
 **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.pbdx.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 www.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; for out-of-network: \$1,000 individual /\$2,000 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: \$5,125 individual / \$10,250 family (medical): \$1,725/\$3,450 (Rx); Out-of-network: \$2,500 individual / \$5,000 family | 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 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 | \$15 copayment | 25% coinsurance | None |
| | Specialist visit | \$15 copayment | 25% coinsurance | None |
| | Preventive care/screening/immunization | Covered in full | 25% 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) | \$0 copayment for blood work \$15 copayment for x-ray | 25% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | \$15 copayment | 25% 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) | \$10 co-pay/prescription (retail and mail order) \$0 co-pay/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) | \$15 co-pay/prescription (retail and mail order) \$0 co-pay/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) | \$20 co-pay/prescription (retail and 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. |

| 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) | |
| | Specialty drugs | \$10 co-pay/generic \$15 co-pay/preferred brand \$20 co-pay/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) | \$15 copayment | 25% 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 | 25% 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 | \$100 copayment | \$100 copayment | None |
| | Urgent care | \$15 copayment | \$15 copayment | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$250 copayment | 25% coinsurance | Prior authorization required. |
| | Physician/surgeon fees | Covered in full | 25% 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) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$15 copayment for Mental Health \$15 copayment for Substance Abuse | 25% coinsurance for Mental Health 25% coinsurance for Substance Abuse | Prior authorization required on certain procedures. Call the number on the back of your ID card for details. |
| | Inpatient services | \$250 copayment for Inpatient Mental Health \$250 copayment for Substance Abuse detox \$250 copayment for Substance Abuse rehab | 25% coinsurance for Mental Health 25% coinsurance for Substance Abuse detox 25% coinsurance for Substance Abuse Rehab | Prior authorization required on certain procedures. Call the number on the back of your ID card for details. Unlimited visits; Subject to medical necessity. |
| If you are pregnant | Office visits | \$15 copayment | 25% coinsurance | None. |
| | Childbirth/delivery professional services | \$15 copayment | 25% coinsurance | For participating providers, cost share applies only to initial visit to determine pregnancy. |
| | Childbirth/delivery facility services | \$250 copayment | 25% coinsurance | None |
| If you need help recovering or have other special health needs | Home health care | Covered in full | 25% coinsurance | None |
| | Rehabilitation services | \$15 copayment | 25% coinsurance | 30 visits per plan yr per therapy, aggregate IN & OON |
| | Skilled nursing care | Covered in full | 25% coinsurance | Prior authorization required. Unlimited days. |
| | Durable medical equipment | 50% 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 | 25% coinsurance | 210 days per cal yr INN & OON aggregate |
| If your child needs dental or eye care | Children's eye exam | \$15 copayment | 25% 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](#).)

- | | | |
|--|---|--|
| <ul style="list-style-type: none">• Dental• Private-duty nursing• 90-day supply of non-maintenance drugs | <ul style="list-style-type: none">• Cosmetic surgery• Long-term care• Acupuncture | <ul style="list-style-type: none">• 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.)

- | | | |
|--|--|---|
| <ul style="list-style-type: none">• Bariatric Surgery• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Chiropractic Care• Routine eye care (Adult) | <ul style="list-style-type: none">• 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, kwijigo 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](#) \$15
- Hospital (facility) [copayment](#) \$250
- Other [copayment](#) \$15

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 | \$650 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$96 |
| The total Peg would pay is | \$746 |

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](#) \$15
- Hospital (facility) [copayment](#) \$250
- 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 | \$795 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$850 |

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$15
- Hospital (facility) [copayment](#) \$250
- Other [copayment](#) \$15

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 | \$405 |
| Coinsurance | \$18 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$423 |

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 BlueCrossBlueShield of WNY at www.Highmark.com/bcbswny 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 סערווייס 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



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 | אויב איר רעדט אידיש, זענען פארהאן פאר איר 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 ১-৮০০-৬৬৫-১৫০২ (TTY: ১-৮০০-৪৩২-১১১০)। |
| 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 انكر 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). |