



**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, [www.myhighmark.com](http://www.myhighmark.com) or call 1-800-544-6679. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.HealthCare.gov/sbc-glossary/](http://www.HealthCare.gov/sbc-glossary/) or call 1-800-544-6679 to request a copy.

| Important Questions                                                       | Answers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | \$6,000 individual/\$12,000 family <u>network</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                               | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                             |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. Office visits, <u>preventive care services</u> , standard diagnostic services, <u>urgent care</u> , <u>rehabilitation services</u> , <u>habilitation services</u> , outpatient mental health, outpatient substance abuse, pediatric vision services, pediatric dental exam, and tier 1 & 2 <u>prescription drug</u> expenses are covered before you meet your <u>deductible</u> .<br><br><u>Copayments</u> and <u>coinsurance</u> amounts don't count toward the <u>network deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | \$8,600 individual/\$17,200 family <u>network</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                               | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                   |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Premiums</u> , balance-billed charges, and health care this <u>plan</u> doesn't cover.                                                                                                                                                                                                                                                                                                                                                                                                         | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                |

|                                                          |                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Will you pay less if you use a <u>network provider</u> ? | Yes. See <a href="http://www.myhighmark.com">www.myhighmark.com</a> or call 1-800-544-6679 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ).<br>Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do I need a <u>referral</u> to see a <u>specialist</u> ? | No.                                                                                                                                 | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |



All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

| Common Medical Event                                          | Services You May Need                            | What You Will Pay                                                                                                   |                                                        | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                     |
|---------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                  | <u>Network Provider</u><br>(You will pay the least)                                                                 | <u>Out-of-Network Provider</u> (You will pay the most) |                                                                                                                                                                                                                                                                            |
| If you visit a health care <u>provider's office</u> or clinic | Primary care visit to treat an injury or illness | \$55 <u>copay</u> /visit<br><u>Deductible</u> does not apply.                                                       | Not covered                                            | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.<br><br>Please refer to your <u>preventive</u> schedule for additional information. |
|                                                               | <u>Specialist</u> visit                          | \$55 <u>copay</u> /visit<br><u>Deductible</u> does not apply.                                                       | Not covered                                            |                                                                                                                                                                                                                                                                            |
|                                                               | <u>Preventive care/screening/Immunization</u>    | No charge<br><u>Deductible</u> does not apply.                                                                      | No coverage                                            |                                                                                                                                                                                                                                                                            |
| If you have a test                                            | <u>Diagnostic test</u> (x-ray, blood work)       | \$55 <u>copay</u> /visit (blood work lab)<br>\$125 <u>copay</u> /visit (x-ray)<br><u>Deductible</u> does not apply. | Not covered                                            | Copayments, if any, do not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse.<br>Precertification may be required.                                                                                                            |
|                                                               | Imaging (CT/PET scans, MRIs)                     | \$600 <u>copay</u> /visit                                                                                           | Not covered                                            |                                                                                                                                                                                                                                                                            |

| Common Medical Event                                                                                                                                                                                          | Services You May Need                          | What You Will Pay                                                                                                                                                                         |                                                        | Limitations, Exceptions, & Other Important Information                                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                               |                                                | <u>Network Provider</u><br>(You will pay the least)                                                                                                                                       | <u>Out-of-Network Provider</u> (You will pay the most) |                                                                                                                                                                                              |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.myhighmark.com">www.myhighmark.com</a> | Tier 1                                         | \$10/\$20/\$30 <u>copay</u> per prescription (retail)<br>\$20 <u>copay</u> per prescription (mail order)<br><u>Deductible</u> does not apply.                                             | Not covered                                            | Up to 31/60/90-day supply retail pharmacy.<br><br>Up to 90-day supply maintenance <u>prescription drugs</u> through mail order.<br><br>This <u>plan</u> uses an Essential <u>Formulary</u> . |
|                                                                                                                                                                                                               | Tier 2                                         | \$30/\$60/\$90 <u>copay</u> per prescription (retail)<br>\$60 <u>copay</u> per prescription (mail order)<br><u>Deductible</u> does not apply.                                             | Not covered                                            |                                                                                                                                                                                              |
|                                                                                                                                                                                                               | Tier 3                                         | \$250/\$500/\$750 <u>copay</u> per prescription (retail)<br>\$500 <u>copay</u> per prescription (mail order)                                                                              | Not covered                                            |                                                                                                                                                                                              |
|                                                                                                                                                                                                               | Tier 4                                         | 50% <u>coinsurance</u><br>\$250/\$500/\$750 min<br>\$1,000/\$2,000/\$3,000 max per prescription (retail)<br>50% <u>coinsurance</u><br>\$500 min/\$2,000 max per prescription (mail order) | Not covered                                            |                                                                                                                                                                                              |
| <b>If you have outpatient surgery</b>                                                                                                                                                                         | Facility fee (e.g., ambulatory surgery center) | \$500 <u>copay</u> /visit                                                                                                                                                                 | Not covered                                            | Precertification may be required.                                                                                                                                                            |
|                                                                                                                                                                                                               | Physician/surgeon fees                         | \$500 <u>copay</u> /visit                                                                                                                                                                 | Not covered                                            | Precertification may be required.                                                                                                                                                            |

