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.mybenefitshome.com or call 1-855-358-3637. 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 1-855-358-3637 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: Individual $0 / Family $0. Out–of–Network: Individual $1,500 / Family $3,000.	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.
Are there services covered before you meet your deductible?	Yes. Emergency care; plus in-network office visits & preventive care are covered before you meet your 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. 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 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-pocket limit for this plan?	Network: Individual $1,500 / Family $3,000. Out–of–Network: Individual $3,000 / Family $6,000.	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.
What is not included in the out–of–pocket limit?	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: Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. For a list of network providers, see at www.mybenefitshome.com or call 1-855-358-3637.	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 I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about **excluded services**.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	30% coinsurance	Includes Internist, General Physician, Family Practitioner, Pediatrician or Gynecologist
	Teladoc	$20 copay/visit	30% coinsurance	----------none----------
	Specialist visit	$30 copay/visit	30% coinsurance	----------none----------
	Other practitioner office visit	$30 copay/visit for chiropractor and acupuncture	30% coinsurance for chiropractor and acupuncture	Combined network and out-of-network per benefit period: 30 chiropractor visits. 12 acupuncture visits when criteria is met.
	Preventive care/Screening/Immunization	No charge for preventive care services	30% coinsurance for preventive care services	Birth to age 3, well-child preventive schedule applies. Children age 3+ and Adults eligible to receive one preventive exam per calendar You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	No charge	30% 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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com Or by calling: 800-711-0917	Tier 1-Generic drugs	Retail: $5 copay/script (up to 30-day supply) / $12.50 copay/script (31-90-day supply)*; Mail Order: $12.50 copay/script	Retail: $5 copay/script (up to 30-day supply).	Mail Order – Covers up to a 90 day supply (mail-order prescriptions) Your plan uses a preferred drug list which identifies the status of covered drugs. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered. If you fill a prescription for a brand-name medication when a generic equivalent is available, you will pay the full cost of the brand-name medication. Certain drugs are limited to specific quantity per fill. *Retail network providers for 31-90 day prescriptions are limited to Good Neighbor Pharmacy (GNP) or Walgreens. OON 30+days refills do not count towards OOP max.
	Tier 2-Brand drugs	Retail: $20 copay/script (up to 30-day supply) / $50 copay/script (31-90-day supply)*; Mail Order: $50 copay/script	Retail: $20 copay/script (up to 30-day supply)	
	Tier 3 – Non-preferred brand drugs	Retail: $50 copay/script (up to 30-day supply) / $125 copay/script (31-90-day supply)*; Mail Order: $125 copay/script	Retail: $50 copay/script (up to 30-day supply)	
	Tier 4 –Specialty Drugs	Your cost varies based on generic, preferred brand or non-preferred brand.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay per surgery	30% coinsurance	Precertification may be required.
	Physician/surgeon fees	No charge	30% coinsurance	Precertification may be required.
If you need immediate medical attention	Emergency room Care	$150 copay/visit	$150 copay/visit	Out-of-network: Not subject to deductible.
	Emergency medical transportation	$100 copay/visit	$100 copay/visit	Out-of-network: Not subject to deductible.
	Urgent care	$50 copay/visit	30% coinsurance	----------none----------

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 have a hospital stay	Facility fee (e.g., hospital room)	$200 copay per admission	30% coinsurance	Precertification may be required.
	Physician/surgeon fee	No charge	30% coinsurance	Precertification may be required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health Outpatient services	$20 copay/visit	30% coinsurance	Precertification may be required.
	Mental/Behavioral health Inpatient services	$200 copay per admission	30% coinsurance	Precertification may be required.
	Substance use disorder outpatient services	$20 copay/visit	30% coinsurance	Precertification may be required.
	Substance use disorder inpatient services	$200 copay per admission	30% coinsurance	Precertification may be required.
If you are pregnant	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. 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.
	Childbirth/delivery professional services	$200 copay per admission	30% coinsurance	
	Childbirth/delivery facility services	$200 copay per admission	30% coinsurance	

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 help recovering or have other special health needs	Home health care	$30 copay/visit	30% coinsurance	Combined network and out-of-network: 120 visits per benefit period. Precertification may be required.
	Rehabilitation services	$30 copay/visit	30% coinsurance	Precertification may be required. Combined in-network and out-of-network: 60 combined physical, occupational and speech therapy visits per benefit period (does not apply for Mental Health services).
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	$200 copay per admission	30% coinsurance	Combined network and out-of-network: 120 days per benefit period. Precertification may be required.
	Durable medical equipment	$30 copay/visit	30% coinsurance	Precertification may be required.
	Hospice service	$200 copay per admission	30% coinsurance	Copay waived if admitted as an inpatient. 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 Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Long-term care
- Routine eye care
- Routine foot care
- Weight loss programs

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

- Acupuncture - Coverage is limited to 12 visits per year. Review clinical policy for criteria.
- Bariatric surgery - Coverage is limited to 1 surgery per lifetime at an IBC Center of Excellence Facility. Review carrier clinical policy for criteria and eligible providers.
- Chiropractic care - coverage is limited to 30 visits per calendar year.
- Coverage provided outside the United States. See www.bcbsa.com
- Hearing aids-1 hearing aid to $1,000 maximum per ear/calendar year.
- Infertility treatment-Limited to the diagnosis and treatment of underlying medical condition, artificial inseminiation and ovulation induction. Advanced reproductive technology: $15,000 lifetime.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing-60 8-hour shifts/calendar year.

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact the AmerisourceBergen COBRA Plan administrator at 877-248-0510 within 31 days of your coverage end date. There are agencies that can help you obtain other coverage: 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 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.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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. **Please note Rx charges are administered by ESI, you should verify limits or exclusions on prescriptions with ESI.**

Laura is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$30
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, Laura would pay:

Cost Sharing	
Deductibles	$0
Copayments (6 specialist visits)	$180
Coinsurance	$0
What isn't covered	
Limits or exclusions (ex: elective Ultrasound)	$200
The total Laura would pay is	**$380**

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	$30
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 (3 specialist visits)	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions (ex: Rx exclusions)	$2,900
The total Joe would pay is	**$2,990**

Mia's Simple Fracture

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

The plan's overall deductible	$0
Specialist copayment	$30
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 (3 specialist visits)	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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

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.
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.

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 .