As a reminder to employees, Highmark now covers preventive services under our medical plan at 100% if a participating provider is used. Below is information that will help you determine what Highmark considers preventive and how the coverage is defined.

“What is preventive or routine care?”
Preventive – or routine – care is medical care that’s provided to a patient who doesn’t have any symptoms. Insurance companies – including Highmark – do not typically pay for services provided to a member with no illness or symptoms because these services are not considered medically necessary.

Highmark BCBS has developed the “Highmark Preventive Schedule” to provide coverage for a specific list of preventive or routine services that allow physicians and members to identify medical issues early and either address the issues or prevent major problems. By providing coverage for screenings and other preventive services, Highmark is helping our members have a greater hand in their health. Examples include:

- Routine physical exams (adult and pediatric)
- Pediatric immunizations
- Adult immunizations
- Routine gynecological examination and Pap test
- Mammograms
- Specified diagnostic and surgical services such as lipid panel, flu shots, PSA test, and colonoscopy (based on the age and risk factors of the member)

The Highmark Preventive Schedule covers these and other services on a specified frequency (for example, annually, once every three years, etc.) based on age and risk factors, using guidelines established on a national basis. For example, flu shots are covered once a year for all members age 50 or over and for other members who are considered high risk. Services under the Preventive Schedule are covered at 100% if a participating provider is used.

“How does the Highmark Preventive Schedule define ‘annual’?”
If services are covered annually, this means on a calendar year (January through December) basis – not based on the member’s contract year. For services that are covered less than annually – such as every three years or every 10 years – each “year” equals a 12-month period, beginning with the last date the service was received.

“Are there exceptions to this rule?”
There are three exceptions to the rule that preventive benefits are paid at the same level as medically necessary services:

- Pap Tests
  If a member receives a Pap test on a non-routine basis – that is, because symptoms indicate the medical necessity for the test – the Pap test is considered a diagnostic service, subject to any program deductible, coinsurance and maximums.

In contrast, a preventive (or routine) Pap test is combined with the routine gynecological exam and is not subject to any deductible or program maximum. Routine Pap tests are paid this way due to a PA state mandate.