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                                              |                                                                | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | <u>Network Provider</u><br>(You will pay the least)            | <u>Out-of-Network Provider</u> (You will pay the most)         |                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                | \$750 <u>copay</u> /visit                                      | \$750 <u>copay</u> /visit                                      | Out-of-network: Subject to <u>network deductible</u> . <u>Copay</u> waived if admitted as an inpatient.                                                                                                                                                                                                                                                                                                           |
|                                                                                  | <u>Emergency medical transportation</u>   | 30% <u>coinsurance</u>                                         | 30% <u>coinsurance</u>                                         | Out-of-network: Subject to <u>network deductible</u> .                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                  | <u>Urgent care</u>                        | \$100 <u>copay</u> /visit<br><u>Deductible</u> does not apply. | \$100 <u>copay</u> /visit<br><u>Deductible</u> does not apply. | The copayment, if any, does not apply to urgent care services prescribed for the treatment of mental illness or substance abuse.                                                                                                                                                                                                                                                                                  |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)        | \$1,125 <u>copay</u> /visit                                    | Not covered                                                    | Precertification may be required.                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                  | Physician/surgeon fees                    | No charge                                                      | Not covered                                                    | Precertification may be required.                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you have mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$55 <u>copay</u> /visit<br><u>Deductible</u> does not apply.  | Not covered                                                    | Precertification may be required.                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                  | Inpatient services                        | \$1,125 <u>copay</u> /visit                                    | Not covered                                                    | Precertification may be required.                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you are pregnant</b>                                                       | Office visits                             | 30% <u>coinsurance</u>                                         | Not covered                                                    | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)                                                                                                                                  |
|                                                                                  | Childbirth/delivery professional services | No charge                                                      | Not covered                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                  | Childbirth/delivery facility services     | \$1,125 <u>copay</u> /visit                                    | Not covered                                                    | <u>Network</u> : The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health <u>Preventive</u> Schedule for additional information. Precertification may be required.                                                                                                                                                                                                      |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>                   | 30% <u>coinsurance</u>                                         | Not covered                                                    | <u>Network</u> : 60 visits per benefit period, aggregate with visiting nurse. Precertification may be required.                                                                                                                                                                                                                                                                                                   |
|                                                                                  | <u>Rehabilitation services</u>            | \$55 <u>copay</u> /visit<br><u>Deductible</u> does not apply.  | Not covered                                                    | <u>Network</u> : 30 combined physical medicine and occupational therapy visits and 30 speech therapy visits per benefit period. Copayment, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. The limit, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. Precertification may be required. |

| Common Medical Event                   | Services You May Need            | What You Will Pay                                             |                                                        | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                  |
|----------------------------------------|----------------------------------|---------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                  | <u>Network Provider</u><br>(You will pay the least)           | <u>Out-of-Network Provider</u> (You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                        | <u>Habilitation services</u>     | \$55 <u>copay</u> /visit<br><u>Deductible</u> does not apply. | Not covered                                            | <u>Network</u> : 30 combined physical medicine and occupational therapy visits and 30 speech therapy visits per benefit period.<br>Copayment, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. The limit, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse.<br>Precertification may be required. |
|                                        | <u>Skilled nursing care</u>      | \$1,125 <u>copay</u> /visit                                   | Not covered                                            | <u>Network</u> : 120 days per benefit period.<br>Precertification may be required.                                                                                                                                                                                                                                                                                                                                      |
|                                        | <u>Durable medical equipment</u> | 30% <u>coinsurance</u>                                        | Not covered                                            | Precertification may be required.                                                                                                                                                                                                                                                                                                                                                                                       |
|                                        | <u>Hospice services</u>          | 30% <u>coinsurance</u>                                        | Not covered                                            | <u>Network</u> : Respite care limit of 7 days every six months.<br>Precertification may be required.                                                                                                                                                                                                                                                                                                                    |
| If your child needs dental or eye care | Children's eye exam              | No charge<br><u>Deductible</u> does not apply.                | Not covered                                            | <u>Network</u> : One eye exam per 12 month period up to age 19.                                                                                                                                                                                                                                                                                                                                                         |
|                                        | Children's glasses               | No charge<br><u>Deductible</u> does not apply.                | Not covered                                            | <u>Network</u> : One pair of frames/lenses every 12 months for members under the age of 19.                                                                                                                                                                                                                                                                                                                             |
|                                        | Children's dental check-up       | No charge<br><u>Deductible</u> does not apply.                | Not covered                                            | <u>Network</u> : One exam every 6 months.                                                                                                                                                                                                                                                                                                                                                                               |

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion, except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the life of the woman in danger unless an abortion is performed.
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Infertility treatment

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or at <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <http://www.HealthCare.gov> or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Highmark, Inc. at 1-800-544-6679.
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

### Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next section.—————

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$6,000 |
| ■ <u>Specialist</u> <u>copayment</u>          | \$55    |
| ■ Hospital (facility) <u>copayment</u>        | \$1,125 |
| ■ Other <u>coinsurance</u>                    | 30%     |

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| <u>Cost Sharing</u> |         |
|---------------------|---------|
| <u>Deductibles</u>  | \$6,000 |
| <u>Copayments</u>   | \$1,900 |
| <u>Coinsurance</u>  | \$0     |

#### ***What isn't covered***

|                                   |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$7,960</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$6,000 |
| ■ <u>Specialist</u> <u>copayment</u>          | \$55    |
| ■ Hospital (facility) <u>copayment</u>        | \$1,125 |
| ■ Other <u>coinsurance</u>                    | 30%     |

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| <u>Cost Sharing</u> |         |
|---------------------|---------|
| <u>Deductibles</u>  | \$800   |
| <u>Copayments</u>   | \$1,200 |
| <u>Coinsurance</u>  | \$0     |

#### ***What isn't covered***

|                                   |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,020</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$6,000 |
| ■ <u>Specialist</u> <u>copayment</u>          | \$55    |
| ■ Hospital (facility) <u>copayment</u>        | \$1,125 |
| ■ Other <u>coinsurance</u>                    | 30%     |

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| <u>Cost Sharing</u> |         |
|---------------------|---------|
| <u>Deductibles</u>  | \$2,000 |
| <u>Copayments</u>   | \$500   |
| <u>Coinsurance</u>  | \$0     |

#### ***What isn't covered***

|                                   |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,500</b> |

The plan would be responsible for the other costs of these EXAMPLE covered services.

Insurance or benefit administration may be provided by Highmark Blue Shield, Highmark Benefits Group, Highmark Select Resources, or Highmark Health Insurance Company, all of which are independent licensees of the Blue Cross and Blue Shield Association.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to <http://www.highmark.com/transparency-in-coverage>; or for a paper copy, call 1-855-873-4110.

## 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](mailto: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 [ocrportal.hhs.gov/ocr/portal/lobby.jsf](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  
Phone: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at [hhs.gov/ocr/office/file/index.html](https://hhs.gov/ocr/office/file/index.html).

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ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (fèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòm aksesib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Для получения помощи позвоните по номеру, указанному на обратной стороне вашей идентификационной карты (TTY: 711).

ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero riportato sul retro della Sua tessera di identificazione (TTY: 711).

ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711) pour obtenir de l'aide.

ÀKÍYÈSÍ: Tí o bá nsọ èdè Yorùbá, àwọn iṣẹ ìtumọ ati ògbufọ èdè wà ní àrọwọtọ lófẹ́ẹ́ fún ọ. Àwọn iṣẹ ìtọ́jú ati ìrànጓwọ́ tó yẹ (bii titẹwé nla, gbigbọ ohùn, ati iwé afọ́jú) lati pèsè iwífúnni ní àwọn ọ̀na irádáyè sì wà pẹ̀lu lófẹ́ẹ́. Pe nọmba tó wà lẹhin kaádi idánimọ rẹ (TTY: 711) fún irànጓwọ́.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזוינע גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל. רופט דעם נומער אויף די אנדערע זייט פון אייער אידענטיטעט קארטל (TTY: 711) פאר הילף.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقات يمكن الوصول إليها من دون أي تكلفة. اتصل على الرقم المدون على ظهر بطاقة هويتك (TTY: 711) للحصول على المساعدة.

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字、音频和盲文），以便您获取无障碍格式的信息。如需帮助，请拨打您的ID卡背面的号码（听障人士专用号码：711）。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિ:શુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેલ) પણ નિ:શુલ્ક ઉપલબ્ધ છે. મદદ માટે તમારા આઈડી કાર્ડની પાછળ આપેલા નંબર (TTY: 711) પર કોલ કરો.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711) để được trợ giúp.

ધ્યાન દિનુહોસ્: યદિ તપાઈ નેપાલી બોલુહુન્છ બને, તપાઈલાઈ નિ:શુલ્ક ભાષા અનુવાદ ર દોભાસે સેવાહરુ ઉપલબ્ધ છન્। પહુચયોગ્ય ઢાંચાહરુમા જાનકારી પ્રદાન ગર્ન ઉપયુક્ત સહાયક પ્રવિધિ ર સેવાહરુ (જસ્તૈ ટૂલો પ્રિન્ટ, અડિયો ર બ્રેલ) પનિ નિ:શુલ્ક ઉપલબ્ધ છન્। મદદતકો લાગિ તપાઈકો ID કાર્ડકો પછાડિકો નમ્બરમા કલ ગર્નુહોસ્ (TTY: 711)।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एकसेस करने योग्य फॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी नि:शुल्क उपलब्ध हैं। सहायता के लिए अपने पहचान कार्ड के पीछे लिखे नंबर (TTY: 711) पर कॉल करें।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용할 수 있습니다. 도움이 필요하시면 ID 카드 뒷면에 있는 번호로 전화하십시오(TTY: 711).