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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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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 to treat your illness or condition**  More information about **prescription drug 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 have outpatient 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 mental health, 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 help recovering 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 needs dental 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. | | |  | | |  | | --- | | **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)**.)** | | |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  | | --- | | * Cosmetic surgery | | * Hearing aids | | * Routine foot care | |  | |  | | --- | | * Custodial care | | * Long-term care | | * Weight loss programs | |  | |  | | --- | | * Dental | | * Private-duty nursing | | |  |  |  | | |  | | **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.)** | | |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  | | --- | | * Acupuncture | | * Elective Abortion | | * Routine eye care (Adult) | |  | |  | | --- | | * Bariatric surgery | | * Infertility treatment | |  | |  | | --- | | * Chiropractic care | | * 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](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 also provide 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, or assistance, 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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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. | |  | |  |  |  |  | |  |  |  |  |  | | | | | | | | |  |  |  |  |  |  |  | | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | |  | | --- | | **Peg is Having a Baby** | | (9 months of in-network pre-natal care and a hospital delivery) | | |  | |  |  |  |  | | |  |  | | --- | --- | | 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** | | | |  | |  |  |  |  | |  | |  | | --- | | **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** | |  |  | |  |  |  |  | |  | |  |  | | --- | --- | | **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** | | |  | | |  | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | |  | | --- | | **Managing Joe’s type 2 Diabetes** | | (a year of routine in-network care of a well-controlled condition) | | |  | |  |  |  |  | | |  |  | | --- | --- | | 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** | | | |  | |  |  |  |  | |  | |  | | --- | | **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** | |  |  | |  |  |  |  | |  | |  |  | | --- | --- | | **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** | | |  | |  | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | |  | | --- | | **Mia’s Simple Fracture** | | (in-network emergency room visit and  follow up care) | | |  | |  |  |  |  | | |  |  | | --- | --- | | 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** | | | |  | |  |  |  |  | |  | |  | | --- | | **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** | |  |  | |  |  |  |  | |  | |  |  | | --- | --- | | **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** | | |  | | | |  |  |  |  |  |  |  | |  | |  | | --- | | 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. | | | | | |  | | |