



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](http://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/](http://www.HealthCare.gov/sbc-glossary/) or call 1-800-241-5704 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	\$150 individual/\$300 family, <u>network</u> . \$1,000 individual/\$2,000 family, out-of- <u>network</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<b>Are there services covered before you meet your deductible?</b>	<u>Network deductible</u> does not apply to <u>preventive care services</u> , office visits, <u>emergency room care</u> , <u>emergency medical transportation</u> , <u>urgent care</u> , professional maternity, and imaging services.  <u>Copayments</u> and <u>coinsurance</u> amounts don't count toward the <u>network deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	\$2,000 individual/\$4,000 family <u>network out-of-pocket limit</u> up to a total maximum out-of-pocket of \$5,530 individual/\$11,060 family.  \$5,000 individual/\$10,000 family out of <u>network</u>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<p><u>Network</u>: <u>Premiums</u>, balance-billed charges, and health care this <u>plan</u> doesn't cover</p> <p><u>Out-of-network</u>: <u>Copayments</u>, <u>deductibles</u>, <u>premiums</u>, balance-billed charges, prescription drug expenses, and health care this <u>plan</u> doesn't cover.</p>	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. For a list of <u>network providers</u> , see <a href="http://www.highmarkbcbs.com">www.highmarkbcbs.com</a> 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 network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). 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.
<b>Do I need a <u>referral</u> to see a <u>specialist</u>?</b>	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 Network Provider (You will pay the least)	Out-of-Network Provider (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	\$15 <u>copay</u> /visit	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.  Please refer to your <u>preventive</u> schedule for additional information.  <u>Out-of-network</u> : <u>Screening</u> services not subject to <u>deductible</u> .
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit	30% <u>coinsurance</u>	
	<u>Preventive care</u> /Screening/Immunization	No charge for <u>preventive care services</u>	30% <u>coinsurance</u> for <u>preventive care services</u>	

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)	
<b>If you have a test</b>	<u>Standard Imaging</u> (x-ray, ultrasounds, etc)	\$25 <u>copay/visit</u> — services done at Vision Imaging	30% <u>coinsurance</u>	Precertification may be required.
		\$50 <u>copay/visit</u> — Services at all other imaging facilities		
	Basis Diagnostic Services (disgnostic Medical, lab/pathology, allergy testing)	10% after <u>deductible</u>	30% after <u>deductible</u>	
	<u>Advanced Imaging</u> (CT/PET scans, MRIs)	\$75 <u>copay/visit</u> – Services done at Vision Imaging	30% <u>coinsurance</u>	
\$150 <u>copay/visit</u> – services at all other imaging facilities				
<b>If you need drugs to treat your illness or condition</b>	Generic drugs	Not covered	Not covered	Prescription drugs not covered.
	Brand drugs	Not covered	Not covered	
More information about <b><u>prescription drug coverage</u></b> is available at 1-800-241-5704.				
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required.
<b>If you need immediate medical attention</b>	<u>Emergency room Care</u>	\$100 <u>copay/visit</u>	\$100 <u>copay/visit</u>	<u>Copay</u> waived if admitted as an inpatient. Out-of- <u>network</u> : Not subject to <u>deductible</u> .
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of- <u>network</u> : Not subject to <u>deductible</u> .
	<u>Urgent care</u>	\$50 <u>copay/visit</u>	30% <u>coinsurance</u>	-----none-----

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)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required. Out-of-network: Failure to precertify will result in benefits payable being reduced by \$500.
	Physician/surgeon fee	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required.
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required.
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required.
<b>If you are pregnant</b>	Office visits	No charge	30% <u>coinsurance</u>	<p><u>Cost sharing</u> does not apply for <u>preventive services</u>.</p> <p>Depending on the type of services, a <u>copayment</u>, <u>coinsurance</u>, or <u>deductible</u> may apply.</p> <p>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</p> <p><u>Network</u>: The first visit to determine pregnancy is covered at no charge.</p> <p>Precertification may be required. Out-of-network: Failure to precertify will result in benefits payable being reduced by \$500.</p>
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	

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 need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : 36 combined physical medicine, speech therapy, and occupational therapy visits per benefit period.  Precertification may be required.
	<u>Habilitation services</u>	Not covered	Not covered	-----none-----
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : 60 days per benefit period  Precertification may be required.  Out-of- <u>network</u> : Failure to precertify will result in benefits payable being reduced by \$500.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required.
	<u>Hospice service</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : 180 days per lifetime. 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 eye care (Adult)
- Cosmetic surgery
- Long-term care
- Routine foot care
- Dental care (Adult)
- Private-duty nursing
- Weight loss programs
- Habilitation services
- Prescription drugs

### 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](http://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](http://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 \$150
- Specialist copayment \$25
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$0
Coinsurance	\$1,000

***What isn't covered***

Limits or exclusions	\$100
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<b>The total Peg would pay is</b>	<b>\$1,250</b>
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**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$150
- Specialist copayment \$25
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$100
Coinsurance	\$200

***What isn't covered***

Limits or exclusions	\$4,300
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<b>The total Joe would pay is</b>	<b>\$4,750</b>
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**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$150
- Specialist copayment \$25
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$100
Coinsurance	\$70

***What isn't covered***

Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$320</b>
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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](https://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](mailto:CivilRightsCoordinator@highmarkhealth.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <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, kantscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kantscht 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 આપેલા 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).

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាភាសាជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នង កាត់សម្គាល់របស់លោកអ្នក (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).

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 yánílti'go, language assistance services, éí t'áá níik'eh, bee níká a'doowol, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'déé' (TTY: 711) jí' hodiilnih.

ધ્યાન દે: યદિ આપ હિન્દી બોલતે હૈ, તો આપકે લિે નિ:શિલ્ક ભાષા સહાયતા સેવા ઉપલબ્ધ હૈ। આપકે સદસ્ય પહચાન (ID) કાર્ડ કે પીછે દિે ગિે નંબર પર 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)۔

ಗಮನಿಕ: ಮೆರು ತಿಲುಗು ಮಾಲ್‌ಲಾಡ್‌ತಿ, ಲಾ'ಗವೆಕ ಅನನ್‌ಬಿನೆನ್ ಸರಿವೆನಿನ್, ಛಾರ್‌ಪಿ ಲೆಕುಂಡ್, ಮೆಕು ಅಂದುಬಾಲುಲೆ ಒನನಾಯೆ. ಮೆ ಮುಂಬರಿ ಎಡಿಂಟಿಫಿಕೇಷನ್ ಕಾರ್ಡು (ಎಡಿ) ವಿನಕ ಒನನ ನಂಬರುಕು ಕಾಲ್ ದಿಯಂಡಿ (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยัง หมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ધ્યાન દનિહોસ્: યદિ તપાઈ નેપાલી ભાષા બોલનુહુનુછ બને, તપાઈકા લાગિભાષા સહાયતા સેવાહર નિ:શિલ્ક ઉપલબ્ધ હુનુછનુ। તપાઈકો આઈડી કાર્ડકો પછાડાઈ ભાગમા રહેકો નમ્બર (TTY: 711) મા ફોન ગરનુહોસ્।

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).

