



DIOCESE OF WHEELING-CHARLESTON

2024 Benefit Overview



Envoy Benefits Solutions

Topics for Review

Major Medical Health Insurance with Highmark WV

OptiMed Deductible Assistance Benefit

MetLife Dental and Vision

TASC Flexible Spending Account

Health Insurance Terminology

Deductible - What you pay for eligible in-patient (hospital) and out-patient (hospital, clinic, doctors office) services.

Copays – What you pay at the doctor's office and pharmacy. Copays are not applied to your deductible with the DWC plan.

Coinsurance – The amount you pay after you meet your deductible. The DWC plan has no coinsurance to pay.

Out-Of-Pocket Maximum – The total amount paid toward deductible and copays for the benefit year.



DMOCESE OF WHEELING-CHARLESTON

Your Major Medical Insurance

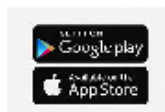


The Diocese of Wheeling-Charleston provides major medical insurance through Highmark WV. Your Highmark benefits utilizes the PPO Blue Card program which offers your access to all Blue Cross/Blue Shield doctors and hospital in the United States at the in-network benefit level.

Your one Highmark card is used for both medical care and prescriptions.

You are strongly encouraged to register as a member at www.myhighmark.com. There you can search for providers, look-up prescriptions, view and download your Explanation of Benefits (EOBs), plus much more.

If you need assistance registering, call Highmark Customer Service at 1-888-809-9121.



You can also download the Highmark app from either app store. With the app you have the same access to your plan information as registering as Highmark member on the myhighmark portal plus you will always have an electronic version of your ID!

Supplemental Deductible Assistance Insurance



OptiMed Health is an additional benefit included with your Highmark major medical that offers deductible payment assistance so you are not responsible to pay the entire in-network eligible major medical deductible.



With OptiMed Health you choose between two different deductible assistance plans, Silver or Platinum.

Regardless of which option you choose, your copayments with your Highmark benefits will be the same for office visits and prescriptions. Only the amount you pay toward your in-network major medical deductible will be different.



What is the OptiMed Deductible Assistance Plan?

The OptiMed Deductible Assistance Plan is an additional benefit that reduces the amount you pay toward your Highmark major medical deductible for eligible benefits.

It is considered a supplement and is not a major medical insurance plan. You must always present your Highmark major medical card and your OptiMed card at the providers office.

Sometimes it is referred to as a "Gap Plan".

Deductible Assistance Plan - Summary

2024		What You Pay	Silver Deductible Assistance Pays	Highmark Deductible	OR	What You Pay	Platinum Deductible Assistance Pays	Highmark Deductible
Major Medical Deductible	Self Self + 1 Self & Family	First \$3,000 First \$6,000 First \$6,000	Next \$4,400 Next \$8,800 Next \$8,800	\$7,400 \$14,800 \$14,800		First \$1,000 First \$2,000 First \$2,000	Next \$ 6,400 Next \$12,800 Next \$12,800	\$7,400 \$14,800 \$14,800

- You will not have to pay the full major medical deductible for eligible services.
- Your choice of deductible assistance option affects how much of the deductible you will actually pay.
- Silver Deductible Assistance option is included with your Highmark medical plan.
- Platinum Deductible Assistance is a buy up option at an additional expense.
- All other copays and benefits are the same with both of deductible assistance options.

Benefits at a Glance



2024 Health Benefits At A Glance

Effective Date	January 1, 2024				
Benefit Period (used for Deductible and Coinsurances limits and certain benefit frequencies.)	2024 Calendar Year				
Major Medical Deductible	Network Total	Your Deductible Assistance Options			
		Silver Deductible Assistance		Platinum Deductible Assistance	
		You Pay	Silver Pays	You Pay	Platinum Pays
Self Only	\$7,400	\$3,000	\$4,400	\$1,000	\$6,400
Self +1 or Self & Family (The deductible may be met collectively)	\$14,800	\$6,000	\$8,800	\$2,000	\$12,800
Coinsurance	You pay \$0 - There is no coinsurance after the deductible is met.				
Total Maximum Out-of-Pocket (Includes Network Deductible and all Copays, including prescriptions.	Network				
Self Only	You accumulate \$9,450 of covered out-of-pocket expenses. Then the plan pays 100%.				
Self +1 or Self & Family (The total maximum may be met collectively)	You accumulate \$18,900 of covered out-of-pocket expenses. Then the plan pays 100%.				
Physician Visits					
Physician visits are deductible-free. Your office visit benefit pays 100% after your copay.		Network			
Primary Care Medical Office Visit / Office Consultation (Includes Specialist Virtual Visits & Outpatient Mental Health & Substance Abuse)		You pay a \$20 copayment per visit, not subject to the deductible			
Specialist Care Medical Office Visit / Office Consultation		You pay a \$40 copayment per visit not subject to the deductible			
Urgent Care Center Visits		You pay a \$40 copayment per visit not subject to the deductible			
Telemedicine Service and Virtual Visit Originating Site – 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.		Once you pay either your Silver or Platinum deductible, you pay \$0.			
Preventive Care Services					
Preventive Care Services in the Highmark Preventive Schedule are deductible-free. Your benefit pays 100%.		Network			
Routine Adult					
Physical exams		You Pay \$0 Plan pays 100%, No Deductible			
Adult immunizations		You Pay \$0 Plan pays 100%, No Deductible			
Colorectal cancer screening		You Pay \$0 Plan pays 100%, No Deductible			
Routine gynecological exams, including Pap Test		You Pay \$0 Plan pays 100%, No Deductible			
Mammograms, annual routine and medically necessary		Routine: Plan pays 100%, No Deductible Medically Necessary: 100% after Deductible			
Diagnostic services and procedures related to preventive care		You Pay \$0 Plan pays 100%, No Deductible			
Routine Pediatric					
Physical exams		You Pay \$0 Plan pays 100%, No Deductible			
Pediatric immunizations		You Pay \$0 Plan pays 100%, No Deductible			
Diagnostic services and procedures related to preventive care		You Pay \$0 Plan pays 100%, No Deductible			
See the Highmark Preventive Schedule for details including guidelines, age limitations, frequencies, and references. The Women's Health Prevention Schedule may apply.					
Prescription Drugs					
Prescription benefits are deductible-free. The pharmacy benefit pays 100% after your prescription copayment or coinsurance. National Select Formulary- Under the Highmark Hard Mandatory Generic Provision, you are responsible for the payment differential when a generic drug is available and you or your doctor specifies 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.	Network				
	Retail (34/60/90-day supply)		Mail Order (90-day maintenance supply)		
	Plan pays 100% after your copayment. Not subject to Deductible.				
Tier 1: Formulary Generic Drugs	Tier 1 – You pay \$3/\$6/\$9		Tier 1 – You pay \$9		
Tier 2: Formulary Brand Drugs	Tier 2 – You pay \$10/\$20/\$30		Tier 2 – You pay \$30		
Tier 3: Formulary Specialty Drugs, Non-Formulary Generic Drugs, Non-Formulary Brand Drugs	Tier 3 – You pay \$175/\$350/\$525		Tier 3 – You pay \$175		
Tier 4: Non-Formulary Specialty Drugs	Tier 4 – 25% coinsurance, up to \$350 Max		Tier 4 – 25% coinsurance, up to \$350 max		
Diabetic Supplies and Insulin ONLY	You pay \$0. Plan pays 100%		You pay \$0. Plan pays 100%		
Additional Preventive Prescription Benefits (Retail or Mail Order). Guidelines are determined by certain Governmental Agencies. You may access this information at www.healthcare.gov . Services are limited to those listed on the Highmark WV Preventive Schedule . Women's Health Preventive Schedule may apply. You may also contact Highmark Member Services or Envy Benefits .					
The following medical services on the next pages require you to pay your Silver or Platinum Deductible before the deductible assistance benefit pays the remainder of the Major Medical Deductible. The plan pays 100% after the full Major Medical Deductible is met.					

