

MRM Residential Management - PPO Blue Sharing \$3,000 with Rx

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
General Provisions		
Effective Date	07/01/2025	
Benefit Period ⁽¹⁾	Contract Year	
Deductible (per benefit period)		
Individual	\$3,000	\$5,000
Family	\$6,000	\$10,000
Plan Pays – payment based on the plan allowance	100% after deductible	50% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	None	\$10,000
Family	None	\$20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copayments, prescription drug cost sharing and other qualified medical expenses, Network only) ⁽²⁾ Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$4,000	Not Applicable
Family	\$8,000	Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$30 copayment	50% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after \$30 copayment	50% after deductible
Specialist Office Visits & Virtual Visits	100% after \$60 copayment	50% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	50% after deductible
Urgent Care Center Visits	100% after \$100 copayment - copayment does not apply to Urgent Care Center Visits prescribed for the treatment of Mental Health or Substance Abuse	50% after deductible
Telemedicine Services ⁽³⁾	100% (deductible does not apply)	Not Covered
Preventive Care ⁽⁴⁾		
Routine Adult		
Physical exams	100% (deductible does not apply)	50% after deductible
Adult immunizations	100% (deductible does not apply)	50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	50% (deductible does not apply)
Breast Cancer Screenings (annual routine and supplemental)	100% (deductible does not apply)	50% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	50% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	50% after deductible
Pediatric immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Emergency Services		
Emergency Room Services ⁽⁵⁾	\$300 copayment (waived if admitted) after network deductible	
Ambulance – Emergency	100% after network deductible	
Ambulance – Non-Emergency ⁽⁶⁾	100% after deductible	50% after deductible
Hospital and Medical/Surgical Expenses (including maternity) ⁽⁵⁾		
Hospital Inpatient	100% after \$500 Inpatient Copayment per Inpatient Day (5 day maximum)	50% after deductible
Hospital Outpatient	100% after deductible	50% after deductible
Outpatient Surgery (facility)	Copayment does not apply to Outpatient Surgery (facility) for the treatment of Mental Health or Substance Abuse	
	\$500 copayment after deductible	50% after deductible
Surgical Services (professional)	100% after deductible	50% after deductible

Benefit	Network	Out-of-Network
Maternity (non-preventive professional services) including dependent daughter	100% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)	100% after deductible	50% after deductible
Therapy and Rehabilitation/Habilitative Services		
Physical Medicine	100% after \$60 copayment	50% after deductible
	Benefit Limit: 30 visits /benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Occupational Therapy	100% after \$60 copayment	50% after deductible
	Benefit Limit: 30 visits /benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Speech Therapy	100% after \$60 copayment	50% after deductible
	Benefit Limit: 20 visits/benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Respiratory Therapy	100% after deductible	50% after deductible
Spinal Manipulations	100% after \$60 copayment	50% after deductible
	Benefit Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	50% after deductible
Mental Health/Substance Abuse		
Inpatient Mental Health Services	100% after \$500 Inpatient Copayment per Inpatient Day (5 day maximum)	50% after deductible
Inpatient Detoxification/Rehabilitation	100% after \$500 Inpatient Copayment per Inpatient Day (5 day maximum)	50% after deductible
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	100% after \$60 copayment	50% after deductible
Outpatient Substance Abuse	100% after \$60 copayment	50% after deductible
Other Services		
Acupuncture	100% after \$60 copayment	50% after deductible
	Benefit Limit: 20 visits/benefit period	
Allergy Extracts and Injections	100% after deductible	50% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	100% after deductible	50% after deductible
Assisted Fertilization Procedures	100% after deductible	50% after deductible
Bariatric Surgery	Not Covered	Not Covered
Dental Services Related to Accidental Injury	100% after deductible	50% after deductible
Diabetes Treatment		
Equipment and Supplies	100% after deductible	50% after deductible
Diabetes Education Program	100% after deductible	50% after deductible
Diabetes Care Management Program (DCMP) – Digitally Monitored, includes telehealth consult for the A1C test	100% (deductible, if any, does not apply)	Not Covered
	Continuous glucose monitor sprints are limited to three (3) per benefit period.	
DCMP – All Other Telehealth Consults	100% (deductible does not apply)	Not Covered
Diagnostic Services	Copayments, if any, do not apply to Diagnostic Services prescribed for the treatment of Mental Health or Substance Abuse	
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after \$200 copayment	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after \$60 copayment	50% after deductible
Mammograms (medically necessary)	100% (deductible does not apply)	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	50% after deductible
Home Health Care	100% after deductible	50% after deductible
	Benefit Limit: 90 visits/benefit period, aggregate with Visiting Nurse	
Hospice	100% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (8)	100% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	50% after deductible
	Benefit Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after \$250 Inpatient Copayment per Inpatient Day (5 day maximum)	50% after deductible
	Benefit Limit: 120 days/benefit period	
Transplant Services	100% after deductible	50% after deductible
Precertification/Authorization Requirements (9)	Yes	

