HIGHMARK WESTERN NEW YORK

1-800-544-2583 bcbswny.com

Benefit Summary:

Effective on or after 1/1/2022

	WNY Platinum PPO Plus (2022)		
	In-Network	Out-of-Network	Additional Information
General Information			
Provider Network	PPO		
Deductible	N/A	$5,000 single / $10,000 family	
Deductible Administration Type	N/A	Embedded deductible - once any individual has met the individual deductible, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied	
Coinsurance	N/A	50% coinsurance after deductible	
Out of Pocket Maximum	$3,500 single / $7,000 family	$10,000 single / $20,000 family	
Out of Pocket Administration Type	Embedded OOP Max - once any individual has met the individual OOP Max, subsequent medical costs will be covered for that individual, even if the family OOP Max has not been satisfied	Embedded OOP Max - once any individual has met the individual OOP Max, subsequent medical costs will be covered for that individual, even if the family OOP Max has not been satisfied	
Benefit Administration Date	Plan year		
Dependent Coverage			
Dependent Age	26/26		
Dependent Coverage Ends	End of birth month		
Domestic Partner and Children	Includes coverage for domestic partner and children		
Prescription Drug Coverage			
Prescription Drugs	$5/$25/50%	Not Covered	
Mail Order	2.5 copays per 90 day supply	Not Covered	
Is Rx subject to Medical Deductible?	No		

	WNY Platinum PPO Plus (2022)		
	In-Network	Out-of-Network	Additional Information
Physician and Other Services			
Primary Office Visit	$5 copayment	50% coinsurance after deductible	
Specialist Office Visit	$25 copayment	50% coinsurance after deductible	
Telemedicine	Covered in full	Not covered	
Allergy Injections	$5 copayment/$25 copayment	50% coinsurance after deductible	
Allergy Testing	$5 copayment/$25 copayment	50% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	$5 copayment/$25 copayment	50% coinsurance after deductible	
Emergency and Urgent Care Services			
Emergency Room	$150 copayment	Covered as in-network	Cost-share waived if admitted
Ambulance	$150 copayment	Covered as in-network	
Urgent Care Center	$40 copayment	Covered as in-network	
Preventive Services			
Bone mineral density measurement or test	Covered in full	50% coinsurance after deductible	
Cholesterol Test (lipid panel)	Covered in full	50% coinsurance after deductible	
Immunizations	Covered in full	50% coinsurance after deductible	
Prostate Test (Prostate Specific Antigen "PSA")	Covered in full	50% coinsurance after deductible	
Routine Physical Exam	Covered in full	Not covered	
Well Child Visits	Covered in full	50% coinsurance after deductible	
Hospital Services			
Inpatient Hospital	$500 copayment	50% coinsurance after deductible	
Outpatient Surgical Procedure (Facility)	$150 copayment	50% coinsurance after deductible	
Skilled Nursing Facility	$500 copayment	50% coinsurance after deductible	
Diagnostic Testing Services			
Laboratory Tests	Covered in full	50% coinsurance after deductible	
Radiology	$25 copayment	50% coinsurance after deductible	

	WNY Platinum PPO Plus (2022)		
	In-Network	Out-of-Network	Additional Information
Maternity Services			
Physician Services: Prenatal and Postnatal Care (initial visit)	$5 copayment	50% coinsurance after deductible	
Inpatient Maternity	$500 copayment	50% coinsurance after deductible	
Mental Health and Substance Abuse			
Inpatient Mental Health	$500 copayment	50% coinsurance after deductible	
Outpatient Mental Health	Covered in full	50% coinsurance after deductible	
Inpatient Substance Abuse - Rehab	$500 copayment	50% coinsurance after deductible	
Inpatient Substance Abuse - Detox	$500 copayment	50% coinsurance after deductible	
Outpatient Substance Abuse	Covered in full	50% coinsurance after deductible	Up to 20 visits a year may be used for family counseling
Diabetic Supplies and Services			
Diabetic Equipment	$5 copayment	50% coinsurance after deductible	Additional benefits available through Livongo.
Insulin and Other Oral Agents	$5 copayment	50% coinsurance after deductible	Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit. Diabetic drugs rendered at pharmacy are only covered in-network.
Diabetic Medical Supplies (Test strips, Syringes, etc)	$5 copayment	50% coinsurance after deductible	Additional benefits available through Livongo.
Rehabilitation Services			
Chiropractic Care	$5 copayment	50% coinsurance after deductible	
Physical - Occupational - Speech Therapies	$5 copayment	50% coinsurance after deductible	60 combined PT/OT/ST visits per condition per plan year
Pulmonary Rehabilitation	$25 copayment	50% coinsurance after deductible	
Additional Services			
Durable Medical Equipment	50% coinsurance	50% coinsurance after deductible	
Prosthetics and Appliances	50% coinsurance	50% coinsurance after deductible	Shoe inserts are not covered. For children, the cost of replacements is also covered but only if the previous device has been outgrown.
Home Health Care	$25 copayment	50% coinsurance after deductible	40 aggregate visits per year; Home Infusion counts toward home health care visit limit.