Outpatient Services	
	Network
Diagnostic, X-ray, Lab and Testing not related to Highmark Preventive Schedule.	Once you pay either your Silver or Platinum deductible, you pay \$0.
Allergy Testing and Treatment	Once you pay either your Silver or Platinum deductible, you pay \$0.
Speech Therapy (Rehabilitative and Habilitative) when necessary due to a medical condition.	Once you pay either your Silver or Platinum deductible, you pay \$0.
Physical Therapy (Rehabilitative and Habilitative Combined) Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per event for chronic pain Limitations are for Physician & Outpatient Facility Rehabilitative and Habilitative, combined.	Once you pay either your Silver or Platinum deductible, you pay \$0. Primary Care office Visit Cost-Sharing will apply for chronic pain.
Spinal Manipulations Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per event for chronic pain Limitations are for Network and Non-Network	Once you pay either your Silver or Platinum deductible, you pay \$0. Primary Care office Visit Cost-Sharing will apply for chronic pain.
Occupational Therapy (Rehabilitative and Habilitative Combined) Limit: 30 visits per benefit period for other than chronic pain Limit: 30 visits per event for chronic pain Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.	Once you pay either your Silver or Platinum deductible, you pay \$0. Primary Care office Visit Cost-Sharing will apply for chronic pain.
Autism Spectrum Disorder, Diagnosis and Treatment Covered Services will be paid according to the benefit category (e.g. Speech Therapy, Office Visit, etc.) Coverage for eligible members to age 18.	Once you pay either your Silver or Platinum deductible, you pay \$0.
Temporomandibular Joint Dysfunction / Craniomandibular Disorders	Once you pay either your Silver or Platinum deductible, you pay \$0.
Respiratory Therapy	Once you pay either your Silver or Platinum deductible, you pay \$0.
Dialysis	Once you pay either your Silver or Platinum deductible, you pay \$0.
Chemotherapy	Once you pay either your Silver or Platinum deductible, you pay \$0.
Radiation Therapy	Once you pay either your Silver or Platinum deductible, you pay \$0.
Infusion Therapy	Once you pay either your Silver or Platinum deductible, you pay \$0.
Skilled Nursing Facility Medical	Once you pay either your Silver or Platinum deductible, you pay \$0.
Surgery, Assistant to Surgery, Anesthesia	Once you pay either your Silver or Platinum deductible, you pay \$0.
Pre-Admission Testing	Once you pay either your Silver or Platinum deductible, you pay \$0.
Second Surgical Opinion Consultations (Outpatient)	Plan Pays 100% No Deductible
Behavioral Health Services	
	Network
Outpatient Mental Health Services	You pay a \$20 copayment per visit not subject to the deductible
Outpatient Substance Abuse Care Services	You pay a \$20 copayment per visit not subject to the deductible
Inpatient Mental Health Care Services	Once you pay either your Silver or Platinum deductible, you pay \$0.
Inpatient Substance Abuse Care Services	Once you pay either your Silver or Platinum deductible, you pay \$0.
In-Patient Hospital Care	
	Network
Unlimited Days Semi-Private Room and Board	Once you pay either your Silver or Platinum deductible, you pay \$0.
Ancillaries, Drugs, Therapy Services, X-ray and Lab	Once you pay either your Silver or Platinum deductible, you pay \$0.
General Nursing Care	Once you pay either your Silver or Platinum deductible, you pay \$0.
Surgical Services	Once you pay either your Silver or Platinum deductible, you pay \$0.
Birthing Center Care / Maternity Services - Dependent daughters are covered.	Once you pay either your Silver or Platinum deductible, you pay \$0.
Emergency Room Services	
	Network
Emergency Accident Care and /or Emergency Medical Care provided in the ER	You pay either your Silver or Platinum deductible and pay a \$250 ER Co-Pay. (Co-Pay waived if admitted)
Emergency Ambulance	100%, No Deductible
Non-Emergency Medical Care provided in the ER	You pay either your Silver or Platinum deductible and pay a \$250 ER Co-Pay. (Co-Pay waived if admitted)
Non-Emergency Ambulance Services	You pay either your Silver or Platinum deductible, and you pay a \$100 Co-Pay per day
Other Covered Services	
	Network
Private Duty Nursing – Maximum 35 visits per Benefit Period - Maximums are Network and Non-Network combined.	Once you pay either your Silver or Platinum deductible, you pay \$0.
Skilled Nursing Facility	Once you pay either your Silver or Platinum deductible, you pay \$0.
Durable Medical Equipment and Oxygen at home	Once you pay either your Silver or Platinum deductible, you pay \$0.
Orthotic Devices and Prosthetic Appliances	Once you pay either your Silver or Platinum deductible, you pay \$0.
Home Health Care – Maximum 100 Visits per Benefit Period - Maximums are Network and Non-Network combined.	Once you pay either your Silver or Platinum deductible, you pay \$0.
Hospice Care	Once you pay either your Silver or Platinum deductible, you pay \$0.
Diabetes Education and Control	Once you pay either your Silver or Platinum deductible, you pay \$0.

Human Organ Transplant / Bone Marrow Procedures	
Human Organ Transplant - Includes transportation, meals and lodging	Once you pay either your Silver or Platinum deductible, you pay \$0.
Bone Marrow Procedures - Includes transportation, meals and lodging	Once you pay either your Silver or Platinum deductible, you pay \$0.
Eligible Dependent Age Limitation	
Coverage stops at the end of the month of the 26 th birthday for an adult Dependent who qualifies as an Eligible Dependent.	

This informational presentation is a summary of the benefits. The full details, including limitations and exclusions, are contained in the Policy Plan Documents (PPDs) of the Diocese of Wheeling-Charleston. The PPDs control the benefits in the event that there is a difference between this presentation and the PPDs.

Deductible Accumulation – Self Only

Silver Deductible Assistance Plan

\$7,400 Highmark Deductible

\$3,000 Your Portion of Deductible

\$4,400 Silver Deductible Assistance (SDA)

Example is only for services that apply to the Highmark deductible.

You meet
\$3,000

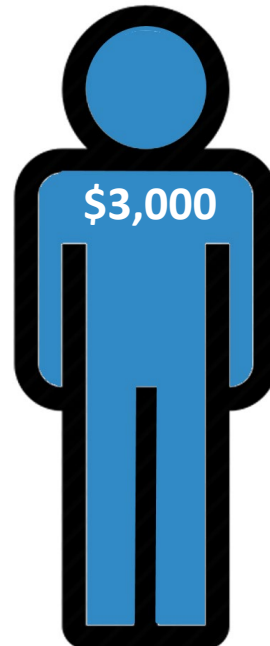


Next \$4,400
paid by SDA



After \$7,400,
Highmark
pays 100%

Your \$3,000 + SDA \$4,400 = \$7,400 met



Deductible Accumulation – Self & 1

Silver Deductible Assistance Plan

\$14,800 Highmark Deductible

\$ 6,000 Your Portion of Deductible

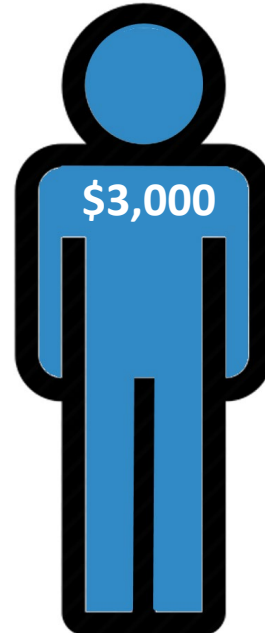
\$ 8,800 Silver Deductible Assistance (SDA)

Example is only for services that apply to the Highmark deductible.

