



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.reynolds.k12.pa.us](http://www.reynolds.k12.pa.us) or call (724)646-5500. 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/](http://www.HealthCare.gov/sbc-glossary/) or call (724)646-5500 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	\$1,500 individual/\$3,000 family, combined <u>network</u> and <u>out-of-network</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<b>Are there services covered before you meet your deductible?</b>	<u>Network deductible</u> does not apply to <u>preventive care services</u> .  <u>Coinsurance</u> amounts don't count toward the <u>network deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	\$0 individual/\$0 family <u>network out-of-pocket limit</u> , up to a total <u>maximum out-of-pocket limit</u> of \$1,500 individual/\$3,000 family.  \$1,500 individual/\$3,000 family <u>out-of-network</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Network</u> : <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover do not apply to your total <u>maximum out-of-pocket limit</u> .  <u>Out-of-network</u> : <u>Deductibles</u> , <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. For a list of <u>network providers</u> , see <a href="http://www.reynolds.k12.pa.us">www.reynolds.k12.pa.us</a> or call (724)646-5500.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do I need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.  Please refer to your preventive schedule for additional information.
	<u>Specialist</u> visit	No charge	30% <u>coinsurance</u>	
	<u>Preventive care/ Screening/Immunization</u>	No charge for <u>preventive care services</u> ; <u>deductible</u> does not apply	30% <u>coinsurance</u> for <u>preventive care services</u>	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge	30% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge	30% <u>coinsurance</u>	-----none-----
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://www.highmarkbcbs.com">www.highmarkbcbs.com</a> .	Generic drugs	No charge (retail and mail order)	Not covered	Up to 30-day supply retail pharmacy.  Up to 90-day supply maintenance <u>prescription drugs</u> through mail order.
	Brand drugs	No charge (retail and mail order)	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	30% <u>coinsurance</u>	-----none-----
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	-----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 immediate medical attention	<u>Emergency room Care</u>	No charge	No charge	-----none-----
	<u>Emergency medical transportation</u>	No charge	30% <u>coinsurance</u>	-----none-----
	<u>Urgent care</u>	No charge	30% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fee	No charge	30% <u>coinsurance</u>	-----none-----
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	No charge	30% <u>coinsurance</u>	-----none-----
	Inpatient services	No charge	30% <u>coinsurance</u>	Precertification may be required.
If you are pregnant	Office visits	No charge	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <u>Network</u> : 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	No charge	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	30% <u>coinsurance</u>	-----none-----
	<u>Rehabilitation services</u>	No charge	30% <u>coinsurance</u>	Combined <u>network</u> and <u>out-of-network</u> : 36 physical medicine visits, 36 speech therapy visits, and 36 occupational therapy visits per benefit period.
	<u>Habilitation services</u>	Not covered	Not covered	-----none-----
	<u>Skilled nursing care</u>	No charge	30% <u>coinsurance</u>	Precertification may be required.
	<u>Durable medical equipment</u>	No charge	30% <u>coinsurance</u>	-----none-----
	<u>Hospice service</u>	No charge	30% <u>coinsurance</u>	-----none-----

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (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
- Coverage provided outside the United States. See <http://www.bcbsa.com>
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- 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](http://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)646-5500.
- 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)646-5500.**

SPANISH (Español): Para obtener asistencia en Español, llame al (724)646-5500.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (724)646-5500.

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (724)646-5500.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (724)646-5500.

————— *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 \$1500
- Specialist coinsurance 0%
- 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:**

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,560</b>

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

- The plan's overall deductible \$1500
- Specialist coinsurance 0%
- 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:**

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,520</b>

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

- The plan's overall deductible \$1500
- Specialist coinsurance 0%
- 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:**

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>

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)646-5500.

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

Insurance or benefit administration may be provided by Highmark Blue Shield which is an independent licensee 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 1-855-873-4108.

### **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](mailto: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 المعونة في اللغة المجانية 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 हन्दी बोलते हैं, तो आपके लए नःशुल्क भाषा सहायता सेवा उपलब्ध है। 1-855-329-0729 पर फोन 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 yánífti'go, language assistance services, éí t'áá níí'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojí' hodílnih 1-855-329-0729 .

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

Wann du Deitsch schwetzsch, kanschd du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kanschd 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.

ಮೆದು ತಿಲುಗು ಮಾಟ್‌ಲಾಜಿತಿ, ಲಾಗ್‌ವೆಜ್ ಅನಿಸ್‌ಟಿನ್‌ನ್ ಸರ್‌ವಿಸೆನ್, ಛಾರ್ಟೆರಿ ಲೆಕುಂಡಾ, ಮೆಕು ಅಂದುಬಾಟುಲೆ ಊನ್‌ನಾಯೆ. ಕಾಲ್ ಡಿಯಂಡೆ 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.