# Super Blue Plus 2000[1]
# WVHTC – Option N4 (Non-Grandfathered)
# $500 Deductible

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| **Group Effective Date** | December 1, 2024 | | |
| **Benefit Period**[2] (used for Deductible and Coinsurance limits) | January 1 through December 31 (Calendar Year) | | |
| **Deductible** (Network and Non-Network Deductibles do not cross apply.)<br>**Note: All Services are subject to the Deductible unless otherwise specified.** | **NETWORK** | | **NON-NETWORK** |
| | **STANDARD** | **BLUE DISTINCTION CENTERS**[3] | |
| Individual | $500 | $0 | $1,000 |
| Family (may be met collectively) | $1,000 | $0 | $2,000 |
| **Carry-Over Deductible Period** | None | | |
| **Coinsurance Limit**: (Network and Non-Network Coinsurance dollars do not cross apply.) | **NETWORK** | | **NON-NETWORK** |
| | **STANDARD** | **BLUE DISTINCTION CENTERS**[3] | |
| Individual | $1,000 | $0 | $2,500 |
| Family (may be met collectively) | $2,000 | $0 | $5,000 |
| **Total Maximum Out-of-Pocket**[4] (Includes Deductible, Copays, and Coinsurance per Benefit Period, Network only) | **NETWORK** | | **NON-NETWORK** |
| Individual | $6,600 | | Not Applicable |
| Family (may be met collectively) | $13,200 | | Not Applicable |
| **Non-Network Liability** | UNLIMITED | | |
| **Lifetime Maximum Benefit for all Covered Services** | UNLIMITED | | |
| **BENEFIT HIGHLIGHTS** | | | |
| | **NETWORK** | | **NON-NETWORK** |
| **Primary Care Medical Office Visit / Office Consultation** - Applies to Charges for Visit only. Does not apply to other Services received during Visit. | BDTC [5]<br>$20 per Office Visit, 100% thereafter, No Deductible | Non-BDTC<br>$25 per Office Visit, 100% thereafter, No Deductible | $25 per Office Visit, 80% thereafter, No Deductible |
| **Specialist Care Medical Office Visit / Office Consultation** (Includes Specialist Virtual Visits). Applies to Charges for Visit only. Does not apply to other Services received during Visit. | $35 per Office Visit, 100% thereafter, No Deductible | | $35 per Office Visit, 80% thereafter, No Deductible |
| **Urgent Care Copay** Co-Pay applies to Charges for Visit only. Does not apply to other Services received during Visit. Co-Pays do not apply to Deductible or Coinsurance limits. | $50 per Office Visit, 100% thereafter, No Deductible | | $50 per Office Visit, 80% thereafter, No Deductible |
| | Copayment, if any, does not apply to Urgent Care Center Visits prescribed for the treatment of Mental Health and Substance Use Disorder | | |
| **Virtual Visit Originating Site** | 80% | | 60% |
| **Telemedicine**[6] | $10 per Visit, 100% thereafter, No Deductible | | Not Covered |

