Summary of PPO Blue $500 100/80 Gold *Benefits*

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 $500 $1,000	 $1,000 $2,000
Coinsurance Member's Coinsurance obligation based on the Plan Allowance or Provider's Allowable Price	$0 after deductible	20% after deductible
Out-of-Pocket Limit (Includes deductible, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period.) Individual Family	 $9,100 $18,200	 $18,200 $36,400
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	$30 copay	20% after deductible
Primary Care Provider Office Visits & Virtual Visits	Office Visit: $30 copay Virtual Visit: $0 copay	20% after deductible
Specialist Office & Virtual Visits	$70 copay	20% after deductible
Virtual Visit Provider Originating Site Fee	$0 after deductible	20% after deductible
Urgent Care Center Visits	$75 copay, the copayment, if any, does not apply to urgent care services prescribed for the treatment of mental illness or substance abuse	20% after deductible
Preventive Care(2)		
Routine Adult		
Adult immunizations	$0	20% after deductible
BRCA-Related Genetic Counseling and Genetic-Testing	$0	20% after deductible
Breast Cancer Screenings	$0	20% after deductible
Colorectal cancer screening	$0	20% after deductible
Diagnostic services and procedures	$0	20% after deductible
Mammograms(annual routine)	$0	20% after deductible
Mammograms (medically necessary)	$0	20% after deductible
Physical exams	$0	20% after deductible
Routine gynecological exams, including a Pap Test	$0	20%
Routine adult vision Screening	$0	Not Covered
Routine Pediatric		
Diagnostic services and procedures	$0	20% after deductible
Pediatric immunizations	$0	20%
Physical exams	$0	20% after deductible
Pediatric Vision(3) - **Davis Vision National Network**		
Exam (including dilation, as professionally indicated)	$0	Not Covered
Pediatric frame selection	$0	Not Covered
Standard eyeglass lenses (per pair)	$0	Not Covered
Contact Lens Benefit (in lieu of eyeglasses)	$0	Not Covered
Evaluation, Fitting & Follow-up Care	$0	Not Covered
Collection Contact Lenses (Disposable; Planned Replacement)	$0	Not Covered
Non-Collection Contact Lenses: Materials Allowance	$150 discounted price	Not Covered
Evaluation, Fitting & Follow-up Care – Standard lens Types and Specialty Lens Types	Not Covered	Not Covered
Pediatric Dental(3) - United Concordia Advantage Network		
Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants)	$0	Not Covered
Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings))	50%	Not Covered
Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.))	50%	Not Covered
Orthodontics(4) (Medically necessary with prior approval)	50%	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	$0 after deductible	20% after deductible
Hospital Outpatient (Non-Surgical)	$0 after deductible	20% after deductible
Outpatient Surgery (8)	$0 after deductible	20% after deductible
Maternity (non-preventive facility) including dependent daughter	$0 after deductible	20% after deductible
Medical Care (including inpatient visits and consultations)**/Surgical Expenses**	$0 after deductible	20% after deductible
Emergency Services		
Emergency Room Services (Facility Fee)	$405 copay (waived if admitted)	
Emergency Room Services (Professional Fee)	$0	