1 person
meets \$3,000

Next \$4,400
paid by SDA

After \$7,400,
Highmark
pays 100%

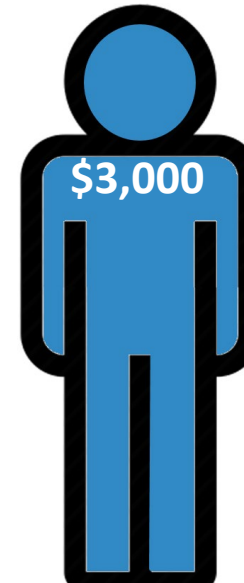


Person 1 - \$3,000 +
SDA \$4,400
= \$7,400

When the
other person
reaches \$3,000

Next \$4,400
paid by SDA

After a separate
\$7,400, Highmark
pays 100%



Person 2 - \$3,000 +
SDA \$4,400
= \$7,400

\$14,800 Deductible Met

Deductible Accumulation – Self & Family

Silver Deductible Assistance Plan

\$14,800 Highmark Deductible

\$ 6,000 Your Portion of Deductible

\$ 8,800 Silver Deductible Assistance (SDA)

Example is only for services that apply to the Highmark deductible.

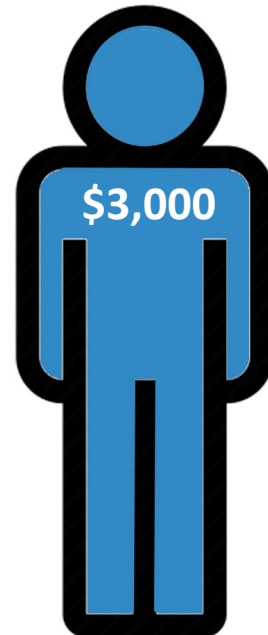
1 person
meets \$3,000



Next \$4,400
paid by SDA



After \$7,400,
Highmark
pays 100%



Person 1 - \$3,000 +
SDA \$4,400
= \$7,400

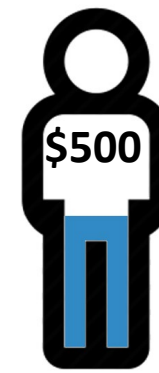
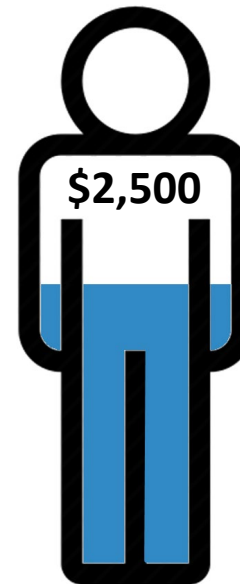
When 1 or the total of
the rest of the family
reaches \$3,000



Next \$4,400
paid by SDA



After a separate
\$7,400, Highmark
pay 100%



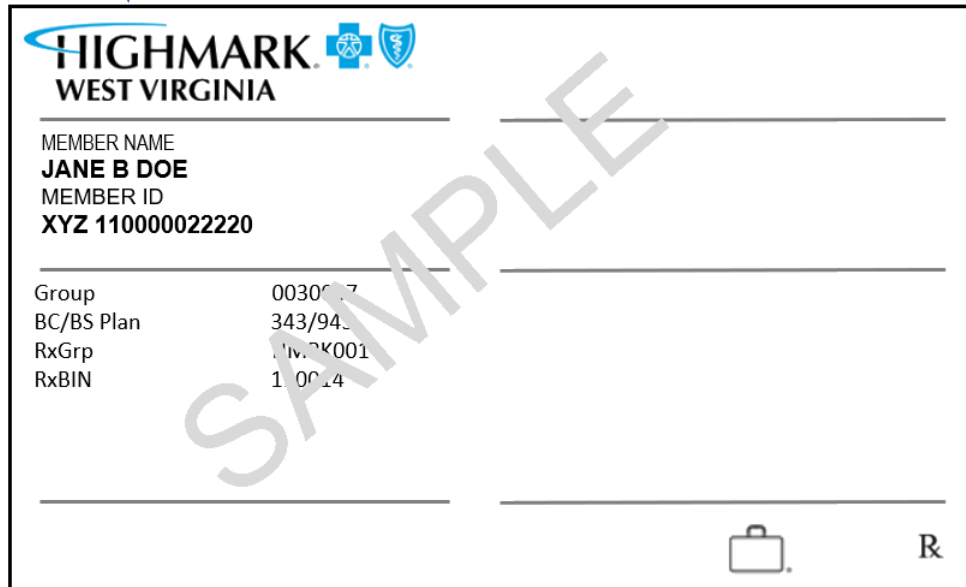
Rest of Family \$3,000 +
SDA \$4,400
= \$7,400


\$14,800 Deductible Met

How Your Two Plans Work

- Show both cards to doctors, hospitals, and other providers every time you have services.
- There is no coordination between Highmark BCBS and OptiMed. Use the separate customer service numbers on the back of each card.
- Prescription benefits are only available using your Highmark BCBS card.

↓ Your Health Plan Insurance Card




HIGHMARK 
WEST VIRGINIA

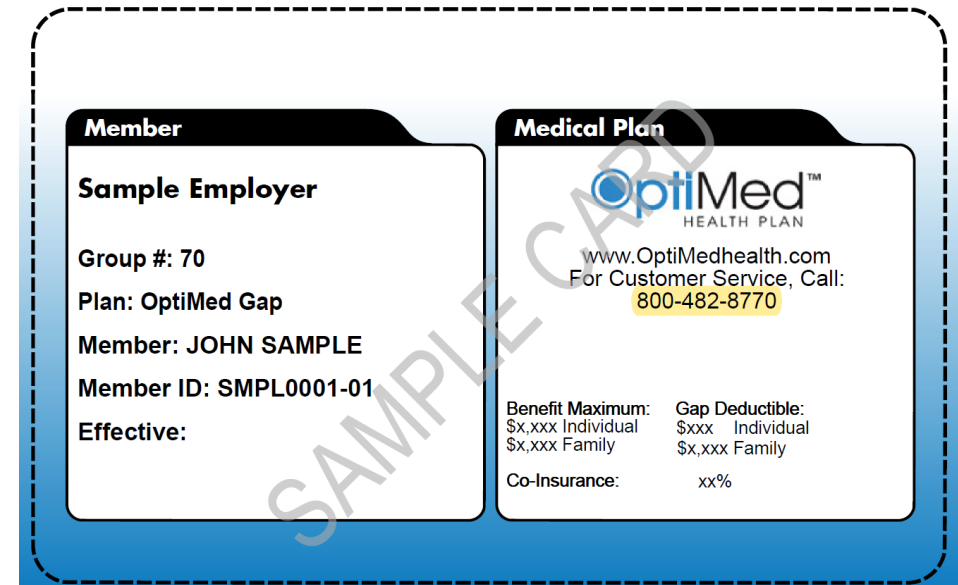
MEMBER NAME
JANE B DOE

MEMBER ID
XYZ 110000022220

Group 003007
BC/BS Plan 343/943
RxGrp 11000001
RxBIN 110014

 R

Your Deductible Assistance Card



Member

Sample Employer

Group #: 70


Plan: OptiMed Gap

Member: JOHN SAMPLE

Member ID: SMPL0001-01

Effective:

