



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, please visit www.highmarkbcbs.com or call 1-800-241-5704. 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 1-800-241-5704 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$300 individual/\$600 family, network. \$1,200 individual/\$2,400 family, out-of-network.	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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	<u>Network deductible</u> does not apply to <u>preventive care services</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 <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$3,000 individual/\$6,000 family network <u>out-of-pocket limit</u> up to a total maximum out-of-pocket of \$6,600 individual/\$13,200 family. \$8,000 individual/\$16,000 family out of network	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> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	Network: Premiums, balance-billed charges, and health care this <u>plan</u> doesn't cover Out-of-network: <u>Copayments</u> , <u>deductibles</u> , premiums, balance-billed charges, prescription drug expenses, 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> .

An example of a benefit book can be found at <https://shop.highmark.com/sales/#!/sbc-agreements>.

*Precertification may be required.

Will you pay less if you use a <u>network provider</u> ?	Yes. For a list of <u>network providers</u> , see www.highmarkbcbs.com or call 1-800-241-5704.	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</u> network. 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>). 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, and Other Important Information
		Enhanced <u>Network Provider</u> (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</u> office or clinic	Primary care visit to treat an injury or illness	\$25 copay/visit	40% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. Please refer to your preventive schedule for additional information.
	<u>Specialist</u> visit	\$35 copay/visit	40% coinsurance after deductible	
	<u>Preventive care/Screening/Immunization</u>	No charge for preventive care services	40% coinsurance for preventive care services after deductible	
If you have a test	<u>Standard Imaging</u> (x-ray, ultrasounds, etc)	100% after \$25 copay—services done at Vision Imaging: NPI 1487609483 and NPI 1487609715	40% coinsurance after deductible	Precertification may be required. Failure to precertify will result in benefits payable being reduced by \$500.
		100% \$50 copay—Services at all other imaging facilities		
	Basis Diagnostic Services (disgnostic Medical, lab/pathology, allergy testing)	20% coinsurance after deductible	40% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Enhanced Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Advanced Imaging (CT/PET scans, MRIs)	100% after \$75 copay – Services done at Vision Imaging: NPI 1487609483 and NPI 1487609715	40% coinsurance after deductible	Precertification may be required. Failure to precertify will result in benefits payable being reduced by \$500.
		100% after \$150 copay – services at all other imaging facilities		
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at 1-800-241-5704.	Low Cost Generic drugs	\$0 copay (retail) \$0 copay (mail order)	Not covered	Up to 30-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order.
	Generic drugs	\$10 copay (retail) \$20 copay (mail order)	Not covered	Certain participating retail pharmacy <u>providers</u> may have agreed to make maintenance prescription drugs available at the same <u>cost-sharing</u> and quantity limits as the mail service coverage.
	Formulary Brand drugs	\$35 copay (retail) \$70 copay (mail order)	Not covered	
	Non-Formulary Brand drugs	\$55 copay (retail) \$165 copay (mail order)	Not covered	
Specialty drugs	Non-formulary Specialty drugs	20% coinsurance with a \$150 maximum per prescription	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Enhanced <u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Precertification may be required. Failure to precertify will result in benefits payable being reduced by \$500.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Precertification may be required. Failure to precertify will result in benefits payable being reduced by \$500.
If you need immediate medical attention	<u>Emergency room Care</u>	No charge after \$100 copay	No charge after \$100 copay	Copay waived if admitted
	<u>Emergency medical transportation</u>	20% coinsurance	20% coinsurance	-----none-----
	<u>Urgent care</u>	\$50 copay/visit	40% coinsurance after deductible	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Precertification may be required. Failure to precertify will result in benefits payable being reduced by \$500.
	Physician/surgeon fee	20% coinsurance after deductible	40% coinsurance after deductible	Precertification may be required. Failure to precertify will result in benefits payable being reduced by \$500.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Enhanced Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Precertification may be required. Failure to precertify will result in benefits payable being reduced by \$500.
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Precertification may be required. Failure to precertify will result in benefits payable being reduced by \$500.
If you are pregnant	Office visits	20% coinsurance after deductible	40% coinsurance after deductible	Cost sharing does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	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. Precertification may be required. Failure to precertify will result in benefits payable being reduced by \$500.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Enhanced <u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% coinsurance after deductible	40% coinsurance after deductible	Precertification may be required. Failure to precertify will result in benefits payable being reduced by \$500.
	<u>Rehabilitation services</u>	20% coinsurance after deductible	40% coinsurance after deductible	Combined network and out-of-network: 36 combined physical medicine, speech therapy and occupational therapy visits per benefit period. Precertification may be required. Failure to precertify will result in benefits payable being reduced by \$500.
	<u>Habilitation services</u>	Not covered	Not covered	
	<u>Skilled nursing care</u>	20% coinsurance after deductible	40% coinsurance after deductible	Combined network and out-of-network: 60 days per benefit period. Precertification may be required. Failure to precertify will result in benefits payable being reduced by \$500.
	<u>Durable medical equipment</u>	20% coinsurance after deductible	40% coinsurance after deductible	Precertification may be required. Failure to precertify will result in benefits payable being reduced by \$500.
	<u>Hospice service</u>	20% coinsurance after deductible	40% coinsurance after deductible	180 days per lifetime. <u>Deductible</u> (if any) applies. Precertification may be required. Failure to precertify will result in benefits payable being reduced by \$500.
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.)

