**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/blueshieldneny 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 deductible?** | $0 deductible In-network; $0 deductible Out-of-network | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Yes | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. |
| **Are there other deductibles for specific services?** | Yes. $100 individual / $200 family additional benefits deductible; 20% coinsurance services. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | $500 individual / $1000 family<br>Excludes deductible | The out-of-pocket limit is the most you could pay in a year for covered services. |
| **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?** | Not Applicable | This plan does not use a provider network. You can receive covered services from any provider. |
| **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 | 20% FS INN 20% UCR OON | 20% FS INN 20% UCR OON | None |
| | Specialist visit | 20% FS INN 20% UCR OON | 20% FS INN 20% UCR OON | None |
| | Preventive care/screening/immunization | N/A | N/A | 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) | 0% coinsurance for x-ray; 0% coinsurance for blood work | 0% coinsurance for x-ray; 0% coinsurance for blood work | |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance | 0% coinsurance | Prior authorization required. |
| **If you need drugs to treat your illness or condition** | Generic (Tier 1) | $0 copayment | Not Covered | ProAct - Class 0001 Mandatory Mail Order for maintenance Rx, Class 0002 / RetireeRx exempt |
| | Preferred brand (Tier 2) | $10 copayment | Not Covered | |
| | Non-preferred brand (Tier 3) | $10 copayment | Not Covered | Mail Order 90day supply - 2 copayments |
| | Specialty drugs (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) | 0% coinsurance | 0% coinsurance | None |
| | Physician/surgeon fees | 0% coinsurance | 0% coinsurance | Prior authorization required on certain procedures. Call the number on the back of your ID card for details. |

| 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** | Emergency room care | 0% coinsurance | 0% coinsurance | None |
| | Emergency medical transportation | 0% coinsurance | 0% coinsurance | None |
| | Urgent care | 20% FS INN 20% UCR OON | 20% FS INN 20% UCR OON | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% coinsurance | 0% coinsurance | Prior authorization required. 365 Days unlimited rollover |
| | Physician/surgeon fees | 0% coinsurance | 0% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% FS INN 20% UCR OON for Mental Health; 0% coinsurance for Substance Abuse | 20% FS INN 20% UCR OON for Mental Health; 0% coinsurance for Substance Abuse | None |
| | Inpatient services | 0% coinsurance for Mental Health; 0% coinsurance for Substance Abuse Detox; 0% coinsurance for Substance Abuse Rehab | 0% coinsurance for Mental Health; 0% coinsurance for Substance Abuse Detox; 0% coinsurance for Substance Abuse Rehab | Prior authorization required. |
| **If you are pregnant** | Office visits | 20% FS INN 20% UCR OON | 20% FS INN 20% UCR OON | None |
| | Childbirth/delivery professional services | 0% coinsurance | 0% coinsurance | For participating providers, cost share applies only to initial visit to determine pregnancy. |
| | Childbirth/delivery facility services | 0% coinsurance | 0% coinsurance | Prior authorization required. |
| **If you need help recovering or have other special health needs** | Home health care | 0% coinsurance | 0% coinsurance | Prior authorization required. 40 visits/cal yr |

| 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** | Rehabilitation services | 0% coinsurance for Occupational; 0% coinsurance for Physical; 0% coinsurance for Speech | 0% coinsurance for Occupational; 0% coinsurance for Physical; 0% coinsurance for Speech | 120 visits aggregate w/inhalation, physical, occupation, speech |
| | Skilled nursing care | 0% coinsurance | 0% coinsurance | Prior authorization required. Unlimited days within 30 days of discharge |
| | Durable medical equipment | 20% FS INN 20% UCR OON | 20% FS INN 20% UCR OON | Prior authorization required. |
| | Hospice services | 0% coinsurance | 0% coinsurance | Unlimited visits, subject to medical necessity. |
| **If your child needs dental or eye care** | Children's eye exam | 20% FS INN 20% UCR OON | Not covered | None |
| | 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 Eye Care (Adult)
- 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.)**

- Infertility treatment
- Chiropractic care
- Elective Abortion
- Non-emergency care when traveling outside the U.S

**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 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 (ᔑ□□):ᓭ□峒せᔑ□□ⓗᖘᕀ□ 刎実㊐ラ征□ 趁 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)

| | |
|---|---|
| ④ The plan's overall deductible | $100.00 |
| ④ Specialist copayment | $0.00 |
| ④ Hospital (facility) coinsurance | 0% |
| ④ Other copayment | $0.00 |

**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** | **$12,732** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copays | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $134 |
| **The total Peg would pay is** | **$134** |

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

| | |
|---|---|
| ④ The plan's overall deductible | $100.00 |
| ④ Specialist copayment | $0.00 |
| ④ Hospital (facility) coinsurance | 0% |
| ④ Other copayment | $0.00 |

**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** | **$7,389** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $100 |
| Copays | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $4,463 |
| **The total Joe would pay is** | **$4,563** |

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

| | |
|---|---|
| ④ The plan's overall deductible | $100.00 |
| ④ Specialist copayment | $0.00 |
| ④ Hospital (facility) coinsurance | 0% |
| ④ Other copayment | $0.00 |

**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** | **$1,925** |

**In this example, Mia would pay:**

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

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