# Health Plan Quality Assurance

## Use this document along with your Summary of Benefits and Coverage and detailed benefit grid

### IN-NETWORK VERSUS OUT-OF-NETWORK CARE

All Highmark plan options let you choose your providers. When you need medical care, you can choose between **in-network** and **out-of-network** providers. It's important to understand the difference because your choice affects how much you pay for services. For example, some plans do not cover care from out-of-network providers, except for emergencies and a few other situations.

#### In-network care

Doctors and hospitals that participate with us are called "in-network" providers. In-network providers include primary care doctors, specialists, hospitals, and a variety of treatment facilities. When you receive health care from an in-network provider, you typically pay less than you would at an out-of-network provider.

**You can use this information to find your plan's in-network doctors and hospitals.**

- **Call My Care Navigator at 1-888-BLUE-428.**
- Visit **highmarkbcbs.com** and click **Find a Doctor or Rx.**

#### Out-of-network care

Doctors and hospitals that do not participate with us are called "out-of-network" providers. Please refer to your plan details to understand what coverage you may or may not have with out-of-network providers. Refer to your Summary of Benefits for a plan's specific coverage.

**Note for members seeking care in western Pennsylvania:** Highmark and UPMC have entered into Consent Decree agreements designed to protect your access to UPMC providers. For important details about how these agreements affect your plan benefits, please go to **Helpful Links** on **highmarkbcbs.com** or call 1-888-BLUE-428.

### MEDICAL NECESSITY, PRIOR AUTHORIZATIONS AND REVIEWS

#### Medically necessary and appropriate

Our Medical Management and Policy (MM&P) team helps you get proper care. They work with your doctor, using specific guidelines to determine if care is medically necessary and appropriate.

Medically necessary and appropriate care helps ensure that you receive the right type of care, in the right place, and for the proper length of time. Medically necessary and appropriate care:

- Must be generally accepted as medical practice standards
- Must be clinically appropriate in type, frequency, extent, site, and duration
- Must be considered effective for your illness, injury, or disease
- Must not be for your or your provider's convenience
- Must not be more costly than another service that may give you similar results

No benefits will be provided unless it is determined that the service or supply is medically necessary and appropriate. If we denied coverage of a service or claim, you have the right to appeal the denial decision. More information about this process is included in the benefit booklet that you will receive after you enroll.

#### Prior authorization, or preservice review

We must approve some services before you can get them. This is called prior authorization, or preservice review.

If you need a service that we must first approve, your in-network doctor will call us to get the authorization. An example of a service needing prior authorization is any kind of inpatient hospital care (except maternity care). If you don't get the prior authorization, you may have to pay up to the full amount of the charges.

The number to call for prior authorization is included on the ID card you will receive after you enroll. Please refer to the specific coverage information you will receive after you enroll.

#### Prior authorization time frames and enrollee responsibilities

Our MM&P team helps you get care:

- In the right setting
- At the appropriate cost
- With the right outcomes

Your plan pays for covered services, supplies, and medications that are medically necessary and appropriate. These might be to prevent, evaluate, diagnose, or treat an illness, injury, or disease, or its symptoms. They:

- Must be generally accepted as standards of medical practice
- Must be clinically appropriate in type, frequency, extent, site and duration
- Must be considered effective for your illness, injury, or disease
- Must not be for your or your provider's convenience
- Must not be more costly than another service that may give you similar results

An in-network provider will contact MM&P to authorize your care. This includes inpatient and outpatient non-emergency care. It is their right to decide if a service, supply, or medication is medically necessary and appropriate. They do this before your plan pays benefits. Your plan will not pay benefits if our team of doctors and nurses decides that the covered service, supply, or medication is not medically necessary and appropriate.

A decision on a request for prior authorization for medical services will typically be made within 72 hours of us receiving the request for urgent cases or 15 days for non-urgent cases.

**No Referrals Needed** — All Highmark plans let you see a specialist without needing a referral from your primary care doctor.

**What We Cover** — Please refer to the Summary of Benefits and Coverage and detailed benefit grid.

### Out-of-network services

It's different if you are admitted to an out-of-network facility. In this case, you must call MM&P to find out if the covered services are medically necessary and appropriate. This does not apply to emergencies.

