HIGHMARK

# IOGA - $2,700 HDHP Embedded Plan

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). 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, 2024 | |
| Benefit Period (1) | Contract Year (January 1 through December 31) | |
| Deductible (per benefit period)<br>Individual<br>Family | <br>$2,700<br>$5,400 | <br>$8,000<br>$16,000 |
| Plan Pays – payment based on the plan allowance | 100% after deductible | 80% after deductible |
| Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period)<br>Individual<br>Family | <br>$0<br>$0 | <br>$8,000<br>$16,000 |
| 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.<br>Individual<br>Family | <br>$2,700<br>$5,400 | <br>Not Applicable<br>Not Applicable |
| **Office/Clinic/Urgent Care Visits(13)** | | |
| Retail Clinic Visits & Virtual Visits | 100% after deductible | 80% after deductible |
| Primary Care Provider Office Visits & Virtual Visits | 100% after deductible | 80% after deductible |
| Specialist Office Visits & Virtual Visits | 100% after deductible | 80% after deductible |
| Virtual Visit Provider Originating Site Fee | 100% after deductible | 80% after deductible |
| Urgent Care Center Visits | 100% after deductible | 80% after deductible |
| | Copayment, if any, does not apply to Urgent Care Center Visits prescribed for the treatment of Mental Health and Substance Use Disorder | |
| Telemedicine Services (3) | 100% after deductible | not covered |
| **Preventive Care (4) (13)** | | |
| **Routine Adult**<br>Physical Exams | <br>100% (deductible does not apply) | <br>80% after deductible |
| Adult Immunizations | 100% (deductible does not apply) | 80% after deductible |
| Routine Gynecological Exams, including a Pap Test | 100% (deductible does not apply) | 80% (deductible does not apply) |
| Mammograms, Annual Routine | 100% (deductible does not apply) | 80% after deductible |
| Diagnostic Services and Procedures | 100% (deductible does not apply) | 80% after deductible |
| **Routine Pediatric**<br>Physical Exams | <br>100% (deductible does not apply) | <br>80% after deductible |
| Pediatric Immunizations | 100% (deductible does not apply) | 80% (deductible does not apply) |
| Diagnostic Services and Procedures | 100% (deductible does not apply) | 80% after deductible |
| **Emergency Services** | | |
| Emergency Room Services (12) | 100% after network deductible | |
| Ambulance<br>Emergency (ground, water, air) | 100% after network deductible | |
| Ambulance<br>Non-Emergency (ground, water)(11) | 100% after deductible | 80% after deductible |
| Ambulance<br>Non- Emergency (air) | 100% after network deductible | |
| **Hospital and Medical / Surgical Expenses (including maternity)** | | |
| Hospital Inpatient (12) | 100% after deductible | 80% after deductible |
| Hospital Outpatient | 100% after deductible | 80% after deductible |
| Mammograms, Medically Necessary | 100% after deductible | 80% after deductible |
| Maternity (non-preventive facility & professional services) including dependent daughter | 100% after deductible | 80% after deductible |
| Medical Care (including inpatient visits and consultations)/Surgical Expenses | 100% after deductible | 80% after deductible |