Medical Plan


HEALTH PLAN

www.OptiMedhealth.com
For Customer Service, Call:
800-482-8770

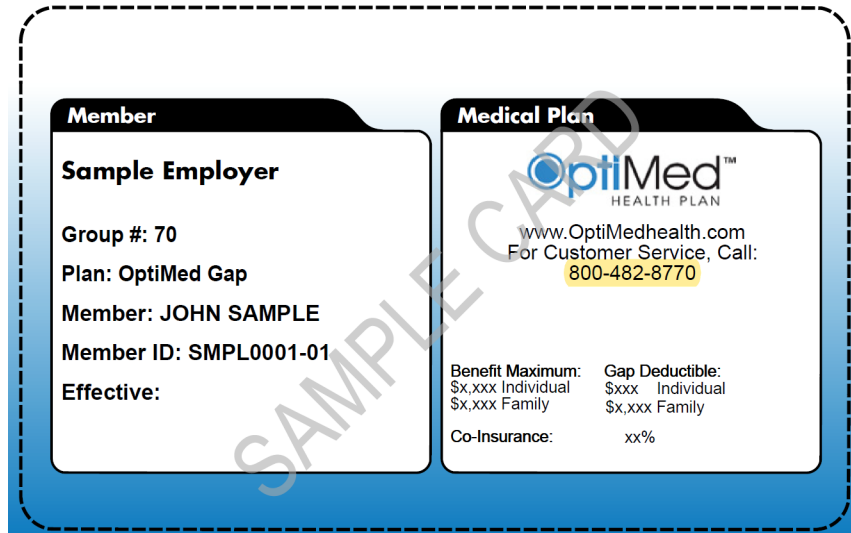
Benefit Maximum: \$x,xxx Individual
\$x,xxx Family

Gap Deductible: \$xxx Individual
\$x,xxx Family

Co-Insurance: xx%

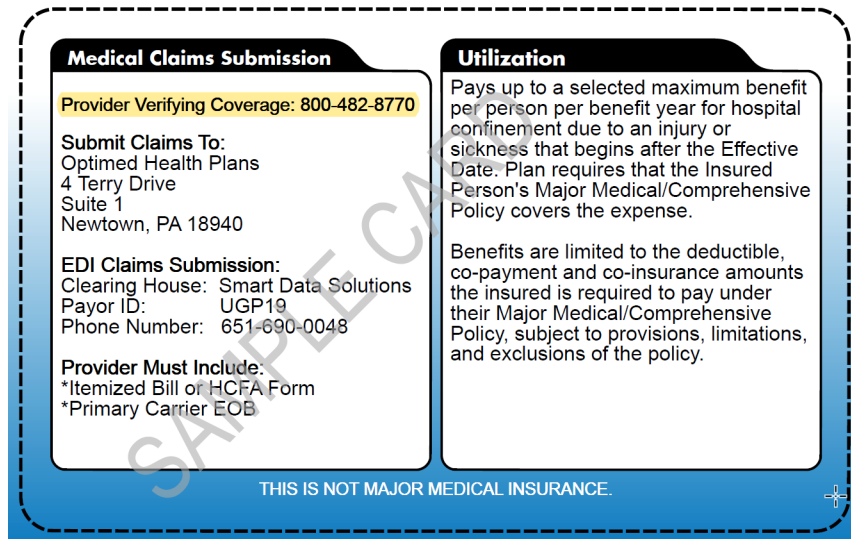
How Your Two Plans Work With Providers

Your Deductible Assistance Card – FRONT & BACK



The front of the card is divided into two main sections: 'Member' and 'Medical Plan'. The 'Member' section on the left contains the following information: Sample Employer, Group #: 70, Plan: OptiMed Gap, Member: JOHN SAMPLE, Member ID: SMPL0001-01, and Effective: (blank). The 'Medical Plan' section on the right features the OptiMed Health Plan logo, the website www.OptiMedhealth.com, and the customer service number 800-482-8770. Below this, it lists the Benefit Maximum and Gap Deductible for both Individual and Family plans, as well as the Co-Insurance rate of xx%.

Member		Medical Plan	
Sample Employer		OptiMedTM HEALTH PLAN	
Group #: 70		www.OptiMedhealth.com	
Plan: OptiMed Gap		For Customer Service, Call:	
Member: JOHN SAMPLE		800-482-8770	
Member ID: SMPL0001-01			
Effective:			
		Benefit Maximum:	Gap Deductible:
		\$x,xxx Individual	\$xxx Individual
		\$x,xxx Family	\$x,xxx Family
		Co-Insurance:	xx%



The back of the card is divided into two main sections: 'Medical Claims Submission' and 'Utilization'. The 'Medical Claims Submission' section on the left provides instructions on where to submit claims (Optimed Health Plans, 4 Terry Drive, Suite 1, Newtown, PA 18940) and how to submit EDI claims (Clearing House: Smart Data Solutions, Payor ID: UGP19, Phone Number: 651-690-0048). It also lists what the provider must include: an Itemized Bill or HCFA Form and a Primary Carrier EOB. The 'Utilization' section on the right explains that the plan pays up to a selected maximum benefit per person per benefit year for hospital confinement due to an injury or sickness that begins after the Effective Date. It also states that benefits are limited to the deductible, co-payment and co-insurance amounts the insured is required to pay under their Major Medical/Comprehensive Policy, subject to provisions, limitations, and exclusions of the policy. At the bottom, a disclaimer states: 'THIS IS NOT MAJOR MEDICAL INSURANCE.'