Call MM&P for precertification at the Member Service number on the back of your ID card before you are admitted to an out-of-network facility, so that you understand your financial responsibility. You should:

- Call seven to 14 days before your planned admission
- Call within 48 hours after an emergency or maternity-related admission
- Call as soon as you can as the last option

### What happens if you don't call?

If you do not call to authorize an out-of-network admission, MM&P will review your care after you receive services. MM&P will decide if the covered service you received was medically necessary and appropriate. If MM&P decides that it was not, you will be responsible for all hospital charges.

Out-of-network providers do not have to contact MM&P. If they do, they do not have to accept MM&P's decision. As a result, you may receive services that are not considered medically necessary and appropriate under your plan. You could be responsible for their costs.

### Postservice review

If we denied payment for a service that you already had, your doctor may ask for a "retrospective review." For this review, we will take a detailed look at your records and information to determine if the services were medically necessary and appropriate.

### Concurrent review

If you are admitted to the hospital and your doctor feels that you may need more days of care, a "concurrent review" may happen. A concurrent review is a detailed review while you are still in the hospital. We do this to determine if the additional in-hospital services are medically necessary and appropriate. Decisions on a request for concurrent review are typically made within 24 hours of receipt.

## CASE MANAGEMENT

If you are injured, seriously ill, or considering certain types of surgery, we may begin a collaborative process that involves case managers, you, your family or significant other, physicians, and institutional providers. Case Management assesses, plans, coordinates, monitors, and evaluates all of the options and services required to meet your health needs with the goal of educating you to self-manage your care.

## NON-COVERED SERVICES

Covered and non-covered services may vary by plan. Please keep in mind that you could be responsible for the total amount of any services not covered by your plan. For more information about services your plan covers, please refer to the benefit materials available to you after you enroll in your Highmark health plan or to the Summary of Benefits and Coverage.

### Non-covered services include, but are not limited to:

- Personal hygiene and convenience items
- Services rendered prior to the member's effective date or after the termination date of coverage
- Custodial care, domiciliary care, and protective and supportive care, including educational service, rest cures, and convalescent care
- Services that are experimental/investigative in nature
- Services that are not medically necessary or appropriate
- Immunizations required for foreign travel or employment except as otherwise set forth in the Preventive Schedule
- Treatment of sexual dysfunction that is not related to organic disease or injury
- Services for or related to surrogate pregnancy
- Routine or periodic physical examinations, except as set forth in the Preventive Schedule, the completion of forms, and the preparations of specialized reports solely for insurance, licensing, employment, or other non-preventive purposes, except as required by law
- Methadone hydrochloride treatment (methadone maintenance) for which no additional functional progress is expected to occur

## PRESCRIPTION DRUG COVERAGE

### Formulary

Your plan uses a formulary, or list of drugs it covers. The formulary includes products in every major treatment category, as well as certain over-the-counter medications. A committee of our pharmacists and physicians developed the formulary. This committee reviews and updates the formulary regularly.

To find out if a drug is on the formulary, please visit your plan's website at: **highmarkbcbs.com**

Select the **Find a Doctor or Rx** tab. Next, choose the **Find a Drug** link. Then select your plan's formulary. Enter the name of the drug to begin your search. In-network providers can also view the formulary. Please refer to the website or talk with your health care provider for the most up-to-date information.

Your prescription drug program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed in the Summary of Benefits and Coverage.

### Participating retail pharmacies

Your plan covers prescriptions when you purchase them through an in-network pharmacy. To find a participating pharmacy, go to your member website listed above. Select the **Find a Doctor or Rx** tab. Then choose on **Find a Pharmacy**. Select the applicable pharmacy network as outlined in the Summary of Benefits and Coverage. Enter the location information and choose the **Locate Pharmacy** button.

### Mail order prescriptions

For long-term or maintenance medicines, you can take advantage of our mail order pharmacy, Express Scripts®. You can get up to a 90-day supply of each covered medication for just one mail order copayment. To learn more or to get started, log in to your member website listed above. Select the **Prescriptions** tab and see the **Save with mail order** section. Find out how you can transfer a prescription or start a new one.

### Generic drugs

Generic drugs have the same chemical composition and therapeutic effect as brand-name drugs and must meet the same Food and Drug Administration (FDA) requirements. Under your prescription coverage, you will pay the lowest copayment or coinsurance amounts when you purchase generic drugs. You will pay a higher copayment for brand-name drugs. Depending on your coverage, if your provider authorizes a generic drug but you purchase a brand-name drug, you will be responsible for paying the cost difference between the brand-name drug and generic drug, as well as the brand-name drug copayment or coinsurance amounts.