	WNY Platinum PPO Plus (2022)		
	In-Network	Out-of-Network	Additional Information
Additional Services			
Hospice	$25 copayment	50% coinsurance after deductible	
Chemotherapy - Outpatient Facility	$5 copayment/$25 copayment	50% coinsurance after deductible	
Dialysis	$5 copayment/$25 copayment	50% coinsurance after deductible	
Wellness Card	$250 per contract	N/A	Benefit allowance accessible through the use of a debit card, at participating providers for exercise centers, fitness clubs, gyms, and recreational or sports camps.
Pediatric Vision Services			
Routine Exam	Covered in full	Not covered	One routine exam every calendar year; coverage up to Age 19
Medical Eye Exam	$25 copayment	50% coinsurance after deductible	
Adult Vision Services			
Routine Exam	Covered in full	Not covered	One routine exam every calendar year
Medical Eye Exam	$25 copayment	50% coinsurance after deductible	
Pediatric Dental Services			
Preventive Dental Care	$25 copayment	Not covered	2 per calendar year
Major Dental Care	50% coinsurance	Not covered	Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals

*Cost share may vary based on place of service for services listed above.

**For a list of Medicare Part D creditable coverage prescription drug plans, please refer to our website.

***This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan. It does not detail all benefits, limitations and exclusions that may apply.

AHRENS

BAR ASSOCIATION MARKETPLACE

See Next Insert for Summary of Benefits and Coverage

What this Plan Covers & What You Pay For Covered Services

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, go to www.bcbswny.com or call 1-888-249-2583. 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.bcbswny.com or call 1-888-249-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: N/A; Out-of-network: $5,000 individual / $10,000 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 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?	Yes. No services are subject to a 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. 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?	In-network: $3,500 individual / $7,000 family; Out-of-network: $10,000 individual / $20,000 family	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-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. See www.bcbswny.com or call 1-888-249-2583 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** costs shown in this chart are after your **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	$5 copayment	50% coinsurance	None
	Specialist visit	$25 copayment	50% coinsurance	None
	Preventive care/screening/immunization	Covered in full	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copayment for x-ray, Covered in full for blood work	50% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
	Imaging (CT/PET scans, MRIs)	$25 copayment	50% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbswny.com	Generic drugs (Tier 1)	$5 copayment	Not covered	Some generic drugs may be subject to non-preferred brand cost share.
	Preferred brand drugs (Tier 2)	$25 copayment	Not covered	None
	Non-preferred brand drugs (Tier 3)	50% coinsurance	Not covered	None
	Specialty drugs (Tier 4)	See limitations & exceptions	See limitations & exceptions	Specialty drugs could be generic, preferred brand or non-preferred brand. Please visit our website for a copy of our medication guide.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copayment	50% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
	Physician/surgeon fees	Covered in full	50% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
If you need immediate medical attention	Emergency room care	$150 copayment	Covered as in-network	None
	Emergency medical transportation	$150 copayment	Covered as in-network	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
	Urgent care	$40 copayment	Covered as in-network	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment	50% coinsurance	Prior authorization 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 have a hospital stay	Physician/surgeon fees	Covered in full	50% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Covered in full for Mental Health; Covered in full for Substance Abuse	50% coinsurance for Mental Health; 50% coinsurance for Substance Abuse	Up to 20 visits a year may be used for family counseling
	Inpatient services	$500 copayment for Mental Health; $500 copayment for Substance Abuse Detox; $500 copayment for Substance Abuse Rehab	50% coinsurance for Mental Health; 50% coinsurance for Substance Abuse Detox; 50% coinsurance for Substance Abuse Rehab	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
If you are pregnant	Office visits	$5 copayment	50% coinsurance	None
	Childbirth/delivery professional services	$5 copayment	50% coinsurance	For participating providers, cost share applies only to initial visit to determine pregnancy.
	Childbirth/delivery facility services	$500 copayment	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	$25 copayment	50% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details. 40 aggregate visits per year; Home Infusion counts toward home health care visit limit.
	Rehabilitation services	$5 copayment	50% coinsurance	60 combined PT/OT/ST visits per condition per plan year
	Habilitation services	$5 copayment	50% coinsurance	60 combined PT/OT/ST visits per condition per plan year
	Skilled nursing care	$500 copayment	50% coinsurance	Prior authorization required.
	Durable medical equipment	50% coinsurance	50% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
	Hospice services	$25 copayment	50% coinsurance	None

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 your child needs dental or eye care	Children's eye exam	Covered in full	Not covered	Member cost share may vary by plan.
	Children's glasses	Covered in full	Not covered	Discounts may apply.
	Children's dental check-up	$25 copayment	Not covered	2 per calendar year

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
- Custodial care
- 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.)

- Bariatric surgery
- Chiropractic care
- Dental
- Elective Abortion
- 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.. 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 on how 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: 1-888-249-2583.

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 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-249-2583.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-249-2583.

Chinese (中文):如果需要中文的帮助，请拨打这个号码 1-888-249-2583.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-249-2583.

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	**$0.00**
Specialist copayment	**$25.00**
Hospital (facility) copayment	**$500.00**
Other copayment	**$5.00**

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	$0
Copays	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$660**

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

The plan's overall deductible	**$0.00**
Specialist copayment	**$25.00**
Hospital (facility) copayment	**$500.00**
Other copayment	**$5.00**

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	$0
Copays	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$320**

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

The plan's overall deductible	**$0.00**
Specialist copayment	**$25.00**
Hospital (facility) copayment	**$500.00**
Other copayment	**$5.00**

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	$0
Copays	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

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: Highmark Blue Cross Blue Shield of Western New York at www.bcbswny.com or call 1-888-249-2583.

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.

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.

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

বাংলায় সহায়তার জন্য, আপনার আইডি কার িডে তালকাভ ুক্ত নম্বর ঃরেতা পররেবায় ঃ◌ান 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 آپ 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.