



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, visit [www.myhighmark.com](http://www.myhighmark.com) or call 800-241-5704. 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](http://www.healthcare.gov/sbc-glossary) or call 800-241-5704 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>\$4,000 individual/\$8,000 family <a href="#">network</a>.                      \$8,000 individual/\$16,000 family <a href="#">out-of-network</a>.</p>	<p>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>. The Medical Expense Reimbursement Program (MERP) administered by Leavitt NE will reimburse for in-network deductible expenses. No out of network deductible will be reimbursed. There is a general deductible where the employee is responsible to pay the first \$2,000 for individual and \$4,000 for family. Participants will be reimbursed 90% of any in network deductible after they have satisfied the above requirements. Participants must submit all explanation of benefits for reimbursement. If you would like more details about the MERP, please contact Leavitt NE (Webber Advisors) at 1-800-326-9850 or reference your MERP plan document.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. Office visits, <a href="#">preventive care</a> services, <a href="#">emergency room care</a>, <a href="#">urgent care</a>, outpatient mental health, outpatient substance abuse, <a href="#">rehabilitation services</a> and <a href="#">prescription drug</a> benefits are covered before you meet your <a href="#">network deductible</a>.</p> <p><a href="#">Copayments</a> and <a href="#">coinsurance</a> amounts don't count toward the <a href="#">network deductible</a>.</p>	<p>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. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>\$1,700 individual/\$3,400 family <a href="#">network out-of-pocket limit</a>. Up to a total maximum out-of-pocket of \$10,150 individual/\$20,300 family.                      \$3,400 individual/\$6,800 family <a href="#">out-of-network</a>.</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. 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.</p>

Important Questions	Answers	Why This Matters:
What is not included in the <a href="#">out-of-pocket limit</a> ?	<u>Network</u> : <a href="#">Premiums</a> , balance-billed charges, and health care this <a href="#">plan</a> doesn't cover do not apply to your total maximum out-of-pocket. <u>Out-of-network</u> : <a href="#">Copayments</a> , <a href="#">deductibles</a> , <a href="#">premiums</a> , balance-billed charges, <a href="#">prescription drug</a> expenses, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.myhighmark.com">www.myhighmark.com</a> or call 800-241-5704 for a list of <a href="#">network providers</a> .	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 <a href="#">out-of-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 <a href="#">out-of-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](#) cost 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 <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.  Please refer to your <a href="#">preventive</a> schedule for additional information.
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> does not apply.	No coverage for <a href="#">preventive care</a> visits 30% <a href="#">coinsurance</a> for <a href="#">screening</a> services 30% <a href="#">coinsurance</a> for immunizations	

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)	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Copayments</u> , if any, do not apply to Diagnostic Services prescribed for the treatment of Mental Health or Substance Abuse.  Precertification may be required.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
<b>If you need drugs to treat your illness or condition.</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://www.myhighmark.com">www.myhighmark.com</a>	Generic drugs	\$15/\$30/\$45 <u>copay</u> /prescription (retail) \$30 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	Up to 31/60/90-day supply retail pharmacy. Up to 90-day supply maintenance <u>prescription drugs</u> through mail order.
	<u>Formulary</u> Brand drugs	\$35/\$70/\$105 <u>copay</u> /prescription (retail) \$70 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
	Non- <u>Formulary</u> Brand drugs	\$60/\$120/\$180 <u>copay</u> /prescription (retail) \$120 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$150 <u>copay</u> /visit <u>Deductible</u> does not apply.	\$150 <u>copay</u> /visit <u>Deductible</u> does not apply.	<u>Copay</u> waived if admitted as an inpatient.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Out-of-network</u> : Subject to <u>network deductible</u> .

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)	
	<a href="#">Urgent care</a>	\$40 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a>	The <a href="#">Copayment</a> , if any, does not apply to <a href="#">Urgent Care</a> Services prescribed for the treatment of Mental Health or Substance Abuse.
<b>If you have a hospital stay</b>	Facility fees (e.g., hospital room)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Precertification may be required.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Precertification may be required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$40 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a>	Precertification may be required.
	Inpatient services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Precertification may be required.
<b>If you are pregnant</b>	Office visits	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<p><a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a>. Depending on the type of services, a <a href="#">copayment</a>, <a href="#">coinsurance</a>, or <a href="#">deductible</a> may apply.</p> <p>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</p> <p><a href="#">Network</a>: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health <a href="#">Preventive</a> Schedule for additional information.</p> <p>Precertification may be required.</p>
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	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)	
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a>	Combined <a href="#">network</a> and <a href="#">out-of-network</a> : 20 physical medicine visits, 20 speech therapy visits and 20 occupational therapy visits per benefit period. Limit does not apply to Therapy Services prescribed for the treatment of Mental Health or Substance Abuse. <a href="#">Copayments</a> , if any, do not apply to Therapy Services prescribed for the treatment of Mental Health or Substance abuse Disorder. Precertification may be required.
	<a href="#">Habilitation services</a>	Not covered	Not covered	None
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Out-of-network</a> : 100 days maximum per benefit period. Precertification may be required.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Precertification may be required.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Precertification may be required.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

## 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
- Habilitation services
- Long-term care
- 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](http://www.bcbsglobalcore.com)
- Private-duty nursing

**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), or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). The Pennsylvania Department of Consumer Services at 1-877-881-6388. 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](#). For more information about your rights, this notice, or assistance, contact:

- Your plan administrator/employer.
- The 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).

**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](#) **\$4,000**
- [Specialist copayment](#) **\$40**
- Hospital (facility) [coinsurance](#) **10%**
- Other [coinsurance](#) **10%**

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>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$4,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,970</b>

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

- The [plan's overall deductible](#) **\$4,000**
- [Specialist copayment](#) **\$40**
- Hospital (facility) [coinsurance](#) **10%**
- Other [coinsurance](#) **10%**

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>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,820</b>

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

- The [plan's overall deductible](#) **\$4,000**
- [Specialist copayment](#) **\$40**
- Hospital (facility) [coinsurance](#) **10%**
- Other [coinsurance](#) **10%**

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>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,300
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,700</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: \_\_\_\_\_.

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

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield and Highmark Choice Company 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](https://www.discoverhighmark.com); or for a paper copy, call 1-800-241-5704.

## 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](mailto: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 of Civil Rights Complaint Portal, available at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://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](http://hhs.gov/ocr/office/file/index.html)

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**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. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòm aksèsib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