### Some drugs need to be approved (pre-authorized)

Certain drugs on the formulary have limits based on medical necessity. Some drugs need your plan's approval to be covered. Your doctor must contact us if a drug needs prior approval. We will tell you and your doctor in writing if we do not approve a drug request. We will also tell you how to file an appeal, if needed. For drugs that are covered by your plan (formulary drugs), a prior authorization decision will typically be made within 72 hours of us receiving the request for urgent cases and 15 days for non-urgent cases.

### Quantity limits

To help ensure the safe and effective use of prescription drugs, your plan includes quantity limits for some drugs. That means the pharmacist will fill a prescription only up to the highest recommended guideline amount. This applies even if a doctor writes it for more. Your doctor will need to call us to discuss approval of a higher quantity.

## Drugs not on the formulary — drug exception time frames and responsibilities

If you have a closed formulary, we must approve payment for drugs that are not on the formulary. If your doctor thinks you need to take a drug that is not on the formulary, your doctor will send us a request for approval. You or someone you designate can also request a non-formulary drug exception.

Exception requests can be mailed to the following address:

Clinical Pharmacy Services
P.O. Box 279
Pittsburgh, PA 15230

Exception requests may also be faxed to 1-866-240-8123 or emailed to RxMbrRequests@highmark.com.

If your request is for a non-formulary drug for a condition that does not seriously jeopardize your life or health (a standard request), we will make a decision and notify you within 72 hours of receiving the request. If the request is for a non-formulary drug for a condition that may seriously jeopardize your life or health (an expedited request) or a drug you are already taking, we will make a decision and notify you within 24 hours of receiving the request.

If you are not happy with our decision on your request for a non-formulary drug, you can contact Member Service at the phone number on your member ID card and ask for an external review. We will then send your request to another organization that will review your request and notify you of a decision within 72 hours for a standard request and 24 hours for an expedited request.

# CLAIMS AND PAYMENTS

## Claims payment policies and practices

- When you need medical care, you can choose between in-network and out-of-network providers. It's important to understand the difference because your choice affects how much you pay for services. For example, care from an out-of-network provider might not be covered except for emergencies or when the services are not available from an in-network provider.
- Doctors and hospitals that participate with us are called "in-network" providers. In-network providers include primary care doctors, specialists, hospitals and a variety of treatment facilities. When you receive health care from an in-network provider, you typically pay less than you would at an out-of-network provider. If you have an HMO or EPO plan, you are not covered for out-of-network services (except for emergency services).
- Doctors and hospitals that do not participate with us are called "out-of-network" providers. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware that your in-network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get care.

## How to submit a claim

A claim is a request you make for payment of the charges or costs for a covered service you received. If you receive services from an in-network provider, you do not have to file a claim. Your in-network provider takes care of that for you. If you go to an out-of-network provider, you may have to file the claim yourself. If you have to file the claim yourself, simply follow these easy steps:

1. Know your benefits. Review your Agreement to see if the services you received are eligible under your plan.
2. Get a detailed bill that includes:
   - The name and address of the service provider
   - The patient's full name
   - Date of service
   - Description of the service/supply
   - Amount charged
   - Diagnosis or nature of illness
   - Doctor's certification for durable medical equipment
   - Nurse's license number and shift worked for private duty nursing
   - Total mileage for ambulance services

   Canceled checks, cash register receipts, or personal lists are not acceptable as bills.
3. Copy bills for your records. You must submit original bills. Once your claim is received, we cannot return bills.
4. Complete a claim form. Make sure all information is completed properly. Date the form. Claim forms may be obtained at https://blog.highmarkhealth.org/medical-prescription-and-spending-account-forms-for-highmark-members/. You can also obtain a claim form by calling the Member Service number on the back of your member ID card. For questions, please call 1-800-294-9568.

   You can submit your claim to:

   Claims (plan code 363)
   P.O. Box 890062
   Camp Hill, PA 17089-0062

   Claims (plan code 378)
   P.O. Box 890173
   Camp Hill, PA 17089-01735

5. After you complete steps 1 through 4, attach all detailed bills to the claim form. Mail the form to the address on the form.

   You can file multiple services for the same family member with one claim form. However, you must complete a separate claim form for each covered member. You must submit your claim no later than 15 months after the date you received services.

