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, https://intranet.marshallhealth.org/ or call Amber Gough 304-691-1646 or Missy Staten 304-691-6741. 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 1-888-809-9121 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 individual/$600 family enhanced value network. $1,000 individual/$2,000 family standard value network. $1,500 individual/$3,000 family out-of-network. All in-network services are credited to both the enhanced and the standard deductibles.	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, emergency medical transportation, urgent care, and prescription drug benefits are covered before you meet your network deductible. 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?	Yes. $50 individual/$100 family for standard value network prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.

What is the out-of-pocket limit for this plan?	$2,500 individual/$5,000 family enhanced value network. $3,000 individual/$6,000 family standard value network. All services are credited to the enhanced, the standard, and the out-of-network out-of-pocket limits. Up to a $4,500 individual/$9,000 family network, combined enhanced and standard value total family total maximum out-of-pocket. $5,000 individual/$10,000 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?	Network: Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket. Out-of-network: Copayments, deductibles, premiums, balance-billed charges, prescription drug expenses, 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. See www.highmarkbcbswv.com or call 1-888-809-9121 for a list of network providers.	You pay the least if you use a provider in Enhanced Network. You pay more if you use a provider in Standard 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). 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 you 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
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	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 Deductible does not apply.	$30 copay/visit Deductible does not apply.	40% 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. Please refer to your preventive schedule for additional information.
	Specialist visit	$20 copay/visit Deductible does not apply.	$50 copay/visit Deductible does not apply.	40% coinsurance	
	Preventive care/screening/immunization	No charge Deductible does not apply.	No charge Deductible does not apply.	40% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	40% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	40% coinsurance	Precertification may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.highmarkbcbswv.com .	Generic drugs	No charge (retail) $12 copay/prescription (mail order) Deductible does not apply.	$5/$12 copay /prescription (retail) $12 copay/prescription (mail order) Deductible does not apply.	Not covered	Up to 34/90-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. This plan uses a Comprehensive Formulary.
	Formulary Brand drugs	$20/$50 copay /prescription (retail) $50 copay/prescription (mail order) Deductible does not apply.	$20/$50 copay /prescription (retail) $50 copay/prescription (mail order) Deductible does not apply.	Not covered	
	Non-Formulary Brand drugs	25% coinsurance (retail) 25% coinsurance (mail order) Deductible does not apply.	25% coinsurance (retail) 25% coinsurance (mail order) Deductible does not apply.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	35% coinsurance, $200 maximum per prescription (retail) 35% coinsurance, $200 maximum per prescription (mail order) Deductible does not apply.	35% coinsurance, $200 maximum per prescription (retail) 35% coinsurance, $200 maximum per prescription (mail order) Deductible does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	40% coinsurance	Precertification may be required.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	40% coinsurance	Precertification may be required.
If you need immediate medical attention	Emergency room care	20% coinsurance after $150 copay/visit	20% coinsurance after $150 copay/visit	20% coinsurance after $150 copay/visit	All tiers: Subject to enhanced value network deductible. Copay waived if admitted as an inpatient.
	Emergency medical transportation	10% coinsurance Deductible does not apply.	10% coinsurance Deductible does not apply.	10% coinsurance Deductible does not apply.	---------none---------
	Urgent care	No charge Deductible does not apply.	$75 copay/visit Deductible does not apply.	40% coinsurance	---------none---------
If you have a hospital stay	Facility fees (e.g., hospital room)	10% coinsurance after $100 copay per admission	20% coinsurance after $100 copay per admission	40% coinsurance after $100 copay per admission	Precertification may be required.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	40% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	20% coinsurance	40% coinsurance	Precertification may be required.
	Inpatient services	$100 copay per admission	20% coinsurance after $100 copay per admission	40% coinsurance after $100 copay per admission	Precertification may be required.
If you are pregnant	Office visits	No charge	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth/delivery professional services	No charge	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	$100 copay per admission	20% coinsurance after $100 copay per admission	40% coinsurance after $100 copay per admission	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	40% coinsurance	Combined network and out-of-network: 100 visits per benefit period. Precertification may be required.
	Rehabilitation services	20% coinsurance (professional services) 20% coinsurance for physical and occupational therapy 20% coinsurance after $100 copay/visit for speech therapy (facility services)	20% coinsurance (professional services) 20% coinsurance for physical and occupational therapy 20% coinsurance after $100 copay/visit for speech therapy (facility services)	40% coinsurance (professional services) 40% coinsurance after $100 copay/visit (facility services)	Combined network and out-of-network: 30 physical medicine visits and 30 occupational therapy visits per benefit period. Combined network and out-of-network: habilitation and rehabilitation services. Precertification may be required.
	Habilitation services	20% coinsurance (professional services) 20% coinsurance for physical and occupational therapy 20% coinsurance after $100 copay/visit for speech therapy (facility services)	20% coinsurance (professional services) 20% coinsurance for physical and occupational therapy 20% coinsurance after $100 copay/visit for speech therapy (facility services)	40% coinsurance (professional services) 40% coinsurance after $100 copay/visit (facility services)	
	Skilled nursing care	20% coinsurance	20% coinsurance	40% coinsurance	Precertification may be required.
	Durable medical equipment	20% coinsurance	20% coinsurance	40% coinsurance	Precertification may be required.
	Hospice services	No charge	No charge	40% coinsurance	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	---------none---------
	Children's glasses	Not covered	Not covered	Not covered	---------none---------
	Children's dental check-up	Not covered	Not covered	Not covered	---------none---------

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.)

- 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.bcbs.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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. West Virginia Offices of the Insurance Commissioner at 1-888-879-9842. 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:

- Your plan administrator/employer.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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	$300
Specialist copayment	$20
Hospital (facility) coinsurance	10%
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	$300
Copayments	$100
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,260**

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

The plan's overall deductible	$300
Specialist copayment	$20
Hospital (facility) coinsurance	10%
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	$300
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$720**

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

The plan's overall deductible	$300
Specialist copayment	$20
Hospital (facility) coinsurance	10%
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	$300
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.highmarkbcbswv.com .

The plan would be responsible for the other costs of these EXAMPLE covered services.

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; 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.

U65_WV_G_P_1Col_12pt_blk_NL

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 .