| PRESCRIPTION DRUGS[7] | | |
|---|---|---|
| **Prescription Drug Deductible**<br>Individual<br>Family | **NETWORK**<br>None<br>None | **NON-NETWORK**<br>No Benefits<br>No Benefits |
| **Prescription Drugs are provided through a Preferred Retail Pharmacy Network –** If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowance, in addition to your Coinsurance, unless the physician writes "brand necessary" (DAW) on the prescription, or if no generic equivalent exists. **Maximum 90 day Supply.**<br>**Note**: Prescription Deductibles, Copayments and/or Coinsurance amounts apply toward the Total Maximum Out-of-Pocket. | **Generic/Brand:** Member pays 30% or $20 Minimum Coinsurance, whichever is greater. No Deductible<br>Maximum out of pocket $100<br>**Specialty Drugs:** Member pays 30% Coinsurance, No Deductible<br>Maximum out of pocket $200<br>Cost-sharing for Prescription Insulin Drugs will not exceed $35 for a 30-day supply<br>Cost sharing for diabetic devices will not exceed $100 for a 30-day supply | No Benefits |
| **Additional Preventive Prescription Benefits[8]** Guidelines as determined by certain Governmental Agencies. You may access this information at www.healthcare.gov. You may also contact Member Services | 100%, No Deductible | No Benefits |
| **Mail Order Drugs -** If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowance, in addition to your Coinsurance, unless the physician writes "brand necessary" (DAW) on the prescription, or if no generic equivalent exists. Maximum **90 day supply.**<br>**Note**: Prescription Deductibles, Copayments and/or Coinsurance amounts apply toward the Total Maximum Out-of-Pocket | **Generic/Brand:** Member pays 30% or $20 Minimum Coinsurance, whichever is greater. No Deductible.<br>Maximum out of pocket $100<br>**Specialty Drugs:** Member pays 30% Coinsurance, No Deductible<br>Maximum out of pocket $200<br>Cost-sharing for Prescription Insulin Drugs will not exceed $35 for a 30-day supply<br>Cost sharing for diabetic devices will not exceed $100 for a 30-day supply | No Benefits |
| **PREVENTIVE CARE SERVICES[8]** | | |
| **Routine Adult** | | |
| **Physical exams** | 100%, No Deductible | 60% after deductible |
| **Adult immunizations** | 100%, No Deductible | 60% after deductible |
| **Colorectal cancer screening** | 100%, No Deductible | 60% after deductible |
| **Routine gynecological exams, including a Pap Test** | 100%, No Deductible | 60% after deductible |
| **Mammograms, annual routine** | 100%, No Deductible | 60% after deductible |
| **Diagnostic services and procedures** | 100%, No Deductible | 60% after deductible |
| **Routine Pediatric** | | |
| **Physical exams** | 100%, No Deductible | 60% after deductible |
| **Pediatric immunizations** | 100%, No Deductible | 60% after deductible |
| **Diagnostic services and procedures** | 100%, No Deductible | 60% after deductible |
| **AUTISM SPECTRUM DISORDER[9]** | | |
| **Services for diagnosis and treatment of Autism Spectrum Disorder.** (See Section V for additional information.) Covered Services will be paid according to the benefit category (e.g. speech therapy, office visit). | 80% | 60% |
| **PHYSICIAN SERVICES** | | |
| **In-Hospital Medical Visit** | 80% | 60% |
| **Surgery, Assistant to Surgery, Anesthesia** | 80% | 60% |
| **Second Surgical Opinion Consultants** (Outpatient) | 100%, No Deductible | 100%, No Deductible |
| **Maternity Care -** Dependent daughters are covered. | 80% | 60% |
| **Newborn Care** including circumcision. | 80% | 60% |
| **Occupational Therapy** (Rehabilitative and Habilitative)<br>**Limit**: 30 visits per benefit period for other than chronic pain<br>**Limit:** 30 visits per event for chronic pain[11]<br>Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.<br>Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder | $20 per Visit, 100% thereafter, No Deductible<br>Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder | $25 per Visit, 80% thereafter, No Deductible |
| **Physical Therapy** (Rehabilitative and Habilitative)<br>**Limit**: 30 visits per benefit period for other than chronic pain<br>**Limit:** 30 visits per event for chronic pain[11]<br>Limitations are for Physician & Outpatient Facility Rehabilitative and | $20 per Visit, 100% thereafter, No Deductible | $25 per Visit, 80% thereafter, No Deductible |

