This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.highmarkblueshield.com or by calling 1-888-510-1084.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,650** individual/**$5,300** family enhanced network, **$5,300** individual/**$10,600** family standard value network, **$10,600** individual/**$21,200** family out-of-network. **Network deductible** does not apply to office visits, preventive care services, diagnostic tests, urgent care, outpatient mental health, outpatient substance use disorder, prescription drug benefits, pediatric dental and vision. Coinsurance amounts don't count toward the **network deductible.**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, **$5,600** individual/**$11,200** family combined enhanced network and standard value network, **$11,200** individual/**$22,400** family out-of-network.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

What is not included in the out–of–pocket limit?	Premiums, balance-billed 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.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers,** see www.highmarkblueshield.com or call 1-888-510-1084.	If you use a **network** doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your **network** doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an Enhanced Value (Network) Provider	Your Cost if You Use a Standard Value (Network) Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit	$70 copay/visit	60% coinsurance	––––––––––none––––––––––
	Specialist visit	$60 copay/visit	$90 copay/visit	60% coinsurance	––––––––––none––––––––––
	Other practitioner office visit	30% coinsurance for chiropractor	50% coinsurance for chiropractor	60% coinsurance for chiropractor	Combined network and out-of-network: 20 visits per benefit period.
	Preventive care Screening Immunization	No charge for preventive care services.	No charge for preventive care services.	No coverage for preventive care services.	Please refer to your preventive schedule for additional information.
If you have a test	Diagnostic test (x-ray, blood work)	$40 copay/visit	$70 copay/visit	60% coinsurance	––––––––––none––––––––––
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	60% coinsurance	––––––––––none––––––––––

Common Medical Event	Services You May Need	Your Cost if You Use an Enhanced Value (Network) Provider	Your Cost if You Use a Standard Value (Network) Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-888-510-1084.	Formulary Generic drugs	$8/$16/$24 copay (retail) $16 copay (mail order)	$8/$16/$24 copay (retail) $16 copay (mail order)	Not covered	Up to 31/60/90-day retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. Certain participating retail pharmacy providers may have agreed to make maintenance prescription drugs available at the same cost-sharing and quantity limits as the mail service coverage.
	Formulary Brand drugs	$45/$90/$135 copay (retail) $90 copay (mail order)	$45/$90/$135 copay (retail) $90 copay (mail order)	Not covered	Up to 31/60/90-day retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. Certain participating retail pharmacy providers may have agreed to make maintenance prescription drugs available at the same cost-sharing and quantity limits as the mail service coverage.

Common Medical Event	Services You May Need	Your Cost if You Use an Enhanced Value (Network) Provider	Your Cost if You Use a Standard Value (Network) Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
	Non-Formulary Brand drugs	$95/$190/$285 copay (retail) $190 copay (mail order)	$95/$190/$285 copay (retail) $190 copay (mail order)	Not covered	Up to 31/60/90-day retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. Certain participating retail pharmacy providers may have agreed to make maintenance prescription drugs available at the same cost-sharing and quantity limits as the mail service coverage.

Common Medical Event	Services You May Need	Your Cost if You Use an Enhanced Value (Network) Provider	Your Cost if You Use a Standard Value (Network) Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
	Formulary Specialty drugs	$95 copay (retail) $190 copay (mail order)	$95 copay (retail) $190 copay (mail order)	Not covered	Up to 31-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. Certain participating retail pharmacy providers may have agreed to make maintenance prescription drugs available at the same cost-sharing and quantity limits as the mail service coverage
	Non-Formulary Specialty drugs	25% coinsurance with a $200 maximum (retail) 25% coinsurance with a $400 maximum (mail order)	25% coinsurance with a $200 maximum (retail) 25% coinsurance with a $400 maximum (mail order)	Not covered	Up to 31-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. Certain participating retail pharmacy providers may have agreed to make maintenance prescription drugs available at the same cost-sharing and quantity limits as the mail service coverage

Common Medical Event	Services You May Need	Your Cost if You Use an Enhanced Value (Network) Provider	Your Cost if You Use a Standard Value (Network) Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	60% coinsurance	––––––––––none––––––––––
	Physician/surgeon fees	30% coinsurance	50% coinsurance	60% coinsurance	––––––––––none––––––––––
If you need immediate medical attention	Emergency room services	30% coinsurance	30% coinsurance	30% coinsurance	Emergency room services benefit is after Enhanced network deductible.
	Emergency medical transportation	30% coinsurance	30% coinsurance	30% coinsurance	Emergency medical transportation services benefit is after Enhanced network deductible.
	Urgent care	$60 copay/visit	$90 copay/visit	60% coinsurance	––––––––––none––––––––––
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	60% coinsurance	Out-of-network: 90 days per benefit period combined with Inpatient Maternity, Mental Health and Substance Abuse services. Precertification may be required.
	Physician/surgeon fee	30% coinsurance	50% coinsurance	60% coinsurance	––––––––––none––––––––––

