HIGHMARK WEST VIRGINIA
An Independent Licensee of the Blue Cross and Blue Shield Association

IOGA - $3,500 Deductible – 90/70 Plan

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Effective Date	January 1, 2021	
Benefit Period (1)	Contract Year (January 1 through December 31)	
Deductible (per benefit period) Individual Family	 $3,500 $7,000	 $10,500 $21,000
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 $500 $1,000	 $1,500 $3,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $8,150 $16,300	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $15 copay	70% after $15 copay
Primary Care Provider Office Visits & Virtual Visits	100% after $15 copay	70% after $15 copay
Specialist Office Visits & Virtual Visits	100% after $15 copay	70% after $15 copay
Virtual Visit Provider Originating Site Fee	90% after deductible	70% after deductible
Urgent Care Center Visits	100% after $15 copay	70% after $15 copay
Telemedicine Services (3)	100% after $10 copay	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 70% after deductible
Adult Immunizations	100% (deductible does not apply)	70% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	70% after deductible
Mammograms, Annual Routine	100% (deductible does not apply)	70% after deductible
Mammograms, Medically Necessary	90% after deductible	70% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 70% after deductible
Pediatric Immunizations	100% (deductible does not apply)	70% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Emergency Services		
Emergency Room Services - Emergency	$150 copay (waived if admitted) then 90% after deductible	
Emergency Room Services - Non-Emergency	$150 copay (waived if admitted) then 90% after deductible	$150 copay (waived if admitted) then 70% after deductible
Ambulance – Emergency (5)	100% (deductible does not apply)	100% (deductible does not apply) Non-Network Liability coverage up to $100,000.00 maximum per Occurrence
Ambulance - Non-Emergency	90% after deductible	70% after deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	90% after deductible	70% after deductible
Hospital Outpatient	90% after deductible	70% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	90% after deductible	70% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	90% after deductible	70% after deductible

Benefit	In Network	Out of Network

Benefit	In Network	Out of Network
Therapy and Rehabilitation Services		
Physical Therapy (Rehabilitative and Habilitative) Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per event for chronic pain (6) Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	90% after deductible for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain	70% after deductible for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain
Respiratory Therapy	90% after deductible	70% after deductible
Speech Therapy	90% after deductible including rehabilitative services and habilitative services	70% after deductible
Occupational Therapy (Rehabilitative and Habilitative) Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per event for chronic pain (6) Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	90% after deductible for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain	70% after deductible for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain
Spinal Manipulations (Rehabilitative and Habilitative) Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per event for chronic pain (6) Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	90% after deductible for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain	70% after deductible for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
Mental Health / Substance Use Disorder		
Inpatient Mental Health Services	90% after deductible	70% after deductible
Inpatient Detoxification / Rehabilitation	90% after deductible	70% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	90% after deductible	70% after deductible
Outpatient Substance Use Disorder Services	90% after deductible	70% after deductible
Other Services		
Allergy Extracts and Injections	90% after deductible	70% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (7)	90% after deductible	70% after deductible
Assisted Fertilization Procedures	90% after deductible	70% after deductible
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	70% after deductible
Home Health Care	90% after deductible limit: 100 visits/benefit period aggregate with visiting nurse	70% after deductible
Hospice	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment (8)	90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible limit: 35 visits/benefit period	70% after deductible
Skilled Nursing Facility Care	90% after deductible	70% after deductible
Transplant Services	90% after deductible	70% after deductible
Precertification Requirements (9)	Yes	Yes

Prescription Drugs	
Prescription Drug Deductible Individual Family	 none none
Prescription Drug Program (10) Soft Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Open Benefit Design **Specialty Drugs must be purchased at Retail or Mail Order.**	**Retail Drugs (34-day Supply)** Member pays: Generic and Preferred Brand- 30% or $10 Minimum Coinsurance, whichever is greater, No Deductible Non-Preferred Brand – 30% or $75 Minimum Coinsurance, whichever is greater, No Deductible Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30-day supply **Specialty Drugs (31-day Supply)** 30% up to $300 Maximum per Prescription, No Deductible **Maintenance Drugs through Mail Order (90-day Supply)** Member pays: Generic and Preferred Brand – 30% or $20 Minimum Coinsurance, whichever is greater, No Deductible Non-Preferred Brand – 30% or $150 Minimum Coinsurance, whichever is greater, No Deductible Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30-day supply

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.
(4) Services are limited to those listed on the Highmark WV Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Benefits for emergency ambulance services rendered by a non-network provider will be subject to the same cost-sharing amount, if any, that is applicable to network services. The member will be responsible for any amounts billed by the non-network provider for emergency ambulance services that are in excess of the amount that Highmark WV pays.
(6) 30 visit maximum per event for combined physical therapy, occupational therapy and spinal manipulations
(7) Coverage for eligible members to age 18. After initial analysis, services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
(8) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(9) Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Please note that certain outpatient procedures also require prior authorization. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that your services are not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
(10) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed. Anti-Cancer medications orally administered or self-injected. Deductible, copayment and coinsurance amounts for patient administered anti-cancer medications that are covered benefits are applied on no less favorable basis than for provider injected or intravenously administered anti-cancer medications.

HIGHMARK. West Virginia

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Discrimination is Against the Law

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 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 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, 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 1-877-959-2562.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-877-959-2562.

如果您说中文，可向您提供免费语言协助服务。
請致電 1-877-959-2562.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-877-959-2562.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-877-959-2562.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم
. 1-877-959-2562

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-877-959-2562.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다.
1-877-959-2562 로 전화.

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。 1-877-959-2562 を呼び出します。

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-877-959-2562.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-877-959-2562.

หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย
โทร 1-877-959-2562.

यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। 1-877-959-2562 मा फोन गर्नुहोस्।

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان
با تماس با شماره 1-877-959-2562 .

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-877-959-2562.

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔
1-877-959-2562 پر کال کریں۔

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-877-959-2562.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-877-959-2562.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-877-959-2562.

Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodíilnih 1-877-959-2562.