## Grace periods and claims submissions

You are required to pay your premium by the scheduled due date. If you do not do so, your coverage could be canceled. For most individual health care plans, if you do not pay your premium on time, you will receive a 30-day grace period. A grace period is a time period when your plan will not terminate even though you did not pay your premium. Any claims submitted for you during that grace period will be pended. When a claim is pended, that means no payment will be made to the provider until your delinquent premium is paid in full. If you do not pay your delinquent premium by the end of the 30-day grace period, your coverage will be terminated. If you pay your full outstanding premium before the end of the grace period, we will pay all claims for covered services you received during the grace period that are properly submitted. If you have an individual HMO plan in Pennsylvania, we will pay your claims during the 30-day grace period; however, your benefits will terminate if your delinquent premium is not paid by the end of that grace period.

If you are enrolled in an individual health care plan offered on the Health Insurance Marketplace and you receive an advance premium tax credit, you will get a three-month grace period, and we will pay all claims for covered services that are properly submitted during the first month of the grace period. During the second and third months of that grace period, we will not pay any claims you incur. If you pay your full outstanding premium before the end of the three-month grace period, we will pay all claims for covered services that are properly submitted for the second and third months of the grace period. If you do not pay all of your outstanding premium by the end of the three-month grace period, your coverage will terminate, and we will not pay for any claims submitted for you during the second and third months of the grace period. Your provider may balance bill you for those services.

## Retroactive denials

A retroactive denial is the reversal of a claim we have already paid. If we retroactively deny a claim we have already paid for you, you will become responsible for payment. Some reasons why you might have a retroactive denial include a claim that was paid during the second or third month of a grace period or a claim paid for a service for which you were not eligible. You can avoid retroactive denials by paying your premiums on time and in full, and making sure you talk to your provider about whether the service being performed is a covered benefit. You can also avoid retroactive denials by obtaining your medical services from an in-network provider.

## Explanation of benefits

Once your claim is processed, you may receive an Explanation of Benefits (EOB) from us. The EOB is not a bill. It's a statement that gives you information about services you received. Services can be from physicians, facilities, or other professional providers. It also includes costs you may owe for these services.

The EOB includes:

- The provider's charge
- The allowable amount
- The copayment, deductible, and coinsurance amounts, if applicable, that you're required to pay
- The total benefits payable
- The total amount you owe

To get your EOBs online, register on **highmarkbcbs.com**. Your EOB can also be mailed to you. If you do not owe a payment to the provider, you may not receive an EOB.

If you are enrolled in a qualified high deductible health plan with a Health Savings Account, you will receive a Plan Activity Statement instead of an EOB. If this applies to you, please refer to the Health Savings Account section in your Benefit Booklet for information about your Plan Activity Statement. For information on how to read and understand your EOB, please refer to How to Read Your Explanation of Benefits (EOB) Statement at the end of this document.

## Coordination of benefits

If you have more than one health insurance plan, those plans need to work together to make sure you are getting the most out of your coverage. One plan is your primary plan. This plan pays your claims first. The other plan is your secondary plan and pays some of any costs remaining after your primary plan pays. If you have other health insurance coverage, you need to tell us so we can coordinate the benefits we provide with the other health insurance plan to establish payment of services. If you have any questions, you can call the Member Service number on the back of your Member ID card or 1-800-294-9568 or TTY 711.

## Overpayment of premium

If you believe you have paid too much for your premium and should receive a refund, please call the Member Service number on the back of your ID card.

## HOW WE PROTECT YOUR RIGHT TO PRIVACY

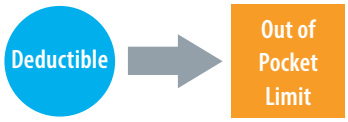
At Highmark, we have established policies and procedures to protect the privacy of our members' protected health information (PHI) from unauthorized or improper use. We restrict access to our members' non-public personal information to only individuals who need to know that information to provide you health products or services. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to safeguard against unauthorized access, use and disclosures. PHI may be oral, written, or electronic.

For example, as permitted by law, we may use or disclose PHI for treatment, payment, and health care operations. This could include claims management, routine audits, coordination of care, quality assessment and measurement, case management, utilization review, performance measurement, customer service, credentialing, medical review, and underwriting. With the use of measurement data, we are able to help manage our members' health care needs. We can identify certain individuals who could benefit from health, wellness, and condition management programs.