Prescription Drugs	
Prescription Drug Deductible Individual Family	None None
Prescription Drug Program ⁽¹⁰⁾ SensibleRx Choice Defined by the National Plus Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with Incentive Benefit Design. Select Specialty Drugs are Limited to a 31-day Supply	Retail Drugs (31/60/90-day Supply) Generic: \$20/ \$40/ \$60 copayment Formulary Brand: \$40 / \$80 / \$120 copayment Non-Formulary Brand: \$70 / \$140 / \$210 copayment Specialty Drugs (Limited to a 31-day Supply) 50% Specialty Drugs \$500 Maximum per Prescription i Maintenance Drugs through Mail Order (90-day Supply) Generic: \$40 copayment Formulary Brand: \$80 copayment Non-Formulary Brand: \$140 copayment

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy / plan documents, as limitations and exclusions apply. The policy / plan documents control in the event of a conflict with this benefit summary.

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_____ Signature of Client Representative	_____ Title	_____ Date
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- 1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
- 2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government, TMOOP must include deductible, coinsurance, copayments, prescription drug cost share and any qualified medical expense.
- 3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g., PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
- 4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
- 5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
- 6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
- 7) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services - Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g., speech therapy, diagnostic services). Services for the treatment of Autism Spectrum Disorders do not reduce visit/day limits.
- 8) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- 9) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.
- 10) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved drugs selected for their quality, safety, and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under SensibleRx Choice, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug member cost share indicated plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed. With the Exclusive Home Delivery program, you can have your maintenance prescription drugs filled at a retail pharmacy location two times. After that, you must have your maintenance prescription drugs filled through the mail order program. Your plan requires that you use a specific specialty pharmacy for hemophilia medications. Please contact member services for more details. Your plan offers the Free Market Health program for select specialty medications. You will be contacted by one of the specialty network pharmacies who will provide quality service, care, and coordination of your specialty prescription fill and delivery. No enrollment necessary.

Benefits and/or benefit administration may be provided by or through Highmark Inc. d/b/a Highmark Blue Shield, which is an independent licensee of the Blue Cross Blue Shield Association.



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, www.myhighmark.com or call 1-800-457-4062. 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 1-800-457-4062 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$3,000 individual/\$6,000 family <u>network</u> . \$5,000 individual/\$10,000 family out-of- <u>network</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Office visits, <u>preventive care</u> services, <u>diagnostic testing</u> , imaging tests, <u>urgent care</u> , inpatient hospital facility, outpatient mental health, outpatient substance abuse, inpatient mental health, inpatient substance abuse, <u>rehabilitation services</u> , <u>habilitation services</u> , skilling nursing facility, and <u>prescription drug</u> benefits are covered before you meet your <u>network deductible</u> . <u>Copayments</u> and <u>coinsurance</u> amounts don't count toward the <u>network deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$0 individual/\$0 family <u>network out-of-pocket limit</u> , up to a total maximum out-of-pocket of \$4,000 individual/\$8,000 family. \$10,000 individual/\$20,000 family out-of- <u>network</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

What is not included in the <u>out-of-pocket limit</u>?	<p><u>Network</u>: <u>Premiums</u>, balance-billed charges, and health care this <u>plan</u> doesn't cover do not apply to your total maximum out-of-pocket.</p> <p><u>Out-of-network</u>: <u>Copayments</u>, <u>deductibles</u>, <u>premiums</u>, balance-billed charges, <u>prescription drug</u> expenses, and health care this <u>plan</u> doesn't cover.</p>	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.myhighmark.com or call 1-800-457-4062 for a list of <u>network providers</u> .	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>).</p> <p>Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	<p>You may have to pay for services that aren't <u>preventive</u>. Ask your <u>provider</u> if the services needed are <u>preventive</u>. Then check what your <u>plan</u> will pay for.</p> <p>Please refer to your <u>preventive</u> schedule for additional information.</p>
	<u>Specialist</u> visit	\$60 <u>copay</u> /visit <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	

