

IOGA - \$2,000 Deductible – 80/60 Plan

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

| Benefit | In Network | Out of Network |
|--|--|--|
| General Provisions | | |
| Effective Date | January 1, 2021 | |
| Benefit Period (1) | Contract Year (January 1 through December 31) | |
| Deductible (per benefit period) | | |
| Individual | \$2,000 | \$6,000 |
| Family | \$4,000 | \$12,000 |
| Plan Pays – payment based on the plan allowance | 80% after deductible | 60% after deductible |
| Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) | | |
| Individual | \$1,000 | \$1,500 |
| Family | \$2,000 | \$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 | \$8,150 | Not Applicable |
| Family | \$16,300 | Not Applicable |
| Office/Clinic/Urgent Care Visits | | |
| Retail Clinic Visits & Virtual Visits | 100% after \$15 copay | 60% after \$15 copay |
| Primary Care Provider Office Visits & Virtual Visits | 100% after \$15 copay | 60% after \$15 copay |
| Specialist Office Visits & Virtual Visits | 100% after \$15 copay | 60% after \$15 copay |
| Virtual Visit Provider Originating Site Fee | 80% after deductible | 60% after deductible |
| Urgent Care Center Visits | 100% after \$15 copay | 60% after \$15 copay |
| Telemedicine Services (3) | 100% after \$10 copay | not covered |
| Preventive Care (4) | | |
| Routine Adult | | |
| Physical Exams | 100% (deductible does not apply) | 60% after deductible |
| Adult Immunizations | 100% (deductible does not apply) | 60% after deductible |
| Routine Gynecological Exams, including a Pap Test | 100% (deductible does not apply) | 60% after deductible |
| Mammograms, Annual Routine | 100% (deductible does not apply) | 60% after deductible |
| Mammograms, Medically Necessary | 80% after deductible | 60% after deductible |
| Diagnostic Services and Procedures | 100% (deductible does not apply) | 60% after deductible |
| Routine Pediatric | | |
| Physical Exams | 100% (deductible does not apply) | 60% after deductible |
| Pediatric Immunizations | 100% (deductible does not apply) | 60% after deductible |
| Diagnostic Services and Procedures | 100% (deductible does not apply) | 60% after deductible |
| Emergency Services | | |
| Emergency Room Services - Emergency | \$150 copay (waived if admitted) then 80% after deductible | |
| Emergency Room Services - Non-Emergency | \$150 copay (waived if admitted) then 80% after deductible | \$150 copay (waived if admitted) then 60% after deductible |
| Ambulance – Emergency (5) | 100% (deductible does not apply) | 100% (deductible does not apply) Non-Network Liability coverage up to \$100,000.00 maximum per Occurrence |
| Ambulance - Non-Emergency | 80% after deductible | 60% after deductible |
| Hospital and Medical / Surgical Expenses (including maternity) | | |
| Hospital Inpatient | 80% after deductible | 60% after deductible |
| Hospital Outpatient | 80% after deductible | 60% after deductible |
| Maternity (non-preventive facility & professional services) including dependent daughter | 80% after deductible | 60% after deductible |
| Medical Care (including inpatient visits and consultations)/Surgical Expenses | 80% after deductible | 60% after deductible |

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

| Benefit | In Network | Out of Network |
|--|--|--|
| Therapy and Rehabilitation Services | | |
| Physical Therapy (Rehabilitative and Habilitative) Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per event for chronic pain (6) Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined. | 80% after deductible for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain | 60% after deductible for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain |
| Respiratory Therapy | 80% after deductible | 60% after deductible |
| Speech Therapy | 80% after deductible | 60% 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. | 80% after deductible for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain | 60% 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. | 80% after deductible for other than chronic pain Primary Care Office Visit Cost-sharing will apply for chronic pain | 60% 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) | 80% after deductible | 60% after deductible |
| Mental Health / Substance Use Disorder | | |
| Inpatient Mental Health Services | 80% after deductible | 60% after deductible |
| Inpatient Detoxification / Rehabilitation | 80% after deductible | 60% after deductible |
| Outpatient Mental Health Services (includes virtual behavioral health visits) | 80% after deductible | 60% after deductible |
| Outpatient Substance Use Disorder Services | 80% after deductible | 60% after deductible |
| Other Services | | |
| Allergy Extracts and Injections | 80% after deductible | 60% after deductible |
| Applied Behavior Analysis for Autism Spectrum Disorder (7) | 80% after deductible | 60% after deductible |
| Assisted Fertilization Procedures | 80% after deductible | 60% after deductible |
| Dental Services Related to Accidental Injury | 80% after deductible | 60% after deductible |
| Diagnostic Services | | |
| Advanced Imaging (MRI, CAT, PET scan, etc.) | 80% after deductible | 60% after deductible |
| Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing) | 80% after deductible | 60% after deductible |
| Durable Medical Equipment, Orthotics and Prosthetics | 80% after deductible | 60% after deductible |
| Home Health Care | 80% after deductible | 60% after deductible |
| limit: 100 visits/benefit period aggregate with visiting nurse | | |
| Hospice | 80% after deductible | 60% after deductible |
| Infertility Counseling, Testing and Treatment (8) | 80% after deductible | 60% after deductible |
| Private Duty Nursing | 80% after deductible | 60% after deductible |
| limit: 35 visits/benefit period | | |
| Skilled Nursing Facility Care | 80% after deductible | 60% after deductible |
| Transplant Services | 80% after deductible | 60% after deductible |
| Precertification Requirements (9) | Yes | Yes |

Prescription Drugs

| | |
|--|--|
| Prescription Drug Deductible Individual Family | none none |
| Prescription Drug Program (10) Soft Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Open Benefit Design Specialty Drugs must be purchased at Retail or Mail Order. | <p align="center">Retail Drugs (34-day Supply)</p> 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 <p align="center">Specialty Drugs (31-day Supply)</p> 30% up to \$300 Maximum per Prescription, No Deductible <p align="center">Maintenance Drugs through Mail Order (90-day Supply)</p> 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.

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 बोलनुहुन्छ 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.