request is completed.

The myCare Navigator health advocates can assist our members and their families with a variety of health care related questions and tasks including:

- Locating network participating primary care physicians, specialists, hospitals, labs, and other providers and facilities that meet their needs
- Scheduling office visits and other appointments
- Arranging for physician-to-physician consultations
- Assisting with the transfer of medical records
- Seeking and coordinating second opinions

Continued on next page

2.4 MYCARE NAVIGATOR, Continued

Health advocates provide personalized assistance (continued)

- Understanding and using their medical benefits and prescription drug coverage to their best advantage
- Directing them to information and resources to help in making informed, appropriate care decisions
- And much more!

There are certain situations when it would be more appropriate to refer a member to Blues On Call rather than myCare Navigator. Those include:

- New clinical diagnosis
- Currently working with a Highmark Health Coach already
- Specialty group conditions
- Critical diagnosis conditions
- Decision support

Directing members to myCare Navigator

Highmark members and their families can reach a myCare Navigator health advocate by calling the following toll-free telephone number:

1-888-BLUE-428 (1-888-258-3428), Option 2

If you receive inquiries about myCare Navigator from your Highmark patients, you can direct them to this number on the back of their Member ID cards (listed as "Blues On Call").

What providers can expect

MyCare Navigator health advocates may be calling your office on behalf of Highmark members or their family members. Please be sure your staff is informed about this service for Highmark members so they are aware of and prepared for these potential incoming calls.

If you have questions about myCare Navigator and the services it offers, please contact Highmark Provider Services.

2.4 PATIENT EXPERIENCE REVIEW

Introduction

Over the past decade, Highmark has expanded the various online tools available to help support members to make informed decisions on their health care services. In 2012, Highmark added to those tools by launching "Patient Experience Review," a convenient patient review tool developed in collaboration with the Blue Cross and Blue Shield Association (BCBSA).

Goal of initiative

Highmark's goal is to present meaningful patient review information to our members directly from the member website in order for them to make informed decisions about their care. At the same time, Highmark anticipates that the information shared will be meaningful to providers as feedback for their own quality improvement programs.

How it works

Highmark members have the ability via the member website to post comments and to respond to a core set of five questions for the professional provider survey and up to seven questions for the facility survey, covering their overall experience. The comments and the display of these ratings is pre-password, but only authenticated members (post-password) can post a review. This process helps assure that only authenticated Blue members who attest that they have seen the physician, or received care at the facility, can contribute to the review process.

Note: Comments are checked for appropriateness before being displayed on the Highmark Online Provider Directory.

Reviews restricted to Highmark members

All Highmark members have the ability to post a review once they log into our secure member website and sign an electronic attestation verifying that they have received services in the past two years from the provider they are rating.

Also, members of other Blue Plans have the ability to rate providers, including our network, using their own patient review tool. This functionality is being coordinated on the national level through the Blue Cross and Blue Shield Association.

Reviews available for public view

Anyone, including members and prospective members, can access the reviews by viewing the Highmark Provider Directory, which is accessible pre-password on our member website.

Providers may also read any reviews by visiting the online Highmark Provider Directory accessible from our regional websites.

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2.4 PATIENT EXPERIENCE REVIEW, Continued

Types of providers that members can review

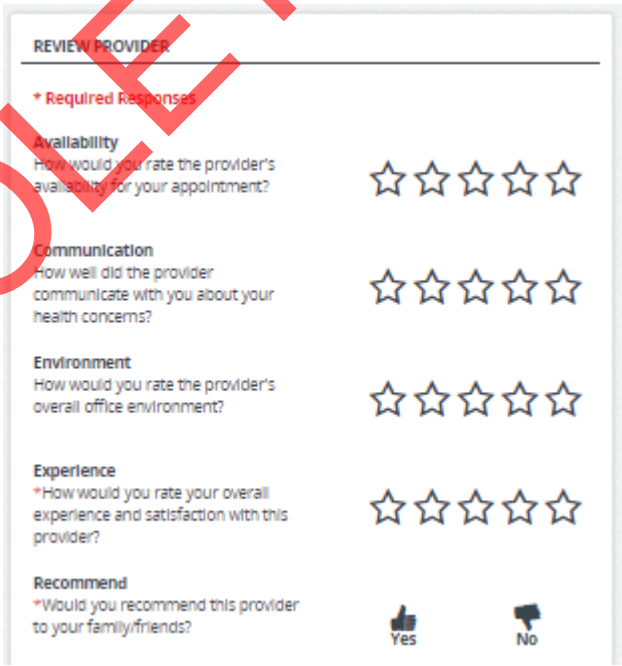
Through Patient Experience Review, members can rate and post comments about professional providers, certain ancillary providers, and the following facility provider types:

- Acute-care hospitals
- Children's hospitals
- Inpatient rehabilitation facilities
- Outpatient rehabilitation facilities
- Ambulatory surgery centers
- Freestanding hospices
- Birthing centers
- Urgent care centers
- Retail health clinics
- Diagnostic imaging centers

Survey questions for providers

The survey tool for providers focuses on five broad categories, with a specific question in each. Members are asked to respond by selecting "yes/no" or from within a five-star range, where one star is "low" and five stars is "high." Responses to the last two questions are required before a member can submit a review.

Members are also given the option to write additional comments, if desired.



Providers can monitor reviews

Providers can monitor the ratings and comments being posted about their services. Through NaviNet®, practitioners and facilities can register an email address and receive an automated alert each time a review is posted. In addition, providers are able to respond to all reviews that are posted, with the ability to remove from public view up to two comments posted in a rolling twenty-four (24) month period.

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2.4 PATIENT EXPERIENCE REVIEW, Continued

Instructional tip sheet available

TIP SHEET

Click on the Tip Sheet icon for instructions on registering an email address. You will receive an email alert when a member rating or comment about your practice or facility is posted in the Highmark Provider Directory. Instructions are also provided on how a practitioner or an individual appointed to monitor facility reviews can read and respond to reviews received.