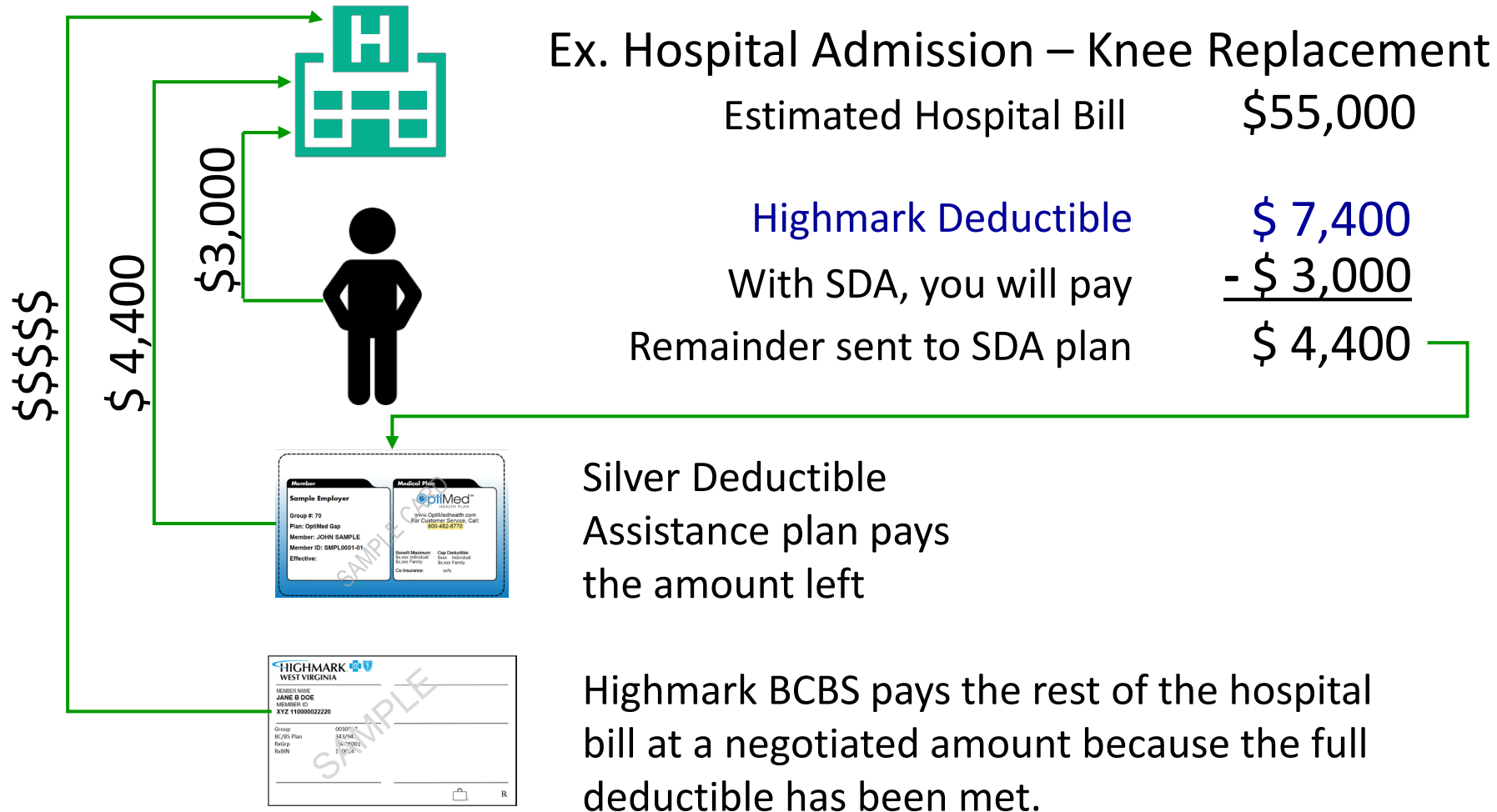
Medical Claims Submission		Utilization	
Provider Verifying Coverage: 800-482-8770		Pays up to a selected maximum benefit per person per benefit year for hospital confinement due to an injury or sickness that begins after the Effective Date. Plan requires that the Insured Person's Major Medical/Comprehensive Policy covers the expense.	
Submit Claims To: Optimed Health Plans 4 Terry Drive Suite 1 Newtown, PA 18940		Benefits are limited to the deductible, co-payment and co-insurance amounts the insured is required to pay under their Major Medical/Comprehensive Policy, subject to provisions, limitations, and exclusions of the policy.	
EDI Claims Submission: Clearing House: Smart Data Solutions Payor ID: UGP19 Phone Number: 651-690-0048			
Provider Must Include: *Itemized Bill or HCFA Form *Primary Carrier EOB			

THIS IS NOT MAJOR MEDICAL INSURANCE.

- Providers may be new to the Deductible Assistance Plan.
- A provider assistance number is on both sides of the OptiMed card.
- Asks the provider to call OptiMed at the number on the card for explanation of benefits and how to file a claim.

How Your Two Plans Work – Real Example

Illustration: Self Only Silver Deductible Assistance (SDA) and Highmark Plan.



OptiMed

Frequently asked Questions

Diocese of Wheeling-Charleston Silver Deductible Assistance (SDA)

Health Insurance and Deductible Assistance Frequently Asked Questions on the Back

Your health insurance plan with Highmark has the following major benefits:
In-Network Only

Blue Card PPO Network:	Blue Cross/Blue Shield National Network	
Deductible (In-Network):	\$7,400 Individual	\$14,800 Family
Coinsurance (In-Network):	None	
Max Out Of Pocket (In-Network):	\$9,450 Individual	\$18,900 Family
PCP/Specialist Copay:	\$20/\$40	
Rx Copay 30/60/90-Day Supply:	Generic Formulary \$3/\$6/\$9 Brand Formulary \$10/\$20/\$30 Specialty Formulary \$175/\$350/\$525 Non-Formulary Specialty 25% to \$350 Maximum	

Silver Deductible Assistance (SDA) Benefit - Terms and Definitions:

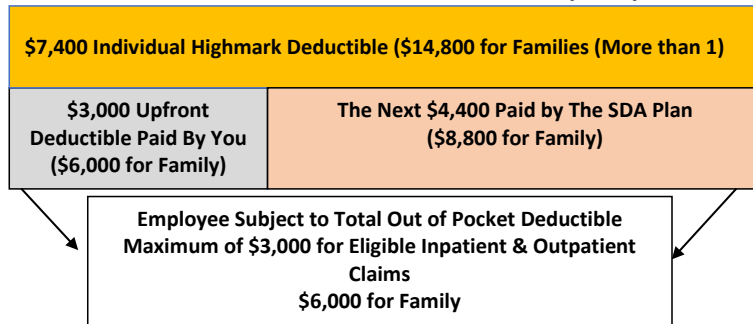
Upfront SDA Deductible: This is what you pay towards your Highmark deductible:
\$3,000 Individual \$6,000 Family (More than 1)

SDA Benefit: This is what OptiMed pays after you pay your upfront deductible:
\$4,400 Individual \$8,800 Family (More than 1)

How the Silver Deductible Assistance policy works with your Health Insurance

You will have an upfront SDA deductible of \$3,000 for an individual or \$6,000 for family for all eligible in-network inpatient and outpatient services with your SDA benefit. ***This upfront SDA deductible is applied to your Highmark major medical deductible. It is NOT in addition to your Highmark deductible.*** After you satisfy your upfront SDA deductible, the SDA benefit will pay the next \$4,400 for individual or \$8,800 for family of eligible in-network deductible eligible claims. ***The SDA plan does not pay for office visit copays or retail/mail-order prescription copays.***

With the Silver Deductible Assistance (SDA) Plan



Frequently Asked Questions

Q. I have a Highmark card and an OptiMed card. How do I use them?

A. Present both cards at the doctor's office or hospital. Your Highmark card is your major medical insurance and your OptiMed card is a secondary payor. Inform the person at the desk your OptiMed card is a supplemental benefit plan that will pay them directly if they file the claim with OptiMed along with Highmark. There is a number on the back of the OptiMed card the staff can call for instructions if needed.

Q. What if the provider's office refuses to file the claim?

A. First ask the person to call the number on the back of the OptiMed card. If they refuse, contact Envoy Benefits at 877-289-7010 let us know the name of the provider and their telephone number. Once you receive your EOB (Explanation of Benefits) from Highmark contact Envoy Benefits and we will submit the claim and EOB on your behalf. You can download your EOB from the member portal site at www.myhighmark.com. To register on the member portal, use the link provided or contact Highmark customer service on the back of your ID card. Payment will be made directly to you and not the provider. It is then your responsibility to pay the provider.

Q. You said the SDA does not cover office visits. Why do I need to present it at the doctor's office?

A. In some cases your provider may perform a procedure in the office that is billed as a diagnostic or outpatient procedure which may be subject to your deductible. In those instances, the procedure(s) would be covered up to your SDA benefit limit once you meet your upfront SDA deductible.

Q. How do Highmark and OptiMed work together to pay my claim?

A. Highmark and Optimed do not coordinate or pass any information to one another. Envoy Benefits acts as the coordinator between the two plans.

Q. How do I know if I've met my upfront SDA deductible?

A. On the back of the last page of your Explanation of Benefits (EOB) is a section titled "Patient Benefit Summary". There will be a line indicating how much you have satisfied toward your Highmark in-network deductible of \$7,400. If that number is less than \$3,000 (\$6,000 for family) you have not met your SDA upfront deductible. You can also call Highmark customer service and they will tell you how much of your Highmark major medical deductible has been satisfied.

