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

GO-WV - $5,000 Deductible – 90/70 Plan – Option 2

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, 2022	
Benefit Period (1)	Contract Year (January 1 through December 31)	
Deductible (per benefit period) Individual Family	 $5,000 $10,000	 $12,000 $24,000
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 $25 copay	70% after $25 copay
Primary Care Provider Office Visits & Virtual Visits	100% after $25 copay	70% after $25 copay
Specialist Office Visits & Virtual Visits	100% after $35 copay	70% after $35 copay
Virtual Visit Provider Originating Site Fee	90% after deductible	70% after deductible
Urgent Care Center Visits	100% after $50 copay	70% after $50 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	$300 copay (waived if admitted) then 90% after deductible	$300 copay (waived if admitted) then 90% after deductible
Emergency Room Services - Non-Emergency	$300 copay (waived if admitted) then 90% after deductible	$300 copay (waived if admitted) then 90% after deductible
Ambulance – Emergency (ground, water, air)	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 (ground, water)	90% after deductible	70% after deductible
Ambulance – Non-Emergency (air)	90% after network deductible	90% after network 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
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 Incentive 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 **Retail Drugs (35-90 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 **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 तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईका लागि भाषा सहायता सेवाहरू नि:शुल्क 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.

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.highmarkbcbswv.com or call 1-888-809-9121. 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 1-888-809-9121 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$5,000 individual/$10,000 family network. $12,000 individual/$24,000 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?	Yes. Office visits, preventive care services, emergency medical transportation, urgent care, and prescription drug benefits are covered before you meet your network deductible. 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?	$500 individual/$1,000 family network out-of-pocket limit, up to a total maximum out-of-pocket of $8,150 individual/$16,300 family. $1,500 individual/$3,000 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-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket. Out-of-network: Copayments, deductibles, premiums, balance-billed charges, prescription drug expenses, 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.highmarkbcbswv.com/find-a-doctor or call 1-888-809-9121 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 overall **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	$25 copay/visit Deductible does not apply.	30% coinsurance after $25 copay/visit Deductible does not apply.	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	$35 copay/visit Deductible does not apply.	30% coinsurance after $35 copay/visit Deductible does not apply.	
	Preventive care/screening/immunization	No charge Deductible does not apply.	30% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.highmarkbcbswv.com/find-a-doctor/#/drug.	Generic and Preferred Brand drugs	30% coinsurance, $10/$20 minimum per prescription (retail) 30% coinsurance, $20 minimum per prescription (mail order) Deductible does not apply.	Not covered	Up to 34/90-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. This plan uses a Comprehensive Formulary. Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30 day supply.
	Non-Preferred Brand drugs	30% coinsurance, $75/$150 minimum per prescription (retail) 30% coinsurance, $150 minimum per prescription (mail order) Deductible does not apply.	Not covered	
	Specialty drugs	30% coinsurance, $300 maximum per prescription (retail) 30% coinsurance, $300 maximum per prescription (mail order) Deductible does not apply.	Not covered	Specialty drugs are limited to a 31-day supply. Specialty Drugs must be purchased at Retail or Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Precertification may be required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Precertification may be required.
If you need immediate medical attention	Emergency room care	10% coinsurance after $300 copay/visit	10% coinsurance after $300 copay/visit	Copay waived if admitted as an inpatient.
	Emergency medical transportation	No charge Deductible does not apply.	No charge Deductible does not apply.	----------none----------
	Urgent care	$50 copay/visit Deductible does not apply.	30% coinsurance after $50 copay/visit Deductible does not apply.	----------none----------
If you have a hospital stay	Facility fees (e.g., hospital room)	10% coinsurance	30% coinsurance	Precertification may be required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	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 need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Precertification may be required.
	Inpatient services	10% coinsurance	30% coinsurance	Precertification may be required.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	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: 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	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	

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 need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Combined network and out-of-network: 100 visits per benefit period, combined with visiting nurse. Precertification may be required.
	Rehabilitation services	10% coinsurance for physical medicine and occupational therapy for other than chronic pain. Primary Care Office Visit Cost-sharing will apply for chronic pain. 10% coinsurance for speech therapy	30% coinsurance for physical medicine and occupational therapy for other than chronic pain. Primary Care Office Visit Cost-sharing will apply for chronic pain. 30% coinsurance for speech therapy	Combined network and out-of-network: 30 physical medicine visits, and 30 occupational therapy visits per benefit period for other than chronic pain. Combined network and out-of-network: habilitation and rehabilitation services. Combined network and out-of-network: 30 combined physical medicine, occupational therapy, and spinal manipulation visits per event for chronic pain. Precertification may be required.
	Habilitation services	10% coinsurance for physical medicine and occupational therapy for other than chronic pain. Primary Care Office Visit Cost-sharing will apply for chronic pain. 10% coinsurance for speech therapy	30% coinsurance for physical medicine and occupational therapy for other than chronic pain. Primary Care Office Visit Cost-sharing will apply for chronic pain. 30% coinsurance for speech therapy	
	Skilled nursing care	10% coinsurance	30% coinsurance	Precertification may be required.
	Durable medical equipment	10% coinsurance	30% coinsurance	Precertification may be required.
	Hospice services	10% coinsurance	30% coinsurance	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	• Hearing aids	• Routine foot care
• Cosmetic surgery	• Long-term care	• Weight loss programs
• Dental care (Adult)	• Routine eye care (Adult)	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Infertility treatment	• Private-duty nursing
• Chiropractic care	• Non-emergency care when traveling outside the U.S. See http://www.bcbsa.com	

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, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. West Virginia Offices of the Insurance Commissioner at 1-888-879-9842. 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 West Virginia at 1-888-809-9121.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, a consumer assistance program can help you file your appeal. Contact the West Virginia Offices of the Insurance Commissioner, Customer Service Division, 900 Pennsylvania Avenue, 7th Floor, Charleston, WV 25301 **(888) 879-9842** http://www.wvinsurance.gov.

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.

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	$5,000
Specialist copayment	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$5,000
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,560**

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

The plan's overall deductible	$5,000
Specialist copayment	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$900
Copayments	$300
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

The plan's overall deductible	$5,000
Specialist copayment	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$1,500
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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: 1-888-809-9121.

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 West Virginia 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; or for a paper copy, call 1-855-873-4110.

Discrimination is Against the Law

The Claims Administrator/Insurer 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/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer:

- 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/Insurer 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.

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.

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

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

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

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

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

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 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.

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

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

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。

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