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| Habilitative, combined.<br>Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder | Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder | | |
| **Spinal Manipulations**<br>**Limit**: 30 visits per benefit period for other than chronic pain<br>**Limit:** 30 visits per event for chronic pain[11]<br>Limitations are for Network and Non-Network | $20 per Visit, 100% thereafter, No Deductible | | $25 per Visit, 80% thereafter, No Deductible |
| **PHYSICIAN SERVICES (Continued)** | | | |
| | **NETWORK** | | **NON-NETWORK** |
| **Respiratory Therapy** | 80% | | 60% |
| **Cardiac Rehabilitation Therapy** | 80% | | 60% |
| **Dialysis** | 80% | | 60% |
| **Chemotherapy** | 80% | | 60% |
| **Radiation Therapy** | 80% | | 60% |
| **Infusion Therapy** | 80% | | 60% |
| **Speech Therapy** (Rehabilitative and Habilitative) when necessary due to a medical condition.<br>Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder | $20 per Visit, 100% thereafter, No Deductible | | $25 per Visit, 80% thereafter, No Deductible<br>Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder |
| **Temporomandibular Joint Dysfunction / Craniomandibular Disorders** | 80% | | 60% |
| **Diagnostic, X-ray, Lab and Allergy Testing** | 80% | | 60%<br>Copayment, if any, does not apply to Diagnostic Services prescribed for the treatment of Mental Health and Substance Use Disorder |
| **Allergy Treatment, extractions and injections** | 80% | | 60% |
| **INPATIENT HOSPITAL / FACILITY SERVICES** | | | |
| **Unlimited Days Semi-Private Room and Board (Bariatric Surgery; Cardiac Care; Knee and Hip Replacement; Spine Surgery and Transplants received at approved Blue Distinction Centers will be subject to the Blue Distinction Center deductible and coinsurance limits)** | **STANDARD**<br>80% | **BLUE DISTINCTION CENTERS[3]**<br>100% | 60% |
| **Ancillaries, Drugs, Therapy Services, X-ray and Lab** | 80% | | 60% |
| **General Nursing Care** | 80% | | 60% |
| **Surgical Services** | 80% | | 60% |
| **Birthing Center Care / Maternity Services -** Dependent daughters are covered. | 80% | | 60% |
| **OUTPATIENT HOSPITAL / FACILITY SERVICES** | | | |
| **Pre-Admission Testing** | 80% | | 60% |
| **Diagnostic, X-ray, Lab and Testing** | 80% | | 60%<br>Copayment, if any, does not apply to Diagnostic Services prescribed for the treatment of Mental Health and Substance Use Disorder |
| **Surgery, Operating Room** | 80% | | 60% |
| **Medically Necessary Mammogram** | 80% | | 60% |
| **Occupational Therapy** (Rehabilitative and Habilitative)<br>**Limit**: 30 visits per benefit period for other than chronic pain<br>**Limit:** 30 visits per event for chronic pain[11]<br>Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined.<br>Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder | $20 per Visit, 100% thereafter, No Deductible | | $25 per Visit, 80% thereafter, No Deductible<br>Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder |
| **Physical Therapy** (Rehabilitative and Habilitative)<br>**Limit**: 30 visits per benefit period for other than chronic pain<br>**Limit:** 30 visits per event for chronic pain[11]<br>Limitations are for Physician & Outpatient Facility Rehabilitative and Habilitative, combined.<br>Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder | $20 per Visit, 100% thereafter, No Deductible | | $25 per Visit, 80% thereafter, No Deductible<br>Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder |
| **Respiratory Therapy** | 80% | | 60% |
| **Cardiac Rehabilitation Therapy** | 80% | | 60% |
| **Dialysis** | 80% | | 60% |
| **Chemotherapy** | 80% | | 60% |
| **Radiation Therapy** | 80% | | 60% |
| **Infusion Therapy** | 80% | | 60% |
| **Speech Therapy** (Rehabilitative and Habilitative**)** when necessary due to a medical condition.<br>Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder | $20 per Visit, 100% thereafter, No Deductible | | $25 per Visit, 80% thereafter, No Deductible<br>Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder |

| BEHAVIORAL HEALTH SERVICES | | |
|---|---|---|
| **Outpatient Mental Health Services** | 80% | 60% |
| **Outpatient Substance Abuse Services** | 80% | 60% |
| **Inpatient Mental Health Care Services** | 80% | 60% |
| **Inpatient Substance Abuse Care Services** | 80% | 60% |
| **EMERGENCY CARE SERVICES** | | |
| **Emergency Room Services(13)** | $150 copayment per visit,<br>80% thereafter, subject to network deductible | |
| **Ambulance**<br>**Emergency (ground, water, air)** | 100%, No Deductible | |

