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, refer to your SPD, go to www.highmark.com/blueshieldneny or call 1-844-639.2444. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. View the Glossary at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 deductible In-network; $0 deductible Out-of-network	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. $100 individual / $200 family additional benefits deductible; 20% coinsurance services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$500 individual / $1000 family Excludes deductible	The out-of-pocket limit is the most you could pay in a year for covered services.
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?	Not Applicable	This plan does not use a provider network. You can receive covered services from any provider.
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	20% FS INN 20% UCR OON	20% FS INN 20% UCR OON	None
	Specialist visit	20% FS INN 20% UCR OON	20% FS INN 20% UCR OON	None
	Preventive care/screening/immunization	N/A	N/A	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% coinsurance for x-ray; 0% coinsurance for blood work	0% coinsurance for x-ray; 0% coinsurance for blood work	
	Imaging (CT/PET scans, MRIs)	0% coinsurance	0% coinsurance	Prior authorization required.
If you need drugs to treat your illness or condition	Generic (Tier 1)	$0 copayment	Not Covered	ProAct - Class 0001 Mandatory Mail Order for maintenance Rx, Class 0002 / RetireeRx exempt
	Preferred brand (Tier 2)	$10 copayment	Not Covered	
	Non-preferred brand (Tier 3)	$10 copayment	Not Covered	Mail Order 90day supply - 2 copayments
	Specialty drugs (Tier 4)	See limitations & exceptions	See limitations & exceptions	Specialty drugs could be generic, preferred brand or non-preferred brand.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	None
	Physician/surgeon fees	0% coinsurance	0% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.

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 immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	None
	Urgent care	20% FS INN 20% UCR OON	20% FS INN 20% UCR OON	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	0% coinsurance	Prior authorization required. 365 Days unlimited rollover
	Physician/surgeon fees	0% coinsurance	0% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% FS INN 20% UCR OON for Mental Health; 0% coinsurance for Substance Abuse	20% FS INN 20% UCR OON for Mental Health; 0% coinsurance for Substance Abuse	None
	Inpatient services	0% coinsurance for Mental Health; 0% coinsurance for Substance Abuse Detox; 0% coinsurance for Substance Abuse Rehab	0% coinsurance for Mental Health; 0% coinsurance for Substance Abuse Detox; 0% coinsurance for Substance Abuse Rehab	Prior authorization required.
If you are pregnant	Office visits	20% FS INN 20% UCR OON	20% FS INN 20% UCR OON	None
	Childbirth/delivery professional services	0% coinsurance	0% coinsurance	For participating providers, cost share applies only to initial visit to determine pregnancy.
	Childbirth/delivery facility services	0% coinsurance	0% coinsurance	Prior authorization required.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	0% coinsurance	Prior authorization required. 40 visits/cal yr

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	Rehabilitation services	0% coinsurance for Occupational; 0% coinsurance for Physical; 0% coinsurance for Speech	0% coinsurance for Occupational; 0% coinsurance for Physical; 0% coinsurance for Speech	120 visits aggregate w/inhalation, physical, occupation, speech
	Skilled nursing care	0% coinsurance	0% coinsurance	Prior authorization required. Unlimited days within 30 days of discharge
	Durable medical equipment	20% FS INN 20% UCR OON	20% FS INN 20% UCR OON	Prior authorization required.
	Hospice services	0% coinsurance	0% coinsurance	Unlimited visits, subject to medical necessity.
If your child needs dental or eye care	Children's eye exam	20% FS INN 20% UCR OON	Not covered	None
	Children's glasses	See limitations & exceptions	See limitations & exceptions	Discounts may apply.
	Children's dental check-up	See limitations & exceptions	See limitations & exceptions	Contact your group administrator for coverage details.

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
- Custodial Care
- Dental
- Hearing Aids
- Long Term Care
- Private Duty Nursing
- 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.)

- Infertility treatment
- Chiropractic care
- Elective Abortion
- Non-emergency care when traveling outside the U.S

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. 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 to submit a claim, appeal, or a grievance for any reason to your plan.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Coverage? **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 (ᔑ□□):ᓭ□峒せᔑ□□ⓗᖘᕀ□ 刎実㊐ラ征□ 趁 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)

④ The plan's overall deductible	$100.00
④ Specialist copayment	$0.00
④ Hospital (facility) coinsurance	0%
④ Other copayment	$0.00

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	**$12,732**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$0
Copays	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$134
The total Peg would pay is	**$134**

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

④ The plan's overall deductible	$100.00
④ Specialist copayment	$0.00
④ Hospital (facility) coinsurance	0%
④ Other copayment	$0.00

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$100
Copays	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,463
The total Joe would pay is	**$4,563**

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

④ The plan's overall deductible	$100.00
④ Specialist copayment	$0.00
④ Hospital (facility) coinsurance	0%
④ Other copayment	$0.00

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copays	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

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