



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, refer to your SPD, go to [www.highmark.com/blueshieldnyny](http://www.highmark.com/blueshieldnyny) or call 1-844-639.2444. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. View the Glossary at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf>

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	In- <a href="#">network</a> : N/A; Out-of- <a href="#">network</a> : \$250 individual / \$500 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In- <a href="#">network</a> : Not Applicable; Out-of- <a href="#">network</a> : \$5,000 individual / \$10,000 family	If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance billing, and non-covered services	Even though you pay these expenses, they do not count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. <a href="http://www.highmark.com/blueshieldnyny">www.highmark.com/blueshieldnyny</a> or call 1-844-639.2444	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copayment</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$20 <a href="#">copayment</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening</a> /immunization	N/A	N/A	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Covered in full	20% <a href="#">coinsurance</a>	Prior authorization may apply.
	Imaging (CT/PET scans, MRIs)	Covered in full	20% <a href="#">coinsurance</a>	Prior authorization may apply.
If you need drugs to treat your illness or condition	Generic (Tier 1)	\$5 copayment	Not covered	Please contact your Pharmacy Benefits Manager (ProAct) for more details.
	Preferred brand (Tier 2)	\$20 copayment	Not covered	Mandatory Mail Order for maintenance
	Non-preferred brand (Tier 3)	\$40 copayment	Not covered	Rx - Mail 90day supply - 2 copayments
	<a href="#">Specialty drugs</a> (Tier 4)	See limitations & exceptions	See limitations & exceptions	Specialty drugs could be generic, preferred brand or non-preferred brand.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$20 <a href="#">copayment</a>	20% <a href="#">coinsurance</a>	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
	Physician/surgeon fees	Covered in full	20% <a href="#">coinsurance</a>	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$35 <a href="#">copayment</a>	Covered as in- <a href="#">network</a>	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 need immediate medical attention	<a href="#">Emergency medical transportation</a>	Covered in full	Covered as in-network	None
	<a href="#">Urgent care</a>	\$20 <a href="#">copayment</a>	Covered as in-network	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Covered in full	20% <a href="#">coinsurance</a>	Prior authorization required.
	Physician/surgeon fees	Covered in full	20% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">copayment</a>	20% <a href="#">coinsurance</a>	Prior authorization required.
	Inpatient services	Covered in full	20% <a href="#">coinsurance</a>	Prior authorization required.
If you are pregnant	Office visits	\$20 <a href="#">copayment</a>	20% <a href="#">coinsurance</a>	None
	Childbirth/delivery professional services	\$20 <a href="#">copayment</a>	20% <a href="#">coinsurance</a>	For participating <a href="#">providers</a> , <a href="#">cost share</a> applies only to initial visit to determine pregnancy.
	Childbirth/delivery facility services	Covered in full	20% <a href="#">coinsurance</a>	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Covered in full	20% <a href="#">coinsurance</a>	Prior authorization may apply.
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copayment</a>	20% <a href="#">coinsurance</a>	20 visits per person / year
	<a href="#">Skilled nursing care</a>	Covered in full	20% <a href="#">coinsurance</a>	Prior authorization may apply.

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 need help recovering or have other special health needs	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Prior authorization may apply.
	<a href="#">Hospice services</a>	Covered in full	20% <a href="#">coinsurance</a>	Prior authorization may apply.
If your child needs dental or eye care	Children's eye exam	\$20 <a href="#">copayment</a>	20% <a href="#">coinsurance</a>	Member <a href="#">cost share</a> may vary by <a href="#">plan</a> .
	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               | • Hearing Aids      | • Long Term Care       |
| • Private Duty Nursing | • 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                                  | • Elective Abortion        |
| • Infertility treatment | • Non-emergency care when traveling outside the U.S. | • 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](http://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](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](#).

### 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 Minimum Value Coverage? 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): 如需帮助，请拨打 1-888-249-2583。

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo 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)

- ④ The [plan's](#) overall [deductible](#) \$0.00
- ④ [Specialist copayment](#) \$20.00
- ④ [Hospital \(facility\) copayment](#) \$0
- ④ [Other copayment](#) \$20.00

**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*)

<b>Total Example Cost</b>	<b>\$13,052</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$0
Copays	\$380
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$134
<b>The total Peg would pay is</b>	<b>\$514</b>

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

- ④ The [plan's](#) overall [deductible](#) \$0.00
- ④ [Specialist copayment](#) \$20.00
- ④ [Hospital \(facility\) copayment](#) \$0
- ④ [Other copayment](#) \$20.00

**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*)

<b>Total Example Cost</b>	<b>\$7,389</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$0
Copays	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,463
<b>The total Joe would pay is</b>	<b>\$4,663</b>

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

- ④ The [plan's](#) overall [deductible](#) \$0.00
- ④ [Specialist copayment](#) \$20.00
- ④ [Hospital \(facility\) copayment](#) \$0
- ④ [Other copayment](#) \$20.00

**This EXAMPLE event includes services like:**  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$0
Copays	\$140
Coinsurance	\$7
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$147</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.