| Benefit | In Network | Out of Network |
|---|---|---|

| Benefit | In Network | Out of Network |
|---|---|---|
| **Therapy and Rehabilitation Services** | | |
| Physical Therapy (Rehabilitative and Habilitative)<br>Limit: 30 visits per benefit period for other than chronic pain<br>Limit: 30 visits per event for chronic pain (6)<br>Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder<br>Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined. | 100% after deductible | 80% after deductible |
| | Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder | |
| Respiratory Therapy | 100% after deductible | 80% after deductible |
| Speech Therapy<br>Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder | 100% after deductible | 80% after deductible |
| | including rehabilitative services and habilitative services<br>Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder | |
| Occupational Therapy (Rehabilitative and Habilitative)<br>Limit: 30 visits per benefit period for other than chronic pain<br>Limit: 30 visits per event for chronic pain (6)<br>Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder<br>Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined. | 100% after deductible | 80% after deductible |
| | Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder | |
| Spinal Manipulations (Rehabilitative and Habilitative)<br>Limit: 30 visits per benefit period for other than chronic pain<br>Limit: 30 visits per event for chronic pain (6)<br>Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined. | 100% after deductible | 80% after deductible |
| Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) | 100% after deductible | 80% after deductible |
| **Mental Health / Substance Use Disorder (13)** | | |
| Inpatient Mental Health Services | 100% after deductible | 80% after deductible |
| Inpatient Detoxification / Rehabilitation | 100% after deductible | 80% after deductible |
| Outpatient Mental Health Services (includes virtual behavioral health visits) | 100% after deductible | 80% after deductible |
| Outpatient Substance Use Disorder Services | 100% after deductible | 80% after deductible |
| **Other Services (13)** | | |
| Allergy Treatments, Allergy Extracts and Injections | 100% after deductible | 80% after deductible |
| Applied Behavior Analysis for Autism Spectrum Disorder (7) | 100% after deductible | 80% after deductible |
| Assisted Fertilization Procedures | 100% after deductible | 80% after deductible |
| Dental Services Related to Accidental Injury | 100% after deductible | 80% after deductible |
| **Diagnostic Services**<br><br>Advanced Imaging (MRI, CAT, PET scan, etc.) | 100% after deductible | 80% after deductible |
| | Copayment, if any, does not apply to Diagnostic Services prescribed for the treatment of Mental Health and Substance Use Disorder | |
| Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing) | 100% after deductible | 80% after deductible |
| | Copayment, if any, does not apply to Diagnostic Services prescribed for the treatment of Mental Health and Substance Use Disorder | |
| Durable Medical Equipment, Orthotics and Prosthetics | 100% after deductible | 80% after deductible |
| | Cost-sharing for eligible Diabetic Devices will not exceed $100 for a 30-day supply | |
| Home Health Care | 100% after deductible | 80% after deductible |
| | limit: 100 visits/benefit period aggregate with visiting nurse | |
| Hospice | 100% after deductible | 80% after deductible |
| Infertility Counseling, Testing and Treatment (8) | 100% after deductible | 80% after deductible |
| Private Duty Nursing | 100% after deductible | 80% after deductible |
| | limit: 35 visits/benefit period | |
| Skilled Nursing Facility Care | 100% after deductible | 80% after deductible |
| Transplant Services | 100% after deductible | 80% after deductible |
| Precertification Requirements (9) | Yes | Yes |
| | Certain services may require prior authorization. A current listing is published at www.myhighmark.com. You may also contact Member Services. Their phone number is on the back of your ID Card | |

| Prescription Drugs | |
|---|---|
| Prescription Drug Deductible<br>Individual<br>Family | <br>Integrated with medical deductible<br>Integrated with medical deductible |
| Prescription Drug Program (10)<br>**SensibleRX Choice**<br>Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.<br><br>Your plan uses the Comprehensive Formulary with an Open Benefit Design<br><br>**Specialty Drugs must be purchased at Retail or Mail Order.**<br>**Specialty drugs limited to 31-day supply** | **Retail and Mail Order Drugs (34/60/90-day Supply)**<br>Plan pays 100% after deductible<br><br>Cost-sharing for Prescription Insulin Drugs will not exceed **$35**<br>for a 30-day supply<br>Cost-sharing for Diabetic Devices<br>will not exceed $100<br>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. If you are enrolled in a "Family" plan, with your embedded deductible, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. In addition, with your embedded out-of-pocket limit, once an individual family member's out-of-pocket limit is satisfied, additional claims reimbursement begins for that person Finally, with your embedded TMOOP, once any eligible family member satisfies his/her individual TMOOP, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year.
(3) Telemedicine services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark designated telemedicine vendor. Additional services provided by a Highmark designated telemedicine vendor are paid according to the benefit category that they fall under (E.G. PCP is eligible under the PCP office visit benefit, behavioral health is eligible under outpatient mental health).
(4) Services are limited to those listed on the Highmark 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 pays.
(6) 30 visit maximum per event for combined physical therapy, occupational therapy and spinal manipulations
(7). After initial evaluation, applied behavioral analysis will be covered as specified above. All other covered services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (E.G. speech therapy, diagnostic services). Treatment for Autism Spectrum Disorders does not reduce visit/day limit.
(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) Highmark 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. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered. 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) At a retail or mail-order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled. 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. This formulary covers all FDA-approved generic and brand-name drugs. Under **SensibleRX Choice**, 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.
(11) Unless otherwise provided for 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 non-emergency ground and water ambulance services that are in excess of the amount that Highmark WV pays.
(12) Benefits for emergency care services rendered by an out-of-network provider will be paid at the network services level. Benefits for hospital services or medical care services rendered by an out-of-network provider to a member requiring an inpatient admission or observation immediately following receipt of emergency care services will be paid at the network services level. The member will not be responsible for any amounts billed by the out-of network provider that are in excess of the plan allowance for such services.
(13)Covered virtual services will be paid according to the benefit category (e.g., primary care provider office visit, maternity visit, etc.) For example, virtual visits relating to the treatment of mental illness or substance use disorder are covered under your outpatient mental health and substance use disorder benefit and subject to the cost sharing amount in this schedule of benefits.