Q. How do office visits and prescription copays affect my deductible?

A. Your office visit and prescriptions are not part of your deductible and not applied toward your deductible. Office visit copays and prescription copays are only applied to your Out-of-Pocket Maximum and not paid by your SDA benefit.

To Upload EOBs
www.envoyftp.com

For Assistance or Questions with Claims Contact Envoy Benefits at
877-289-7010
Or Email
claims@envoybenefits.com

Diocese of Wheeling-Charleston Platinum Deductible Assistance (PDA)

Health Insurance and Deductible Assistance Frequently Asked Questions on the Back

Your health insurance plan with Highmark has the following major benefits:
In-Network Only

Blue Card PPO Network:	Blue Cross/Blue Shield National Network	
Deductible (In-Network):	\$7,400 Individual	\$14,800 Family
Coinsurance (In-Network):	None	
Max Out Of Pocket (In-Network):	\$9,450 Individual	\$18,900 Family
PCP/Specialist Copay:	\$20/\$40	
Rx Copay 30/60/90-Day Supply:	Generic Formulary \$3/\$6/\$9 Brand Formulary \$10/\$20/\$30 Specialty Formulary \$175/\$350/\$525 Non-Formulary Specialty 25% to \$350 Maximum	

Platinum Deductible Assistance (PDA) Benefit - Terms and Definitions:

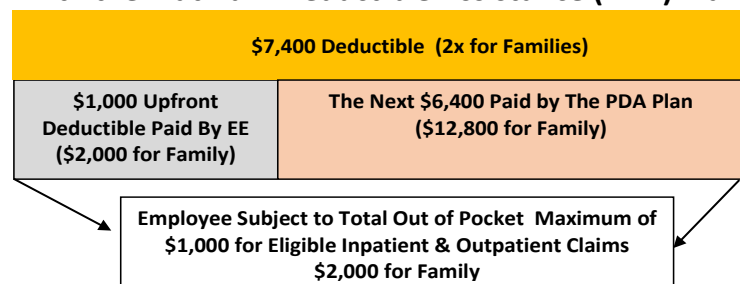
Upfront PDA Deductible: This is what you pay towards your Highmark deductible:
\$1,000 Individual \$2,000 Family (More than 1)

PDA Benefit: This is what OptiMed pays after you pay your upfront deductible:
\$6,400 Individual \$12,800 Family (More than 1)

How the Platinum Deductible Assistance policy works with your Health Insurance

You will have an upfront PDA deductible of \$1,000 for an individual or \$2,000 for family for all eligible in-network inpatient and outpatient services with your PDA benefit. ***This upfront PDA deductible is applied to your Highmark major medical deductible. It is NOT in addition to your Highmark deductible.*** After you satisfy your upfront PDA deductible, the PDA benefit will pay the next \$6,400 for individual or \$12,800 for family of eligible in-network deductible eligible claims. **The PDA plan does not pay for office visit copays or retail/mail-order prescription copays.**

With the Platinum Deductible Assistance (PDA) Plan



Frequently Asked Questions

Q. I have a Highmark card and an OptiMed card. How do I use them?

A. Present both cards at the doctor's office or hospital. Your Highmark card is your major medical insurance and your OptiMed card is a secondary payor. Inform the person at the desk your OptiMed card is a supplemental benefit plan that will pay them directly if they file the claim with OptiMed along with Highmark. There is a number on the back of the OptiMed card the staff can call for instructions if needed.

Q. What if the provider's office refuses to file the claim?

A. First ask the person to call the number on the back of the OptiMed card. If they refuse, contact Envoy Benefits at 877-289-7010 let us know the name of the provider and their telephone number. Once you receive your EOB (Explanation of Benefits) from Highmark contact Envoy Benefits and we will submit the claim and EOB on your behalf. You can download your EOB from the member portal site at www.myhighmark.com. To register on the member portal, use the link provided. ***The recommended method is contact Highmark customer service on the back of your ID card and request your EOBs.*** Payment will be made directly to you and not the provider. It is then your responsibility to pay the provider.

Q. You said the PDA does not cover office visits. Why do I need to present it at the doctor's office?

A. In some cases your provider may perform a procedure in the office that is billed as a diagnostic or outpatient procedure which may be subject to your deductible. In those instances, the procedure(s) would be covered up to your PDA benefit limit once you meet your upfront PDA deductible.

Q. How do Highmark and OptiMed work together to pay my claim?

A. Highmark and Optimed do not coordinate or pass any information to one another. Envoy Benefits acts as the coordinator between the two plans.

Q. How do I know if I've met my upfront PDA deductible?

A. On the back of the last page of your Explanation of Benefits (EOB) is a section titled "Patient Benefit Summary". There will be a line indicating how much you have satisfied toward your Highmark in-network deductible of \$7,400. If that number is less than \$1,000 (\$2,000 for family) you have not met your PDA upfront deductible. You can also call Highmark customer service and they will tell you how much of your Highmark major medical deductible has been satisfied.

Q. How do office visits and prescription copays affect my deductible?

A. Your office visit and prescriptions are not part of your deductible and not applied toward your deductible. Office visit copays and prescription copays are only applied to your Out-of-Pocket Maximum and not paid by your PDA benefit.

To Upload EOBs
www.envoyftp.com

**For Assistance or Questions with Claims Contact Envoy Benefits at 877-289-7010
Or Email
claims@envoybenefits.com**

When you become a member with OptiMed Health you will instantly have tools available to keep track of your benefits, as well as service your needs. Our member portal gives you the support and freedom to access your benefits 24/7.



First time portal users will need to register for our portal using links provided on our website.

Returning users can login using links available on our website.

Website: <https://www.optimedhealth.com/login/>

Member and Provider Login

Need Help with our Portal....

Contact our Customer Care team, and we can help with navigation or questions about your member portal.

customer care@optimedhealth.com

1-800-482-8770

Call-in Hours Available: Monday-Friday 8:00 AM- 5:00 PM (EST)



What can member's do on the portal?

- Support links to contact us, or talk with customer service representatives
- Links for easy claim submission
- View Processed Claims that have been Submitted
 - The claims data will be available for previous years, as well as current year
- View deductible information, current year utilization of the plans, and limits of coverage
- View plan eligibility and when your coverage began
- Print a Temporary ID card, or request a new ID card to be mailed
- Access plan documents, claim forms, benefit information, and a copy of the policy.
- Update member information within the profile

OptiMed PATIENT ADVOCACY PROGRAM

Contact OptiMed If:

- A claim is denied because necessary documents were not received.
- A claim was not received, and the medical provider is billing you

An OptiMed Customer Service Agent will contact the provider and request the missing or updated information on your behalf.

Customer Service Line: 1-800-482-8770

E-Mail Address: customer care@optimedhealth.com

OptiMed Filing Process

Provider files the claim directly to OptiMed (best scenario)

Provider does not file the claim you can:

Once you receive your EOB(s) file the EOB(s) through the OptiMed portal – payment is made directly to you by OptiMed.

Set-Up Your OptiMed Account at

<https://www.optimedhealth.com/login>

OptiMed Customer Service can provide assistance setting up your account and navigating the portal if needed.

1-800-482-8770

OptiMed Filing Process

Submit your EOB(s) to Envoy Benefits and we will file the claim on your behalf— payment is made directly to you by OptiMed.