- Acupuncture
- Hearing aids
- Routine eye care (Adult)
- Cosmetic surgery
- Long-term care
- Routine foot care
- Dental care (Adult)
- Private-duty nursing
- Weight loss programs

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

- Bariatric surgery
- Coverage provided outside the United States. See <http://www.bcbsa.com>
- Non-emergency care when traveling outside the U.S.
- 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: 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 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:

- Your plan administrator/employer

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 page.*-----

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 \$250
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$300

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

- The plan's overall deductible \$250
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$600

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

- The plan's overall deductible \$250
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$200
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$600

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: 1-800-241-5704.

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

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield, First Priority Life Insurance Company or First Priority Health, all of 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/QualityAssurance; 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. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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, 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).

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).

Geb Acht: Wann du Deutsch schwetzsch, kannsch du en Dolmetscher griedge, un iss die Hilf Koschdefrei. Kansch du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

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

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 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).

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.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

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

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ប្រការចង់ចាំ៖ បើលោកអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាភាសាជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នង កាតសម្គាល់របស់លោកអ្នក (TTY: 711) ។

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

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.

BAA ÁKONÍNÍZIN: Diné k'ehgo yánilti'go, language assistance services, éi t'áa níik'eh, bee níka a'doowoł, éi bee ná'ahóót'i'. ID bee néehózingo nanitinigíi bine'déé' (TTY: 711) jí' hodíilnih.

ધ્યાન દે: યદિ આપ હિન્દી બોલતે હૈ, તો આપકે લિ નિશ્ચિત્ક ભાષા સહાયતા સેવા ઉપલબ્ધ હૈ। આપકે સદસ્ય પહચાન (ID) કાર્ડ કે પીછે દલિ ગલ નંબર ફોન કરૈ। (TTY: 711).

توجه فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

ဂမ္မနိက: မိဝု ခဲလုဂု မာတ်လာဇီဇီ, တာဂ်မ်ဇ် အလ်ဇီဇ်နီ နဝ်ဇီဇ်, ဘာဇီဇ် ဝဲကံဇ်, မိဝု အဝုဇာဇီဇ် ဇီဇ်နာဇီ. မိဝု မိဝုဇ် ဝဲဇီဇ်နီဇ်နီဇ် ကာဇ်ဇ် (ဇီဇ်) ဝဲကံဇ် ဇီဇ်နီ နဝ်ဇီဇ်နီဇ် (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปแจ้งหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ધ્યાન દનિહોસ્: યદિ તપાઈ નેપાલી ભાષા બોલુનુહુનુહુ અને, તપાઈકા લાગિ ભાષા સહાયતા સેવાહર નિશ્ચિત્ક ઉપલબ્ધ હુનુહુનુ. તપાઈકો આઈડી કાર્ડકો પછાડાઈ ભાગમા રહેકો નમ્બર (TTY: 711) મા ફોન ગરુનુહોસ્।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).