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, call 1-800-348-7468 x3264. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-348-7468 x3264 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500/individual or $3,000/family for network providers $3,000/individual or $6,000/family for out-of-network providers	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. Preventive care services, prescription drugs, and office visits are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment 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?	For network providers $8,700 individual / $17,400 family; for out-of-network providers $5,500 individual / $11,000 family. For prescription drug copayments $3,000 individual.	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-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?	Yes. See www.highmarkbcbs.com or call 1-800-810-BLUE (2583) 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 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	$25 copay/office visit (deductible does not apply). 30% coinsurance for other outpatient services. $15 copay/Amwell virtual physician visit (deductible does not apply).	50% coinsurance	Well360 Virtual Health visits available only through the Amwell network of physicians.
	Specialist visit	$25 copay/office visit (deductible does not apply). 30% coinsurance for other outpatient services	50% coinsurance	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling Express Scripts at 1-800-818-9787	Tier 1 Generic drugs	Deductible does not apply. 10% copay / prescription (retail & mail order).	Not covered	Mandatory step therapy applies. Covers up to a 90-day supply for retail purchase or 90-day supply for mail order purchase. Preauthorization required for all specialty drugs. No benefits without preauthorization. No benefits if prescription drug card is not used.
	Tier 2 Preferred brand drugs	Deductible does not apply. 30% copay / prescription (retail & mail order)	Not covered	
	Tier 3 Non-preferred brand drugs	Deductible does not apply. 50% copay / prescription (retail & mail order)	Not covered	
	Tier 4 Specialty drugs	Deductible does not apply. 30% copay / prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	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)	
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	Network deductible applies for emergency room care and emergency medical transportation provided by out-of-network providers.
	Emergency medical transportation	30% coinsurance	30% coinsurance	
	Urgent care	$25 copay/office visit (deductible does not apply). 30% coinsurance for other outpatient services	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Preauthorization is required 7-10 days prior to a planned admission; within 48 hours following emergency admission.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit (deductible does not apply). 30% coinsurance for other outpatient services	50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	Preauthorization is required 7-10 days prior to a planned admission; within 48 hours following emergency admission.
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	Cost sharing does not apply to preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	Preauthorization is required prior to extension of inpatient stay beyond 48 hours for vaginal delivery or 96 hours for cesarean delivery.

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	Home health care	30% coinsurance	50% coinsurance	None
	Rehabilitation services	30% coinsurance	50% coinsurance	Physical medicine limited to 25 visits/year; speech therapy limited to 25 visits/year; occupational therapy limited to 25 visits/year.
	Habilitation services	30% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 100 days/year. Preauthorization is required 7-10 days prior to a planned inpatient admission; within 48 hours following emergency inpatient admission.
	Durable medical equipment	30% coinsurance	50% coinsurance	Excludes vehicle modifications, home modifications, and exercise equipment.
	Hospice services	30% coinsurance	50% coinsurance	Preauthorization required 7-10 days prior to a planned inpatient admission; within 48 hours following emergency inpatient admission.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Excluded service
	Children's glasses	Not covered	Not covered	Excluded service
	Children's dental check-up	Not covered	Not covered	Excluded service

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 (except to correct a congenital defect, a condition resulting from an accident, or a functional impairment resulting from a covered disease or injury)
- Dental care (Adult)
- Dental check-up (Child)
- Eye exam and glasses (Child)
- Hearing aids
- Long-term care
- Routine eye care (Adult)
- Routine foot care (except when related to treatment of diabetes)
- 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, up to 25 visits/year
- Infertility treatment (diagnosis and treatment of underlying medical condition
- Infertility services (assisted fertilization) up to $5,000 per lifetime
- Non-emergency care when traveling outside the U.S. (Blue Cross Blue Shield Global Core Program)
- Private-duty nursing

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact the plan at 1-574-535-7000. 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: Assistance is available 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 Blue Cross Blue Shield at 1-800-226-2239 or your plan representative at 1-574-535-7000.

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	$1,500
Specialist copayment	$25
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$1,500
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	$1,500
Specialist copayment	$25
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$350
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,570**

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

The plan's overall deductible	$1,500
Specialist copayment	$25
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$1,500
Copayments	$50
Coinsurance	$330
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,880**

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