Your EOB(s) are mandatory to file your claim.
Provider bills alone are not sufficient but can be included with your EOB(s)

www.envoyftp.com (secure portal)

claims@envoybenefits.com

Fax: 1-827-340-0290

Questions: 1-877-289-7010

Explanation of Benefits

EOBs



DUPLICATE

SEPTEMBER 16, 2023

Page 1 of 6

Explanation of Benefits

Need Help? Call 1-888-809-9121

THIS IS NOT A BILL

Contract Holder Name:	
Member ID:	
Patient Account Number:	
Group Name:	DIOCESE OF WHEELING CHARLESTON OPTION PL
Group ID:	105464-099
Claim Activity For:	
Claim Number:	2 6

EXPLANATION AT A GLANCE	
Date of Service:	08/25/23
We Sent Payment To:	WHEELING HOSPITAL INC A Network Facility
Claim Payment Amount:	\$ 55.99
Provider May Bill You (If Not Already Paid):	\$ 350.00

Provider Date of Service Type of Service Service Code (Number of Services)	Provider's Charge	Non-Billable To Member	Member Responsibility			Amount You Owe Provider (Total of Shaded Columns)	See Remarks
			Non Covered Charges	Plan Allowance (Covered Charges)	Health Plan Pays		
WHEELING HOSPITAL INC 08/25/23 LABORATORY SERVICE 301 (1)	76.00	0.00	76.00	0.00	0.00	76.00	U5006
WHEELING HOSPITAL INC 08/25/23 LABORATORY SERVICE 301 (1)	121.00	65.01 J4047	0.00	55.99	55.99	0.00	
WHEELING HOSPITAL INC 08/25/23 LABORATORY SERVICE 301 (1)	105.00	0.00	105.00	0.00	0.00	105.00	U5006
WHEELING HOSPITAL INC 08/25/23 LABORATORY SERVICE 301 (1)	169.00	0.00	169.00	0.00	0.00	169.00	U5006
TOTALS	471.00	65.01	350.00	55.99	55.99	350.00	



DUPLICATE

SEPTEMBER 16, 2023

Page 2 of 6

Need Help? Call 1-888-809-9121

Claim Activity For:	
Claim Number: 2	6
Patient Account Number:	

EXPLANATION AT A GLANCE	
Date of Service:	08/23/23
Provider:	WHEELING HOSPITAL INC
	A Network Facility
Provider May Bill You (If Not Already Paid):	\$ 0.01

Member Responsibility					
Provider Date of Service Type of Service Service Code (Number of Services)	Provider's Charge	Non-Billable To Member	Plan Allowance (Covered Charges)	Your Deductible	Amount You Owe Provider (Total of Shaded Columns)
WHEELING HOSPITAL INC	112.00	111.99	0.01	0.01	0.01
08/23/23		J4047		X5018	
CLINIC SERVICE					
510 (1)					
TOTALS	112.00	111.99	0.01	0.01	0.01

Explanation of Remark Codes	
J4047	- This is the difference between the provider's charge and our allowance. Since the provider is in-network, you are not responsible for this amount.
U5006	- The patient's coverage does not provide for diagnostic services for routine conditions, or for screening services for non-routine conditions. Therefore, no payment can be made. If your provider submitted this claim, they will receive a separate notification with this information.
X5018	- The allowance for this service has been applied to the dollar deductible amount required under the patient's coverage.
We provide administrative claims payment services only and do not assume any financial risk or obligation regarding claims.	

PATIENT BENEFIT SUMMARY	
Patient:	Group Number: 105464-099
Benefit Period: 01/01/23 - 12/31/23	
\$234.35 has been applied to your \$8,150.00 individual in network total maximum out-of-pocket amount.	
You have satisfied \$98.01 of your \$7,400.00 individual in network deductible.	



DUPLICATE

Need Help? Call 1-888-809-9121

PATIENT BENEFIT SUMMARY (Continued)

Please refer to your benefit booklet or agreement for further information. Amount(s) shown may include totals from claims which are still being processed and for which you have not been notified.

PROGRAM BENEFIT SUMMARY

Benefit Period: 01/01/23 - 12/31/23

Group Number: 105464-099

\$257.81 has been applied to your \$16,300.00 program in network total maximum out-of-pocket amount.

You have satisfied \$121.47 of your \$14,800.00 program in network deductible.

Please refer to your benefit booklet or agreement for further information. Amount(s) shown may include totals from claims which are still being processed and for which you have not been notified.

Visit Our Website

"VISIT US AT OUR WEBSITE: www.highmarkbcbswv.com"

Things To Remember

- You will always receive the full deductible assistance benefit for eligible claims.
- In most cases, the provider will submit the claim to the deductible assistance plan administrator, OptiMed.
- If you file the claim or Envoy Benefits files a claim, you will be reimbursed directly by OptiMed.
- Envoy Benefits Solutions will always be there to help you receive the full deductible assistance for eligible claims.



DMCESE OF WHEELING-CHARLESTON

Drug Financial Assistance Form

This form is used by Envoy Benefits Solutions to research any available financial assistance or cost reduction associated with your drug(s) by the manufacturer. There is no implied guarantee that your drug(s) will be eligible for financial assistance. Please provide the information below and email to info@envoybenefits.com or fax to 877-340-0290 ATTN: Specialty Drugs

Name: _____

Email Address: _____

Telephone Number: _____

Best Method of Contact (Circle): Email Phone Both

Drug 1: _____

Drug 2: _____

Drug 3: _____

Drug 4: _____

Drug 5: _____

Note (Optional):

Direct any questions to Envoy Benefits Solutions at 877-289-7010 or info@envoybenefits.com.

MetLife

Dental and Vision

MetLife Dental

MetLife Dental uses the MetLife PDP Plus National Network

ID Cards are not required just your Social Security number

You can download the MetLife app from the Apple and Goggle App Stores

MetLife Vision

MetLife Dental uses the VSP Signature National Network

ID Cards are not required just your Social Security number

You can download the MetLife app from the Apple and Goggle App Stores



Dental and Vision Benefits are provided through MetLife.

With MetLife, there is no need for ID cards for dental and vision services! Simply tell your doctor you are with MetLife and provide your social security number.

Your Dental Benefits Summary – PDP Plus Network

	In-Network	Out-of-Network
Deductible – Type B & C Services Only		
Individual	\$50	\$50
Family	\$150	\$150
Annual Benefit Maximum		
Per Individual	\$1,250	\$1,250
Dependent Age	Eligible for benefits until the day he or she turns 26	
Coverage Type	In-Network What MetLife Pays	Out-of-Network What MetLife Pays
Type A - Preventive	100% of Negotiated Fee	100% of Reasonable and Customary Fee
Oral Exams	2 in a year	
Full Mouth X-Rays	1 in 5 years	
Bitewing X-Rays (Adult/Child)	1 in a year	
Prophylaxis – Cleanings	2 in a year	
Topical Fluoride	1 in 12 months - Children to age 13	
Type B - Basic Restorative	100% of Negotiated Fee	100% of Reasonable and Customary Fee
Sealants	1 in 60 months – Children to age 13	
Amalgam & Composite Fillings	1 in 24 months	
Repairs	1 in 12 months	
Periodontal Scaling & Root Planning	1 in 24 months per quadrant	
Periodontal Maintenance	2 in 1 year, includes cleanings	
Oral Surgery (Simple Extractions)		
Emergency Palliative Treatment		
Consultations	2 in 12 months	
Type C – Major Restorative	50% of Negotiated Fee	50% of Reasonable and Customary Fee
Space Maintainers	1 per lifetime per tooth area – Children up to age 18	
Crowns/Inlays/Overlays	1 per tooth in 84 months	
Prefabricated Crowns	1 in 84 months	
Endodontics Root Canal	1 per tooth per lifetime	
Periodontal Surgery	1 in 36 months	
Other Oral Surgery		
Bridges & Dentures	1 in 84 months	
General Anesthesia		
Implant Services	1 service per tooth in 84 months – 1 repair per 84 months	



