

 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.highmark.com/blueshieldnyny](http://www.highmark.com/blueshieldnyny) or call 1-844-639-2440. 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 1-844-639-2440 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$1,500 individual/\$3,000 family <u>in-network</u> . \$5,000 individual/\$10,000 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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care services</u> , pediatric vision, pediatric dental exam, and <u>prescription drugs</u> are covered before you meet your <u>in-network deductible</u> .  <u>Copayments</u> and <u>coinsurance</u> amounts don't count toward the <u>in-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>	\$6,000 individual/\$12,000 family <u>in-network</u> . \$10,000 individual/\$20,000 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 out-of-pocket limit?</b>	<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> .
<b>Will you pay less if you use a in-network provider?</b>	Yes. See <a href="http://www.highmark.com/blueshieldnyny/find-a-doctor/">www.highmark.com/blueshieldnyny/find-a-doctor/</a> or call 1-844-639-2440 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider in-network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's in-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>in-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 referral to see a specialist?</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, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-In-network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	50% <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>Specialist</u> visit	\$40 <u>copay</u> /visit	50% <u>coinsurance</u>	
	<u>Preventive care/screening/Immunization</u>	Covered in full <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	\$40 <u>copay</u> /visit	50% <u>coinsurance</u>	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	\$40 <u>copay</u> /visit	50% <u>coinsurance</u>	Precertification may be required.
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="https://www.highmark.com/blueshieldnny/find-a-doctor/#/drug">https://www.highmark.com/blueshieldnny/find-a-doctor/#/drug</a>	Generic drugs	\$10 <u>copay</u> per prescription (retail) <u>Deductible</u> does not apply.	Not covered	Some generic drugs may be subject to non-preferred brand cost share.  In- <u>network</u> : <u>Specialty drugs</u> could be generic, preferred brand or non-preferred brand. Please visit our website for a copy of our medication guide.
	<u>Formulary</u> Brand drugs	\$35 <u>copay</u> per prescription (retail) <u>Deductible</u> does not apply.	Not covered	
	Non- <u>Formulary</u> Brand drugs	\$100 <u>copay</u> per prescription (retail) <u>Deductible</u> does not apply.	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100 <u>copay</u> /visit	50% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	\$40 <u>copay</u> /visit	50% <u>coinsurance</u>	Precertification may be required.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	<u>Copay</u> waived if admitted as an inpatient. Out-of- <u>network</u> : Subject to in- <u>network deductible</u> .
	<u>Emergency medical transportation</u>	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	Out-of- <u>network</u> : Subject to in- <u>network deductible</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-network Provider</u> (You will pay the least)	<u>Out-of-In-network Provider</u> (You will pay the most)	
	<u>Urgent care</u>	\$60 <u>copay</u> /visit	\$60 <u>copay</u> /visit	<u>Out-of-network</u> : Subject to in- <u>network deductible</u> .
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$1,000 <u>copay</u> /admission	50% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	Covered in full	50% <u>coinsurance</u>	Precertification may be required.
<b>If you have mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <u>copay</u> /visit	50% <u>coinsurance</u>	Precertification may be required.
	Inpatient services	\$1,000 <u>copay</u> /admission	50% <u>coinsurance</u>	Precertification may be required.
<b>If you are pregnant</b>	Office visits	\$25 <u>copay</u> /visit	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> .  Professional services: For participating <u>providers</u> , cost share applies only to initial visit to determine pregnancy.
	Childbirth/delivery professional services	\$25 <u>copay</u> /visit	50% <u>coinsurance</u>	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	\$1,000 <u>copay</u> /admission	50% <u>coinsurance</u>	<u>In-network</u> : The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health <u>Preventive</u> Schedule for additional information.  Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-network Provider</u> (You will pay the least)	<u>Out-of-In-network Provider</u> (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	\$40 <u>copay</u> /visit	50% <u>coinsurance</u>	Combined <u>in-network</u> and out-of-network: 40 visits per benefit period, aggregate with visiting nurse. Home Infusion counts toward visit limit. Precertification may be required.
	<u>Rehabilitation services</u>	\$25 <u>copay</u> /visit	50% <u>coinsurance</u>	Combined <u>in-network</u> and out-of-network: combined habilitation and rehabilitation services. Combined <u>in-network</u> and out-of-network: 60 physical medicine, 60 occupational therapy visits and 60 speech therapy visits per benefit period. Precertification may be required.
	<u>Habilitation services</u>	\$25 <u>copay</u> /visit	50% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	\$1,000 <u>copay</u> /admission	50% <u>coinsurance</u>	Precertification may be required.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification may be required.
	<u>Hospice services</u>	\$40 <u>copay</u> /visit	50% <u>coinsurance</u>	Precertification may be required.
<b>If your child needs dental or eye care</b>	Children's eye exam	Covered in full <u>Deductible</u> does not apply.	Not covered	<u>In-network</u> : One eye exam per 12-month period up to age 19.
	Children's glasses	Covered in full <u>Deductible</u> does not apply.	Not covered	<u>In-network</u> : One pair frames/lenses every 12 months.
	Children's dental check-up	\$25 <u>copay</u> /visit <u>Deductible</u> does not apply.	\$25 <u>copay</u> /visit <u>Deductible</u> does not apply.	Combined <u>in-network</u> and out-of-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.)

- Acupuncture
- Long-term care
- Routine foot care
- Cosmetic surgery
- Private-duty nursing
- Weight loss programs
- Custodial care

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

- Chiropractic care
- Elective abortion
- Non-emergency care when traveling outside the U.S.
- Bariatric surgery
- Hearing aids
- Routine eye care (Adult)
- Dental 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: 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](http://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

**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 1-844-639-2440.
- The 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).
- 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 <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>copayment</u>	\$1,000
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,960</b>

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>copayment</u>	\$1,000
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,320</b>

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>copayment</u>	\$1,000
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

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

## Notice of Nondiscrimination

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. The plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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)
- 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, please call the customer service number on the back of your member ID card or 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, you can file a grievance with: Civil Rights Coordinator, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email: [CivilRightsCoordinator@highmarkhealth.org](mailto:CivilRightsCoordinator@highmarkhealth.org)

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US 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 US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

**For assistance in English, call the customer service number listed on your member ID card.**

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں۔

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لیے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

**Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.**

**Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.**

Rele nimewo sêvis kliyantêl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Diné k' ehjí yá ' áti ' bee shiká adoowot nohsingo naaltsoos nihaa halne ' go nidaahtinigíí bine ' déé ' Customer Service bibéesh bee hane ' é biká'ígíí bich ' j ' dahodootnih.