Benefit	Network	Out-of-Network
Ambulance (9)	$0 after in-network deductible	
Ambulance – Non-Emergency (10)	$0 after deductible	20% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Medicine (Rehabilitative and Habilitative)	$70 copay	20% after deductible
Physical Medicine – Benefit Maximum - Combined with Occupational Therapy	Limit: 30 rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to therapy services for the treatment of a Mental Health or Substance Abuse diagnosis	
Respiratory Therapy	$0 after deductible	20% after deductible
Speech Therapy (Rehabilitative and Habilitative)	$70 copay	20% after deductible
Speech Therapy- Benefit Maximum	Limit: 30 rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to therapy services for the treatment of a Mental Health or Substance Abuse diagnosis	
Occupational Therapy (Rehabilitative and Habilitative)	$70 copay	20% after deductible
Occupational Therapy – Benefit Maximum - Combined with Physical Therapy	Limit: 30 rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to therapy services for the treatment of a Mental Health or Substance Abuse diagnosis	
Spinal Manipulations	$70 copay	20% after deductible
	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	$0 after deductible	20% after deductible
Mental Health/Substance Abuse		
Inpatient	$0 after deductible	20% after deductible
Inpatient Detoxification/Rehabilitation	$0 after deductible	20% after deductible
Outpatient Includes Virtual Behavioral Health Visits	Office Visit: $70 copay Virtual Visit: $0 copay	20% after deductible
Other Services		
Allergy Extracts and Injections	$0 after deductible	20% after deductible
Artificial Insemination	$0 after deductible	20% after deductible
Dental Services Related to Accidental Injury	$0 after deductible	20% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	Member Savings Site = $375 copay: All Other Network Providers = $750 copay, the copayment, if any, does not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse	20% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical)	Member Savings Site = $65 copay: All Other Network Providers = $130 copay, the copayment, if any, does not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse	20% after deductible
Lab/Pathology	Member Savings Site = $65 copay: All Other Network Providers = $130 copay, the copayment, if any, does not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse	20% after deductible
Durable Medical Equipment	$0 after deductible	20% after deductible
Orthotics and Prosthetics	$0 after deductible	20% after deductible
Home Health Care	$0 after deductible	20% after deductible
	Limit: 60 visits/benefit period	
House Call Program	$0	Not Covered
	Limited to one (1) per benefit period	
Hospice	$0 after deductible	20% after deductible
	Respite care limit of 7 days every 6 months	
Infertility Counseling, Testing and Treatment(5)	$0 after deductible	20% after deductible
Skilled Nursing Facility Care	$0 after deductible	20% after deductible
	Limit: 120 days/benefit period	
Transplant Services	$0 after deductible	20% after deductible
Precertification Requirements(6)	YES	
Prescription Drugs		
Prescription Drug Deductible Individual Family	None N/A	
Prescription Drug Program(7) Sensible Rx Complete *Defined by the National Plus Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the HCR Comprehensive Formulary with an Incentive Benefit Design.*	**Retail Drugs (31/60/90-day Supply)** $3 / $6 / $9 low cost generic copay -- $20 / $40 / $60 standard generic copay $65 / $130 / $195 formulary brand copay $90 / $180 / $270 non-formulary copay 20% formulary specialty coinsurance -- $350 Maximum (31-day supply-Retail) 30% non-formulary specialty coinsurance -- $500 Maximum (31-day supply-Retail) **Maintenance Drugs through Mail Order (up to 90-day Supply)** $3 low cost generic copay -- $20 standard generic copay $130 formulary brand copay $180 non-formulary brand copay 20% formulary specialty coinsurance -- $700 Maximum (Mail Order) 30% non-formulary specialty coinsurance -- $1000 Maximum (Mail Order)	

Benefit	Network	Out-of-Network

To access more information about the drug formulary, including tiering, please go to:
http://www.highmark.com/transparency-in-coverage or for a paper copy, call 1-855-873-4106.

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
(2) Benefits are provided as further detailed in the Preventive Schedule, and the frequency and eligibility of services is subject to change.
(3) Pediatric vision and dental benefits are only available to dependent children or health plan members under age 19.
(4) A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality. Prior approval is required. See your benefit booklet for more details.
(5) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(6) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.
(7) The formulary is a listing of Prescription Drugs and Over-the-Counter Drugs selected by Highmark for their quality, safety and effectiveness. This listing is subject to periodic review and modification by Highmark or a designated committee of Physician or pharmacists. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under SensibleRx Complete, you are responsible for the payment differential when a generic drug is available and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.
(8) Refers to outpatient surgical procedure provided in a hospital or ambulatory facility setting.
(9) Benefits for Emergency Ambulance Services rendered by an OutofNetwork Provider will be paid at the Network Services level and subject to the Deductible amount, if any, applicable to Network Services. The Member will not be responsible for any amounts billed by the OutofNetwork Provider that are in excess of the Plan Allowance for such Services.
(10) Benefits for Ambulance Services provided by air and rendered by an OutofNetwork Provider will be paid at the Network Services level and subject to the Deductible amount, if any, that is applicable to Network Services. The Member will not be responsible for any amounts billed by the OutofNetwork Provider that are in excess of the Plan Allowance for such Services.