| | NETWORK | NON-NETWORK |
|---|---|---|
| **Ambulance**<br>**Non-Emergency (ground, water)(10)** | 80% | 60% |
| **Ambulance**<br>**Non-Emergency (air)** | 80% | |
| **OTHER COVERED SERVICES (12)** | | |
| **Private Duty Nursing - Maximum 35 visits per calendar year**<br>Note: Maximums are Network and Non-Network combined. | 80% | 60% |
| **Skilled Nursing Facility** | 80% | 60% |
| **Durable Medical Equipment and Oxygen at home** | 80% | 60% |
| | Cost sharing for eligible Diabetic Devices will not exceed $100 for a 30-day supply | |
| **Orthotic Devices and Prosthetic Appliances** | 80% | 60% |
| **Home Health Care - Maximum 100 Visits**<br>Note: Maximums are Network and Non-Network combined. | 80% | 60% |
| **Hospice Care** | 80% | 60% |
| **Diabetes Education & Control** | 80% | 60% |

| HUMAN ORGAN TRANSPLANT / BONE MARROW PROCEDURES | | | |
|---|---|---|---|
| **Human Organ Transplant (Transplants received at approved Blue Distinction Centers will be subject to the Blue Distinction Center deductible and coinsurance limits)**<br>• Includes transportation, meals and lodging. | **STANDARD**<br>80% | **BLUE DISTINCTION CENTERS[3]**<br>100% | 60% |
| **Bone Marrow Procedures (Transplants received at approved Blue Distinction Centers will be subject to the Blue Distinction Center deductible and coinsurance limits)**<br>• Includes transportation, meals and lodging. | **STANDARD**<br>80% | **BLUE DISTINCTION CENTERS[3]**<br>100% | 60% |

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| **Eligible Dependent Age Limitation** | Coverage stops at the end of the month of the 26th birthday for an adult dependent who is an Eligible Dependent. |

**This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/plan documents control in the event of a conflict with this benefits summary**

(1) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
(2) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(3) Blue Distinction Center Benefits apply for inpatient care at Blue Distinction Centers for the following services: **BARIATRIC SURGERY; CARDIAC CARE; COMPLEX AND RARE CANCERS; KNEE AND HIP REPLACEMENT; SPINE SURGERY AND TRANSPLANTS**
(4) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(5) Copay differentials apply to Highmark BDTC PCP providers in PA, WV, and DE.
(6) Telemedicine services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark designated telemedicine vendor. Additional services provided by a Highmark designated Telemedicine vendor are paid according to the benefit category that they fall under (e.g.PCP is eligible under the PCP office visit benefit, behavioral health is eligible under outpatient mental health.
(7) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. This formulary lists the specific prescription drugs your program covers. To request a prescription drug that is not on this formulary, your provider must complete the Prescription Drug Medication Request Form and return it to the Pharmacy Affairs Department for clinical review. Under SensibleRX Choice, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed. Anti-Cancer medications orally administered or self-injected. Deductible, copayment and coinsurance amounts for patient administered anti-cancer medications that are covered benefits are applied on no less favorable basis than for provider injected or intravenously administered anti-cancer medications.
(8) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).

(9) After initial evaluation, Applied Behavioral Analysis will be covered as specified above. All other covered services for the treatment of autism spectrum disorders will be covered according to the benefit category (e.g speech therapy, diagnostic services). Treatment for autism spectrum disorders does not reduce visit/day limit.

(10) Unless otherwise provided for benefits for emergency ambulance services rendered by a non-network provider will be subject to the same cost-sharing amount, if any, that is applicable to network services. The member will be responsible for any amounts billed by the non-network provider for non-emergency ground and water ambulance services that are in excess of the amount that Highmark pays.

(11) 30 visit maximum per event for combined physical therapy, occupational therapy and spinal manipulations

(12) Covered virtual services will be paid according to the benefit category (e.g., primary care provider office visit, maternity visit, etc.) For example, virtual visits relating to the treatment of mental illness or substance use disorder are covered under your outpatient mental health and substance use disorder benefit and subject to the cost sharing amount in this schedule of benefits.

(13) Benefits for care services rendered by an out-of-network provider will be paid at the network services level. Benefits for hospital services or medical care services rendered by an out-of-network provider to a member requiring an inpatient admission or observation immediately following receipt of emergency care services will be paid at the network level. The member will not be responsible for any amounts billed by the out-of-network provider that are in excess of the plan allowance for such services