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 have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$60 <u>copay</u> /visit <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	<u>Copayments</u> , if any, do not apply to Diagnostic Services prescribed for the treatment of Mental Health or Substance Abuse. Precertification may be required.
	Imaging (CT/PET scans, MRIs)	\$200 <u>copay</u> /visit <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myhighmark.com .	Generic drugs	\$20/\$40/\$60 <u>copay</u> per prescription (retail) \$40 <u>copay</u> per prescription (mail order) <u>Deductible</u> does not apply.	Not covered	Up to 31/60/90-day supply retail pharmacy. Up to 90-day supply maintenance <u>prescription drugs</u> through mail order.
	<u>Formulary</u> Brand drugs	\$40/\$80/\$120 <u>copay</u> per prescription (retail) \$80 <u>copay</u> per prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
	Non- <u>Formulary</u> Brand drugs	\$70/\$140/\$210 <u>copay</u> per prescription (retail) \$140 <u>copay</u> per prescription (mail order) <u>Deductible</u> does not apply.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Specialty drugs</u>	50% <u>coinsurance</u> \$500 maximum <u>copay</u> per prescription (retail) <u>Deductible</u> does not apply.	Not covered	Select <u>Specialty drugs</u> are limited to a 31-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500 <u>copay</u> /visit	50% <u>coinsurance</u>	<u>Copayment</u> , if any, does not apply to Outpatient Surgery (Facility Services) prescribed for the treatment of Mental Health or Substance Abuse Precertification may be required.
	Physician/surgeon fees	No charge	50% <u>coinsurance</u>	Precertification may be required.
If you need immediate medical attention	<u>Emergency room care</u>	\$300 <u>copay</u> /visit	\$300 <u>copay</u> /visit	Out-of- <u>network</u> : Subject to <u>network deductible</u> . <u>Copay</u> waived if admitted as an inpatient.
	<u>Emergency medical transportation</u>	No charge	No charge	Out-of- <u>network</u> : Subject to <u>network deductible</u> .
	<u>Urgent care</u>	\$100 <u>copay</u> /visit <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	The <u>Copayment</u> , if any, does not apply to <u>Urgent Care</u> Services prescribed for the treatment of Mental Health or Substance Abuse.
If you have a hospital stay	Facility fees (e.g., hospital room)	\$500 <u>copay</u> /day for the first 5 days <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	No charge	50% <u>coinsurance</u>	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$60 <u>copay</u> /visit <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	Precertification may be required.
	Inpatient services	\$500 <u>copay</u> /day for the first 5 days <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	Precertification may be required.
If you are pregnant	Office visits	No charge	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery professional services	No charge	50% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	\$500 <u>copay</u> /day for the first 5 days <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	<u>Network</u> : The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health <u>Preventive</u> Schedule for additional information.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	50% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : 90 visits per benefit period, combined with visiting nurse. Precertification may be required.
	<u>Rehabilitation services</u>	\$60 <u>copay</u> /visit <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : <u>Rehabilitation</u> and <u>habilitation services</u> . Combined <u>network</u> and out-of- <u>network</u> : 30 physical therapy visits, 20 speech therapy visits, and 30 occupational therapy visits per benefit period.
	<u>Habilitation services</u>	\$60 <u>copay</u> /visit <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	Limit does not apply to Therapy Services prescribed for the treatment of Mental Health or Substance Abuse. Precertification may be required.
	<u>Skilled nursing care</u>	\$250 <u>copay</u> /day for the first 5 days <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : Limited to 120 days per benefit period. Precertification may be required.
	<u>Durable medical equipment</u>	No charge	50% <u>coinsurance</u>	Precertification may be required.
	<u>Hospice services</u>	No charge	50% <u>coinsurance</u>	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	-----none-----
	Children's dental check-up	Not covered	Not covered	-----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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- 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.)

- Acupuncture
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See www.bcbsglobalcore.com
- Private-duty nursing

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. The Pennsylvania Department of Consumer Services at 1-877-881-6388. 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. For more information about your rights, this notice, or assistance, contact:

- Highmark, Inc. at 1-800-457-4062.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- 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 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 the 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.

—————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 <u>plan's</u> overall <u>deductible</u>	\$3,000
■ <u>Specialist copayment</u>	\$60
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,000
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$4,060
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Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,000
■ <u>Specialist copayment</u>	\$60
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$800
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$20
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The total Joe would pay is	\$1,920
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Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,000
■ <u>Specialist copayment</u>	\$60
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,600
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$2,100
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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: 1-800-457-4062.

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

Insurance or benefit administration may be provided by Highmark Blue Shield and Highmark Choice Company which are independent licensees of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to [DiscoverHighmark.com](https://www.DiscoverHighmark.com); or for a paper copy, call 1-855-873-4106.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- 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 the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator 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>

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyonang tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注: 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.