HIGHMARK

IOGA - $2,000 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, 2025	
Benefit Period (1)	Contract Year (January 1 through December 31)	
Deductible (per benefit period) Individual Family	 $2,000 $4,000	 $6,000 $12,000
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	 $9,200 $18,400	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits (13)		
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
	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 $10 copay	not covered
Preventive Care (4)(13)		
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
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 (12)	$150 copay (waived if admitted) then 90% after network deductible	
Ambulance Emergency (ground, water, air)	100% (deductible does not apply)	
Ambulance Non-Emergency (ground, water) (11)	90% after network deductible	70% after network deductible
Ambulance Non-Emergency (air)	90% after network deductible	
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient (12)	90% after deductible	70% after deductible
Hospital Outpatient	90% after deductible	70% after deductible
Mammograms, Medically Necessary	90% after deductible	70% after deductible
Maternity (non-preventive facility & professional services) including dependent(s)	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) Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	100% after $15 copay per visit	70% after $15 copay per visit
	Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder	
Respiratory Therapy	90% after deductible	70% after deductible
Speech Therapy Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	100% after $15 copay per visit	70% after $15 copay per visit
	including rehabilitative services and habilitative services 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) Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per event for chronic pain (6) Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	100% after $15 copay per visit	70% after $15 copay per visit
	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) 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.	100% after $15 copay per visit	70% after $15 copay per visit
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
Mental Health / Substance Use Disorder (13)		
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 (13)		
Allergy Treatments, 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
	Cost-sharing for eligible Diabetic Devices will not exceed $100 for a 30-day supply	
Home Health Care	90% after deductible	70% after deductible
	limit: 100 visits/benefit period aggregate with visiting nurse	
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	70% after deductible
	limit: 35 visits/benefit period	
Skilled Nursing Facility Care	90% after deductible	70% after deductible
Transplant Services	90% after deductible	70% after deductible
Diabetes Care Management Program (DCMP) – Digitally Monitored, includes telehealth consult for the A1C test	100%, No Deductible Continuous glucose monitor sprints are limited to three (3) per benefit period.	No Benefits
DCMP – All Other Telehealth Consults	100%, No Deductible	No Benefits
Precertification Requirements (9)	Yes	Yes

Benefit	In Network	Out of Network
	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 Individual Family	 none none
Prescription Drug Program (10) **SensibleRX Choice** 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 and Mail Order 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 **$35** for a 30-day supply Cost-sharing for Diabetic Devices will not exceed $100 for a 30-day supply **Retail and Mail Order 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 Cost-sharing for Prescription Insulin Drugs will not exceed **$35** for a 30-day supply Cost-sharing for Diabetic Devices will not exceed $100 for a 30-day supply **Specialty Drugs (31-day Supply)** 30% up to $300 Maximum per Prescription, No Deductible

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) 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 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 **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.

Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association

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.