Common Medical Event	Services You May Need	Your Cost if You Use an Enhanced Value (Network) Provider	Your Cost if You Use a Standard Value (Network) Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$60 copay/visit	$60 copay/visit	60% coinsurance	––––––––––none––––––––––
	Mental/Behavioral health inpatient services	30% coinsurance	30% coinsurance	60% coinsurance	Standard Value Network is after Enhanced network deductible. Out-of-network: 90 days per benefit period combined with Inpatient Hospital, Maternity, and Substance Abuse services. Precertification may be required.
	Substance use disorder outpatient services	$60 copay/visit	$60 copay/visit	60% coinsurance	––––––––––none––––––––––
	Substance use disorder inpatient services	30% coinsurance	30% coinsurance	60% coinsurance	Standard Value Network is after Enhanced network deductible. Out-of-network: 90 days per benefit period combined with Inpatient Hospital, Maternity, and Mental Health services. Precertification may be required.

Common Medical Event	Services You May Need	Your Cost if You Use an Enhanced Value (Network) Provider	Your Cost if You Use a Standard Value (Network) Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	30% coinsurance	50% coinsurance	60% coinsurance	Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information.
	Delivery and all inpatient services	30% coinsurance	50% coinsurance	60% coinsurance	Out-of-network: 90 days per benefit period combined with Inpatient Hospital, Mental Health and Substance Abuse services. Precertification may be required.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	60% coinsurance	Combined network and out-of-network: 60 visits per benefit period.
	Rehabilitation services	30% coinsurance	50% coinsurance	60% coinsurance	Combined network and out-of-network: 30 physical medicine visits, 30 combined speech therapy and occupational therapy visits per benefit period.
	Habilitation services	30% coinsurance	50% coinsurance	60% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	60% coinsurance	Combined network and out-of-network: 120 days per benefit period limited to 50 days out-of-network.
	Durable medical equipment	30% coinsurance	50% coinsurance	60% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost if You Use an Enhanced Value (Network) Provider	Your Cost if You Use a Standard Value (Network) Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
	Hospice service	30% coinsurance	50% coinsurance	60% coinsurance	––––––––––none––––––––––
If your child needs dental or eye care	Eye exam	No charge	No charge	Not covered	One routine eye exam every 12 months.
	Glasses	No charge	No charge	Not covered	One pair frames/lenses every 12 months.
	Dental check-up	No charge	No charge	Not covered	Two examinations every 12 months.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Coverage provided outside the United States. See www.bcbsa.com
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-510-1084. You may also contact your state insurance department at The Pennsylvania Department of Consumer Services at 1-877-881-6388.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- The Pennsylvania Department of Consumer Services at 1-877-881-6388.
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

To obtain language assistance, call 1-888-510-1084.

SPANISH (Español): Para obtener asistencia en Español, llame al **1-888-510-1084**.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-888-510-1084**.

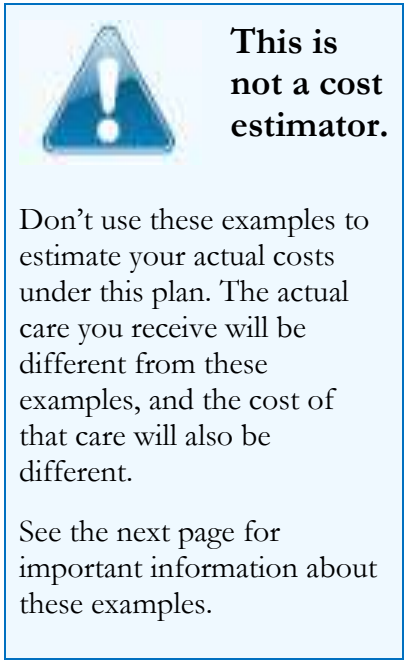
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 **1-888-510-1084**.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-888-510-1084**.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,490
- **Patient pays** $4,050

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,650
Copays	$200
Coinsurance	$1,200
Limits or exclusions	$0
Total	**$4,050**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,100
- **Patient pays** $2,300

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,600
Copays	$700
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,300**

You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from **network providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.