

## Westmoreland County Public School Consortium Plan E

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	In Network	Out of Network
<b>General Provisions</b>		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period)		
Individual	None	\$250
Family	None	\$500
Plan Pays – payment based on the plan allowance	100%	80% after deductible
Out-of-Pocket Limit ( Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	None	\$1,000
Family	None	\$2,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, 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	\$7,150	Not Applicable
Family	\$14,300	Not Applicable
<b>Office/Clinic/Urgent Care Visits</b>		
Retail Clinic Visits & Virtual Visits	100% after \$5 copay	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after \$5 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after \$5 copay	80% after deductible
Virtual Visit Originating Site Fee	100%	80% after deductible
Urgent Care Center Visits	100% after \$5 copay	80% after deductible
Telemedicine Services (3)	not covered	not covered
<b>Preventive Care (4)</b>		
<b>Routine Adult</b>		
Physical Exams	100%	not covered
Adult Immunizations	100%	80% after deductible
Routine Gynecological Exams, including a Pap Test	100%	80% (deductible does not apply)
Mammograms, Annual Routine	100%	80% after deductible
Mammograms, Medically Necessary	100%	80% after deductible
Diagnostic Services and Procedures	100%	80% after deductible
<b>Routine Pediatric</b>		
Physical Exams	100%	not covered
Pediatric Immunizations	100%	80% (deductible does not apply)
Diagnostic Services and Procedures	100%	80% after deductible
<b>Emergency Services</b>		
Emergency Room Services	100% after \$20 copay (waived if admitted)	100% no for life threatening and emergency situations yes for non-emergencies plus after \$20 copay (waived if admitted)
Ambulance - Emergency and Non-Emergency	100%	100% (deductible does not apply)
<b>Hospital and Medical / Surgical Expenses (including maternity)</b>		
Hospital Inpatient	100%	80% after deductible
Hospital Outpatient	100%	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100%	80% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100%	80% after deductible
<b>Therapy and Rehabilitation Services</b>		
Physical Medicine	100%	80% after deductible
Respiratory Therapy	100%	100% (deductible does not apply)
Speech Therapy	100%	80% after deductible
Occupational Therapy	100%	80% after deductible

Benefit	In Network	Out of Network
Spinal Manipulations	100% after \$5 copay	80% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible
<b>Mental Health / Substance Abuse</b>		
Inpatient Mental Health Services	100%	80% after deductible
Inpatient Detoxification / Rehabilitation	100%	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100%	80% after deductible
Outpatient Substance Abuse Services	100%	80% after deductible
<b>Other Services</b>		
Allergy Extracts and Injections	100%	80% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	100%	80% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	100%	80% after deductible
<b>Diagnostic Services</b>		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible
Home Health Care	100%	80% after deductible
Hospice	100%	80% after deductible
Infertility Counseling, Testing and Treatment (6)	100%	80% after deductible
Private Duty Nursing	100%	100% (deductible does not apply)
Skilled Nursing Facility Care	100%	80% after deductible
Transplant Services	100%	80% after deductible
Precertification Requirements (7)	Yes	Yes
<b>Prescription Drugs</b>		
Prescription Drug Deductible Individual Family		none none
Prescription Drug Program (8) Soft Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.  Your plan uses the Comprehensive Formulary with an Open Benefit Design	<b>Retail Drugs (34-day Supply or 100 Dosage Units whichever is greater)</b> \$5 generic copay \$10 brand copay  <b>Maintenance Drugs through Mail Order (60-day Supply)</b> \$6 generic copay \$12 brand copay	

## Questions? Call [1-800-215-7865](tel:1-800-215-7865)

**Reference Code: P0060417**

*(Please have your Reference Code ready when you call)*

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 benefits summary.

- (1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
- (2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
- (3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.
- (4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
- (5) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
- (6) 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.
- (7) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (8) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription 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. This formulary covers all FDA-approved generic and brand-name drugs. Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed.

**Discrimination is Against the Law**

The claims administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- 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 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>.

