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, go to www.highmark.com/bcbswny or call 1-888-249-2583. Complete Prescription plan information can be obtained at www.pbdrx.com or by calling 1-888-878-9172. 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 ww.healthcare.gov/sbc-glossary or call 1-844-639-2441 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $0; Out-of-network: $500 individual /$1,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. No services are subject to a 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?	In-network: $4,750 individual / $9,500 family (medical): $1,600/$3,200 (Rx); Out-of-network: $2,000 individual / $4,000 family	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.highmark.com/bcbswny.com or call 1-888-249-2583 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	Core: $20 Plus: 10 or $20	20% coinsurance	None
	Specialist visit	Core: $20 Plus: $30 or $20	20% coinsurance	None
	Preventive care/screening/ immunization	Covered in full	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Flu vaccine covered in full out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	$20 Core; $30 or $20 Plus for x-ray; $0 for blood work	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$20 Core; $30 or $20 Plus	20% coinsurance	Prior authorization required on certain procedures.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pbdrx.com	Generic drugs (Tier 1)	$7 copay/prescription (retail & mail order) $0 copay/prescription contraceptives	Not Applicable	A 30-day supply at retail is 1 co-pay; a 90-day supply (maintenance drugs) at retail is 2½ co-pays; a 90-day supply (maintenance drugs) at mail order is 1 co-pay. Some generic drugs may be subject to non-preferred brand co-pay.
	Preferred brand drugs (Tier 2)	$25 copay/prescription (retail & mail order) $0 copay/prescription Contraceptives if no generic is available	Not Applicable	A 30-day supply at retail is 1 co-pay; a 90-day supply (maintenance drugs) at retail is 2½ co-pays; a 90-day supply (maintenance drugs) at mail order is 1 co-pay. If a generic equivalent is available, members will pay the cost differential between the brand and generic drug plus the brand co-pay
	Non-preferred brand drugs (Tier 3)	$40 copay/prescription (retail & mail order) $0 copay/prescription contraceptives if no generic is	Not Applicable	A 30-day supply at retail is 1 co-pay; a 90-day supply (maintenance drugs) at retail is 2½ co-pays; a 90-day supply (maintenance drugs) at mail order is 1 co-pay.

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)	
		available		
	Specialty drugs	$7 copay/generic $25 copay/preferred brand $40 copay/non-preferred brand	Not Applicable	Specialty drugs could be generic, preferred brand or non-preferred brand, and must be obtained from Reliance Rx or an associated participating specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Core: $20 Plus: $30 or $20	20% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
	Physician/surgeon fees	Covered in full	20% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
If you need immediate medical attention	Emergency room care	$100 copayment	$100 copayment	Prudent layperson language applies
	Emergency medical transportation	$50 copayment	$50 copayment	None
	Urgent care	Core: $20 Plus: 10 or $20	Core: $20 Plus: 10 or $20	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500/$1,000	20% coinsurance	Prior authorization required. $500 inividdual per admission, not to exceed $500 individual / $1,000 family
	Physician/surgeon fees	Covered in full	20% coinsurance	Prior authorization required oncertain procedures.

