**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.moniteau.org or call (724)637-2117. 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 (724)637-2117 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | $400 individual/$800 family network,<br>$800 individual/$1,600 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 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?** | Network deductible does not apply to office visits, preventive care services, diagnostic services, emergency room care, urgent care, outpatient mental health, outpatient substance abuse, rehabilitation services, and prescription drug coverage.<br><br>Copayments and coinsurance amounts don't count toward the network 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?** | $0 individual/$0 family network out-of-pocket limit, up to a total maximum out-of-pocket limit of $6,350 individual/$12,700 family.<br><br>$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. |
| **What is not included in the out–of–pocket limit?** | Network: Premiums, balance-billing charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket limit.<br><br>Out-of-network: Premiums, deductibles, copayments, balance-billing charges, prescription drug coverage, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

An example of a benefit book can be found at https://shop.highmark.com/sales/#!/sbc-agreements.

| | | |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. For a list of network providers, see www.moniteau.org or call (724)637-2117. | 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).<br>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 |
|---|---|---|---|---|
| | | 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 | $10 copay/visit; deductible does not apply | 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.<br><br>Please refer to your preventive schedule for additional information. |
| | Specialist visit | $25 copay/visit; deductible does not apply | 20% coinsurance | |
| | Preventive care/Screening/Immunization | No charge for preventive care services; deductible does not apply | No coverage for preventive care visits<br>20% coinsurance for screening services<br>20% coinsurance for immunizations | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $15 copay per date of service per provider; deductible does not apply | 20% coinsurance | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | $15 copay per date of service per provider; deductible does not apply | 20% 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 need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.highmarkbcbs.com. | Generic drugs | No charge; deductible does not apply (retail)<br>No charge; deductible does not apply (mail order) | Not covered | Up to 31-day supply retail pharmacy.<br><br>Up to 90-day supply maintenance prescription drugs through mail order. |
| | Brand drugs | $35 copay/prescription; deductible does not apply (retail)<br>$35 copay/prescription; deductible does not apply (mail order) | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | 20% coinsurance | ----------none---------- |
| | Physician/surgeon fees | No charge | 20% coinsurance | ----------none---------- |
| **If you need immediate medical attention** | Emergency room Care | $100 copay/visit; deductible does not apply | $100 copay/visit; deductible does not apply | Copay waived if admitted as an inpatient. |
| | Emergency medical transportation | No charge | No charge after network deductible | ----------none---------- |
| | Urgent care | $25 copay/visit; deductible does not apply | 20% coinsurance | ----------none---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | 20% coinsurance | Precertification may be required. |
| | Physician/surgeon fee | No charge | 20% 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 mental health, behavioral health, or substance abuse needs** | Outpatient services | No charge; deductible does not apply | 20% coinsurance; deductible does not apply | ----------none---------- |
| | Inpatient services | No charge | 20% coinsurance | Precertification may be required. |
| **If you are pregnant** | Office visits | No charge | 20% coinsurance | Precertification may be required for inpatient facility services.<br>Cost sharing does not apply for preventive services.<br>Depending on the type of services, a copayment, coinsurance, or deductible may apply.<br>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)<br>Network: The first visit to determine pregnancy is covered at no charge.<br>Please refer to the Women's Health Preventive Schedule for additional information. |
| | Childbirth/delivery professional services | No charge | 20% coinsurance | |
| | Childbirth/delivery facility services | No charge | 20% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | No charge | No charge after network deductible | ----------none---------- |
| | Rehabilitation services | $10 copay/visit; deductible does not apply | 20% coinsurance | ----------none---------- |
| | Habilitation services | Not covered | Not covered | ----------none---------- |
| | Skilled nursing care | No charge | No charge after network deductible | Combined network and out-of-network: 240 days per benefit period.<br>Precertification may be required. |
| | Durable medical equipment | No charge | No charge after network deductible | ----------none---------- |
| | Hospice service | No charge | No charge after network deductible | ----------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 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
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See http://www.bcbsa.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: U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 at (724)637-2117.
- Highmark Inc. at 1-800-241-5704.
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

**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 obtain language assistance, call (724)637-2117.**

SPANISH (Español): Para obtener asistencia en Español, llame al (724)637-2117.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (724)637-2117.

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (724)637-2117.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (724)637-2117.

*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 | $400 |
| Specialist copayment | $25 |
| 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** | **$12,700** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $400 |
| Copayments | $75 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$535** |

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

| | |
|---|---|
| The plan's overall deductible | $400 |
| Specialist copayment | $25 |
| 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** | **$5,600** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $400 |
| Copayments | $605 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,025** |

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

| | |
|---|---|
| The plan's overall deductible | $400 |
| Specialist copayment | $25 |
| 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** | **$2,800** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $400 |
| Copayments | $195 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$595** |

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 (724)637-2117.

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

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; or for a paper copy, call 1-855-873-4106.

**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.***

If you speak English, language assistance services, free of charge, are available to you. Call 1-855-329-0729.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة للمجانية متاحة لك. اتصل على الرقم 1-855-329-0729 .

如果您说中文，可向您提供免费语言协助服务。 請致電 1-855-329-0729 .

Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel 1-855-329-0729 .

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-855-329-0729 .

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-855-329-0729 .

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-855-329-0729 .

જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-855-329-0729 નંબર પર ફોન કરો.

यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। 1-855-329-0729 पर फ़ोन करें।

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-855-329-0729.

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。 1-855-329-0729 を呼び出します。

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-855-329-0729 로 전화.

បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ការហៅ 1-855-329-0729 ។

Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodíilnih 1-855-329-0729.

यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। 1-855-329-0729 मा फोन गर्नुहोस्।

Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du 1-855-329-0729 uffrufe.

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-855-329-0729 .

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-855-329-0729.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-855-329-0729.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-855-329-0729.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-855-329-0729.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-855-329-0729.

మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. కాల్ చేయండి 1-855-329-0729.

หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย

โทร 1-855-329-0729.

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ 1-855-329-0729 پر کال کریں ۔

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-855-329-0729.