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, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, 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 discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, 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, email: CivilRightsCoordinator@highmarkhealth.org. You can 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, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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).

ATENCIÓN: 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).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (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).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (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).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (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).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung.
Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注： 日本語が母国語の方は言語アシスタンス・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）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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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, www.myhighmark.com or call 1-800-457-4062. 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 1-800-457-4062 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 individual/$1,000 family network. $1,000 individual/$2,000 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?	Yes. Office visits, preventive care services, emergency room care, diagnostic services, urgent care, outpatient mental health, outpatient substance abuse, rehabilitation services, habilitation services, pediatric dental, pediatric vision, and prescription drug benefits are covered before you meet your network deductible. 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?	$9,100 individual/$18,200 family network out-of-pocket. $18,200 individual/$36,400 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, 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?	Yes. See www.myhighmark.com or call 1-800-457-4062 for a list of network providers.	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, & 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	$30 copay/visit Deductible does not apply.	20% 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	$70 copay/visit Deductible does not apply.	20% coinsurance	
	Preventive care/screening/immunization	No charge Deductible does not apply.	20% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	Member saving site $65 copay/visit All other network providers $130 copay/visit Deductible does not apply.	20% coinsurance	Copayments, if any, do not apply to diagnostic services prescribed for the treatment of mental health or substance abuse. Precertification may be required.

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)	
	Imaging (CT/PET scans, MRIs)	Member saving site $375 copay/visit All other network providers $750 copay/visit Deductible does not apply.	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myhighmark.com.	Low Cost Generic drugs	$3/$6/$9 copay/prescription (retail) $3 copay/prescription (mail order) Deductible does not apply.	Not covered	Up to 31/60/90-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. This plan uses an HCR Comprehensive Formulary.
	Generic drugs	$20/$40/$60 copay/prescription (retail) $20 copay/prescription (mail order) Deductible does not apply.	Not covered	
	Formulary Brand drugs	$65/$130/$195 copay/prescription (retail) $130 copay/prescription (mail order) Deductible does not apply.	Not covered	

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)	
	Non-Formulary Brand drugs	$90/$180/$270 copay/prescription (retail) $180 copay/prescription (mail order) Deductible does not apply.	Not covered	
	Formulary Specialty drugs	20% coinsurance, $350 max/prescription (retail) 20% coinsurance, $700 max/prescription (mail order) Deductible does not apply.	Not covered	Up to 31-day supply specialty drugs retail pharmacy. Up to 90-day supply maintenance specialty prescription drugs through mail order. This plan uses an HCR Comprehensive Formulary.
	Non-Formulary Specialty drugs	30% coinsurance, $500 max/prescription (retail) 30% coinsurance, $1,000 max/prescription (mail order) Deductible does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Precertification may be required.
	Physician/surgeon fees	No charge	20% coinsurance	Precertification may be required.
If you need immediate medical attention	Emergency room care	$405 copay/visit Deductible does not apply.	$405 copay/visit Deductible does not apply.	Copay waived if admitted as an inpatient.
	Emergency medical transportation	No charge	No charge	Out-of-network: Subject to network deductible.

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)	
	Urgent care	$75 copay/visit Deductible does not apply.	20% coinsurance	The copayment, if any, does not apply to urgent care services prescribed for the treatment of mental health or substance abuse.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Precertification may be required.
	Physician/surgeon fees	No charge	20% coinsurance	Precertification may be required.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$70 copay/visit Deductible does not apply.	20% coinsurance	Precertification may be required.
	Inpatient services	No charge	20% coinsurance	Precertification may be required.
If you are pregnant	Office visits	No charge	20% 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	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Combined network and out-of-network: 60 visits per benefit period, aggregate with visiting nurse. Precertification may be required.
	Rehabilitation services	$70 copay/visit Deductible does not apply.	20% coinsurance	Combined network and out-of-network: 30 combined physical medicine and occupational therapy visits and 30 speech therapy visits per benefit period. Copayment, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. Limit does not apply to services for the treatment of a mental health or substance abuse diagnosis. Precertification may be required.

