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 1-800-318-2596 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$1,500 individual/$3,000 family combined network and out-of-network.</td>
<td>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 policy, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Network deductible does not apply to preventive care services. Copayments and coinsurance amounts don’t count toward the network deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$1,500 individual/$3,000 family network out-of-pocket limit, up to a total maximum out-of-pocket of $3,000 individual/$6,000 family. $3,000 individual/$6,000 family out-of-network.</td>
<td>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, the overall family out-of-pocket limit must be met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Network: Premiums, balance-billed charges, and health care this plan doesn’t cover do not apply to your total maximum out-of-pocket. Out-of-network: Copayments, deductibles, premiums, balance-billed charges, prescription drug expenses, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
</tbody>
</table>

An example of a benefit book can be found at [https://shop.highmark.com/sales/#!/sbc-agreements](https://shop.highmark.com/sales/#!/sbc-agreements).
| Will you pay less if you use a network provider? | Yes. For a list of network providers, see [www.highmarkbcbs.com](http://www.highmarkbcbs.com) or call 1-800-241-5704. | 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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, and Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/Screening/Immunization</td>
<td>No charge for preventive care services</td>
<td>No coverage for preventive care visits 30% coinsurance for screening services 30% coinsurance for immunizations</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, and Other Important Information</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-----------------------</td>
<td>------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Network Provider (You will pay the least) 10% coinsurance (retail) 10% coinsurance (mail order)</td>
<td>Not covered</td>
</tr>
<tr>
<td>More information about <strong>prescription drug coverage</strong> is available at ________________________________</td>
<td>Brand drugs</td>
<td>Network Provider (You will pay the least) 10% coinsurance (retail) 10% coinsurance (mail order)</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance 30% coinsurance</td>
<td>Precertification may be required.</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>10% coinsurance 30% coinsurance</td>
<td>10% coinsurance 30% coinsurance</td>
<td>Precertification may be required.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room Care</td>
<td>10% coinsurance 10% coinsurance</td>
<td>10% coinsurance 10% coinsurance</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>10% coinsurance 10% coinsurance</td>
<td>10% coinsurance 10% coinsurance</td>
<td>Precertification may be required.</td>
</tr>
<tr>
<td>Urgent care</td>
<td>10% coinsurance 30% coinsurance</td>
<td>10% coinsurance 30% coinsurance</td>
<td>Precertification may be required.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance 30% coinsurance</td>
<td>Precertification may be required.</td>
</tr>
<tr>
<td>Physician/surgeon fee</td>
<td>10% coinsurance 30% coinsurance</td>
<td>10% coinsurance 30% coinsurance</td>
<td>Precertification may be required.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, and Other Important Information</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Outpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s Eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Habilitation services</td>
</tr>
<tr>
<td>• Hearing aids</td>
</tr>
<tr>
<td>• Routine eye care (Adult)</td>
</tr>
<tr>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Weight loss programs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Coverage provided outside the United States. See <a href="http://www.bcbsa.com">http://www.bcbsa.com</a></td>
</tr>
<tr>
<td>• Infertility treatment</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
</tr>
</tbody>
</table>

---

**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](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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe's type 2 Diabetes</th>
<th>Mia's Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network prenatal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>$1500</td>
<td>$1500</td>
<td>$1500</td>
</tr>
<tr>
<td>Specialist coinsurance</td>
<td>Specialist coinsurance</td>
<td>Specialist coinsurance</td>
</tr>
<tr>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>Hospital (facility) coinsurance</td>
<td>Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>Other coinsurance</td>
<td>Other coinsurance</td>
</tr>
<tr>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

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)

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)

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

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe's type 2 Diabetes</th>
<th>Mia's Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>$12,800</td>
<td>$7,400</td>
<td>$1,900</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe's type 2 Diabetes</th>
<th>Mia's Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this example, Peg would pay:</td>
<td>In this example, Joe would pay:</td>
<td>In this example, Mia would pay:</td>
</tr>
<tr>
<td><strong>Cost Sharing</strong></td>
<td><strong>Cost Sharing</strong></td>
<td><strong>Cost Sharing</strong></td>
</tr>
<tr>
<td>Deductibles</td>
<td>Deductibles</td>
<td>Deductibles</td>
</tr>
<tr>
<td>$1,500</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>Copayments</td>
<td>Copayments</td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Coinsurance</td>
<td>Coinsurance</td>
</tr>
<tr>
<td>$1,100</td>
<td>$600</td>
<td>$40</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe's type 2 Diabetes</th>
<th>Mia's Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>What isn’t covered</td>
<td>What isn’t covered</td>
<td>What isn’t covered</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>Limits or exclusions</td>
<td>Limits or exclusions</td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>The total Joe would pay is</td>
<td>The total Mia would pay is</td>
</tr>
<tr>
<td>$2,600</td>
<td>$2,100</td>
<td>$1,540</td>
</tr>
</tbody>
</table>

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 Human Resources.

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 and Highmark Choice Company 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; 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 you, 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 discriminate 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,
e-mail: CivilRightsCoordinator@highmarkhealth.org

You can also 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, HHSS Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)


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).

ATTENTION: 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).


警告： 한국어를 사용하시는 분들께 위도 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하시는 시도해 주십시오 (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).

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).


پیام بیانک: دنیا می‌کند، چه به دنبال چیزی هستی، چه به دنبال چیزی هستی، چه به دنبال چیزی هستی، چه به دنبال چیزی هستی، چه به دنبال چیزی هستی، چه به دنبال چیزی هستی، چه به دنبال چیزی هستی (TTY: 711).


Kominike: Si se Kreyol Ayisyen ou pale, gen sevis entèpre. gratis-ticheri, ki la pou ede w. Rele nan rimoun ki nan do ou idé nan tay la w (TTY: 711).

प्रमाण पत्री के पीछे एक भाषा सहायता सेवा है, जो आपके पीछे के निष्क्रिय कार्य समय या उपहार है। आपके सड़क पत्र (ID) कार्ड के पीछे दिए गए संख्या पर नोंद करें। (TTY: 711).

KOMMENTAR: I niagg samba w. die way dina kriyay. Awa mënu na bëggat na bëggat (TTY: 711).

注： 日本語で母国語の方は言語支援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).

توضيح: اگر شما به فارسی صحبت می‌کنید، دسترسی به خدمات رایگان در این نامه در تهران تضمین است (TTY: 711).

BAA AKONINIZIH: Dinë k’eho yänhîgo lo, language assistance services, ëi t’aa nil k’ee, bee nikà a doowul, ëi bee na ahôti”. ËI bee nehilëzo nga nanitigii bine’di” (TTY: 711) jëf” lodiënë.

प्रयोग करें: यह आपके इनियो होते हैं, तो आपके नाम निष्क्रिय कार्य समय या उपहार है। आपके सड़क पत्र (ID) कार्ड के पीछे दिए गए संख्या पर नोंद करें। (TTY: 711).

注： フランス語で母国語の方は言語支援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).

BAA NGENINZIH: Dinë k’eho yänhîgo lo, language assistance services, ëi t’aa nil k’ee, bee nikà a doowul, ëi bee na ahôti”. ËI bee nehilëzo nga nanitigii bine’di” (TTY: 711) jëf” lodiënë.

प्रयोग करें: यह आपके इनियो होते हैं, तो आपके नाम निष्क्रिय कार्य समय या उपहार है। आपके सड़क पत्र (ID) कार्ड के पीछे दिए गए संख्या पर नोंद करें। (TTY: 711).

Aandacht: Indien u Nederlands spreekt, is de taaladvidesdiest gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).

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