MRM Residential Management - PPO Blue Healthy Savings $3,000Q 80/50 with Rx

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
General Provisions		
Effective Date	07/01/2025	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual Family	 $3,000 $6,000	 $5,000 $10,000
Plan Pays – payment based on the plan allowance	80% after deductible	50% after deductible
Out-of-Pocket Limit (Includes prescription drug expenses, coinsurance, and copayments). Once met, the plan pays 100% coinsurance for the rest of the benefit period. Individual Family	 None None	 $10,000 $20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copayments, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $4,000 $8,000	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	$30 copayment after deductible	50% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	$30 copayment after deductible	50% after deductible
Specialist Office Visits & Virtual Visits	$60 copayment after deductible	50% after deductible
Virtual Visit Provider Originating Site Fee	80% after deductible	50% after deductible
Urgent Care Center Visits	$100 copayment after deductible - copayment does not apply to Urgent Care Center Visits prescribed for the treatment of Mental Health or Substance Abuse	50% after deductible
Telemedicine Services (3)	80% after deductible	Not Covered
Preventive Care (4)		
Routine Adult Physical exams	 100% (deductible does not apply)	 50% after deductible
Adult immunizations	100% (deductible does not apply)	50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	50% (deductible does not apply)
Breast Cancer Screenings (annual routine and supplemental)	100% (deductible does not apply)	50% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	50% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Routine Pediatric Physical exams	 100% (deductible does not apply)	 50% after deductible
Pediatric immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Hospital and Medical/Surgical Expenses (including maternity) (5)		
Hospital Inpatient	$500 Inpatient Copayment per Inpatient Day (5 day maximum) after deductible	50% after deductible
Hospital Outpatient	80% after deductible	50% after deductible
Outpatient Surgery (facility)	**Copayment does not apply to Outpatient Surgery (facility) for the treatment of Mental Health or Substance Abuse**	
	$500 copayment after deductible	50% after deductible
Surgical Services (professional)	80% after deductible	50% after deductible

Benefit	Network	Out-of-Network
Maternity (non-preventive professional services) including dependent daughter	80% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)	80% after deductible	50% after deductible
Emergency Services		
Emergency Room Services (5)	$300 copayment (waived if admitted) after network deductible	
Ambulance – Emergency	80% after network deductible	
Ambulance – Non-Emergency (6)	80% after network deductible	50% after deductible
Therapy and Rehabilitation/Habilitative Services		
Physical Medicine	$60 copayment after deductible	50% after deductible
	Benefit Limit: 30 visits /benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Occupational Therapy	$60 copayment after deductible	50% after deductible
	Benefit Limit: 30 visits /benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Speech Therapy	$60 copayment after deductible	50% after deductible
	Benefit Limit: 20 visits/benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Respiratory Therapy	80% after deductible	50% after deductible
Spinal Manipulations	$60 copayment after deductible	50% after deductible
	Benefit Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	50% after deductible
Mental Health/Substance Abuse		
Inpatient Mental Health Services	$500 Inpatient Copayment per Inpatient Day (5 day maximum) after deductible	50% after deductible
Inpatient Detoxification/Rehabilitation	$500 Inpatient Copayment per Inpatient Day (5 day maximum) after deductible	50% after deductible
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	$60 copayment after deductible	50% after deductible
Outpatient Substance Abuse	$60 copayment after deductible	50% after deductible
Other Services		
Acupuncture	$60 copayment after deductible	50% after deductible
	Benefit Limit: 20 visits/benefit period	
Allergy Extracts and Injections	80% after deductible	50% after deductible
Autism Spectrum Disorder Applied Behavioral Analysis (7)	80% after deductible	50% after deductible
Assisted Fertilization Procedures	80% after deductible	50% after deductible
Bariatric Surgery	Not Covered	Not Covered
Dental Services Related to Accidental Injury	80% after deductible	50% after deductible
Diabetes Treatment		
Equipment and Supplies	80% after deductible	50% after deductible
Diabetes Education Program	80% after deductible	50% after deductible
Diabetes Care Management Program (DCMP) – Digitally Monitored, includes telehealth consult for the A1C test	100% (deductible does not apply) Continuous glucose monitor sprints are limited to three (3) per benefit period.	Not Covered
DCMP – All Other Telehealth Consults	80% after deductible	Not Covered
Diagnostic Services	Copayments, if any, do not apply to Diagnostic Services prescribed for the treatment of Mental Health or Substance Abuse.	
Advanced Imaging (MRI, CAT, PET scan, etc.)	$200 copayment after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	$60 copayment after deductible	50% after deductible
Mammograms (medically necessary)	80% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	50% after deductible
Home Health Care	80% after deductible	50% after deductible
	Benefit Limit: 90 visits/benefit period	
Hospice	80% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (8)	80% after deductible	50% after deductible
Private Duty Nursing	80% after deductible	50% after deductible
	Benefit Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	$250 Inpatient Copayment per Inpatient Day (5 day maximum) after deductible	50% after deductible
	Benefit Limit: 120 days/benefit period	
Transplant Services	80% after deductible	50% after deductible
Precertification/Authorization Requirements (9)	Yes	

Benefit	Network	Out-of-Network
Prescription Drugs		
Prescription Drug Deductible Individual Family	 Integrated with medical deductible Integrated with medical deductible	
Prescription Drug Program (10) SensibleRx Choice Defined by the National Plus Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with Incentive Benefit Design. **Select Specialty Drugs are Limited to a 31-Day Supply**	**Retail Drugs (31/60/90-day Supply)** Generic: $20/ $40/ $60 copayment after network deductible Formulary Brand: $40 / $80 / $120 copayment after network deductible Non-Formulary Brand: $70 / $140 / $210 copayment after network deductible **Specialty Drugs (Limited to a 31-day Supply)** 50% Specialty Drugs $500 Maximum per Prescription after network deductible **Maintenance Drugs through Mail Order (90-day Supply)** Generic: $40 copayment after network deductible Formulary Brand: $80 copayment after network deductible Non-Formulary Brand: $140 copayment after network deductible	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy / plan documents, as limitations and exclusions apply. The policy / plan documents control in the event of a conflict with this benefit summary.