*Please note that your employer – and not the claims administrator – is entirely responsible for determining member eligibility and for the design of your plan/program; including, any exclusion or limitation described in the benefit Booklet.*

**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).

**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).

**Geb Acht:** Wann du Deutsch schwetzsch, kannsch du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kansch du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

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

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 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).

**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.

ध्यान आवासी: जो तमे गुजराती भाषा बोलता हो, तो भाषा सहायता सेवाओ, मुफ्तमा तमने उपलब्ध छे. तमारा ओपलपत्रना पालना भाओ आवेला नंबर पर कल करे (TTY: 711).

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

**Kominike:** Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខជំនួយសេវាសុខភាព ភាគីសម្រាប់សមាសធាតុ (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).

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

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.

**BAA ÁKONÍNÍZIN:** Diné k’ehgo yáníítí’go, language assistance services, éí t’áá nífk’eh, bee níká a’doowol, éí bee ná’alóótí’i. ID bee nééhózingo nanítíníí’ bine’déé’ (TTY: 711) jì’ hodiilnih.

ध्यान दें: यदि आप हिनदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दए गए नंबर पर फोन करें। (TTY: 711).

توجه فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడితే, లాగ్ వీజ్ అసినదినన్ సరవీసిన, ధారణి లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఇడెంటిఫికేషన్ కార్డు (పట్టి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปขง หมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दनुहोस्: यदि तपाईं नेपाली भाषा बोलनुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। तपाईंको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

**Aandacht:** Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).



**⚠ 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, please visit [www.highmarkbcbs.com](http://www.highmarkbcbs.com) or call 1-800-241-5704. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other undefined terms see the Glossary. You can view the Glossary at [www.HealthCare.gov/sbc-glossary/](http://www.HealthCare.gov/sbc-glossary/) or call 1-800-241-5704 to request a copy.**

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	\$0 individual/\$0 family network. \$250 individual/\$500 family out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
<b>Are there services covered before you meet your deductible?</b>	No.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	\$0 individual/\$0 family network out-of-pocket limit, up to a total maximum out-of-pocket of \$7,150 individual/\$14,300 family.  \$1,000 individual/\$2,000 family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. 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.
<b>What is not included in the out-of-pocket limit?</b>	Network: Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket.  Out-of-network: Copayments, deductibles, premiums, balance-billed charges, prescription drug expenses, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

<p><b>Will you pay less if you use a <u>network provider</u>?</b></p>	<p>Yes. For a list of <u>network providers</u>, see <a href="http://www.highmarkbcbs.com">www.highmarkbcbs.com</a> or call 1-800-241-5704</p>	<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 charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). 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. You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>
<p><b>Do I need a <u>referral</u> to see a <u>specialist</u>?</b></p>	<p>No.</p>	