If we ever use your PHI for non-routine uses, we will ask you to give us your permission by signing a special authorization form, except with regard to court orders and subpoenas. You have the right to access the information your doctor has been keeping in your medical records, and any such request should be directed first to your network physician.

You benefit from the many safeguards we have in place to protect the use of data we maintain. This includes not discussing PHI outside of our offices, confirming who you are before we discuss PHI on the phone, requiring our employees to sign statements in which they agree to protect your confidentiality, using computer passwords to limit access to your PHI, and including confidentiality language in our contracts with doctors, hospitals, vendors, and other health care providers. For more information about our privacy practices, please review our Notice of Privacy Practices at highmark.com/hmk2/privacy.shtml.

We provide aggregate information to employer groups whenever possible. In those instances when PHI is required, the employer group will be required to sign an agreement before the information is released.




# HOW TO READ YOUR EXPLANATION OF BENEFITS (EOB) STATEMENT

## FOR PLANS WITH A DEDUCTIBLE THAT IS INCLUDED IN THE OUT-OF-POCKET LIMIT

An EOB is not a bill. Instead, it explains how your benefits have been applied. It shows what you may owe after your health insurance claim has been processed. You should review it to make sure you received the services that are being billed.

HIGHMARK.
An Independent Licensee of the Blue Cross and Blue Shield Association

**Explanation of Benefits**
**THIS IS NOT A BILL**

| | |
|---|---|
| 1 | Contract Holder Name: SAMUEL SAMPLE |
| 2 | Member ID: 012345678910 |
| | Group Name: ABC CORP. |
| | Group ID: 123456 789 |
| 3 | Claim Activity For: SAMUEL SAMPLE |
| 4 | Claim Number: 12345678910 |

| EXPLANATION AT A GLANCE | | |
|---|---|---|
| 5 Date of Service: 01/28/14 | | |
| We Sent Payment To:<br>6 PATHOLOGY PRACTICE<br>A Network Provider | | |
| Claim Payment Amount: | $ | 90.00 |
| 7 Provider May Bill You (If Not Already Paid) : | $ | 7.00 |

| Member Responsibility | | | | | |
|---|---|---|---|---|---|
| Provider<br>Date of Service<br>Type of Service<br>Service Code<br>(Number of Services) | Provider's Charge | Non-Billable To Member | Plan Allowance (Covered Charges) | Your Deductible | Amount You Owe Provider (total of shaded columns) |
| 8 PATHOLOGY PRACTICE<br>01/28/14<br>SURGICAL PATHOLOGY TEST<br>88305 (2) | 284.00 | 187.00<br>J4047 | 97.00 | 7.00 | 7.00 |
| TOTALS | 9 284.00 | 10 187.00 | 11 97.00 | 12 7.00 | 13 7.00 |

| 14 Explanation of Remark Codes | |
|---|---|
| J4047 | - This is the difference between the provider's charge and our allowance. Since the provider is in-network, you are not responsible for this amount. |
| X5018 | - The allowance for this service has been applied to the dollar deductible amount required under the patient's coverage. |

**15 PATIENT BENEFIT SUMMARY**

Patient: SAMUEL SAMPLE Group Number: 123456-789
Benefit Period: 01/01/14 - 12/31/14
$2,350.00 has been applied to your $6,350.00 individual in network total maximum out-of-pocket amount.
$2,350.00 has been applied to your $3,000.00 individual in network out-of-pocket limit.
You have satisfied $1,000.00 of your $1,000.00 individual in network deductible.

Please refer to your benefit booklet or agreement for further information. Amount(s) shown may include totals from claims which are still being processed and for which you have not been notified.

**16 PROGRAM BENEFIT SUMMARY**

Benefit Period: 01/01/14 - 12/31/14 Group Number: 123456-789
$2,350.00 has been applied to your $12,700.00 program in network total maximum out-of-pocket amount.
$2,350.00 has been applied to your $4,000.00 program in network out-of-pocket limit.
You have satisfied $1,000.00 of your $2,000.00 program in network deductible.

Please refer to your benefit booklet or agreement for further information. Amount(s) shown may include totals from claims which are still being processed and for which you have not been notified.

Please turn this page over for definitions of health insurance terms.

To better understand your EOB and how charges are calculated, here are definitions for terminology used in the statement.