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 mental health, behavioral health, or substance abuse services	Outpatient services	Core: $20 copay Plus: $10 or $20 for Mental Health Core: $20 copay Plus: $10 or $20 for Substance Abuse	20% coinsurance for mental health; 20% coinsurance for Substance Abuse	Prior authorization required on certain procedures. Call the number on the back of your ID card.
	Inpatient services	$500/$1,000 for Inpatient Mental Health $500/$1,000 for Substance Abuse detox $500/$1,000 for Substance Abuse rehab	20% coinsurance for Mental Health; 20% coinsurance for Substance Abuse Detox; 20% coinsurance for Substance Abuse Rehab	Prior authorization required on certain procedures. Call the number on the back of your ID card. Unlimited visits; subject to medical necessity. $500 indivdual per admission, not to exceed $500 individual / $1,000 family
If you are pregnant	Office visits	Core: $20 Plus: 10 or $20	20% coinsurance	None
	Childbirth/delivery professional services	Core: $20 Plus: 10 or $20	20% coinsurance	For participating providers, cost share applies only to initial visit to determine pregnancy
	Childbirth/delivery facility services	$500 individual / $1,000 family	20% coinsurance	$500 individual per admission, not to exceed $500 individual/$1,000 family
If you need help recovering or have other special health needs	Home health care	Core: $20 Plus: $30 or $20	20% coinsurance	Unlimited visits IN; 365 visits OON. Any IN visit counts toward the OON limit.
	Rehabilitation services	Core: $20 Plus: $30 or $20	20% coinsurance	20 visits; aggregate IN + OON with PT/OT/ST, per plan year
	Skilled nursing care	$500/$1,000	20% coinsurance	Prior authorization required. 50 days. $500 individual per admission, not to exceed $500 individula/$1,000 family
	Durable medical equipment	20% coinsurance	50% coinsurance	Prior authorization required on certain equipment. Call the number on the back of your ID card for details.
	Hospice services	Covered in full	20% coinsurance	210 days per cal yr IN & OON aggregate
If your child needs dental or eye care	Children's eye exam	Core: $20; Plus: $30 or $20	20% coinsurance	Member cost share may vary by plan
	Children's glasses	See limitations and exceptions	See limitations and exceptions	Discounts may apply.
	Children's dental check-up	See limitations and exceptions	See limitations and exceptions	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
- Dental
- Private-duty nursing
- 90 day supplyof non-maintenance drugs
- Long-term care
- Routine foot care
- Custodial Care
- Hearing aids
- 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
- Non-emergency care when traveling outside the U.S.
- Chiropractic Care
- Routine eye care (Adult)
- Infertility treatment
- Elective abortion

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 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. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how 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: 1-800-888-1238

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 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-249-2583.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-249-2583.
Chinese (中文):如果需要中文的帮助，请拨打这个号码 1-888-249-2583.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-249-2583

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$500
Other copayment	$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)*

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$180
Coinsurance	$0
What isn't covered	
Limits or exclusions	$96
The total Peg would pay is	**$276**

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$500
Other copayment	$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)*

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$720
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$755**

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$500
Other copayment	$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)*

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$80
Coinsurance	$7
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$87**

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: Highmark BlueCross BlueShield of WNY at www.highmark.com/bcbswny.com or call 1-888-249-2583.*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" page 1.
The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Notice of Nondiscrimination

Highmark BlueCross BlueShield of Western New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Highmark BlueCross BlueShield of Western New York does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Highmark BlueCross BlueShield of Western New York:

• 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, please call the customer service number on the back of your ID card or contact the Civil Rights Coordinator..

If you believe that Highmark BlueCross BlueShield of Western New York 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, PO Box 22492., Pittsburgh, PA , 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email: civilrightscoordinator@highmarkhealth.org . You can file a grievance in person or by mail, fax, or email. 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, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*

For assistance in English, call the customer service at the number listed on your ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט
אויף אייער ID קארטל.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

Notice of Nondiscrimination

Pharmacy Benefit Dimensions®
An Independent Health company

Discrimination is Against the Law

Pharmacy Benefit Dimensions is a subsidiary of Independent Health and complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Pharmacy Benefit Dimensions does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Pharmacy Benefit Dimensions:

- 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 Pharmacy Benefit Dimensions' Member Services Department.

If you believe that Pharmacy Benefit Dimensions 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: Pharmacy Benefit Dimensions' Member Services Department, 511 Farber Lakes Drive, Buffalo, NY 14221, 1-800-501-3439, TTY users call 1-800-432-1110, fax (716) 635-3504, memberservice@servicing.independenthealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Pharmacy Benefit Dimensions' Member Services Department 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.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-665-1502 (TTY: 1-800-432-1110).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-665-1502 (TTY: 1-800-432-1110).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-665-1502（TTY：1-800-432-1110）。
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-665-1502 (телетайп: 1-800-432-1110).
French Creole	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-665-1502 (TTY: 1-800-432-1110).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-665-1502 (TTY: 1-800-432-1110)번으로 전화해 주십시오.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-665-1502 (TTY: 1-800-432-1110).
Yiddish	אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-665-1502 (TTY: 1-800-432-1110).
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-665-1502 (TTY: ১-800-432-1110)।
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-665-1502 (TTY: 1-800-432-1110).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل بر-1-800-665-1502 (رقم هاتف الصم والبكم: 1-800-432-1110).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-665-1502 (ATS : 1-800-432-1110).
Urdu	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-665-1502 (TTY: 1-800-432-1110).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-665-1502 (TTY: 1-800-432-1110).
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-665-1502 (TTY: 1-800-432-1110).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-665-1502 (TTY: 1-800-432-1110).