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 call 412-432-1128. 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 1-800-382-1428 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** individual/**$500** family.	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. The deductible does not apply to preventive care, generic drugs, hospitalization, dental, and vision services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	**$650** Individual/**$900** Family (includes deductibles detailed above).	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, the overall family out-of-pocket limit must be met.
What is not included in the out–of–pocket limit?	Copayments, 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 you use a network provider?	Yes. For Highmark hospitalization see www.highmark.com or call 1-800-241-5704. For hospitals not participating in the Highmark network and a list of all other participating providers, see www.aetna.com/docfind/custom/meritain/ or call 1-800-382-1428.	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.

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
		Participating Provider (you will pay the least)	Non-Participating 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% coinsurance	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.
	Specialist visit	20% coinsurance	20% coinsurance	
	Preventive care/Screening/Immunization	No charge	No charge	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge up to allowed amount, then 20% coinsurance.	Services are not subject to deductible if a participating provider is used. Precertification may be required.
	Imaging (CT/PET scans, MRIs)	No charge	No charge up to allowed amount, then 20% coinsurance.	Services are not subject to deductible if a participating provider is used. Precertification may be required.
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 1-800-988-5481	Generic drugs	No Charge	20% coinsurance	If you choose a brand-name drug when a generic is available, you will pay the cost difference between the generic and the brand-name drug. This rule applies even if your doctor writes "Dispense as Written" on your prescription. This benefit is available only if you have your prescriptions filled at a Giant Eagle Pharmacy, except in certain emergency situations or if you are not in the service area of a Giant Eagle Pharmacy.
	Brand drugs – Formulary	$15 copay for 30-60-90 day maintencance and Express Scripts Mail-service drugs	20% coinsurance	
	Brand drugs – Non-Formulary	$30 copay for 30-60-90 day maintenance and Express Scripts mail-service drugs	20% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Precertification may be required.
	Physician/surgeon fees	No charge	No charge up to allowed amount, then 20% coinsurance.	Precertification may be required. Services are not subject to deductible if a participating provider is used.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Participating Provider (you will pay the least)	Non-Participating Provider (you will pay the most)	
If you need immediate medical attention	Emergency room care	Facility-no charge, Non-Facility 20% coinsurance.	Facility-no charge, Non-Facility 20% coinsurance.	Coinsurance waived if admitted as an inpatient. Services are not subject to deductible if admitted
	Emergency medical transportation	No charge up to $800, then 20% coinsurance.	No charge up to $800, then 20% coinsurance.	Services are not subject to deductible if charges are under $800.
	Urgent care	Facility-no charge, Non-Facility 20% coinsurance.	Facility-no charge, Non-Facility 20% coinsurance.	Coinsurance waived if services are life threatening or sudden and severe. Services are not subject to deductible if life threatening or sudden and severe.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Precertification may be required.
	Physician/surgeon fee	No charge	No charge up to allowed amount, then 20% coinsurance.	Services are not subject to deductible if a participating provider is used.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance.	20% coinsurance.	Precertification for facility charges may be required. Services are subject to deductible for non-facility charges.
	Inpatient services	No charge	No charge	Precertification may be required. Services are not subject to deductible.
If you are pregnant	Office visits (routine)	No charge	No charge	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound). Participating Provider: The first visit to determine pregnancy is subject to deductible. Precertification may be required.
	Childbirth/delivery professional services	No charge	No charge	
	Childbirth/delivery facility services	No charge	No charge	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Participating Provider (you will pay the least)	Non-Participating Provider (you will pay the most)	
If you need help recovering or have other special health needs	Home health care	Facility-no charge, Non-Facility-20% coinsurance.	Facility-no charge, Non-Facility-20% coinsurance.	Facility: 100 visits per benefit period. Precertification may be required. Services are not subject to deductible for facility charges.
	Rehabilitation services	Facility-No charge for physical medicine, 20% coinsurance for speech therapy and occupational therapy.	Facility-No charge for physical medicine, 20% coinsurance for speech therapy and occupational therapy.	Facility: 21 physical medicine visits per calendar year. Precertification may be required. Services are not subject to deductible for facility charges. Precertification may be required.
	Habilitation services	Facility-No charge for physical medicine, 20% coinsurance for speech therapy and occupational therapy.	Facility-No charge for physical medicine, 20% coinsurance for speech therapy and occupational therapy.	Precertification may be required.
	Skilled nursing care	No charge	No charge	Precertification may be required.
	Durable medical equipment	20% coinsurance	20% coinsurance	Precertification may be required.
	Hospice service	No charge	No charge	Precertificaton may be required.
If your child needs dental or eye care	Children's Eye exam	No charge up to allowance	No charge up to allowance	Maximum of $50 per eye exam reimbursed. Services are not subject to deductible.
	Children's Glasses	No charge up to allowance	No charge up to allowance	Per exam: $75-single vision lenses or $90-contacts; $75 frames. Services are not subject to deductible.
	Children's Dental check-up	20% coinsurance	20% coinsurance	Subject to $2000 annual family limit, except for essential pediatric dental services. Services are not subject to deductible.

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).

- Bariatric surgery
- Cosmetic Surgery
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document).

- Acupuncture-limited to maximum of 26 visits per year for Accupunture & Chiropractic combined
- Chiropractic care-limited to maximum of 26 visits for Accupunture & Chiropractic combined
- Coverage provided outside the United States. See www.bcbsa.com
- Dental care (Adult)
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)

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 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 at 412-432-1130 or 1-800-382-1428
- 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.

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

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	0%
Other coinsurance	20%

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	$158
Copayments	$0
Coinsurance	$40
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$258**

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

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	0%
Other coinsurance	20%

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	$250
Copayments	$0
Coinsurance	$310
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$615**

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

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	0%
Other coinsurance	20%

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	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$109
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$359**

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

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 .