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 1-833-585-7337. 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 1-833-585-7337 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$800 individual/$1,600 family 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Network deductible does not apply to office visits, preventive care services, emergency room services, urgent care, standard diagnostic services, rehabilitation services, habilitation services, outpatient mental health, outpatient substance abuse, pediatric vision services, pediatric dental exam, and prescription drug benefits. 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?	Yes, $25 individual/ $75 family for adult dental services There are no other specific deductibles	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. * See below.
What is the out-of-pocket limit for this plan?	$6,000 individual/$12,000 family network. $1,000 individual for adult dental services.	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?	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. For a list of network providers, see www.highmarkbcbs.com or call 1-833-585-7337.	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 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	No charge for visits 1-2 then $10 copay/visit	Not covered	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	$45 copay/visit	Not covered	
	Preventive care/Screening/Immunization	No charge for preventive care services	No coverage for preventive care services	
If you have a test	Diagnostic test (x-ray, blood work)	$15 copay/visit for laboratory $45 copay/visit for x-ray	Not covered	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	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 More information about prescription drug coverage is available at 1-833-585-7337.	Tier 1	$10/$20/$30 copay (retail) $20 copay (mail order)	Not covered	Up to 31/60/90-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. This plan uses an Essential Formulary.
	Tier 2	$45/$90/$135 copay (retail) $90 copay (mail order)	Not covered	
	Tier 3	$90/$180/$270 copay (retail) $180 copay (mail order)	Not covered	
	Tier 4	50% coinsurance $250/$500/$750 minimum $1,000/$2,000/$3,000 maximum per prescription (retail) 50% coinsurance $500 minimum $2,000 maximum per prescription (mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/visit	Not covered	Precertification may be required.
	Physician/surgeon fees	20% coinsurance	Not covered	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 immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	Out-of-network: Not subject to deductible. Copay waived if admitted as an inpatient.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network: Subject to network deductible.
	Urgent care	$45 copay/visit	$45 copay/visit	Out-of-network: Not subject to deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Precertification may be required.
	Physician/surgeon fee	20% coinsurance	Not covered	Precertification may be required.
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	No charge for visits 1-2 then $10 copay/visit	Not covered	Precertification may be required. Network: 2 free Mental Health and 2 free Substance Abuse visits.
	Inpatient services	20% coinsurance	Not covered	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 are pregnant	Office visits	20% coinsurance	Not covered	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. Precertification may be required.
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	

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	20% coinsurance	Not covered	Network: 60 visits per benefit period, aggregate with visiting nurse. Precertification may be required.
	Rehabilitation services	$45 copay/visit	Not covered	Network: 30 combined physical medicine and occupational therapy visits and 30 speech therapy visits per benefit period. Precertification may be required.
	Habilitation services	$45 copay/visit	Not covered	Network: 30 combined physical medicine and occupational therapy visits and 30 speech therapy visits per benefit period. Limit does not apply to services for the treatment of a mental health or substance abuse diagnosis. Precertification may be required.
	Skilled nursing care	20% coinsurance	Not covered	Network: 120 days per benefit period. Precertification may be required.
	Durable medical equipment	20% coinsurance	Not covered	Precertification may be required.
	Hospice service	20% coinsurance	Not covered	Network: Respite care limit of 7 days every six months. Precertification may be required.
If your child needs dental or eye care	Children's Eye exam	No charge	Not covered	Network: One eye exam per 12 month period up to age 19.
	Children's Glasses	No charge	Not covered	Network: One pair frames/lenses every 12 months.
	Children's Dental check-up	No charge	Not covered	Network: One exam every 6 months.

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.)		
• Abortion, except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the life of the woman in danger unless an abortion is performed. • Acupuncture	• Bariatric surgery • Cosmetic surgery • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • 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.)	
• Chiropractic care • Dental care (Adult)	• Routine eye care (Adult) • 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:

- Highmark, Inc. at 1-833-585-7337.
- 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
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	$800
Specialist copayment	$45
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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$800
Copayments	$100
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$3,100

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

The plan's overall deductible	$800
Specialist copayment	$45
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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$500
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,600

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

The plan's overall deductible	$800
Specialist copayment	$45
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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$800
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,200

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

Highmark Blue Cross Blue Shield is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Coverage Advantage or Highmark Health Insurance Company, all of which are independent licensees of the Blue Cross and Blue Shield Association.

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 Plan 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 Plan 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 Plan 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 Plan 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 Plan:

- 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 Plan 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 .