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| **Coverage Period: 1/1/2023 - 12/31/2023** |

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| **Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services |

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| **Coverage for:-**All Tiers | **Plan Type:** POS |

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|  | **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 1-844-639-2444.  For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary.  You can view the Glossary at www.Highmark.com/bcbswny or call 1-844-639-2444 to request a copy. |

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| **Important Questions** | **Answers** | **Why This Matters:** |
| **What is the overall deductible?** | In-network: N/A; Out-of-network: $750 individual / $1,500 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. 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-pocketlimit for this plan?** | In-network: $‎3,000 individual / $‎6,000 family; Out-of-network: $3,750/$7,500 | 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 youuse a networkprovider?** | Yes. See www.Highmark.com/bcbswny or call 1-844-639-2444 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.  |

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

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| **Common Medical Event** | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions & Other ImportantInformation** |
| **Network Provider****(You will pay the least)** | **Out-of-NetworkProvider** **(You will pay the most)** |
| **If you visit a healthcare provider’s office or clinic** | Primary care visit to treat an injury or illness | $20 copayment | 25% coinsurance | None |
| Specialist visit | $20 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.  |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $‎20 copayment for x-ray, Covered in full for blood work | 25% coinsurance | None |
| Imaging (CT/PET scans, MRIs) | $‎20 copayment | 25% coinsurance | Prior authorization required on certain procedures. Call the number on the back of your ID card for details.  |
| **If you need drugs totreat your illness or condition**More informationabout **prescriptiondrug coverage** is available at www.Highmark.com/bcbswny | Generic drugs (Tier 1) | $5 copayment | Not covered | Some generic drugs may be subject to non-preferred brand cost share. |
| Preferred brand drugs (Tier 2) | $20 copayment | Not covered | None |
| Non-preferred brand drugs (Tier 3) | $35 copayment | Not covered | None |
| Specialty drugs (Tier 4) | See limitations & exceptions | See limitations & exceptions | Specialty drugs could be generic, preferred brand or non-preferred brand. Please visit our website for a copy of our medication guide. |
| **If you haveoutpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $‎20 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 | $‎150 copayment | $‎150 copayment | Prudent layperson language applies |
| Emergency medical transportation | $‎50 copayment | $‎50 copayment | None |
| Urgent care | $‎20 copayment | 25% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $250/cal yr | 25% coinsurance | Prior authorization required.  |
| 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 mentalhealth, behavioral health, or substance abuse services** | Outpatient services | $‎20 copayment for Mental Health; $‎20 copayment for Substance Abuse | 25% coinsurance for Mental Health; 25% coinsurance for Substance Abuse | None |
| Inpatient services | $250/cal yr for Mental Health; $250/cal yr for Substance Abuse Detox; $250/cal yr 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.  |
| **If you are pregnant** | Office visits | $20 copayment | 25% coinsurance | None |
| Childbirth/delivery professional services | $‎20 copayment | 25% coinsurance | For participating providers, cost share applies only to initial visit to determine pregnancy. |
| Childbirth/delivery facility services | $250/cal yr | 25% coinsurance | None |
| **If you need helprecovering or have other special health needs** | Home health care | $0 per stay | 25% coinsurance | No copay for early maternity discharge;unlimited in-net; max 365 agg all Home Care OON red by # rec in-net |
| Rehabilitation services | $‎20 copayment | 25% coinsurance | 30 visits for PT, 30 visits for OT, 30 visits for ST, agg in & oon |
| Skilled nursing care | $250/cal yr | 25% coinsurance | Prior authorization required. Unlimited |
| Durable medical equipment | 50% coinsurance | 50% coinsurance | Prior authorization required on certain procedures. Call the number on the back of your ID card for details.  |
| Hospice services | Covered in full | 25% coinsurance | 210 days per cal yr IN & OON aggregate |
| **If your child needsdental or eye care** | Children’s eye exam | $‎20 copayment | 25% coinsurance | Member cost share may vary by plan. |
| 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. |

