
 **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 1-800-544-6679. 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 1-800-544-6679 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|---|--|
| What is the overall deductible? | \$0 individual/\$0 family <u>network</u> . | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. |
| Are there services covered before you meet your deductible? | No | 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 deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this <u>plan</u>? | \$7,500 individual/\$15,000 family <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. |
| What is not included in the out-of-pocket limit? | <u>Premiums</u> , balance-billed charges, 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> . |
| Will you pay less if you use a <u>network provider</u>? | Yes. See www.myhighmark.com or call 1-800-544-6679 for a list of <u>network providers</u> . | 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 charge</u> 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, & 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 <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$20 <u>copay</u> /visit | Not covered | <p>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.</p> <p>Please refer to your <u>preventive</u> schedule for additional information.</p> |
| | <u>Specialist</u> visit | \$20 <u>copay</u> /visit | Not covered | |
| | <u>Preventive care/screening/Immunization</u> | No charge | Not covered | |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | \$35 <u>copay</u> /visit | Not covered | <p><u>Copayments</u>, if any, do not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse. Precertification may be required.</p> |
| | Imaging (CT/PET scans, MRIs) | \$450 <u>copay</u> /visit | Not covered | |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myhighmark.com | Tier 1 | No charge per prescription (retail) No charge per prescription (mail order) | Not covered | <p>Up to 31/60/90-day supply retail pharmacy.</p> <p>Up to 90-day supply maintenance <u>prescription drugs</u> through mail order.</p> <p>This <u>plan</u> uses an Essential <u>Formulary</u>.</p> |
| | Tier 2 | \$30/\$60/\$90 <u>copay</u> per prescription (retail) \$60 <u>copay</u> per prescription (mail order) | Not covered | |
| | Tier 3 | \$150/\$300/\$450 <u>copay</u> per prescription (retail) \$300 <u>copay</u> per prescription (mail order) | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|---|--|
| | | <u>Network Provider</u> (You will pay the least) | <u>Out-of-Network Provider</u> (You will pay the most) | |
| | Tier 4 | 50% <u>coinsurance</u> \$250/\$500/\$750 min \$1,000/\$2,000/\$3,000 max per prescription (retail) 50% <u>coinsurance</u> \$500 min/\$2,000 max per prescription (mail order) | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$500 <u>copay</u> /visit | Not covered | Precertification may be required. |
| | Physician/surgeon fees | \$500 <u>copay</u> /visit | Not covered | Precertification may be required. |
| If you need immediate medical attention | <u>Emergency room care</u> | \$300 <u>copay</u> /visit | \$300 <u>copay</u> /visit | <u>Copay</u> waived if admitted as an inpatient. Out-of-network: Subject to <u>network deductible</u> . |
| | <u>Emergency medical transportation</u> | 30% <u>coinsurance</u> | 30% <u>coinsurance</u> | Out-of-network: Subject to <u>network deductible</u> . |
| | <u>Urgent care</u> | \$40 <u>copay</u> /visit | \$40 <u>copay</u> /visit <u>Deductible</u> does not apply. | The <u>copayment</u> , if any, does not apply to <u>urgent care</u> services prescribed for the treatment of mental illness or substance abuse. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$725 <u>copay</u> /visit | Not covered | Precertification may be required. |
| | Physician/surgeon fees | \$10 <u>copay</u> /visit | Not covered | Precertification may be required. |
| If you have mental health, behavioral health, or substance abuse services | Outpatient services | \$20 <u>copay</u> /visit | Not covered | Precertification may be required. |
| | Inpatient services | \$725 <u>copay</u> /visit | Not covered | Precertification may be required. |
| If you are pregnant | Office visits | 30% <u>coinsurance</u> | Not covered | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. |
| | Childbirth/delivery professional services | \$10 <u>copay</u> /visit | Not covered | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <u>Network</u> : The first visit to determine pregnancy is |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---------------------------------------|---|---|--|
| | | <u>Network Provider</u> (You will pay the least) | <u>Out-of-Network Provider</u> (You will pay the most) | |
| | Childbirth/delivery facility services | \$725 <u>copay</u> /visit | Not covered | covered at no charge. Please refer to the Women's Health <u>Preventive</u> Schedule for additional information. Precertification may be required. |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 30% <u>coinsurance</u> | Not covered | <u>Network</u> : 60 visits per benefit period, aggregate with visiting nurse. Precertification may be required. |
| | <u>Rehabilitation services</u> | \$20 <u>copay</u> /visit | Not covered | <u>Network</u> : 30 combined physical medicine and occupational therapy visits and 30 speech therapy visits per benefit period. <u>Copayment</u> , if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. The limit, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. Precertification may be required. |
| | <u>Habilitation services</u> | \$20 <u>copay</u> /visit | Not covered | <u>Network</u> : 30 combined physical medicine and occupational therapy visits and 30 speech therapy visits per benefit period. <u>Copayment</u> , if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. The limit, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. Precertification may be required. |
| | <u>Skilled nursing care</u> | \$725 <u>copay</u> /visit | Not covered | <u>Network</u> : 120 days per benefit period. Precertification may be required. |
| | <u>Durable medical equipment</u> | 30% <u>coinsurance</u> | Not covered | Precertification may be required. |
| | <u>Hospice services</u> | 30% <u>coinsurance</u> | Not covered | <u>Network</u> : Respite care limit of 7 days every six months. Precertification may be required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|----------------------------|---|---|---|
| | | <u>Network Provider</u> (You will pay the least) | <u>Out-of-Network Provider</u> (You will pay the most) | |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | <u>Network</u> : One eye exam per 12 month period up to age 19. |
| | Children's glasses | No charge | Not covered | <u>Network</u> : One pair of frames/lenses every 12 months for members under the age of 19. |
| | Children's dental check-up | No charge | Not covered | <u>Network</u> : 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)
- Infertility treatment
- Routine eye care (Adult)

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or at <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 1-800-544-6679.
- 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 \$0
- Specialist copayment \$20
- Hospital (facility) copayment \$725
- Other coinsurance 30%

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:

| <u>Cost Sharing</u> | |
|---------------------|---------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$1,300 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

| | |
|-----------------------------------|----------------|
| The total Peg would pay is | \$1,360 |
|-----------------------------------|----------------|

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

- The plan's overall deductible \$0
- Specialist copayment \$20
- Hospital (facility) copayment \$725
- Other coinsurance 30%

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:

| <u>Cost Sharing</u> | |
|---------------------|-------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$700 |
| <u>Coinsurance</u> | \$200 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$20 |
|----------------------|------|

| | |
|-----------------------------------|--------------|
| The total Joe would pay is | \$920 |
|-----------------------------------|--------------|

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

- The plan's overall deductible \$0
- Specialist copayment \$20
- Hospital (facility) copayment \$725
- Other coinsurance 30%

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:

| <u>Cost Sharing</u> | |
|---------------------|-------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$500 |
| <u>Coinsurance</u> | \$400 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|--------------|
| The total Mia would pay is | \$900 |
|-----------------------------------|--------------|

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

Insurance or benefit administration may be provided by Highmark Blue Shield, Highmark Benefits Group, Highmark Select Resources, 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](https://www.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 libheng 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 المساعدة 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 .