Signature of Client Representative _____ Title _____ Date _____

1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. If you are enrolled in a "Family" plan, with your non-embedded deductible, the entire family deductible must be satisfied before claims reimbursement begins. In addition, with your non-embedded out-of-pocket limit, the entire family out-of-pocket limit must be satisfied before additional claims reimbursement begins. Finally, with your embedded TMOOP, once any eligible family member satisfies his/her individual TMOOP, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family TMOOP amount is met.
3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g., PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
7) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services - Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g., speech therapy, diagnostic services). Services for the treatment of Autism Spectrum Disorders do not reduce visit/day limits.
8) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
9) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.
10) At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you pay for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled. The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved drugs selected for their quality, safety, and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under SensibleRx Choice, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug member cost share indicated plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed. Your plan requires that you use a specific specialty pharmacy for hemophilia medications. Please contact member services for more details. Your plan offers the Free Market Health program for select specialty medications. You will be contacted by one of the specialty network pharmacies who will provide quality service, care, and coordination of your specialty prescription fill and delivery. No enrollment necessary.

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 or call 1-800-457-4062. 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/ or call 1-800-457-4062 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,000 individual/$6,000 family network. $5,000 individual/$10,000 family out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your network deductible. Copayments and coinsurance amounts don't count toward the network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$0 individual/$0 family network out-of-pocket limit, up to a total maximum out-of-pocket of $4,000 individual/$8,000 family. $10,000 individual/$20,000 family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Network: Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket. Out-of-network: Deductibles, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. See www.myhighmark.com or call 1-800-457-4062 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. 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 your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to your preventive schedule for additional information.
	Specialist visit	$60 copay/visit	50% coinsurance	
	Preventive care/screening/immunization	No charge Deductible does not apply.	50% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	$60 copay/visit	50% coinsurance	Copayments, if any, do not apply to Diagnostic Services prescribed for the treatment of Mental Health or Substance Abuse. Precertification may be required.
	Imaging (CT/PET scans, MRIs)	$200 copay/visit	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myhighmark.com.	Generic drugs	$20/$40$60 copay per prescription (retail) $40 copay per prescription (mail order)	Not covered	Up to 31/60/90-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order.
	Formulary Brand drugs	$40/$80/$120 copay per prescription (retail) $80 copay per prescription (mail order)	Not covered	
	Non-Formulary Brand drugs	$70/$140/$210 copay per prescription (retail) $140 copay per prescription (mail order)	Not covered	
	Specialty drugs	50% coinsurance $500 maximum copay per prescription (retail)	Not covered	Select Specialty drugs are limited to a 31-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay/visit	50% coinsurance	Copayment, if any, does not apply to Outpatient Surgery (Facility Services) prescribed for the treatment of Mental Health or Substance Abuse Precertification may be required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$300 copay/visit	$300 copay/visit	Out-of-network: Subject to network deductible. Copay waived if admitted as an inpatient.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network: Subject to network deductible.
	Urgent care	$100 copay/visit	50% coinsurance	The Copayment, if any, does not apply to Urgent Care Services prescribed for the treatment of Mental Health or Substance Abuse.
If you have a hospital stay	Facility fees (e.g., hospital room)	$500 copay/day for the first 5 days	50% coinsurance	Precertification may be required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$60 copay/visit	50% coinsurance	Precertification may be required.
	Inpatient services	$500 copay/day for the first 5 days	50% coinsurance	Precertification may be required.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$500 copay/day for the first 5 days	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Combined network and out-of-network: 90 visits per benefit period, combined with visiting nurse. Precertification may be required.
	Rehabilitation services	$60 copay/visit	50% coinsurance	Combined network and out-of-network: Rehabilitation and habilitation services. Combined network and out-of-network: 30 physical therapy visits, 20 speech therapy visits, and 30 occupational therapy visits per benefit period. Limit does not apply to Therapy Services prescribed for the treatment of Mental Health or Substance Abuse. Precertification may be required.
	Habilitation services	$60 copay/visit	50% coinsurance	
	Skilled nursing care	$250 copay/day for the first 5 days	50% coinsurance	Combined network and out-of-network: Limited to 120 days per benefit period. Precertification may be required.
	Durable medical equipment	20% coinsurance	50% coinsurance	Precertification may be required.
	Hospice services	20% coinsurance	50% coinsurance	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	----------none----------
	Children's glasses	Not covered	Not covered	----------none----------
	Children's dental check-up	Not covered	Not covered	----------none----------

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- 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.)

- Acupuncture
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See www.bcbsglobalcore.com
- Private-duty nursing

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. The Pennsylvania Department of Consumer Services at 1-877-881-6388. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit 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 1-800-457-4062.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- 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 plan's overall deductible	$3,000
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$700
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$500
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,600**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-457-4062.

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

Insurance or benefit administration may be provided by Highmark Blue Sheild and Highmark Choice Company which are independent licensees of the Blue Cross and Blue 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 go to DiscoverHighmark.com; 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

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

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

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：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。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان **فارسی** صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.