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| **Excluded Services & Other Covered Services:** |
| **Services Your** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** |
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| * Cosmetic surgery
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| * Hearing aids
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| * Routine foot care
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| * Custodial care
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| * Long-term care
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| * Weight loss programs
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| * Dental
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| * Private-duty nursing
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| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document.)** |
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| * Acupuncture
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| * Elective Abortion
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| * Routine eye care (Adult)
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| * Bariatric surgery
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| * Infertility treatment
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| * Chiropractic care
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| * Non-emergency care when traveling outside the U.S.
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| **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](https://www.healthcare.gov/sbc-glossary/#health-insurance) [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace). For more information about the [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace), visit [www.HealthCare.gov](https://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](https://www.healthcare.gov/sbc-glossary/#plan) for a denial of a [claim](https://www.healthcare.gov/sbc-glossary/#claim). This complaint is called a[grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal](https://www.healthcare.gov/sbc-glossary/#appeal). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](https://www.healthcare.gov/sbc-glossary/#claim). Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents alsoprovide complete information on how to submit a [claim](https://www.healthcare.gov/sbc-glossary/#claim), [appeal](https://www.healthcare.gov/sbc-glossary/#appeal), or a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan](https://www.healthcare.gov/sbc-glossary/#plan). For more information about your rights, this notice, orassistance, contact: 1-844-639-2444.  |
| **Does this plan provide Minimum Essential Coverage? Yes**[Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) generally includes [plans](https://www.healthcare.gov/sbc-glossary/#plan), [health insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) available through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage), you may not be eligible for the [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits). |
| **Does this plan meet Minimum Value Standards? Yes**If your [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t meet the [Minimum Value Standards](https://www.healthcare.gov/sbc-glossary/#minimum-value-standard), you may be eligible for a [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits) to help you pay for a [plan](https://www.healthcare.gov/sbc-glossary/#plan) through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace). |
| **Language Access Services:**Spanish (Español): Para obtener asistencia en Español, llame al 1-844-639-2444.Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-639-2444.Chinese (中文):如果需要中文的帮助，请拨打这个号码 1-844-639-2444.Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-639-2444.––––––––––––––––––––––*To see examples of how this plan might cover costs for a sample medical situation, see the next section.–––––––––––*––––––––––– |

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| **About these Coverage Examples:** |

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| **This is not a cost estimator.** Treatments shown are just examples of how this [plan](https://www.healthcare.gov/sbc-glossary/#plan) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](https://www.healthcare.gov/sbc-glossary/#provider) charge, and many other factors. Focus on the [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) amounts ([deductibles](https://www.healthcare.gov/sbc-glossary/#deductible), [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) and [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance)) and [excluded services](https://www.healthcare.gov/sbc-glossary/#excluded-services) under the [plan](https://www.healthcare.gov/sbc-glossary/#plan). Use this information to compare the portion of costs you might pay under different health [plans](https://www.healthcare.gov/sbc-glossary/#plan). Please note these coverage examples are based on self-only coverage. |

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| **Peg is Having a Baby** |
| (9 months of in-network pre-natal care and a hospital delivery) |

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| n **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) | **$0.00** |
| n [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$20.00** |
| n **Hospital (facility)** [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$250.00** |
| n **Other** [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$20.00** |

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| **This EXAMPLE event includes services like:**Specialist office visits (*prenatal care)*Childbirth/Delivery Professional ServicesChildbirth/Delivery Facility ServicesDiagnostic tests (*ultrasounds and blood work)*Specialist visit *(anesthesia)* |

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| **Total Example Cost** | **$12,700** |

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| **In this example, Peg would pay:** |
| *Cost Sharing* |
| Deductibles\* | $0 |
| Copays | $300 |
| Coinsurance | $0 |
| *What isn’t covered* |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$360** |

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

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| n **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) | **$0.00** |
| n [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$20.00** |
| n **Hospital (facility)** [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$250.00** |
| n **Other** [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$20.00** |

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| **This EXAMPLE event includes services like:**Primary care physician office visits (*including disease education)*Diagnostic tests *(blood work)*Prescription drugsDurable medical equipment *(glucose meter)* |

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| **Total Example Cost** | **$5,600** |

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| **In this example, Joe would pay:** |  |
| *Cost Sharing* |
| Deductibles\* | $0 |
| Copays | $600 |
| Coinsurance | $0 |
| *What isn’t covered* |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$620** |

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

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| n **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) | **$0.00** |
| n [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$20.00** |
| n **Hospital (facility)** [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$250.00** |
| n **Other** [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$20.00** |

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| **This EXAMPLE event includes services like:**Emergency room care *(including medical**supplies)*Diagnostic test *(x-ray)*Durable medical equipment *(crutches)*Rehabilitation services *(physical therapy)*  |

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| **Total Example Cost** | **$2,800** |

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| **In this example, Mia would pay:** |  |
| *Cost Sharing* |
| Deductibles\* | $0 |
| Copays | $500 |
| Coinsurance | $100 |
| *What isn’t covered* |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$600** |

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| Note: These numbers assume the patient does not participate in the [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) wellness program.  If you participate in the [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) wellness program, you may be able to reduce your costs.  For more information about the wellness program, please contact: Highmark Blue Cross Blue Shield of Western New York at www.Highmark.com/bcbswny or call 1-844-639-2444.\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above. |

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