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)	
	Habilitation services	$70 copay/visit Deductible does not apply.	20% coinsurance	Combined network and out-of-network: 30 combined physical medicine and occupational therapy visits and 30 speech therapy visits per benefit period. Copayment, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. Limit does not apply to services for the treatment of a mental health or substance abuse diagnosis. Precertification may be required.
	Skilled nursing care	No charge	20% coinsurance	Combined network and out-of-network: 120 days per benefit period. Precertification may be required.
	Durable medical equipment	No charge	20% coinsurance	Precertification may be required.
	Hospice services	No charge	20% coinsurance	Combined network and out-of-network: Respite care limit of 7 days every 6 months. Precertification may be required.
If your child needs dental or eye care	Children's eye exam	No charge Deductible does not apply.	Not covered	Network: One eye exam per 12-month period up to age 19.
	Children's glasses	No charge Deductible does not apply.	Not covered	Network: One pair frames/lenses every 12 months.
	Children's dental check-up	No charge Deductible does not apply.	Not covered	Network: One exam every 6 months.

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)
- 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.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See www.bcbsglobalcore.com

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. 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:

- Highmark, Inc. at 1-800-457-4062.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- 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 plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 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)

The plan's overall deductible	$500
Specialist copayment	$70
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,260**

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

The plan's overall deductible	$500
Specialist copayment	$70
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

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

The plan's overall deductible	$500
Specialist copayment	$70
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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

Highmark Senior Health Company is an independent licensee of the Blue Cross Blue Shield Association

Insurance or benefit administration may be provided by Highmark Blue Shield, Highmark Benefits Group, Highmark Health Insurance Company, or Highmark Senior Health Company all of which are independent licensees of the Blue Cross and Blue Shield Association.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to http://www.highmark.com/transparency-in-coverage; or for a paper copy, call 1-855-873-4110.

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, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, 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 discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, 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
Email: CivilRightsCoordinator@highmarkhealth.org

You can 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 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, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Для получения помощи позвоните по номеру, указанному на обратной стороне вашей идентификационной карты (TTY: 711).

ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero riportato sul retro della Sua tessera di identificazione (TTY: 711).

ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711) pour obtenir de l'aide.

ÀKÍYÈSÍ: Tí o bá nsọ èdè Yorùbá, àwọn iṣẹ ìtumọ ati òǵbufọ èdè wà ní àrọwọtó lọ́fẹ̀ẹ́ fún ọ. Awọn iṣẹ ìtọ́jú ati ìràànlọ́wọ́ tó yẹ (bíi titẹwé nla, gbigbọ ohùn, atì ìwé afọ́jú) lati pèsè iwifúnni ni awọn ọna ìrááyè si wà pẹlu lọ́fẹ̀ẹ́. Pe nọmba tó wà lẹhin kaádì ìdánimọ rẹ (TTY: 711) fún iràànlọwọ.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזויווי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל. רופט דעם נומער אויף די אנדערע זייט פון אייער אידענטיטעט קארטל (TTY: 711) פאר הילף.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقاتٍ يمكن الوصول إليها من دون أي تكلفة. اتصل على الرقم المدوّن على ظهر بطاقة هويتك (TTY: 711) للحصول على المساعدة.

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字体、音频和盲文），以便您获取无障碍格式的信息。如需帮助，请拨打您的 ID 卡背面的号码（听障人士专用号码： 711）。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિઃશુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઑડિયો અને બ્રેઇલ) પણ નિઃશુલ્ક ઉપલબ્ધ છે. મદદ માટે તમારા આઇડી કાર્ડની પાછળ આપેલા નંબર (TTY: 711) પર કૉલ કરો.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711) để được trợ giúp.

ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई निःशुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि निःशुल्क उपलब्ध छन्। मद्दतको लागि तपाईंको ID कार्डको पछाडिको नम्बरमा कल गर्नुहोस् (TTY: 711)।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ़्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फ़ॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी निःशुल्क उपलब्ध हैं। सहायता के लिए अपने पहचान कार्ड के पीछे लिखे नंबर (TTY: 711) पर कॉल करें।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용할 수 있습니다. 도움이 필요하시면 ID 카드 뒷면에 있는 번호로 전화하십시오(TTY: 711).