Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Highmark Blue Cross Blue Shield: WNY IND Essential Plan 3

Coverage Period: 01/01/2024 - 12/31/2024
Coverage for: Individual/Family   **Plan** Type: EPO

⚠ **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, www.highmark.com or call 1-855-344-3425. 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 1-855-344-3425 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 individual network.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	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 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?	$200 individual 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?	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. See www.highmark.com/find-a-doctor/ or call 1-855-344-3425 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 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.

A copy of your agreement can be found at https://shop.highmark.com/sales/#!/sbc-agreements.

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	No charge	Not covered	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	No charge	Not covered	
	Preventive care/screening/Immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Precertification may be required.
If you need drugs to treat your illness or condition

More information about prescription drug coverage is available at https://www.highmark.com/find-a-doctor/#/drug | Tier 1 | $1 copay per prescription (retail) | Not covered | Some generic drugs may be subject to non-preferred brand cost share.

Network: Specialty drugs could be generic, preferred brand or non-preferred brand. Please visit our website for a copy of our medication guide. |
	Tier 2	$3 copay per prescription (retail)	Not covered	
	Tier 3	$3 copay per prescription (retail)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Precertification may be required.
	Physician/surgeon fees	No charge	Not covered	Precertification may be required.
If you need immediate medical attention	Emergency room care	No charge	No charge	-----------none-----------
	Emergency medical transportation	No charge	No charge	-----------none-----------
	Urgent care	No charge	No charge	-----------none-----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Precertification may be required.
	Physician/surgeon fees	No charge	Not covered	Precertification may be required.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	Precertification may be required.
	Inpatient services	No charge	Not covered	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	Not covered	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: Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Network: 40 visits per benefit period, aggregate with visiting nurse. Home Infusion counts toward visit limit. Precertification may be required.
	Rehabilitation services	No charge	Not covered	Precertification may be required.
	Habilitation services	No charge	Not covered	
	Skilled nursing care	No charge	Not covered	Network: 200 days per year. Precertification may be required.
	Durable medical equipment	No charge	Not covered	Precertification may be required.
	Hospice services	No charge	Not covered	Network: 210 days per year. 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 • Cosmetic surgery	• Long-term care • Private-duty nursing	• 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 • Bariatric surgery • Dental care (Adult)	• Hearing aids • Infertility treatment	• Non-emergency care when traveling outside the U.S. • 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or at https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa, or the U.S. Department of Health and Human Services 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:
- Highmark, Inc. at 1-855-344-3425.
- Additionally, an independent consumer assistance program can help you file your appeal. Contact the consumer assistant services at 1-888-614-5400.

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.*————————————

> **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 network pre-natal care and a hospital delivery)		**Managing Joe's type 2 Diabetes** (a year of routine network care of a well-controlled condition)		**Mia's Simple Fracture** (network emergency room visit and follow up care)	
■ The plan's overall deductible	$0	■ The plan's overall deductible	$0	■ The plan's overall deductible	$0
■ Specialist coinsurance	0%	■ Specialist coinsurance	0%	■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%	■ Hospital (facility) coinsurance	0%	■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%	■ Other coinsurance	0%	■ Other coinsurance	0%

This EXAMPLE event includes services like:

Peg:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Joe:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Mia:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$12,700**

Total Example Cost	**$5,600**

Total Example Cost	**$2,800**

In this example, Peg would pay:

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

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$20**

In this example, Mia would pay:

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

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

Notice of Nondiscrimination

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

The plan 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)
- 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, please call the customer service number on the back of your member ID card or contact the Civil Rights Coordinator.

If you believe that the plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US 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 US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

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

For assistance in English, call the customer service number listed on your member ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

פאר הילף אין איידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس اپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Diné k´ehjí yá´áti´bee shíká adoowot nohsingo naaltsoos nihaa halne´go nidaahtinígíí bine´déé´ Customer Service bibéésh bee hane´é biká'ígíí bich´j´dahodootnih.