**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, go to www.highmark.com or call 1-888-249-2583. 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.highmark.com or call 1-888-249-2583 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-network: N/A; Out-of-network: Not covered | 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?** | Yes. No services are subject to a 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. 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?** | In-network: $3,000 individual / $6,000 family; Out-of-network: Not covered | In-network: 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-billing 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. See www.highmark.com/bcbswny or call 1-888-249-2583 for a list of network providers. | 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 you 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 **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 provider's office or clinic** | Primary care visit to treat an injury or illness | $10 copayment | Not covered | $0 copayment for members under the age of 19 |
| | Specialist visit | $15 copayment | Not covered | $0 copayment for members under the age of 19 |
| | Preventive care/screening/immunization | Covered in full | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Flu vaccine covered in full out-of-network. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $15 copayment for x-ray, Covered in full for blood work | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | $15 copayment | Not covered | Prior authorization required on certain procedures. Call the number on the back of your ID card for details. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.highmark.com/bcbswny | Generic drugs (Tier 1) | $5 copayment | Not covered | Some generic drugs may be subject to non-preferred brand cost share. |
| | Preferred brand drugs (Tier 2) | $30 copayment | Not covered | None |
| | Non-preferred brand drugs (Tier 3) | $60 copayment | Not covered | None |
| | Specialty drugs (Tier 4) | See limitations & exceptions | See limitations & exceptions | Specialty drugs could be generic, preferred brand or non-preferred brand. Please visit our website for a copy of our medication guide. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $100 copayment | Not covered | Prior authorization required on certain procedures. Call the number on the back of your ID card for details. |
| | Physician/surgeon fees | Covered in full | Not covered | Prior authorization required on certain procedures. Call the number on the back of your ID card for details. |
| **If you need immediate medical attention** | Emergency room care | $100 copayment | Covered as in-network | None |
| | Emergency medical transportation | $100 copayment | Covered as in-network | None |
| | Urgent care | Covered in full | Covered as in-network | None |

| 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 have a hospital stay** | Facility fee (e.g., hospital room) | Covered in full | Not covered | Prior authorization required. |
| | Physician/surgeon fees | Covered in full | Not covered | Prior authorization required on certain procedures. Call the number on the back of your ID card for details. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $10 copayment for Mental Health; $10 copayment for Substance Abuse | Not covered for Mental Health; Not covered for Substance Abuse | Prior authorization required on certain procedures. Call the number on the back of your ID card for details. Up to 20 visits a year may be used for family counseling |
| | Inpatient services | Covered in full for Mental Health; Covered in full for Substance Abuse Detox; Covered in full for Substance Abuse Rehab | Not covered for Mental Health; Not covered for Substance Abuse Detox; Not covered for Substance Abuse Rehab | Prior authorization required on certain procedures. Call the number on the back of your ID card for details. |
| **If you are pregnant** | Office visits | $10 copayment | Not covered | None |
| | Childbirth/delivery professional services | Covered in full | Not covered | For participating providers, cost share applies only to initial visit to determine pregnancy. |
| | Childbirth/delivery facility services | Covered in full | Not covered | None |
| **If you need help recovering or have other special health needs** | Home health care | $15 copayment | Not covered | None |
| | Rehabilitation services | $15 copayment | Not covered | 20 combined PT/OT/ST visits per plan year |
| | Skilled nursing care | Covered in full | Not covered | Prior authorization required. |
| | Durable medical equipment | 50% coinsurance | Not covered | Prior authorization required on certain procedures. Call the number on the back of your ID card for details. |
| | Hospice services | Covered in full | Not covered | Unlimited |
| **If your child needs dental or eye care** | Children's eye exam | Covered in full | Not covered | Discounts may apply. |
| | Children's glasses | See limitations & exceptions | See limitations & exceptions | Discounts may apply. |
| | Children's dental check-up | See limitations & exceptions | See limitations & exceptions | Contact your group administrator for coverage details. |

## 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
- Cosmetic surgery
- Custodial care
- Dental
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

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

- Bariatric surgery
- Chiropractic care
- Elective Abortion
- Hearing aids
- 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit 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 on how 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: 1-888-249-2583.

**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 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.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-249-2583.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-249-2583.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-249-2583.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-249-2583.

*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 | $0.00 |
| Specialist copayment | $15.00 |
| Hospital (facility) copayment | $0 |
| Other copayment | $10.00 |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copays | $50 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$110** |

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

| | |
|---|---|
| The plan's overall deductible | $0.00 |
| Specialist copayment | $15.00 |
| Hospital (facility) copayment | $0 |
| Other copayment | $10.00 |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copays | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$420** |

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

| | |
|---|---|
| The plan's overall deductible | $0.00 |
| Specialist copayment | $15.00 |
| Hospital (facility) copayment | $0 |
| Other copayment | $10.00 |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copays | $500 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$600** |

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: Highmark Blue Cross Blue Shield at www.highmark.com or call 1-888-249-2583.

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