



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/blueshieldnyny](http://www.highmark.com/blueshieldnyny) 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 <a href="#">deductible</a> ?	\$0 <a href="#">deductible</a> In- <a href="#">network</a> ; \$0 <a href="#">deductible</a> Out-of- <a href="#">network</a>	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes	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.
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$250 individual / \$500 family additional benefits <a href="#">deductible</a> ; 20% <a href="#">coinsurance</a> services. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$500 individual / \$1000 family Excludes deductible	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billing charges, 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> ?	Not Applicable	This <a href="#">plan</a> does not use a <a href="#">provider network</a> . You can receive covered services from any <a href="#">provider</a> .
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](#) 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 <a href="#">provider's</a> 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
	<a href="#">Specialist</a> visit	20% FS INN 20% UCR OON	20% FS INN 20% UCR OON	None
	<a href="#">Preventive care/screening</a> /immunization	N/A	N/A	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. Flu vaccine covered in full out-of- <a href="#">network</a> .
If you have a test	Diagnostic test (x-ray, blood work)	0% <a href="#">coinsurance</a> for x-ray; 0% <a href="#">coinsurance</a> for blood work	0% <a href="#">coinsurance</a> for x-ray; 0% <a href="#">coinsurance</a> for blood work	
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	Prior authorization required. MRI: Preauth for spine & lower extremity; MRA: UM Review.
If you need drugs to treat your illness or condition	Generic (Tier 1)	\$5 copayment	Not Covered	Please contact your Pharmacy Benefits Manager (ProAct) for more details.
	Preferred brand (Tier 2)	\$20 copayment	Not Covered	Mandatory Mail Order for maintenance
	Non-preferred brand (Tier 3)	\$40 copayment	Not Covered	Rx - 90 day supply - 2 copayments
	<a href="#">Specialty drugs</a> (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% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	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	<a href="#">Emergency room care</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	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% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	Prior authorization required. 365 Days unlimited rollover
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% FS INN 20% UCR OON for Mental Health; 0% <a href="#">coinsurance</a> for Substance Abuse	20% FS INN 20% UCR OON for Mental Health; 0% <a href="#">coinsurance</a> for Substance Abuse	None
	Inpatient services	0% <a href="#">coinsurance</a> for Mental Health; 0% <a href="#">coinsurance</a> for Substance Abuse Detox; 0% <a href="#">coinsurance</a> for Substance Abuse Rehab	0% <a href="#">coinsurance</a> for Mental Health; 0% <a href="#">coinsurance</a> for Substance Abuse Detox; 0% <a href="#">coinsurance</a> 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% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	For participating <a href="#">providers</a> , <a href="#">cost share</a> applies only to initial visit to determine pregnancy.
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	Prior authorization required.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	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	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a> for Occupational; 0% <a href="#">coinsurance</a> for Physical; 0% <a href="#">coinsurance</a> for Speech	0% <a href="#">coinsurance</a> for Occupational; 0% <a href="#">coinsurance</a> for Physical; 0% <a href="#">coinsurance</a> for Speech	120 visits aggregate w/inhalation, physical, occupation, speech
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	Prior authorization required. Unlimited days within 30 days of discharge
	<a href="#">Durable medical equipment</a>	20% FS INN 20% UCR OON	20% FS INN 20% UCR OON	Prior authorization required.
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Dental</li> <li>Private Duty Nursing</li> <li>Weight Loss Programs</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic surgery</li> <li>Hearing Aids</li> <li>Routine Eye Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Custodial Care</li> <li>Long Term Care</li> <li>Routine Foot Care</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Elective Abortion</li> </ul>

**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). 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](#).

**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 (中文): 如需帮助, 请拨打 1-888-249-2583。

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-249-2583

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*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
<b>The total Peg would pay is</b>	<b>\$134</b>

**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
<b>The total Joe would pay is</b>	<b>\$4,563</b>

**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
<b>The total Mia would pay is</b>	<b>\$0</b>

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