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 1-866-267-3280. 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 1-866-267-3280 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$200 individual/$400 family in-network. $500 individual/$1,000 family out-of-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 care, emergency medical transportation, urgent care, outpatient mental health, outpatient substance abuse, rehabilitation services, eye exam, hospice service, and hearing aids. 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,500 individual/$3,000 family in-network $2,000 individual/$4,000 family out-of-network.	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, prescription drug expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

An example of a benefit book can be found at 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 or call 1-866-267-3280.	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	$20 copay/visit	30% coinsurance	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	$20 copay/visit	30% coinsurance	
	Preventive care/Screening/Immunization	No charge for preventive care services	30% coinsurance for preventive care services	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Precertification may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-866-267-3280.	Generic drugs	Not covered	Not covered	----------none----------
	Brand drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Precertification may be required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	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	$50 copay/visit	$50 copay/visit	Copay waived if admitted as an inpatient. Out-of-network: Not subject to deductible.
	Emergency medical transportation	No charge	No charge	Out-of-network: Not subject to deductible.
	Urgent care	$30 copay/visit	$30 copay/visit	Out-of-network: Not subject to deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Precertification may be required.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	Precertification may be required.
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$20 copay/visit	30% coinsurance	Precertification may be required.
	Inpatient services	10% coinsurance	30% coinsurance	Precertification may be required.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	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	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	

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	10% coinsurance	30% coinsurance	Out-of-network: 30 visits per benefit period. Precertification may be required.
	Rehabilitation services	$20 copay/visit	30% coinsurance	Combined network and out-of-network: 60 physical medicine visits and occupational therapy visits per benefit period. Precertification may be required.
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	10% coinsurance	30% coinsurance	Precertification may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Precertification may be required.
	Hospice service	No charge	No charge	Out-of-network: Not subject to deductible. Precertification may be required.
If your child needs dental or eye care	Children's Eye exam	$20 copay/visit	30% coinsurance	Combined network and out-of-network: One diabetic eye exam per benefit period.
	Children's Glasses	Not covered	Not covered	----------none----------
	Children's Dental check-up	Not covered	Not covered	----------none----------

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
- Dental care (Adult)
- Habilitation services
- Long-term care
- Prescription drugs
- 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.)

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See http://www.bcbsa.com
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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, 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:

- Your plan administrator/employer.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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	$200
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$200
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$200
The total Peg would pay is	**$1,600**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$200
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$200
Copayments	$100
Coinsurance	$400
What isn't covered	
Limits or exclusions	$2,900
The total Joe would pay is	**$3,600**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$200
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$200
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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: 1-866-267-3280.

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.