**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.highmarkbcbswv.com or call 1-888-601-2109. 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 1-888-601-2109 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP;<br>$7,500 individual/$15,000 family network.<br>$15,000 family individual/$30,000 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. Office visits, preventive care services, urgent care, outpatient mental health, outpatient substance abuse, rehabilitation services, habilitation services, generic prescription drug benefits, pediatric vision services, and pediatric dental exam are covered before you meet your 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?** | $9,400 individual/$18,800 family network.<br>$18,800 family individual/$37,600 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?** | Premiums, balance-billed charges, 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.<br>See www.highmarkbcbswv.com/find-a-doctor/ or call 1-888-601-2109 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).<br>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 I 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 |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP 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 | $50 copay/visit<br>Deducible does not apply. | 60% 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 | $100 copay/visit<br>Deducible does not apply. | 60% coinsurance | |
| | Preventive care/screening/immunization | No charge | No charge<br>Deductible does not apply. | Not covered | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | 50% coinsurance | 60% coinsurance | Copayments, if any, do not apply to diagnostic services prescribed for the treatment of mental health or substance abuse.<br>See Below* |
| | Imaging (CT/PET scans, MRIs) | No charge | 50% coinsurance | 60% coinsurance | |

*Cost sharing waived at non- IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP 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 https://www.highmarkbcbswv.com/find-a-doctor/#/drug | Tier 1 | No charge per prescription (retail)<br>No charge per prescription (mail order) | $25/$50/$75 copay per prescription (retail)<br>$75 copay per prescription (mail order)<br>Deductible does not apply. | Not covered | Up to 34/60/90-day supply retail pharmacy.<br><br>Up to 90-day supply maintenance prescription drugs through mail order.<br><br>Specialty drugs limited to a 34-day supply – retail or mail order.<br><br>This plan has an Essential Formulary.<br><br>Cost-sharing for prescription insulin drugs will not exceed $35 for a 30-day supply. Cost-sharing for eligible Diabetic Devices will not exceed $100 for a 30-day supply. See Below* |
| | Tier 2 | No charge per prescription (retail)<br>No charge per prescription (mail order) | $50/$100/$200 copay per prescription (retail)<br>$200 copay per prescription (mail order) | Not covered | |
| | Tier 3 | No charge per prescription (retail)<br>No charge per prescription (mail order) | $100/$200/$400 copay per prescription (retail)<br>$400 copay per prescription (mail order) | Not covered | |
| | Tier 4 | No charge per prescription (retail)<br>No charge per prescription (mail order) | $500/$1,000/$1,500 copay per prescription (retail)<br>$1,500 copay per prescription (mail order) | Not covered | |
| **If you have outpatient** | Facility fee (e.g., ambulatory surgery center) | No charge | 50% coinsurance | 60% coinsurance | Precertification may be required. See Below* |

*Cost sharing waived at non- IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| **surgery** | Physician/surgeon fees | No charge | 50% coinsurance | 60% coinsurance | Precertification may be required. See Below* |
| **If you need immediate medical attention** | Emergency room care | No charge | 50% coinsurance | 50% coinsurance | Out-of-network: Subject to non IHCP network deductible. See Below* |
| | Emergency medical transportation | No charge | 50% coinsurance | 50% coinsurance | Out-of-network: Subject to non IHCP network deductible. See Below* |
| | Urgent care | No charge | $75 copay/visit Deducible does not apply. | $75 copay/visit Deducible does not apply. | The copayment, if any, does not apply to urgent care services prescribed for the treatment of mental health or substance abuse. See Below* |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | 50% coinsurance | 60% coinsurance | Precertification may be required. See Below* |
| | Physician/surgeon fees | No charge | 50% coinsurance | 60% coinsurance | Precertification may be required. See Below* |
| **If you have mental health, behavioral health, or substance abuse services** | Outpatient services | No charge | $50 copay/visit Deducible does not apply. | 60% coinsurance | Precertification may be required. See Below* |
| | Inpatient services | No charge | 50% coinsurance | 60% coinsurance | Precertification may be required. See Below* |
| **If you are pregnant** | Office visits | No charge | 50% coinsurance | 60% coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing). |
| | Childbirth/delivery professional services | No charge | 50% coinsurance | 60% coinsurance | |
| | Childbirth/delivery facility services | No charge | 50% coinsurance | 60% coinsurance | |

*Cost sharing waived at non- IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | No charge | 50% coinsurance | 60% coinsurance | Combined network and out-of-network: 100 visits per benefit period, aggregate with visiting nurse.<br>Precertification may be required.<br>See Below* |
| | Rehabilitation services | No charge | $50 copay/visit<br>Deducible does not apply. | 60% coinsurance | Combined network and out-of-network: 30 physical medicine visits and 30 occupational therapy visits for other than chronic pain per benefit period.<br>Combined network and out-of-network: 20 combined physical medicine, occupational therapy, and spinal manipulation visits per event for chronic pain<br>Limit does not apply to services for the treatment of a mental health or substance abuse diagnosis.<br>Precertification may be required.<br>See Below* |
| | Habilitation services | No charge | $50 copay/visit<br>Deducible does not apply. | 60% coinsurance | Combined network and out-of-network: 30 physical medicine visits and 30 occupational therapy visits for other than chronic pain per benefit period.<br>Combined network and out-of-network: 20 combined physical medicine, occupational therapy, and spinal manipulation visits per event for chronic pain<br>Limit does not apply to services for the treatment of a mental health or substance abuse diagnosis.<br>Precertification may be required. See Below* |

*Cost sharing waived at non- IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| | Skilled nursing care | No charge | 50% coinsurance | 60% coinsurance | Combined network and out-of-network: Benefits must be recertified every two weeks. Benefits expire when patient cannot present any significant improvement. Precertification may be required. See Below* |
| | Durable medical equipment | No charge | 50% coinsurance | 60% coinsurance | Precertification may be required. See Below* |
| | Hospice services | No charge | 50% coinsurance | 60% coinsurance | Precertification may be required. See Below* |
| **If your child needs dental or eye care** | Children's eye exam | No charge | No charge Deductible does not apply. | Not covered | Combined IHCP and non-IHCP network: One eye exam per 12 month period up to age 19. See Below* |
| | Children's glasses | No charge | No charge Deductible does not apply. | Not covered | Combined IHCP and non-IHCP network: One pair frames/lenses every 12 months. See Below* |
| | Children's dental check-up | No charge | No charge Deductible does not apply. | Not covered | Combined IHCP and non-IHCP network: One exam every 6 months. See Below* |

*Cost sharing waived at non- IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

## 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.)**

- Abortion, except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the life of the woman in danger unless an abortion is performed.
- 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.bcbsa.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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or at https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 1-888-601-2109.
- Additionally, a consumer assistance program can help you file your appeal. Contact: West Virginia Offices of the Insurance Commissioner, Consumer Service Division 1124 Smith St, Room 309 Charleston, WV 25301 **(888) 879-9842** https://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 | $0 |
| 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 | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$60** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| 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 | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$20** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| 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 | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$0** |

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 .