

IOGA - \$1,500 HDHP Non-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, 2021	
Benefit Period (1)	Contract Year (January 1 through December 31)	
Deductible (per benefit period)		
Individual	\$1,500	\$6,000
Family	\$3,000	\$12,000
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)		
Individual	\$0	\$6,000
Family	\$0	\$12,000
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	\$1,500	Not Applicable
Family	\$3,000	Not Applicable
Office/Clinic/Urgent Care Visits		
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
Telemedicine Services (3)	100% after deductible	not covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	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
Mammograms, Medically Necessary	100% after deductible	80% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	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 - Emergency	\$100% after deductible	
Emergency Room Services - Non-Emergency	100% after deductible	80% after deductible
Ambulance – Emergency (5)	100% after deductible	100% after deductible; benefit maximum of \$100,000/occurrence for emergency services only
Ambulance - Non-Emergency	100% after deductible	80% after deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient	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
Therapy and Rehabilitation Services		

Benefit	In Network	Out of Network
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.	100% after deductible for other than chronic pain	80% after deductible for other than chronic pain
Respiratory Therapy	100% after deductible	80% after deductible
Speech Therapy	100% after deductible	80% after deductible
including rehabilitative services and habilitative services		
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.	100% after deductible for other than chronic pain	80% after deductible for other than 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.	100% after deductible for other than chronic pain	80% after deductible for other than chronic pain
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health / Substance Use Disorder		
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		
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 Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
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

Prescription Drugs

Prescription Drug Deductible Individual Family	Integrated with medical deductible Integrated with medical deductible
Prescription Drug Program (10) Soft Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Open Benefit Design Specialty Drugs must be purchased at Retail or Mail Order.	<p align="center">Retail Drugs (34-day Supply) Plan pays 100% after deductible</p> <p align="center">Cost-sharing for Prescription Insulin Drugs will not exceed \$100 for a 30-day supply (deductible does not apply)</p> <p align="center">Maintenance Drugs through Mail Order (90-day Supply) Plan pays 100% after deductible</p> <p align="center">Cost-sharing for Prescription Insulin Drugs will not exceed \$100 for a 30-day supply (deductible does not apply)</p>

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 non-embedded deductible, the entire family deductible must be satisfied before claims reimbursement begins. In addition, with your non-embedded out-of-pocket limit, the entire family out-of-pocket limit must be satisfied before additional claims reimbursement begins. Finally, with your non-embedded TMOOP, once the entire family TMOOP is satisfied, claims will pay at 100% of the plan allowance for covered expenses for the family, for the rest of the plan year.
- (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) 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 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.

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 المساعدة في اللغة المجانية متاحة لك. اتصل على الرقم
1-877-959-2562.

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

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

日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。1-877-959-2562 を呼び出します。

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

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

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

यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू
नशुल्क 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 yánílti'go, language assistance services, éí t'áá níík'eh, bee níká
a'doowól, éí bee ná'ahóót'i'. Kojí' hodíílnih 1-877-959-2562.