**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.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注： 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。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

**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.myhighmark.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?** | $2,700 individual/$5,400 family network.<br>$8,000 individual/$16,000 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. Preventive care services are covered before you meet your network deductible.<br><br>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?** | $0 individual/$0 family network out-of-pocket limit, up to a total maximum out-of-pocket of $2,700 individual/$5,400 family.<br><br>$8,000 individual/$16,000 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.<br><br>Out-of-network: Copayments, deductibles, premiums, balance-billed charges, prescription drug expense, 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.myhighmark.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 | No charge | 20% coinsurance | 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.<br><br>Please refer to your preventive schedule for additional information. |
| | Specialist visit | No charge | 20% coinsurance | |
| | Preventive care/screening/immunization | No charge<br>Deductible does not apply. | 20% coinsurance | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | 20% coinsurance | Copayments, if any, do not apply to diagnostic services prescribed for the treatment of mental health or substance abuse.<br>Precertification may be required. |
| | Imaging (CT/PET scans, MRIs) | No charge | 20% 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 drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.myhighmark.com/find-a-doctor/#/drug. | Generic drugs | No charge (retail)<br>No charge (mail order) | Not covered | Up to 34/60/90-day supply retail pharmacy and maintenance prescription drugs through mail order.<br><br>This plan uses a Comprehensive Formulary.<br><br>Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30-day supply-deductible does not apply.<br><br>Specialty drugs must be purchased at retail or mail order. |
| | Formulary Brand drugs | No charge (retail)<br>No charge (mail order) | Not covered | |
| | Non-Formulary Brand drugs | No charge (retail)<br>No charge (mail order) | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | 20% coinsurance | Precertification may be required. |
| | Physician/surgeon fees | No charge | 20% coinsurance | Precertification may be required. |
| **If you need immediate medical attention** | Emergency room care | No charge | No charge | Out-of-network: Subject to network deductible. |
| | Emergency medical transportation | No charge | No charge | Out-of-network: Subject to network deductible. |
| | Urgent care | No charge | 20% coinsurance | The copayment, if any, does not apply to urgent care services prescribed for the treatment of mental health or substance abuse. |
| **If you have a hospital stay** | Facility fees (e.g., hospital room) | No charge | 20% coinsurance | Precertification may be required. |
| | Physician/surgeon fees | No charge | 20% coinsurance | Precertification may be required. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge | 20% coinsurance | Precertification may be required. |
| | Inpatient services | No charge | 20% 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 are pregnant** | Office visits | No charge | 20% 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.)<br><br>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 | No charge | 20% coinsurance | |
| | Childbirth/delivery facility services | No charge | 20% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | No charge | 20% coinsurance | Combined network and out-of-network: 100 visits per benefit period, combined with visiting nurse. Precertification may be required. |
| | Rehabilitation services | No charge for | 20% coinsurance | 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.<br><br>Combined network and out-of-network: 30 combined physical medicine, occupational therapy, and spinal manipulation visits per event for chronic pain. Copayment, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. The limit, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. Precertification may be required. |
| | Habilitation services | No charge | 20% coinsurance | |
| | Skilled nursing care | No charge | 20% coinsurance | Precertification may be required. |
| | Durable medical equipment | No charge | 20% coinsurance | Cost-sharing for Diabetic Devices will not exceed $100 for a 30-day supply. Precertification may be required. |
| | Hospice services | No charge | 20% 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 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)
- 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
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See http://www.bcbsglobalcore.com
- 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: 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 Inc. 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 | $2,700 |
| 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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,700 |
| Copayments | $0 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,760** |

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

| | |
|---|---|
| The plan's overall deductible | $2,700 |
| 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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,700 |
| Copayments | $0 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,720** |

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

| | |
|---|---|
| The plan's overall deductible | $2,700 |
| 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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,700 |
| Copayments | $0 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,700** |

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: 1-888-809-9121.

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

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 .