1. **CONTRACT HOLDER NAME –** the health care coverage is listed under this person's name.
2. **MEMBER ID –** contract holder's member identification number.
3. **CLAIM ACTIVITY FOR –** the person who received the services, either the contract holder, a spouse, or dependent.
4. **CLAIM NUMBER –** the system assigns each claim a number for identification purposes.
5. **DATES OF SERVICE –** the day or days when services were performed.
6. **WE SENT PAYMENT TO –** health care provider that received payment for services.
7. **PROVIDER MAY BILL YOU –** what you may owe the provider.
8. **PROVIDER –** facility or professional providing medical service, such as a hospital or a doctor.
   - A. **DATE OF SERVICE –** the day or days when services were performed.
   - B. **TYPE OF SERVICE –** surgery, office visit or test, for example.
   - C. **SERVICE CODE –** medical billing code to identify what services were performed.
   - D. **NUMBER OF SERVICES –** total number of services performed.
9. **PROVIDER CHARGES –** the amount the provider charged for the services.
10. **NON-BILLABLE TO MEMBER –** amount that the provider discounts for being in-network and does not charge you.
11. **PLAN ALLOWANCE (COVERED CHARGES) –** the amount your plan allows as payment. This is the discounted rate you receive.
12. **DEDUCTIBLE –** the amount that has been applied toward meeting your deductible.
13. **AMOUNT YOU OWE PROVIDER (TOTAL OF SHADED COLUMNS) –** the total amount you owe, including any deductible, coinsurance, or copayment amounts.
14. **EXPLANATION OF REMARK CODES –** these codes explain why payments are approved or denied.
15. **PATIENT BENEFIT SUMMARY –** summarizes a single patient's coverage within a benefit period.
    - A. **INDIVIDUAL IN-NETWORK TOTAL MAXIMUM OUT-OF-POCKET AMOUNT** the most you pay during a benefit period ***including*** deductibles, copayments, and coinsurance. Once this amount is reached, the health plan pays 100% of the allowed amount for covered services.
    - B. **INDIVIDUAL IN-NETWORK OUT-OF-POCKET LIMIT –** the most you pay during a benefit period, ***excluding*** copayments. This amount generally includes only coinsurance. Once this amount is reached, the health plan pays 100% of the allowed amount for covered services. You may still be responsible for copayments or to fulfill the deductible.
    - C. **INDIVIDUAL IN-NETWORK DEDUCTIBLE –** the amount you pay during a benefit period before your health plan begins to pay anything.
16. **PROGRAM BENEFIT SUMMARY –** similar to the Patient Benefit Summary (#15), these amounts are added together to summarize all family members' coverage within a benefit period.
    - A. **INDIVIDUAL IN-NETWORK TOTAL MAXIMUM OUT-OF-POCKET AMOUNT** the most you pay during a benefit period ***including*** deductibles, copayments, and coinsurance. Once this amount is reached, the health plan pays 100% of the allowed amount for covered services.
    - B. **INDIVIDUAL IN-NETWORK OUT-OF-POCKET LIMIT –** the most you pay during a benefit period, ***excluding*** copayments. This amount generally includes only coinsurance. Once this amount is reached, the health plan pays 100% of the allowed amount for covered services. You may still be responsible for copayments or to fulfill the deductible.
    - C. **INDIVIDUAL IN-NETWORK DEDUCTIBLE –** the amount you pay during a benefit period before your health plan begins to pay anything.

If you suspect fraud or abuse involving your health insurance, please call the toll-free fraud or abuse hotline at 1-800-438-2478.

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Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Coverage Advantage, Highmark Health Insurance Company, First Priority Health or First Priority Life Insurance Company, all of which are independent licensees of the Blue Cross and Shield Association. Health care plans are subject to terms of the benefit agreement.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please review Health Plan Quality Assurance by visiting discoverhighmark.com/region-selector or for a paper copy, call 1-855-873-4106.

**Discrimination is Against the Law**

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

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

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

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

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

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

If you speak English, language assistance services, free of charge, are available to you. Call 1-800-876-7639.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-800-876-7639.

如果您说中文，可向您提供免费语言协助服务。
請致電 1-800-876-7639.

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-800-876-7639.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다.
1-800-876-7639 로 전화.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-800-876-7639.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-800-876-7639.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-800-876-7639 .

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-800-876-7639.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-800-876-7639.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-800-876-7639.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-800-876-7639.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-800-876-7639.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.

日本語が母国語の方は言語アシスタンス・ サービスを無料でご利用いただけます。 1-800-876-7639 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان
با تماس با شماره 1-800-876-7639 .

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