



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, visit www.myhighmark.com or call 1-877-426-7027. 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 1-877-426-7027 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0 individual/\$0 family network . \$300 individual/\$600 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Emergency room care , emergency medical transportation services are covered before you meet your out-of-network deductible . Copayments and coinsurance amounts don't count toward the out-of-network deductible .	You will have to meet the deductible before the plan pays for any services. 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 ?	0 individual/\$0 family network out-of-pocket limit . Up to a total maximum network out-of-pocket of \$4,500 individual/\$9,000 family and total maximum out of network out of pocket of \$7,500 individual/\$15,000 family . \$0 individual/\$0 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.
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 : Not applicable	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.myhighmark.com or call 1-877-426-7027 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 .



All [copayment](#) and [coinsurance](#) cost 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
		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	20% coinsurance	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. Please refer to your preventive schedule for additional information.
	Specialist visit	\$30 copay /visit	20% coinsurance	
	Preventive care/screening/immunization	No charge	20% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	\$100 copay /visit (hospital owned provider) No charge (independent provider)	20% coinsurance	Copayments , 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)	\$100 copay /visit (hospital owned provider) No charge (independent provider)	20% coinsurance	

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)	
<p>If you need drugs to treat your illness or condition.</p> <p>More information about prescription drug coverage is available at https://www.caremark.com/</p>	Brand / Generic drugs	Not covered	Not covered	Prescription drugs are not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 copay /visit	20% coinsurance	Precertification may be required.
	Physician/surgeon fees	No charge	20% coinsurance	Precertification may be required.
If you need immediate medical attention	Emergency room care	\$200 copay /visit Deductible does not apply.	\$200 copay /visit Deductible does not apply.	Copay waived if admitted as an inpatient.
	Emergency medical transportation	No charge Deductible does not apply.	No charge Deductible does not apply.	None
	Urgent care	\$20 copay /visit	20% coinsurance	The Copayment , if any, does not apply to Urgent Care Services prescribed for the treatment of Mental Health or Substance Abuse.
If you have a hospital stay	Facility fees (e.g., hospital room)	\$100 inpatient copay /day up to \$200 inpatient copay / admission.	20% coinsurance	Precertification may be required.
	Physician/surgeon fees	No charge	20% coinsurance	Precertification may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay /visit	20% coinsurance	Precertification may be required.
	Inpatient services	\$100 inpatient copay /day up to \$200 inpatient copay / admission.	20% coinsurance	Precertification may be required.

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 are pregnant	Office visits	No charge	20% coinsurance	<p>Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply.</p> <p>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</p> <p>Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information.</p> <p>Precertification may be required.</p>
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	\$100 inpatient copay /day up to \$200 inpatient copay / admission.	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	<p>Combined network and out-of-network: 240 visits per benefit period, aggregate with visiting nurse.</p> <p>Precertification may be required.</p>
	Rehabilitation services	15% coinsurance	20% coinsurance	<p>Limit does not apply to Therapy Services prescribed for the treatment of Mental Health or Substance Abuse.</p> <p>Copayments, if any, do not apply to Therapy Services prescribed for the treatment of Mental Health or Substance Use Disorder.</p> <p>Precertification may be required.</p>

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)	
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	No charge	20% coinsurance	Combined network and out-of-network : 120 days per confinement; benefits renew after 180 days without care. Precertification may be required.
	Durable medical equipment	No charge	20% coinsurance	Precertification may be required.
	Hospice services	No charge	20% coinsurance	Combined network and out-of-network : Covered for up to 365 days. 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](#).)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- [Habilitation services](#)
- Long-term care
- Prescription drugs
- 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.)

- Chiropractic care
- Hearing aids
- 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 Delaware Department of Insurance Consumer Assistance Program at 302.674.7300 (local) or 800.282.8611 (toll free). 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:

- Your plan administrator/employer.
- Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Delaware Department of Insurance/Consumer Assistance Program: 1351 West North St., Suite 101, Dover, DE 19904, or consumer@state.de.us.

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 [plan's overall deductible](#) \$0
- [Specialist copayment](#) \$30
- Hospital (facility) [copayment](#) \$100
- 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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$170

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) [copayment](#) \$100
- 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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$3,500
The total Joe would pay is	\$3700

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

- The [plan's overall deductible](#) \$0
- [Specialist copayment](#) \$30
- Hospital (facility) [copayment](#) \$100
- 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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$360

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: _____.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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 1-800-633-2563.

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 of Civil Rights Complaint Portal, available at 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

Phone 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html

ATTENTION If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

ATENCIÓN Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

ACHTUNG Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).

ATANSYON Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòm aksesib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

