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 deductible? | $250 individual/$750 family network. $500 individual/$1,500 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? | Network deductible does not apply to office visits, preventive care services, emergency room care, urgent care, and prescription drug benefits.<br><br>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 $8,150 individual/$16,300 family.<br>$2,000 individual/$4,000 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.<br><br>Out-of-network: Copayments, deductibles, premiums, balance-billed charges, prescription drug expenses, 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. For a list of network providers, see www.highmarkbcbs.com or call 1-800-241-5704. | 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).<br>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 I 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, and 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 | $20 copay/visit | 20% 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.<br><br>Out-of-network: Screening services not subject to deductible.<br><br>Please refer to your preventive schedule for additional information. |
| | Specialist visit | $35 copay/visit | 20% coinsurance | |
| | Preventive care/Screening/Immunization | No charge for preventive care services | 20% coinsurance for preventive care services | |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | 20% coinsurance | Precertification may be required. |
| | Imaging (CT/PET scans, MRIs) | No charge | 20% coinsurance | Precertification may be required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, and 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<br><br>More information about prescription drug coverage is available at 1-800-241-5704. | Generic drugs | 20% coinsurance<br>$15 minimum/<br>$100 maximum per prescription<br>(retail)<br>20% coinsurance<br>$30 minimum/<br>$200 maximum per prescription<br>(mail order) | Not covered | Up to 30-day supply retail pharmacy.<br>Up to 90-day supply maintenance prescription drugs through mail order. |
| | Brand drugs | 20% coinsurance<br>$15 minimum/<br>$100 maximum per prescription<br>(retail)<br>20% coinsurance<br>$30 minimum/<br>$200 maximum per prescription<br>(mail order) | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 20% coinsurance | Precertification may be required. |
| | Physician/surgeon fees | No charge | 20% coinsurance | Precertification may be required. |
| If you need immediate medical attention | Emergency room care | $100 copay/visit | $100 copay/visit | Out-of-network: Not subject to deductible.<br>Copay waived if admitted as an inpatient. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Out-of-network: Subject to network deductible.<br>Combined network and out-of-network: coinsurance limit of $400 per benefit period. |
| | Urgent care | $35 copay/visit | 20% coinsurance | ----------none---------- |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, and Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 20% coinsurance | Precertification may be required.<br>Out-of-network: Failure to precertify will result in benefits payable being reduced by $500. |
| | Physician/surgeon fee | No charge | 20% coinsurance | Precertification may be required. |
| If you have mental health, behavioral health, or substance abuse needs | Outpatient services | No charge | 20% coinsurance | Precertification may be required. |
| | Inpatient services | No charge | 20% coinsurance | Precertification may be required.<br>Combined network and out-of-network: 45 days per benefit period for inpatient substance abuse rehabilitation. |
| If you are pregnant | Office visits | No charge | 20% coinsurance | Cost sharing does not apply for preventive services.<br>Depending on the type of services, a copayment, coinsurance, or deductible may apply.<br>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)<br>Network: The first visit to determine pregnancy is covered at no charge.<br>Please refer to the Women's Health Preventive Schedule for additional information.<br><br>Precertification may be required<br>Out-of-network: Failure to precertify will result in benefits payable being reduced by $500. |
| | Childbirth/delivery professional services | No charge | 20% coinsurance | |
| | Childbirth/delivery facility services | No charge | 20% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, and 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 | No charge | 20% coinsurance | Precertification may be required. |
| | Rehabilitation services | No charge | 20% coinsurance | Combined network and out-of-network: 36 combined physical medicine, speech therapy, and occupational therapy visits per benefit period.<br>Precertification may be required. |
| | Habilitation services | Not covered | Not covered | ----------none---------- |
| | Skilled nursing care | No charge | 20% coinsurance | Precertification may be required.<br>Failure to precertify will result in benefits payable being reduced by $500. |
| | Durable medical equipment | No charge | 20% coinsurance | Combined network and out-of-network: $5,000 maximum per benefit period, combined with prosthetics and orthotics.<br>Precertification may be required. |
| | Hospice service | No charge | 20% coinsurance | Combined network and out-of-network: Limit: 180 days per lifetime. Respite care is limited to a maximum of 5 days per 3 month period.<br>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.) | | |
|---|---|---|
| • Acupuncture | • Hearing aids | • Routine foot care |
| • Cosmetic surgery | • Long-term care | • Weight loss programs |
| • Dental care (Adult) | • Routine eye care (Adult) | |
| • Habilitation services | | |

| 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.bcbs.com | • Non-emergency care when traveling outside the U.S. |
| • Chiropractic care | • Infertility treatment | • 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 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 copayment | $35 |
| 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 |

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $50 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Peg would pay is | $600 |

### 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 copayment | $35 |
| 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 |

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $0 |
| Coinsurance | $3,200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Joe would pay is | $3,450 |

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

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist copayment | $35 |
| 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 |

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $100 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $450 |

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, 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 .