Your Vision Benefits Summary – VSP Signature Network

	In-Network Coverage	Out-of-Network Reimbursement
Eye Exams	\$10 copay	\$45 Allowance
Retinal Imaging	Up to \$39	Applied to exam allowance
Materials/Eyewear Either Glasses or Contacts		
Single Vision	\$25 Copay	\$30 Allowance
Lined Bifocal	\$25 Copay	\$50 Allowance
Lined Trifocal	\$25 Copay	\$65 Allowance
Lenticular	\$25 Copay	\$100 Allowance
Standard Lens Enhancements		
Ultraviolet Coating	Covered in Full	Applied to allowance for the applicable corrective lens
Standard Polycarbonate (child to age 18)	Covered in Full	Applicable to allowance for the applicable corrective lens
Additional Lens Enhancements		
Progressive Standard	Up to \$55 Copay	\$50 Allowance
Progressive Premium/Custom	Premium: up to \$95-\$105 Copay Custom: Up to \$150-\$175 Copay	\$50 Allowance
Standard Polycarbonate (Adult)	Single Vision: Up to \$31 Copay Multifocal: Up to \$35 Copay	Applicable to allowance for the applicable corrective lens
Scratch-Resistant Coating	Up to \$17 - \$33 Copay	Applicable to allowance for the applicable corrective lens
Tints (Plastic Lenses)	Pink I & II: \$0 Copay Solid Plastic: \$15 Copay Plastic Gradient Dye: \$17 Copay	Applicable to allowance for the applicable corrective lens
Anti-Reflective Coating	Up to \$41-\$85 Copay	Applicable to allowance for the applicable corrective lens
Photochromic	Up to \$47-\$82 Copay	Applicable to allowance for the applicable corrective lens
Frame Allowance You will receive an additional 20% off any amount that you pay over your allowance. This offer is available from all participating locations except Costco, Walmart and Sam's Club	\$120 Allowance \$140 Allowance on featured frames	\$55 Allowance
Costco, Walmart & Sam's Club	\$64 Allowance	\$55 Allowance
Contact Lenses		
Elective	\$120 Allowance	\$105 Allowance
Necessary	Covered in full after eyewear copay	Applied to contact lens allowance

Flexible Spending Account (FSA)





Save money with FSA pretax benefit accounts.

A Flexible Spending Account (FSA) puts more money in your pocket by reducing your taxable income when you contribute pretax dollars to pay for common expenses like these:

HEALTHCARE

- Medical/dental office visit co-pays
- Dental/orthodontic care services
- Prescriptions, vaccinations, and OTC
- Eye exams; prescription glasses/lenses

DEPENDENT CARE

- Daycare expenses
- Before & after school care
- Nanny/nursery school
- Elder care

TIPS

- Determine your elections based on your estimated out-of-pocket expenses for the year
- Your employer may offer other types of Benefit Accounts too; ask for details
- For a complete list of eligible expenses, see IRS Publications 502 & 503 at [irs.gov](https://www.irs.gov)

Increase your take-home pay by reducing your taxable income.

Each \$1 you contribute to your FSA reduces your taxable income by \$1.

With less tax taken, your take-home pay increases!

Consider this example: (for illustration only)



Richard has:

- Gross monthly pay of \$3,500
- \$600 per month in eligible expenses

Here is his net monthly take-home pay:

Without FSA

(\$600 spent using post-tax dollars)

\$1,932

With FSA

(\$600 spent using pretax dollars)

\$2,098

That's a net increase in take-home pay of **\$166 every month!**

To estimate potential savings based on your income and expenses, use the Tax Savings Calculator at www.tasconline.com/tasc-calculators.

See how easy it is to start saving with a TASC Benefit Account. See details on reverse.



Save up to 30% on eligible expenses

Enroll in a TASC Flexible Spending Account (FSA) so you can use pretax dollars to pay for common, everyday expenses and reduce your taxable income.

Below is a partial list of reimbursable expenses that may be incurred by you, your spouse, or qualified dependents. NOTE: If you (or your spouse) enroll in an HSA Plan, you may only enroll in a Limited-Purpose Healthcare FSA (LPHSA). The eligible expenses under an LPHSA are limited to Dental and Vision expenses only.

Eligible Medical Expenses

- Acupuncture
- Artificial limbs
- Bandages & dressings
- Birth control, contraceptive devices
- Birthing classes/Lamaze (only the mother's portion, not the coach/spouse, and the class must be only for birthing instruction, not child rearing)
- Blood pressure monitor
- Chiropractic therapy/exams/adjustments
- Contact lens and contact lens solutions
- Co-payments
- Crutches (purchased or rented)
- Deductibles & co-insurance
- Diabetic care & supplies
- Feminine care products (tampons, pads, etc)
- Eye exams
- Eyeglasses, contacts, or safety glasses (prescription)
- First aid kits & supplies
- Hearing aids & hearing aid batteries
- Heating pad
- Incontinence supplies
- Infertility treatments
- Insulin
- Lactation expenses (breast pumps, etc.)
- Laser eye surgery; LASIK
- Legal sterilization
- Medical supplies to treat an injury or illness
- Mileage to and from doctor appointments
- Optometrist's or ophthalmologist's fees
- Orthopedic inserts
- Personal Protective Equipment (PPE; facial masks, hand sanitizer, sanitizing wipes)*

*PPE expenses must be used for the purpose of preventing the spread of coronavirus.

- Physical exams
- Physical therapy (as medical treatment)
- Physician's fee and hospital services
- Pregnancy tests
- Prescription drugs and medications
- Psychiatric care, psychotherapy (as medical treatment)
- Sales tax on eligible expenses
- Sleep apnea services/products (as prescribed)
- Smoking cessation programs & deterrents (gum, patch)
- Treatment for alcoholism or drug dependency
- Vaccinations & flu shots
- X-ray fees

Eligible OTC Medicines and Drugs

Over-the-counter (OTC) medicines and drugs are reimbursable via FSA, HRA, and HSA without a prescription or physician's note. Eligible OTC products include items that are primarily for a medical purpose, and are compliant with federal tax rules under IRS Code Section 213(d).

- Allergy, cough, cold, flu & sinus medications
- Anti-diarrheals, anti-gas medications & digestive aids
- Canker/cold sore relievers & lip care
- Foot care (corn/wart medication, antifungal treatments, etc.)
- Hemorrhoid creams & treatments
- Itch relief (calamine lotion, Cortizone cream, etc.)
- Oral care (denture cream, pain reliever, teething gel, etc.)
- Pain relievers (Tylenol, Advil, Bengay, etc.)
- Skin care (sunscreen w/SPF15+, acne medication, etc.)
- Sleep aids & stimulants (nasal strips, etc.)
- Stomach & nausea remedies (antacids, Dramamine, etc.)
- Wound Treatments/Washes (hydrogen peroxide, iodine)

Continued on next page...

Contact Resources

www.myhighmark.com – Online access to all you Highmark information including EOBs

Highmark Customer Service – 1-888-809-9121

<https://www.optimedhealth.com/login/> - Online member portal registration and login

OptiMed Patient Advocacy – 1-800-482-8770 email: customercare@optimedhealth.com

TASC – Customer Care 1-800-422-4661

Envoy Benefits Solutions – 1-877-289-7010 email: info@envoybenefits.com

Employee Resource Website – www.ebsdwc.com

Q & A

Envoy Benefits Solutions

1-877-289-7010

info@envoybenefits.com