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 1-800-241-5704.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** individual/**$1,000** family tier 1 network, **$1,500** individual/**$3,000** family tier 2 network, **$4,000** individual/**$8,000** family out-of-network. **Tier 1 In Network deductible** does not apply to office visits, preventive care services, emergency medical transportation, urgent care, rehabilitation services, and prescription drug benefits. **Tier 2 In Network deductible** does not apply to preventive care services, emergency medical transportation, 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 4 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 4 for other costs for services this plan covers.

Questions: Call 1-800-241-5704 or visit us at www.highmarkbcbs.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.HealthCare.gov or call 1-800-241-5704 to request a copy. An example of a benefit book can be found at https://shop.highmark.com/sales/#!/sbc-agreements.

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Is there an out–of–pocket limit on my expenses?	Tier 1 In Network: **$0** individual/**$0** family. Tier 2 In network: **$3,350** individual/**$6,700** family. Out-of-network **$6,000** individual/**$12,000** family. Up to a **$7,150** individual/**$14,300** family, combined tier 1 and tier 2 total maximum out-of-pocket.	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?	Tier 1 and tier 2 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, deductibles, copayments, prescription drug expenses, 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 4 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 _____ or call _____.	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 4 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 an In-network Tier 1 Provider	Your Cost if You Use an In-network Tier 2 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	$20 copay/visit	30% coinsurance	40% coinsurance	––––––––––none––––––––––
	Specialist visit	$40 copay/visit	30% coinsurance	40% coinsurance	––––––––––none––––––––––
	Other practitioner office visit	$40 copay/visit for chiropractor	30% coinsurance for chiropractor	40% coinsurance for chiropractor	Combined network and out-of-network: 12 visits per benefit period.
	Preventive care Screening Immunization	No charge for preventive care services	No charge for preventive care services	40% coinsurance for preventive care services	Please refer to your preventive schedule for additional information. .
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	40% coinsurance	––––––––––none––––––––––
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	40% coinsurance	––––––––––none––––––––––

Common Medical Event	Services You May Need	Your Cost if You Use an In-network Tier 1 Provider	Your Cost if You Use an In-network Tier 2 Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at _____ _____.	Retail Drugs	$3/$15/$30/$50 copay	Not Covered	Not covered	Up to 31-day supply retail pharmacy.
	Mail Order Drugs	$6/$30/$60/$100 copay	Not Covered	Not covered	Up to 90-day supply maintenance prescription drugs through mail order..
	Specialty Drugs	Applicable tier copay applies	Not Covered	Not covered	----------none----------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	40% coinsurance	----------none----------
	Physician/surgeon fees	No charge	30% coinsurance	40% coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost if You Use an In-network Tier 1 Provider	Your Cost if You Use an In-network Tier 2 Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	No Charge	30% coinsurance after tier 1 deductible	40% coinsurance after tier 1 deductible	Copay waived if admitted as an inpatient.
	Emergency medical transportation	No charge (deductible does not apply) for emergencies. No charge after program deductible for non-emergencies	No charge (deductible does not apply) for emergencies. 30% coinsurance after program deductible for non-emergencies	No charge (deductible does not apply) for emergencies. 40% coinsurance after program deductible for non-emergencies	
	Urgent care	100% after $40 copay	30% coinsurance	40% coinsurance	––––––––––none––––––––––
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	40% coinsurance	Failure to precertify will result in benefits payable being reduced by $500.
	Physician/surgeon fee	No charge	30% coinsurance	40% coinsurance	––––––––––none––––––––––

Common Medical Event	Services You May Need	Your Cost if You Use an In-network Tier 1 Provider	Your Cost if You Use an In-network Tier 2 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	No charge	30% coinsurance	40% coinsurance	––––––––––none––––––––––
	Mental/Behavioral health inpatient services	No charge	30% coinsurance	40% coinsurance	Failure to precertify will result in benefits payable being reduced by $500.
	Substance use disorder outpatient services	No charge	30% coinsurance	40% coinsurance	––––––––––none––––––––––
	Substance use disorder inpatient services	No charge	30% coinsurance	40% coinsurance	Failure to precertify will result in benefits payable being reduced by $500.
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	40% coinsurance	Network: The first visit to determine pregnancy is covered at no charge.
	Delivery and all inpatient services	No charge	30% coinsurance	40% coinsurance	Failure to precertify will result in benefits payable being reduced by $500.

Common Medical Event	Services You May Need	Your Cost if You Use an In-network Tier 1 Provider	Your Cost if You Use an In-network Tier 2 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	No charge	30% coinsurance	40% coinsurance	––––––––––none––––––––––
	Rehabilitation services	No charge	30% coinsurance	40% coinsurance	Combined network and out-of-network: 20 physical medicine visits, 12 speech therapy visits, and 12 occupational therapy visits per benefit period.
	Habilitation services	Not covered	Not covered	Not covered	––––––––––none––––––––––
	Skilled nursing care	No charge	30% coinsurance	40% coinsurance	Combined network and out-of-network: 60 days per benefit period.
	Durable medical equipment	No charge	30% coinsurance	40% coinsurance	––––––––––none––––––––––
	Hospice service	No charge	30% coinsurance	40% coinsurance	180 days per lifetime.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	–––––––––none–––––––––
	Glasses	Not covered	Not covered	Not covered	–––––––––none–––––––––
	Dental check-up	Not covered	Not covered	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See www.bcbsa.com
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-241-5704. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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:

- Highmark Inc. at 1-800-241-5704.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform .
- 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.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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** $7,030
- **Patient pays** $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	$500
Copays	$10
Coinsurance	$0
Limits or exclusions	$0
Total	**$510**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,600
- **Patient pays** $800

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	$500
Copays	$300
Coinsurance	$0
Limits or exclusions	$0
Total	**$800**

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.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield, First Priority Life Insurance Company or First Priority Health, all of 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.

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An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- 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 Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, 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 1-844-679-6930.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-844-679-6930.

请注意：如果您说中文，可向您提供免费语言协助服务。

請致電 1-844-679-6930 。

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 1-844-679-6930.

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-844-679-6930.

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du 1-844-679-6930 uffrufe.

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-844-679-6930 로 전화.

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-844-679-6930.

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-844-679-6930.

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-844-679-6930.

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-844-679-6930.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-844-679-6930 નંબર પર ફોન કરો.

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-844-679-6930.

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le 1-844-679-6930.

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នក ដោយឥតគិតថ្លៃ។ ការហៅ 1-844-679-6930 ។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-844-679-6930.

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-844-679-6930.

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。1-844-679-6930 を呼び出します。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-844-679-6930. موجود است.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodíilnih 1-844-679-6930.