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, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p><b>If you visit a <u>health care provider's office</u> or <u>clinic</u></b></p>	<p>Primary care visit to treat an injury or illness <u>Specialist</u> visit <u>Preventive care</u>/<u>Screening</u>/<u>immunization</u></p>	<p>\$5 <u>copay</u>/visit \$5 <u>copay</u>/visit No charge for <u>preventive care services</u></p>	<p>20% <u>coinsurance</u> 20% <u>coinsurance</u> No coverage for <u>preventive care visits</u> 20% <u>coinsurance</u> for <u>screening services</u> and <u>immunizations</u></p>	<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.  Please refer to your <u>preventive schedule</u> for additional information.  Pre<u>certification</u> may be required. Pre<u>certification</u> may be required.</p>
<p><b>If you have a <u>test</u></b></p>	<p><u>Diagnostic test</u> (x-ray, blood work) <u>Imaging</u> (CT/PET scans, MRIs)</p>	<p>No charge No charge</p>	<p>20% <u>coinsurance</u> 20% <u>coinsurance</u></p>	<p>Pre<u>certification</u> may be required. Pre<u>certification</u> may be required.</p>
<p><b>If you need <u>drugs</u> to <u>treat your illness</u> or <u>condition</u></b>  More information about <u>prescription drug coverage</u> is available at <a href="http://www.highmarkbcbs.com">www.highmarkbcbs.com</a></p>	<p>Generic drugs  Brand drugs</p>	<p>\$5 <u>copay</u> (retail) \$6 <u>copay</u> (mail order)  \$10 <u>copay</u> (retail) \$12 <u>copay</u> (mail order)</p>	<p>Not covered  Not covered</p>	<p>Greater of 34-day supply or 100 units retail pharmacy. Up to 60-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 <u>cost-sharing</u> and quantity limits as the mail service coverage.</p>
<p><b>If you have <u>outpatient surgery</u></b></p>	<p>Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees</p>	<p>No charge No charge</p>	<p>20% <u>coinsurance</u> 20% <u>coinsurance</u></p>	<p>Pre<u>certification</u> may be required. Pre<u>certification</u> may be required.</p>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$20 copay/visit	\$20 copay/visit	Copay waived if admitted as an inpatient. Out-of-network: Not subject to deductible.
	<u>Emergency medical transportation</u>	No charge	No charge	Out-of-network: Not subject to deductible.
	<u>Urgent care</u>	\$5 copay/visit	20% coinsurance	-----none-----
	<u>Facility fee (e.g., hospital room)</u>	No charge	20% coinsurance	Precertification may be required.
	<u>Physician/surgeon fee</u>	No charge	20% coinsurance	Precertification may be required.
	<u>Outpatient services</u>	No charge	20% coinsurance	Precertification may be required.
	<u>Inpatient services</u>	No charge	20% coinsurance	Precertification may be required.
	<u>Office visits</u>	No charge	20% coinsurance	Cost sharing does not apply for preventive services.
	<u>Childbirth/delivery professional services</u>	No charge	20% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	<u>Childbirth/delivery facility services</u>	No charge	20% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	20% coinsurance	Precertification may be required.
	<u>Rehabilitation services</u>	No charge	20% coinsurance	Precertification may be required.
	<u>Habilitation services</u>	Not covered	Not covered	-----none-----
	<u>Skilled nursing care</u>	No charge	20% coinsurance	Precertification may be required.
	<u>Durable medical equipment</u>	No charge	20% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice service	No charge	20% coinsurance	Recertification 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.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- 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.)**

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See <http://www.bcbsa.com>
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- 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](http://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](http://www.cciio.cms.gov). The Pennsylvania Department of Consumer Services at 1-877-881-6388. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <http://www.HealthCare.gov> or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Your plan administrator/employer.

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet 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 page.-----

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 plan's overall deductible \$0
- Specialist copayment \$5
- Hospital (facility) coinsurance 0%
- Other coinsurance 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** \$12,800

**In this example, Peg would pay:**

Cost Sharing	
Deductibles	\$0
Copayments	\$30
Coinsurance	\$0
<b>What isn't covered</b>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$30</b>

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: 1-800-241-5704.

### Managing Joe's type 2 Diabetes

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

- The plan's overall deductible \$0
- Specialist copayment \$5
- Hospital (facility) coinsurance 0%
- Other coinsurance 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** \$7,400

**In this example, Joe would pay:**

Cost Sharing	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$0
<b>What isn't covered</b>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$300</b>

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

### Mia's Simple Fracture

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

- The plan's overall deductible \$0
- Specialist copayment \$5
- Hospital (facility) coinsurance 0%
- Other coinsurance 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** \$1,900

**In this example, Mia would pay:**

Cost Sharing	
Deductibles	\$0
Copayments	\$30
Coinsurance	\$0
<b>What isn't covered</b>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$30</b>

Insurance or benefit administration may be provided by Highmark Blue Cross 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/QualityAssurance](http://DiscoverHighmark.com/QualityAssurance); 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](mailto: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>.

If you speak English, language assistance services, free of charge, are available to you. Call 1-800-876-7639.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-800-876-7639.

如果您说中文，可向您提供免费语言协助服务。請致電 1-800-876-7639。

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-800-876-7639.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-800-876-7639 로 전화.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-800-876-7639.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-800-876-7639.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-800-876-7639.

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-800-876-7639.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-800-876-7639.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-800-876-7639.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-800-876-7639.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-800-876-7639.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.

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。 1-800-876-7639 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-800-876-7639.

