This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.highmarkbcbs.com or by calling 888-510-1064.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** individual/**$3,000** family network, **$3,000** individual/**$6,000** family out-of-network. **Network deductible** does not apply to preventive care services, pediatric dental, pediatric vision, and prescription drug benefits. Copayments and coinsurance amounts don't count toward the **network deductible.**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Network: Out-of-pocket up to a total maximum out-of-pocket of **$6,850** individual/**$13,700** family. Out-of-network: **$13,700** individual/**$27,400** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

What is not included in the out–of–pocket limit?	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: Premiums, balance-billed 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.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers,** see www.highmarkbcbs.com or call 888-510-1064.	If you use a **network** doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your **network** doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	40% coinsurance	——————none——————
	Specialist visit	$70 copay/visit	40% coinsurance	——————none——————
	Other practitioner office visit	$70 copay/visit for chiropractor	40% coinsurance for chiropractor	Combined network and out-of-network: 20 visits per benefit period.
	Preventive care Screening Immunization	No charge for preventive care services	No coverage for preventive care services	Please refer to your preventive schedule for additional information.
If you have a test	Diagnostic test (x-ray, blood work)	$40 copay/visit	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 888-510-1064.	Formulary Low Cost Generic drugs	$3/$6/$9 copay (retail) $6 copay (mail order)	Not covered	Up to 31/60/90-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. Certain participating retail pharmacy providers may have agreed to make maintenance prescription drugs available at the same cost-sharing and quantity limits as the mail service coverage. This plan has Progressive Formulary.
	Formulary Generic drugs	$10/$20/$30 copay (retail) $20 copay (mail order)	Not covered	
	Formulary Brand drugs	$50/$100/$150 copay (retail) $100 copay (mail order)	Not covered	

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
	Non-Formulary Brand and Non-Formulary Generic drugs	$100/$200/$300 copay (retail) $200 copay (mail order)	Not covered	Up to 31/60/90-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. Certain participating retail pharmacy providers may have agreed to make maintenance prescription drugs available at the same cost-sharing and quantity limits as the mail service coverage. This plan has Progressive Formulary.

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
	Formulary Specialty drugs	50% coinsurance with a $600 maximum (retail) 50% coinsurance with a $1,200 maximum (mail order)	Not covered	Up to 31-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. Certain participating retail pharmacy providers may have agreed to make maintenance prescription drugs available at the same cost-sharing and quantity limits as the mail service coverage. This plan has Progressive Formulary.
	Non-Formulary Specialty drugs	50% coinsurance with a $1,000 maximum (retail) 50% coinsurance with a $2,000 maximum (mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	––––––––––none––––––––––
	Physician/surgeon fees	20% coinsurance	40% coinsurance	––––––––––none––––––––––

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	Out-of-network: Subject to network deductible.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network: Subject to network deductible.
	Urgent care	$70 copay/visit	40% coinsurance	––––––––––none––––––––––
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Out-of-network: 90 days per benefit period combined with inpatient mental health services, inpatient substance abuse services, and inpatient maternity services. Precertification may be required.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	––––––––––none––––––––––

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$70 copay/visit	40% coinsurance	––––––––––none––––––––––
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Out-of-network: 90 days per benefit period combined with inpatient substance abuse services, inpatient hospital services, and inpatient maternity services. Precertification may be required.
	Substance use disorder outpatient services	$70 copay/visit	40% coinsurance	––––––––––none––––––––––
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Out-of-network: 90 days per benefit period combined with inpatient mental health services, inpatient hospital services, and inpatient maternity services. Precertification may be required.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Out-of-network: 90 days per benefit period combined with inpatient mental health services, inpatient substance abuse services, and inpatient hospital services. Precertification may be required.

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Combined network and out-of-network: 60 visits per benefit period.
	Rehabilitation services	20% coinsurance	40% coinsurance	Combined network and out-of-network: 30 physical medicine visits, 30 combined speech therapy and occupational therapy visits per benefit period.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Combined network and out-of-network: 120 days per benefit period limited to 50 days out-of-network.
	Durable medical equipment	20% coinsurance	40% coinsurance	––––––––––none––––––––––
	Hospice service	20% coinsurance	40% coinsurance	––––––––––none––––––––––
If your child needs dental or eye care	Eye exam	No charge	Not covered	Network: One routine eye exam every 12 months.
	Glasses	No charge	Not covered	Network: One pair frames/lenses every 12 months.
	Dental check-up	No charge	Not covered	––––––––––none––––––––––

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Abortions, 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
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Coverage provided outside the United States. See www.bcbsa.com
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud.
- The insurer stops offering services in the State.
- You move outside the coverage area.

For more information on your rights to continue coverage, contact the insurer at 888-510-1064. You may also contact your state insurance department at The Pennsylvania Department of Consumer Services at 1-877-881-6388.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- The Pennsylvania Department of Consumer Services at 1-877-881-6388.
- 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

To obtain language assistance, call 888-510-1064.
SPANISH (Español): Para obtener asistencia en Español, llame al **888-510-1064**.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **888-510-1064**.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 **888-510-1064**.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **888-510-1064**.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,030
- **Patient pays** $2,510

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$10
Coinsurance	$1,000
Limits or exclusions	$0
Total	**$2, 510**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3, 680
- **Patient pays** $1,720

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Copays	$200
Coinsurance	$20
Limits or exclusions	$0
Total	**$1,720**

You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from **network providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.