Summary of Health Savings Blue PPO 3000 *Benefits*

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	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Employee Only Plan Family Plan	 $3,000 $6,000	 $6,000 $12,000
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible
Out-of-Pocket Limit (Includes deductible, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period.) Employee Only Plan Family Plan	 $6,550 $13,100	 $13,100 $26,200
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	90% after deductible	70% after deductible
Primary Care Provider Office Visits	90% after deductible	70% after deductible
Specialist Office & Virtual Visits	90% after deductible	70% after deductible
Virtual Visit Originating Site Fee	90% after deductible	70% after deductible
Urgent Care Center Visits	90% after deductible	70% after deductible
Telemedicine Service(2)	90% after deductible	Not Covered
Preventive Care(3)		
Routine Adult		
Adult immunizations	100% (deductible does not apply)	Not Covered
Colorectal cancer screening	100% (deductible does not apply)	Not Covered
Diagnostic services and procedures	100% (deductible does not apply)	Not Covered
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 90% after deductible	Not Covered
Physical exams	100% (deductible does not apply)	Not Covered
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	Not Covered
Routine adult vision exam	Not Covered	Not Covered
Routine Pediatric		
Diagnostic services and procedures	100% (deductible does not apply)	Not Covered
Pediatric immunizations	100% (deductible does not apply)	Not Covered
Physical exams	100% (deductible does not apply)	Not Covered
Pediatric Vision(4)		
Exam (including dilation, as professionally indicated)	100% (deductible does not apply)	Not Covered
Pediatric frame selection	100% after deductible	Not Covered
Standard eyeglass lenses (per pair)	100% after deductible	Not Covered
Pediatric Dental(4)		
Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants)	100% (deductible does not apply)	Not Covered
Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings))	90% after deductible	Not Covered
Major Services (crowns, crown repair, endodontic therapy (root canals, etc.))	90% after deductible	Not Covered
Orthodontics(5) (Medically necessary with prior approval. Waiting limits apply.)	90% after deductible	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	90% after deductible	70% after deductible
Hospital Outpatient	90% after deductible	
Maternity (non-preventive facility & professional services) including dependent daughter	90% after deductible	
Medical Care (including inpatient visits and consultations)**/Surgical Expenses**	90% after deductible	
Emergency Services		
Emergency Room Services	90% after deductible	
Emergency Room Services – Non-Emergency	90% after deductible	70% after deductible
Ambulance	90% after in-network deductible	
Ambulance - – Non-Emergency	90% after deductible	70% after deductible
Therapy, Rehabilitative and Habilitative Services		
Occupational Therapy (Rehabilitative and Habilitative)	90% after deductible	70% after deductible
	Limit: 30 Rehabilitative and 30 Habilitative visits / benefit period'	
Physical Therapy (Rehabilitative and Habilitative)	90% after deductible	70% after deductible
	Limit: 30 Rehabilitative and 30 Habilitative visits / benefit period'	
Respiratory Therapy	90% after deductible	70% after deductible
Speech Therapy (Rehabilitative and Habilitative)	90% after deductible	70% after deductible
Spinal Manipulations (Rehabilitative and Habilitative)	90% after deductible	70% after deductible
	Limit: 30 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible

Benefit	Network	Out-of-Network
Mental Health/Substance Abuse		
Inpatient	90% after deductible	70% after deductible
Inpatient Detoxification/Rehabilitation	90% after deductible	
Outpatient	90% after deductible	
Other Services		
Allergy Extracts and Injections	90% after deductible	70% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	70% after deductible
Home Health Care	90% after deductible	70% after deductible
	Limit: 100 visits/benefit period - aggregate with Visiting Nurse	
Hospice	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment(6)	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
Precertification Requirements(7)	YES	
Prescription Drugs		
Prescription Drug Deductible Individual Family	 Combined with Medical Combined with Medical	
Prescription Drug Program(8) None Mandatory Generic *Defined by the National West Virginia 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.*	**Retail Drugs (34 -day Supply)** Generic: 90% after deductible Formulary Brand:90% after deductible Non-Formulary: 90% after deductible **Maintenance Drugs through Mail Order (90-day Supply) (34-day Supply for Specialty Drugs)** Mail Generic: 90% after deductible Mail Formulary Brand:90% after deductible Mail Non-Formulary: 90% after deductible	

(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) Services must be performed by a Highmark approved telemedicine provider.
(3) Services are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
(4) Pediatric vision and dental benefits are only available to dependent children or health plan members under age 19.
(5) A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality. Prior approval is required. 12 month waiting period required. See your benefit booklet for more details.
(6) 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.
(7) 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 not, you are responsible for contacting MM&P. 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.
(8) Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply. 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.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield West Virginia which is an independent licensee of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement. To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4110.

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you speak English, language assistance services, free of charge, are available to you. Call 1-877-959-2562.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-877-959-2562.

如果您说中文，可向您提供免费语言协助服务。 請致電 1-877-959-2562.

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

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

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

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

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

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

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

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

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

यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। 1-877-959-2562 मा फोन गर्नुहोस्।

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

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

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ 1-877-959-2562 پر کال کریں ۔

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

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-877-959-2562.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-877-959-2562.

Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodíilnih 1-877-959-2562.

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